Working Together:
Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice

Editors: Pat Dudgeon, Helen Milroy and Roz Walker
Foreword by Tom Calma

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Disclaimer
This publication represents the views of the authors, not necessarily those of the Australian Government.

The publication aims to assist students and others to understand a variety of perspectives about the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander people, and to assist reflection and open discussion.

Front cover artwork *Under the Milky Way* by Nellie Green.

The extract from Rob Riley's Indigenous keynote address *From exclusion to negotiation: the role of psychology in Aboriginal social justice* presented at the Australian Psychological Society Conference in 1995 is kindly reprinted with permission from his family. The photograph of Rob Riley is reproduced with the permission of the West Australian. © The West Australian.

Aboriginal and Torres Strait Islander readers are advised that this book may contain images or information on deceased persons.

Under The Milky Way

About the Cover Artwork

Spiritual and emotional wellbeing are at the heart of Indigenous cultures. Aboriginal Australians, despite suffering the greatest disadvantages and adversity, demonstrate the strongest resistance to those actions that are foreign to our unique culture, like separation from families, discrimination and removal from Country.

Over the years we have seen the damage done to Aboriginal and Torres Strait Islander communities and the level of disadvantage we experience on many levels has increased. We have seen the lasting impact this has on our people, yet our social position and the historical issues continue to haunt us. In the end, our men, women and children remain disempowered if society continues to neglect the emotional and spiritual needs of our Peoples.

I believe that ultimately, our Ancestors surround and protect us like an invisible spiritual cloak—this is symbolised by the purples and mauves in the painting. The Milky Way is vast and awesome and magnetic. It is an unknown dimension that holds a lot of power—much like the power of Indigenous spirituality. It is said that our Creator Spirit(s) call the Milky Way 'home', finding rest and comfort there following the creation work they undertook.

The moon and stars signify strength and the smaller circles symbolise the elements of our culture that sustain us and keep us going despite the desperation and shame we often feel as victims of racism and exclusion. The deep plum background is symbolic of our Mother Earth, from where we come and to where we return. When we hurt our mothers, children and fathers, we in turn hurt our Mother Earth and should recognise this.

Strong individuals and strong families are central to strong and resilient communities.
We need to work towards protecting ourselves and each other. In this way we can respect those who came before us and those who are yet to come.

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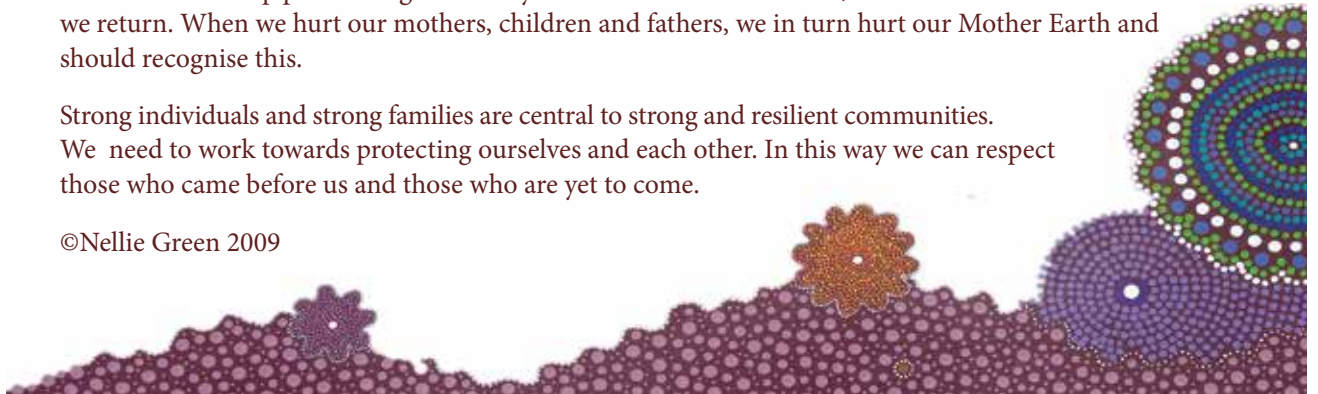
About the Artist

Jonelle (Nellie) Green is a Badimaya woman from the Yamatji people of the Central Wheatbelt area of Western Australia. Born in Morawa, Western Australia, she lived most of her life in Perth and Fremantle, before moving to Melbourne in 2001. Nellie has 3 sisters and 2 brothers and is an Aunty and Great Aunty.
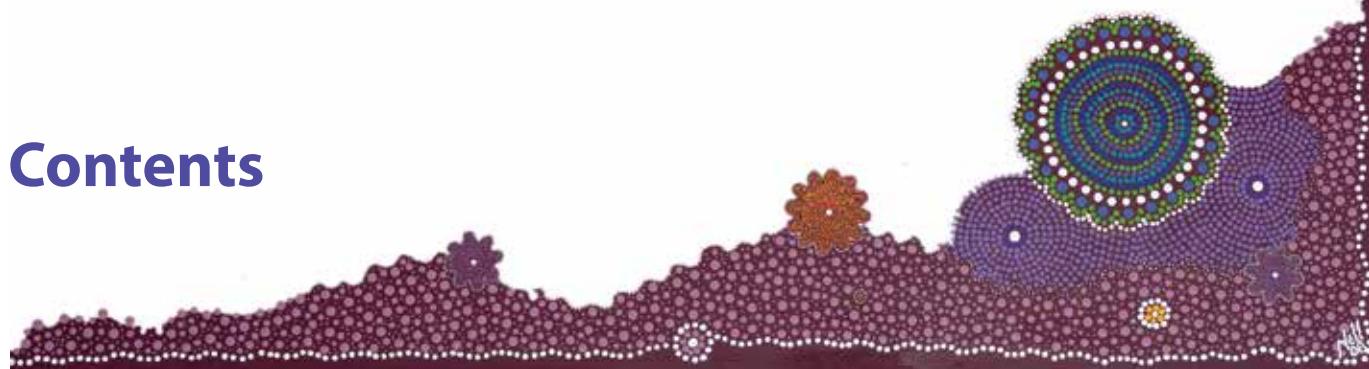
Nellie has a strong professional background in higher education, and is involved in issues concerning media representation, creative writing, social justice and the human rights of Indigenous peoples.

Over the years, Nellie has represented her Community/s locally, regionally, nationally and internationally. She was winner of the 2000 NAIDOC Aboriginal Artist of the Year in the ATSIC Noongar (Perth) Region awards and has been published in Indigenous anthologies and other publications. Nellie produced the beautiful artwork 'Spirit Strength' for the cover of the first edition of *Working Together*.

In 2010 Nellie graduated with a Bachelor of Applied Science (Indigenous Community Development and Management) Honours from Curtin University. She is currently enrolled at Curtin University undertaking a master of Philosophy (Indigenous Research and Development) with the topic 'Pragmatism and Symbolism— Towards the Implementation of Indigenous Cultural Protocols in Higher Education'.

Nellie is the Manager of Indigenous Student Services at La Trobe University, Melbourne, where she is responsible for the academic, personal and cultural support for all enrolled and intending Indigenous students at the Melbourne and regional campuses of the university.
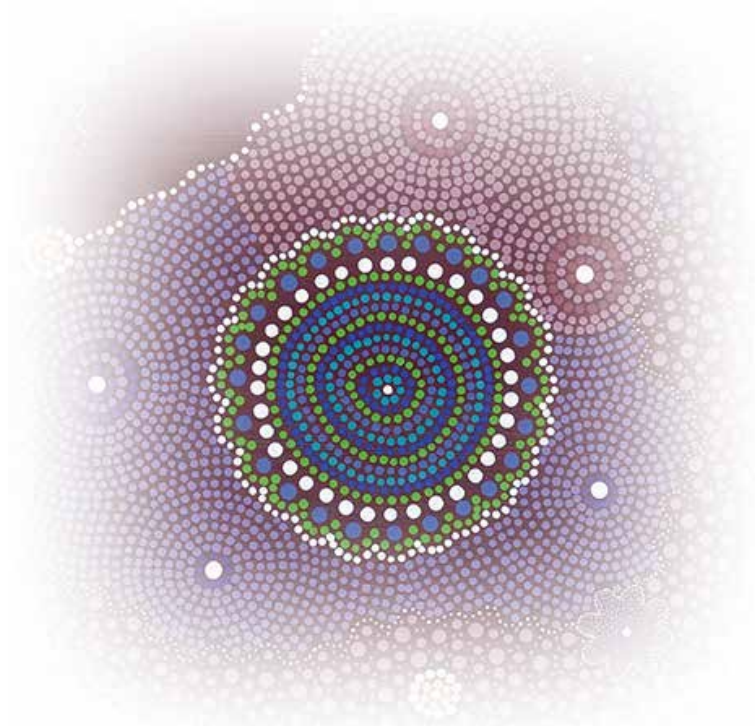
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Foreword

In 2010, I welcomed the publication of the first edition of *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* as an important milestone on the road to understanding and improving the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples, and closing the overall health gap between us and other Australians.

In fact, the first edition far exceeded my expectations—it met a hitherto unrecognised thirst for knowledge about Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing, with over 48,000 copies printed and a similar number of copies downloaded as electronic versions in three years. Feedback suggests that not only mental health professionals benefited, but the work of a wide range of service providers whose worked touched on Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing and its determinants.

It also became an authority in the field, proving an important further step towards recognising the existence of a distinct field of Aboriginal and Torres Strait Islander psychology, and raising awareness about the inappropriate application of western mental health models to Aboriginal and Torres Strait Islander peoples. It did so, in part, by highlighting the unique determinants of our mental health: the resilience that social and emotional wellbeing (drawn from the healthy functioning of our communities, our families, and our cultures) provides us in relation to both our mental and physical health; and, on the other hand, the devastating impact of colonisation, assimilation, racism, trauma, poverty and social exclusion. It demonstrated the value of Aboriginal and Torres Strait Islander leadership in the field, and the importance of traditional and innovative contemporary healing practices.

I am extremely delighted to welcome this second edition, funded by the Australian Government Department of the Prime Minister and Cabinet and developed under the tireless and passionate editorial leadership of Pat Dudgeon, Helen Milroy and Roz Walker of the Telethon Institute for Child Health Research and the University of Western Australia. Together they have coordinated the efforts of 44 Aboriginal and Torres Strait Islander authors and 32 other authors to create this significantly expanded and enriched edition. It will surely mark another watershed in this ever-growing field, and it is my hope that it not only continues to inform mental health policy and practice in Australia to the benefit of Aboriginal and Torres Strait Islander peoples, but that all Australians benefit from the understanding of Aboriginal and Torres Strait Islander peoples that it provides.

I wholeheartedly commend this second edition of *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* to you.

Dr Tom Calma AO

Former Aboriginal and Torres Strait Islander Social Justice Commissioner
Chair, Reconciliation Australia
Chancellor, University of Canberra

Message from the Minister

I am delighted to introduce the second edition of *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice.*

The first edition of *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, published in 2010, has become an important resource for mental health professionals, social and emotional wellbeing workers and students studying in the fields of Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing.

This government has made improving the lives of Aboriginal and Torres Strait Islander people a high priority and has identified three policy priorities that are essential to doing this – getting children to school, getting adults into work and creating safe communities.

The expansion of this new edition to include a greater focus on children and young people, the significant impacts of mental health in the justice system and the cultural determinants of social and emotional wellbeing is welcomed.

The knowledge contained in this book directly supports the Government's efforts to address the underlying causes of the disadvantages many Aboriginal and Torres Strait Islander people face. Good social and emotional wellbeing and mental health underpin the ability of people to work and live lives free of alcohol, drugs and violence and many of the things that lead to community breakdown. Similarly, good education, worthwhile employment and safe communities are fundamental to good health and wellbeing.

This book recognises the need for local and culturally appropriate solutions as fundamental to improving Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing. Local Indigenous people need to take the lead in solving local issues.

I commend the commitment of the experts who have contributed their time, experience and extensive knowledge. I am sure that, as well as being a valuable resource to Aboriginal and Torres Strait Islander workers and students, it will also benefit all who take the time to read it.

Senator the Honourable Nigel Scullion

Minister for Indigenous Affairs

Message from the Director

On behalf of the Telethon Institute for Child Health Research, I welcome the publication of the second edition of *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*.

This book is an important contribution to improve the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples, across Australia and beyond.This second edition of Working Together was initiated in response to the overwhelmingly positive feedback from numerous Aboriginal organisations and communities, mental health professionals, students and a diverse range of service providers who regarded it as an invaluable resource.

The first edition advanced people's understanding of the issues and ways of working to promote mental health and wellbeing by giving them unique access to the views, experiences and knowledge of a number of Aboriginal and non-Aboriginal experts, practitioners and thinkers.

This edition builds on the first by providing important revisions to many of the chapters on policy and practice, workforce development and capacity building, and evidence based research. It also includes ten new contributions with a strong focus on healing models and programs that reflects the significance to Aboriginal people and to the maintenance and restoration of their health and wellbeing. It also covers priority issues including mental health and the criminal justice system, intellectual disabilities, fetal alcohol spectrum disorder and the role of families in caring for someone with a mental illness.

The Working Together book embodies the Institute's aim to provide the highest level of research and best practice, and its commitment to prioritising Aboriginal people's health and wellbeing. It also reflects our proud history of working with Aboriginal people to build on existing strategies and strengths, as well identifying new ways of supporting and improving the lives of their families, communities and children and young people.

I would like to thank all those who have contributed to this important work and acknowledge the significant efforts of the editors. I am pleased to see that so many Institute and University of Western Australia staff have contributed as authors and reviewers, as well as, in the design and editing of this edition.

I am confident that this book will promote a deeper understanding of ways of working to make a genuine difference and have a lasting impact in improving Aboriginal mental health and wellbeing outcomes.

Jonathan Carapetis
Director
Telethon Institute for Child Health Research

Acknowledgments

This book would not have come to fruition without significant collaboration and the sustained energy, ideas, support and input of many people.

The editors would like to thank, foremost, the important contribution of all authors who volunteered their time and shared their expertise. Their contribution is acknowledged with gratitude and admiration.

The editors would also like to thank the Australian Government which funded the project; and members of the Department of the Prime Minister and Cabinet and the National Expert Reference Group for the revision of *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* for their valued advice and editorial assistance:

John Shevlin	Department of the Prime Minister and Cabinet
Helen Rankin	Department of the Prime Minister and Cabinet
Sandra Brown	Department of the Prime Minister and Cabinet
Prof. Pat Dudgeon	School of Indigenous Studies, University of Western Australia; Centre for Research Excellence in Aboriginal Health and Wellbeing, Telethon Institute for Child Health Research (Institute)
Prof. Helen Milroy	Royal Commission into Institutional Child Sexual Abuse
A/Prof. Roz Walker	Centre for Research Excellence in Aboriginal Health and Wellbeing, Telethon Institute for Child Health Research; University of Western Australia
Dr Stephanie Gilbert	The Wollotuka Institute, University of Newcastle; Australian Association of Social Workers
A/Prof. Robert Parker	The Royal Australian and New Zealand College of Psychiatrists and the Top End Mental Health Services, Northern Territory
Tom Brideson	Statewide Coordinator, New South Wales Aboriginal Mental Health Workforce Program
Dr Robert Brooks	Previously of The Healing Foundation; School of Psychology, University of New South Wales
Dr Lawrence Dadd	Chair, Aboriginal and Torres Strait Islander Mental Health Committee of the Royal Australian and New Zealand College of Psychiatrists
Craig Dukes	Australian Indigenous Allied Health Organisation
Prof. Rhonda Marriott	Murdoch University; National Health and Medical Research Council; Centre for Research Excellence in Aboriginal Health and Wellbeing, Telethon Institute for Child Health Research; Centre for Child Development, University of Western Australia and Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
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Leanda Verrier	Western Australian Perinatal Mental Health Unit, Faculty of Health Sciences, Curtin University
Katherine Wiggins	Previously of the Justice and Forensic Mental Health Network

The stakeholders for their considered feedback during consultations:

Aboriginal and Torres Strait Islander Mental Health Advisory Group

Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

Community Services and Health Industry Skills Council

beyondblue

Lifeline

Kidsmatter

MindMatters

Justice Health and Forensic Mental Health Network

The Working Together team at the Telethon Institute for Child Health Research who assisted with a range of tasks. We are especially grateful to Carolyn Mascall and Jacqui Bradley for their major contributions in assisting with coordination and liaison activities throughout the project.

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Jaxon Reibel and Richard Easton for their eye for detail and persistence in editing and proofreading the first and second editions respectively.

We would like to acknowledge the important contribution of the many hundreds of mental health practitioners, students, lecturers, service providers and policy makers in areas that address the social determinants of mental health who completed the evaluation surveys and interviews and provided valuable feedback for improving the book. Their suggestions are reflected in this revised edition.

Finally, and sadly, we pay respect to the late Dr Nola Purdie and acknowledge her valuable contribution as an editor on the first edition of *Working Together*.

Principal Editors and Authors

Professor Pat Dudgeon

Professor Pat Dudgeon is from the Bardi and Gija people of the Kimberley. She is a Research Fellow at the School of Indigenous Studies, University of Western Australia (UWA). She was the first Aboriginal psychologist to be awarded the grade of Fellow in the Australian Psychological Society. She is well known for her significant leadership in Indigenous psychology and in higher education. Her roles include Chief Investigator in an ARC (Indigenous Discovery) grant, *Cultural Continuity and Change: Indigenous Solutions to Mental Health Issues*. She is also a Chief Investigator in the NHMRC Centre for Research Excellence Grant, *Aboriginal Health and Wellbeing* at the Telethon Institute for Child Health Research. She is a Chief Investigator and Research Node Leader (health) on the National Indigenous Research and Knowledges Network, a multidisciplinary network of Indigenous researchers. Pat was the inaugural Chair of the Aboriginal and Torres Strait Islander Mental Health Advisory Group; the inaugural Chair of the Australian Indigenous Psychologists Association and now a steering committee member; a member of the National Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group; a member of the National Aboriginal and Torres Strait Islander Health Equality Council; and is a Commissioner on the new National Mental Health Commission. She co-chairs the Reconciliation Action Plan Working Party in the Australian Psychological Society (APS) with the President of the APS.

Winthrop Professor Helen Milroy

Dr. Helen Milroy is a descendant of the Palyku people of the Pilbara region of Western Australia born and educated in Perth. She studied Medicine at UWA, worked as a General Practitioner and Consultant in Childhood Sexual Abuse at Princess Margaret Hospital for Children for several years before completing specialist training in Child and Adolescent Psychiatry. Helen is a Royal Commissioner on the Royal Commission into Institutional Child Sexual Abuse which is being conducted for the next three years. Until February 2013, Helen held the positions of Winthrop Professor and Director of the Centre for Aboriginal Medical and Dental Health at UWA; and Consultant Child and Adolescent Psychiatrist with the Specialist Aboriginal Mental Health Service, Department of Health. Helen was Country Lead Investigator of the Australian team [July 2010 to January 2013] on the National Health and Medical Research Council (NHMRC) International Collaborative Grant, *Educating for Equity* exploring how health professional education can reduce disparities in chronic disease. Helen was conjoint award recipient of the World Council for Psychotherapy's Sigmund Freud Award 2011 for contributions to the field of psychotherapy. She was also 2011 Yachad Scholar. Helen is a board member of the Australian Institute of Health and Welfare (AIHW). She plays a significant role on many State and National committees and advisory groups including the NHMRC Indigenous Health and Mental Health Advisory Groups; and ADHD Expert Working Group, and many more.

Associate Professor Roz Walker

Associate Professor Roz Walker has been involved in research, evaluation and education with Aboriginal communities building local capacity within both Aboriginal and non-Aboriginal organisations for thirty years. Roz is a senior researcher with both the University of Western Australia and the Telethon Institute for Child Health Research and a Principal Investigator on the Institute Faculty. She is a Chief Investigator in several national ARC grants as well as in the NHMRC Centre for Research Excellence Grant, *Aboriginal Health and Wellbeing* at the Institute. Roz also serves on a number of high level steering committees and national Indigenous networks. Her key areas of interest include developing transformative and decolonising strategies at individual, organisational and community levels as well as promoting system level change. She has worked in Aboriginal education in teaching, curriculum development, academic coordination, research and evaluation. She has extensive experience in translating research into policy and practice and community-based participatory action research methods and ethics to achieve health related outcomes. Roz has taught extensively at undergraduate and graduate levels in Aboriginal community management and development and early years education in remote areas. Roz was co-editor of the first edition of the *Working Together* book and led the highly effective communication and dissemination strategy for the book. Roz has published widely in Aboriginal maternal and child health and mental health and wellbeing.
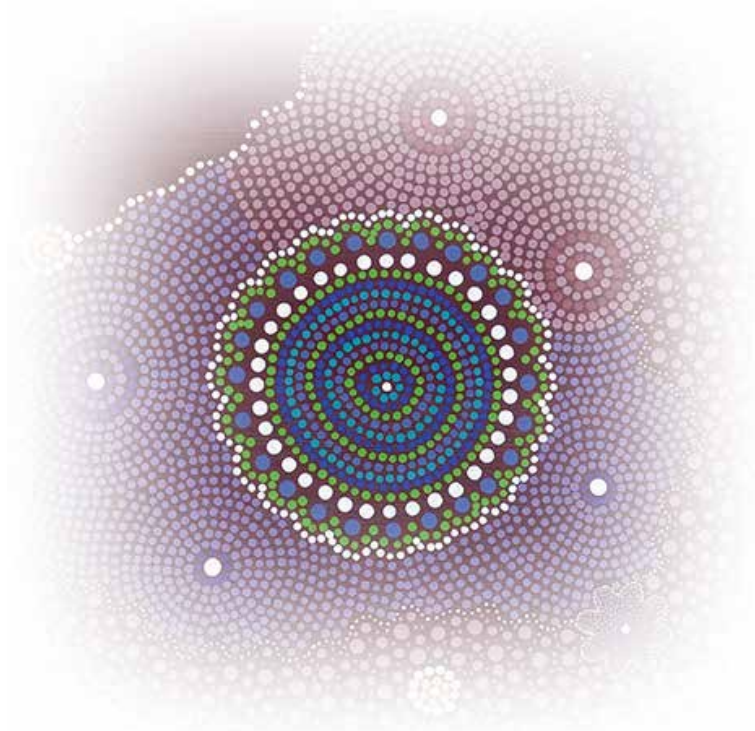
A Charge to Mental Health Practitioners

Rob Riley

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In September 1995, Rob Riley, renowned Aboriginal leader and activist for social justice and self-determination presented a seminal paper at the Australian Psychological Society Annual Conference held in Perth, Western Australia in which he challenged the practice of psychology to facilitate Aboriginal self-determination in the treatment of Aboriginal and Torres Strait Islander mental health. The following is an extract from that paper.

In his opening comments, Rob revealed his drive and compassion in pursuing improved outcomes in the mental wellbeing of Aboriginal people. In doing so, he encouraged the discipline of psychology and other professions to find ways to better deliver outcomes for Aboriginal people.

> I believe there are profound obligations for those who commit themselves to helping their fellow human beings in the pursuit of a better quality of life. This is especially true where what we do impacts on the mental wellbeing of individuals in these dramatically changing times.

> There are of course daunting and at times seemingly insurmountable obstacles, yet the challenges can be stimulating and enticing. This is my personal philosophy and it is also what I perceive to be the reality that confronts the discipline of psychology. I make the assumption that you, like professionals from all health and social science disciplines, have the motives and 'open-mindedness' to incorporate different perspectives within the discipline that you have chosen.

> In my address I make reference to a number of reports that have been published over the years to provide an historical background to the current mental health status of Aboriginal peoples in this country, and the problems that have hindered provision of appropriate psychological services to them. My intention is not to lay blame or promote feelings of guilt—these are negative emotions that achieve little—but to invite you to share the challenge of finding better ways that have better outcomes for all of us.

> I outline the initiatives already taken by the profession in its attempts to improve its service to Aboriginal Australians. And suggest ways in which I feel psychology can further enhance its response to the needs of the contemporary Aboriginal community. I truly hope that what I have to say has both meaning and relevance and that it will give you a better insight into the issues which confront Aboriginal people on a daily basis. I share this knowledge on the assumption that information freely given will be openly received and that this knowledge may challenge you, as individuals, to contemplate your functional role and responsibilities to all Australians, especially in this context to Aboriginal Australians.

Rob was strong on the issue of social justice and how it related to the mental health of Aboriginal people.

> The current problematic mental health status of Aboriginal people can be traced directly to denial of social justice. The history of this denial is best told in the underlying issues report to the Royal Commission into Aboriginal Deaths in Custody. This report is the most comprehensive analysis of the

myriad of social welfare variables, identified by the Aboriginal community as being fundamental issues that have perpetuated welfarism and that have maintained the co-dependency between the community and the bureaucracy, which I sum up as 'administrative genocide'. Aboriginal people have not been empowered to make decisions about their lives and the lives and futures of their children.

He described the gradual change from the long process of Aboriginal disempowerment and destabilisation that came with colonisation to one of increased empowerment through legislative change that gradually removed the onerous and punitive measures of earlier legislation and through 'affirmative action programs aimed at encouraging Aboriginal participation in decision making'. But as Rob noted:

The process of empowerment, in one sense, has come far—but in many others, as illustrated, it has proved to be an illusion, and the cost to the community in achieving even these modest gains over a period of some 150 years has been enormous.

An issue personally experienced by Rob was the removal of Aboriginal children from their parents, families and communities. He described the profound impact on the children and members of their families who were directly affected by the assimilation policies and indicated the duty of care that psychologists and other health professionals have in the reparation process.

The anguish of their grief-stricken parents, families, kinship groups and communities, and the children themselves was brusquely discounted as inconsequential and at any event of a temporary nature. Today the legacy of those policies (should) haunt the conscience of white Australia, as it has haunted the memories of generations of Aboriginal families. The residue of unresolved anger and grief that blankets the Aboriginal community has had a devastating effect on the physical, emotional and mental well-being of so many.

The removal of children report cannot be allowed to suffer the fate of previous reports . . . The recommendations made in this report can and must go some way toward easing the anguish that plagues the Aboriginal community. These recommendations provide a blueprint for direct and unequivocal intervention, on behalf of the state government, to repatriate families and to care for the broken spirit of thousands of our people.

Psychologists, other health and social science professionals have an absolute obligation and a duty of care to share in this reparation process. More importantly the paramount obligation on the profession is to guarantee the participation of control by Indigenous people in any area of psychological study, counselling, and preparation of reports that pertain to the Indigenous community.

Rob's conclusion and charge to mental health practitioners is profound as has been its powerful impact on progressing improved mental and physical health outcomes for Aboriginal and Torres Strait Islander people.

. . . the pertinent question for the Australian Psychological Society and you as practitioners is 'how can the profession facilitate Aboriginal self-determination'? How can this begin and how can it be sustained?

We as individuals have the obligation and the power to ensure that positive social change occurs. On another level however, organisations and departments need to show leadership and commitment by subscribing formally to the principles and guidelines for achieving social justice.

The world we live in is in a state of intense and unprecedented environmental, political, economic and social change that impacts on every living thing on this planet. We are an active part of this change and we as individuals, as collectives in families or in work organisations can and must direct where our world is going.

Until recently the practice of psychology has largely served to oppress, control and assimilate minority groups, especially Aboriginal people. In the past few years a range of Aboriginal mental health initiatives, some connected with the Australian Psychology Society have been established.[i]

There are, of course, a myriad of mental health initiatives happening on the ground in Aboriginal communities at local and regional levels, as Aboriginal people themselves are attempting to identify and seek solutions to the inequitable situations they live in. To the members of the Australian Psychology Society I would say 'join us in this quest'.

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i Aboriginal mental health initiatives are outlined in Chapter 3 (Dudgeon and colleagues).

- *What part can the discipline of psychology and you as psychologists play in the pursuit of social justice?*
- *How many psychologists have an understanding of Aboriginal people?*
- *How many of you have an understanding of Aboriginal culture, history and contemporary issues?*

For many of you this knowledge is crucial given the social conditions and your work environments such as prisons and the welfare sector and where there are large numbers of Aboriginal clients. It is your responsibility to seek that knowledge and understanding now, and to ensure that it is available for future generations of psychologists, in psychology training and educational programs. To their credit some psychology departments have been actively involved in Reconciliation Study Circles. Some educational institutions have begun introducing more appropriate and relevant contemporary Aboriginal issues into their curriculum and training for psychologists. I applaud the Universities and again, I applaud the leadership in your profession for these real and important initiatives. They represent a most appropriate and empowering process because the initiatives I have just mentioned are developed, designed and delivered by Aboriginal people. Aboriginal participation in their own matters, academic or otherwise, is integral. This is the basis of equity and self-determination.

Another challenge to psychology is to examine the discipline and its theory; training practices; methods employed, and their appropriate application to Aboriginal people (e.g. the use of Western tests on Aboriginal clients. It has been recognised that these tests were not 'culture-fair' but they are still being used.)

The discipline of psychologists needs to be open to change but more-so, it needs to be dynamic and be prepared to change. The signs are positive, as I have acknowledged. But so many obstacles remain and still much needs to be done. We cannot allow ourselves to become complacent nor limit potential simply because we think we have done enough.

I am enthused and I hope you are as well, by the guiding principles contained within the National Aboriginal and Islander Mental Health Policy Report, authorised by Swan and Raphael. These principles intended to guide the development of an Aboriginal and Torres Strait Islander mental health strategy and plan, are principles that your profession should take on board. I commend them to you as the basis for your future proactive involvement in meeting the challenges outlined here. They include the understanding that:

- *The Aboriginal concept of health is holistic.*
- *Self-determination is central to the provision of Aboriginal health services.*
- *Culturally valid understanding must shape provision of Aboriginal health (and mental health) care.*
- *The experience of trauma and loss contribute to the impairment of Aboriginal culture and mental health wellbeing.*
- *The human rights of Aboriginal people must be recognised and enforced.*
- *Racism, stigma, adversity and social disadvantage must be addressed in strategies aimed at improving Aboriginal mental health.*
- *The strength and centrality of Aboriginal family and kinship must be understood and accepted.*
- *The concept of a single homogenous culture and/or groups is erroneous.*

Aboriginal people have great strengths including creativity, endurance, humour, compassion and spirituality. These characteristics of Aboriginal people have enabled their survival through the period of dispossession and oppression that you have had described in some detail to you today. This has helped us (Aboriginal peoples) through the worst of times.

They will go on sustaining us until, with your understanding and support and commitment, we are ready and able to enjoy with all Australians, the best of times.

Finally, I say to you, two thoughts that I keep in the back of my mind when the struggle along the road to social justice and equity gets a bit tough:

- *You can't be wrong if you're right, and*
- *You don't stop fighting for justice simply because those around you don't like it. Just keep on fighting.*

A Reflective Story by Gladys Milroy

The Little Green Frog

The little green frog sat at the edge of the waterhole watching the ripples in the water. It was so beautiful and clear you could almost see the coloured stones lying on the bottom except the movement of the water put them out of focus. The little green frog longed to swim to the bottom but he knew it was too deep. It was very deceiving because the water was so pure. He would love to have collected some of the coloured stones.
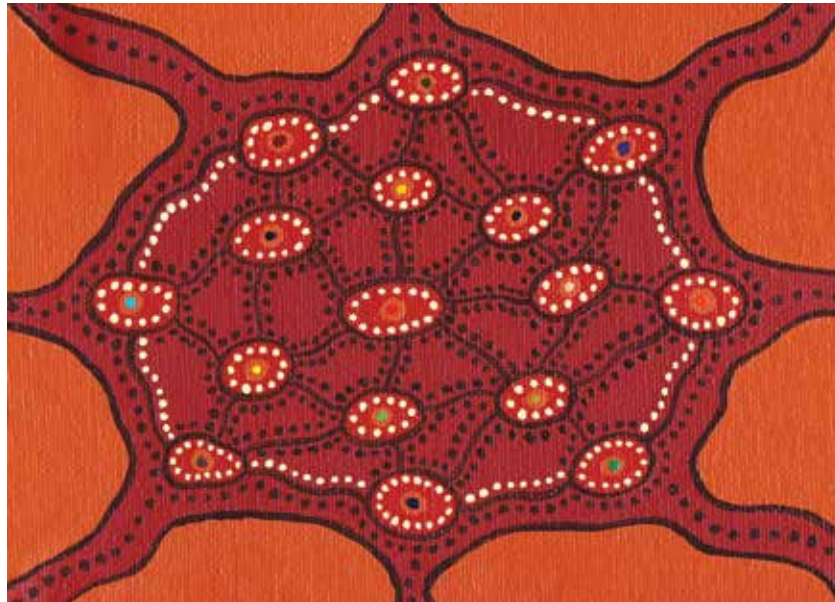
© Painting by Helen Milroy

Suddenly a large barramundi swam into the waterhole and rested on the colourful stones. 'Are you looking at my pretty stones frog?' asked the barramundi.

'Yes' frog replied, 'I am too small to swim to the bottom of your waterhole but I would love to have one.'

Barramundi swam to the surface with a bright red stone in his mouth. 'Here is a present for you frog' he said giving frog the red stone.

'Oh thank you barramundi but I haven't got a present to give you.'

'You can give me one of those blue flowers that grow on the rocks' barramundi said.

Frog picked a blue flower and gave it to barramundi.

'The pretty stones you see I have been collecting since I was young' barramundi said, 'they are all memories, the red stone is full of happy memories.'

'Oh thank you, I will treasure it always' said frog.

Each day frog would visit the waterhole; each day barramundi would give frog a pretty stone, in turn frog gave barramundi a lovely flower. The little green frog was enjoying the beautiful coloured stones as they made him feel very happy so he didn't visit the waterhole for a while. 'I will go and visit my friend today' he thought and set off for the waterhole where his friend barramundi lived.

Barramundi was floating on top of the water with a black stone in his mouth and surrounded by half dead and rotting flowers.

You can't give away your past memories, you need them to see the future.

There are many ways to understand this story.

We often take stories from our communities and our clients with little in return. We consult over and over again and yet ignore the recommendations or fail to implement policy.

Do we get caught up with what we have taken and fail to return to those who have given us their gifts so freely?

How many beautiful stones have we been given and what have we done with all of those memories? As we hold the stories in our minds and hearts, it is our responsibility to give back hope for a better future.

© Story by Gladys Milroy

Introduction

The Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice had its origins in the Australian Government's commitment to improve mental health services nationally. The book was a key strategy to support Aboriginal and Torres Strait Islander-specific initiatives of the Council of Australian Governments (COAG) mental health reform over five years. When we undertook the first edition it was evident that there was a lack of culturally appropriate resources to educate and assist mental health professionals to work with Aboriginal and Torres Strait Islander people experiencing social and emotional wellbeing issues and mental health conditions across all life stages. Further, those resources currently used by mental health clinicians were found to have little cross-cultural validity. It is pleasing, however, in this book to see a number of Aboriginal psychologists and allied health practitioners writing about their work in addressing many of the issues surrounding diagnosis, assessment of mental health and social emotional wellbeing issues.

The first edition of *Working Together* provided a culturally appropriate resource; models of practices and strategies to enhance the effectiveness of a range of professionals who work with Aboriginal and Torres Strait Islander people with a range of social and emotional and mental health issues. It provided a comprehensive, culturally relevant, and specific resource to support the provision of services to Aboriginal and Torres Strait Islander people who are striving to effectively deal with their loss, grief, suffering and other impacts of past policies and practices. The book was also intended for students in vocational education and training and undergraduate and postgraduate courses in relevant fields.

The first and second editions of the book have been written by recognised experts, practitioners and researchers in a range of disciplines within the mental health field and have presented a variety of perspectives related to the causes and possible solutions to many of the social and emotional and mental health issues experienced by Aboriginal and Torres Strait Islander people. A strong Aboriginal voice permeates both editions of the book; indeed the high number of Aboriginal and Torres Strait Islander authors and the strength of the collegiality and collaboration between authors have made both the first and second editions unique. In the second edition there are 76 authors, 44 Aboriginal and Torres Strait Islander authors and 32 non-Aboriginal and Torres Strait Islander authors. This speaks well to the growing number of Aboriginal and Torres Strait Islander experts who are writing and adding to the body of knowledge around mental health and associated areas.

BACKGROUND TO THE REVISION

As with the first edition, this revised book has been made possible through the dedication, time and shared wisdom of the authors about the social and emotional wellbeing of Aboriginal Australians. Since the first edition was published in June 2010, the widespread and ongoing dissemination of the book has been, and continues to be an effective strategy to enhance the cultural competence of the mental health workforce and the mental health services.

Over 48,000 hard copies and 48,000 PDF downloads of the book have been distributed to or accessed by a broad range of target audiences. In addition, at least 50,000 copies of the book and chapters were downloaded from the *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* website. The volume of hard copies and electronic copies disseminated during the past three years has greatly exceeded expectations. It is also evident from the high volume of books disseminated to target audiences around Australia that there remains a high demand for the book which is filling an area of a perceived and actual gap in the knowledge base and resources for health and mental health practitioners and for academics delivering courses to future mental health practitioners.

The feedback and evaluation since its introduction confirms that *Working Together* is an important and effective resource for a range of relevant health and allied health practitioners and educators and other professionals who have front line involvement with Aboriginal and Torres Strait Islander people experiencing mental health issues, and agencies supporting and working with them. Since the introduction of the book, extensive stakeholder consultation has taken place to inform the development of the revision of the book. The main focus of activities has been twofold: to enhance the promotion and dissemination of the *Working Together* book and to collate feedback and evaluation findings in preparation for the revision.

While the first edition was indeed an important milestone in addressing Aboriginal mental health and social and emotional wellbeing, the inclusion of many additional topics and resources in the second edition contributes even more significantly. These new chapters bring important knowledge and understanding identified by the Expert Reference Group and evaluations. The addition of Aboriginal psychiatrist Helen Milroy as an editor and author has brought yet another level of clinical and cultural expertise, experience and wisdom to the revision. Importantly, the inclusion of the 'Charge to Psychologists' by Rob Riley is yet another distinctive feature of this revised book.

LEGACY OF LEADERS

In addition to the contribution of the late Rob Riley, we would like to pay tribute to two other leaders—the late Joe Roe and the late Dr Mark Sheldon—whose ideas and models and ways of working are an important legacy. All three leaders had a strong influence on people's lives and their work is reflected throughout this book.

Joe Roe

Another inspirational leader is the late Joe Roe (Purungu by skin name). Joe was a Karajarri/ Yawru man. His people are also from the Broome and Bidyadanga area in the Kimberley. He completed a Bachelor of Applied Science in Indigenous Community Health (Mental Health Counselling specialisation) in 1996. Mr Roe worked in the area of Aboriginal mental health for over 10 years, which included working with the Aboriginal Visitors Scheme, Pinikarra Aboriginal Counselling Service and the Kimberley Aboriginal Medical Services Council. Mr Roe also worked as the Psych/Social Rehabilitation worker with Northwest Mental Health Services in Broome.

In that time he developed the Ngarlu model—a highly regarded and culturally appropriate way of working to support Aboriginal people's spiritual, social and emotional wellbeing. The Ngarlu model aims to strengthen and heal the spirit of Aboriginal people and is based on cultural beliefs and holistic understandings of health and wellbeing. These traditional concepts of emotional, spiritual, and social wellbeing are being rekindled to support social, spiritual and emotional reconnection. His family has kindly given permission for Mr Roe's unique work to be incorporated into policies, healing practices and programs that have continued to be adapted and developed by his family so that his legacy can continue.

Dr Mark Sheldon

The late Dr Mark Sheldon was one of the leading psychiatrists working in the field of Aboriginal mental health. He was a pioneer psychiatrist with a mission to provide psychiatric services to remote Aboriginal communities. His work is equally informative for all mental health and wellbeing practitioners intending to work with Aboriginal people. In the vastness of central Australia, Mark learnt to overcome cultural and language barriers in his work with Indigenous people and was honoured by having an Aboriginal name bestowed upon him. He sought to find alternative ways of working clinically in the cross-cultural setting of traditional and semi-traditional contexts, offering a different approach to suit the setting. It required adjustments in history-taking, mental state examination, diagnosis, management, professional boundaries, and the way one works with colleagues. He approached all of these issues in a modified way, with considerable reflection on, and appraisal of, his clinical experiences. Many of his ideas are still relevant and are included in relevant chapters in this book. He was awarded the Fellowship of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in October 1997. Memorial prizes in the name of Mark Sheldon have been established by the RANZCP and by his old high school. Mark's family has kindly given permission for his unique work to be presented in this book so that his legacy can continue.

TERMINOLOGY

In Australia there are many Indigenous nations, languages, and cultures. This is shown clearly in the Horton's map of Australia's Indigenous languages, which indicates the general location of larger groupings of people but may include smaller groups such as clans, dialects, or individual languages in a group (see page 533).

It is difficult to identify terminology that is appropriate and acceptable to all these groups. Indigenous Australians are people of Aboriginal and/or Torres Strait Islander descent who identify, and are accepted as an Aboriginal and/or Torres Strait Islander person in the community in which they live, or have lived.

In this book, we have chosen Aboriginal and Torres Strait Islander in the title of the book to indicate the distinctiveness of these two major groups of people and to respect the term most Aboriginal and/or Torres Strait Islander people prefer to use. Authors have used a range of terms and in general we have retained their language, although this has been changed sometimes to aid the flow of text for the reader. Overall our intent has been to use language that accords respect and dignity to Australia's Indigenous peoples. Throughout this book, authors use the term Aboriginal, Aboriginal and Torres Strait Islander and Indigenous peoples.

GUIDING PRINCIPLES

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009* contains nine guiding principles that further emphasise the holistic and whole-of-life view of health held by Aboriginal and Torres Strait Islander people. The Framework was endorsed by the Commonwealth and State/Territory governments and represented agreement among a wide range of stakeholders on the broad strategies that needed to be pursued.

The nine principles enunciated in the Framework guided the development of *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. The nine principles are:

1 Aboriginal and Torres Strait Islander health is viewed in a holistic context that encompasses mental health and physical, cultural and spiritual health. Land is central to wellbeing. Crucially, it must be understood that while the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill health will persist.

2 Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services.

3 Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander peoples' health problems generally and mental health problems in particular.

4 It must be recognised that the experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continue to have intergenerational effects.

5 The human rights of Aboriginal and Torres Strait Islander peoples must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health (as against mental ill health). Human rights relevant to mental illness must be specifically addressed.

6 Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander peoples' mental health and wellbeing.

7 The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.

8 There is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships and tribes, as well as ways of living. Furthermore, Aboriginal and Torres Strait Islander peoples may currently live in urban, rural or remote settings, in urbanised, traditional or other lifestyles, and frequently move between these ways of living.

9 It must be recognised that Aboriginal and Torres Strait Islander peoples have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment *(National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009, page 6)*

A SOCIAL AND EMOTIONAL WELLBEING PERSPECTIVE

Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice has proved to be a unique and invaluable resource to educate and assist health professionals to work with Aboriginal Australians. In both editions we have taken a particular approach.

Aboriginal and Torres Strait Islander people prefer to take a holistic view of mental health. To reflect this, we have adopted a social and emotional wellbeing approach to mental health in both editions of the book. The holistic view incorporates the physical, social, emotional, and cultural wellbeing of individuals and their communities.

In this respect Tom Calma, the former Aboriginal and Torres Strait Islander Social Justice Commissioner, has observed that we need to break down 'health silos'; he argues that we must break down the silos that separate out mental health, family violence, and substance abuse services. He proposes that these should be integrated within comprehensive primary health care services to reflect the fact that these issues are often linked (Calma, 2005).

The holistic view of health of Aboriginal Australians is evident in their capacity to sustain self and community in the face of historically hostile and imposed culture. Unique protective factors contained within Indigenous cultures and communities have been sources of strength and healing when the effects of colonisation and what many regard as oppressive legislation have resulted in grief, loss and trauma.

Aboriginal and Torres Strait Islander authors in this book remind us of the importance of recognising existing frameworks of healing in Indigenous communities and how culture and spirituality in relation to social and emotional wellbeing are ongoing sources of strength. For instance, Chapter 4 explores determinants that have shaped Aboriginal and Torres Strait Islander social and emotional wellbeing outcomes and the chapters in Part 6 specifically discuss the importance of accessing traditional and contemporary Indigenous healing models, programs and trainings developed by Aboriginal and Torres Strait Islander people themselves.

DISSEMINATION

Since the book was published in June 2010, the Telethon Institute has coordinated a highly effective communication and dissemination strategy. This has involved the establishment of a database of all stakeholders who have requested copies of the book. Information about the book was, and continues to be, distributed to contact personnel on these lists inviting them to promote the *Working Together* book to their networks. In addition, a targeted dissemination strategy was implemented in the health, mental health, education and community services sectors and among Commonwealth funded organisations with an exceptional response and uptake, far exceeding expectations.

A total of 44 university campuses ordered the book for their libraries, undergraduate and postgraduate courses in health, mental health, psychology, nursing and social work and Aboriginal health schools and divisions. Since the project commenced, there has been an increase in interest and requests by major tertiary hospitals, general practice divisions, and local and state government and university libraries around Australia. Other stakeholders include high schools, the Department of Education and Training, Department of Housing and Works, Centrelink offices, all allied health professions, and non-government organisations and community services throughout Australia. Stakeholder groups and professional/specialised bodies such as the Royal Australian College of Obstetricians and Gynaecologists, the Perinatal Society of Australia and New Zealand and the Australian Medical Association have endorsed the book.

EVALUATION

An evaluation examined the extent to which *Working Together* was perceived as contributing to enhancing understanding of Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health; and improving organisational, professional and individual practice. The evaluation methodology included a Survey Monkey questionnaire. Readers, teachers and course coordinators in nursing, psychology, allied health, general practice and psychiatry were invited to provide additional feedback regarding their perceptions of the books usefulness within their specific areas and how the layout, content, reflective exercises and program information could be improved. Various groups undertaking professional and cultural awareness training or professional development workshops were asked to obtain feedback to assess the relevance of *Working Together* for students, practitioners and participants. These groups included the Australian Indigenous Psychologists Association (AIPA), and Aboriginal training delivering courses in mental health, social work and nursing. Outcomes from the evaluations have informed the second edition in additional new chapters and overall content of all chapters such as stronger inclusion of critically reflective exercises.

The book is also being sought by professionals, practitioners and students who, while not directly in the first line of mental health aid, are nevertheless dealing with Aboriginal and Torres Strait Islander people who are experiencing mental health issues. These include Department of Child Protection workers, ambulance drivers, Royal Flying Doctor Service staff and emergency staff in hospitals, Centrelink employees, employment agencies, non-government organisations, judiciary staff, justice workers and prison officers, to name a few.

THE PROCESS

The Australian Government Department of Health and Ageing commissioned the Telethon Institute of Child Health Research to produce the second edition of this book. An Expert Reference Group (see the acknowledgments) provided support and advice to the editors with respect to commissioning key experts and stakeholders in the mental health sector to contribute to various topics in the book. This list included clinicians and education and cultural experts. A small editorial team (see acknowledgments), led by Associate Professor Roz Walker managed the day-to-day production of the book. During the process for the second edition, all chapters were reviewed and updated. New chapters were identified and the most suitable experts were invited to contribute. The second edition was informed by evaluation and advice from the Expert Reference Group.

THE STRUCTURE OF THE BOOK

The book is structured into six parts.

Part One: History and Contexts

Provides an overview from a historical, social, emotional and cultural context, within a mental health framework. Impacts of colonisation and cultural devastation in contrast to resistance, resilience, equality, empowerment and cultural recognition are discussed from a social and emotional wellbeing and psychological perspective. Progression of policies reflective of situation and time are outlined.

Part Two: Issues and Influences

Describes various issues and influences on people's mental health and social and emotional wellbeing, including a clinical description and diagnosis of mental health. Substance misuse, suicide and the over-representation of people in the criminal justice system are viewed as most significantly impacting on individuals and communities.

Part Three: Standards, Principles and Practice

Better health outcomes can be achieved by best work practice, which includes consideration of and working to the National Practice Standards and ensuring, where possible, support is offered within an interdisciplinary team in a culturally competent and culturally secure environment.

Part Four: Assessment and Management

Assessing and managing an individual and ensuring cultural competency and a culturally secure environment are highlighted. Acknowledging and understanding the diversity of attributes impacting on an individual's assessment, such as trauma and transgenerational trauma and unrecognised or undiagnosed disability are considerations. A range of tools appropriate for assessment are provided.

Part Five: Working with Children, Families and Communities

Focuses on the complex issues surrounding young Aboriginal people and explores ways for families and communities to deal with these issues. Issues discussed include factors influencing parental and infant mental health, addressing fetal alcohol spectrum disorder and understanding the lives of Aboriginal children and families using case studies. Also discussed are ways of working with behavioural and emotional problems in young people and how to move forward when family violence occurs.

Part Six: Aboriginal Healing Models and Programs

A number of culturally sensitive, culturally driven, culturally developed and culturally implemented programs and models provide pathways forward for individuals and communities. Involvement in these cultural specific models and programs will enable individuals and communities to benefit as part of the healing process. It will also encourage forward movement and positive participation at a community level.
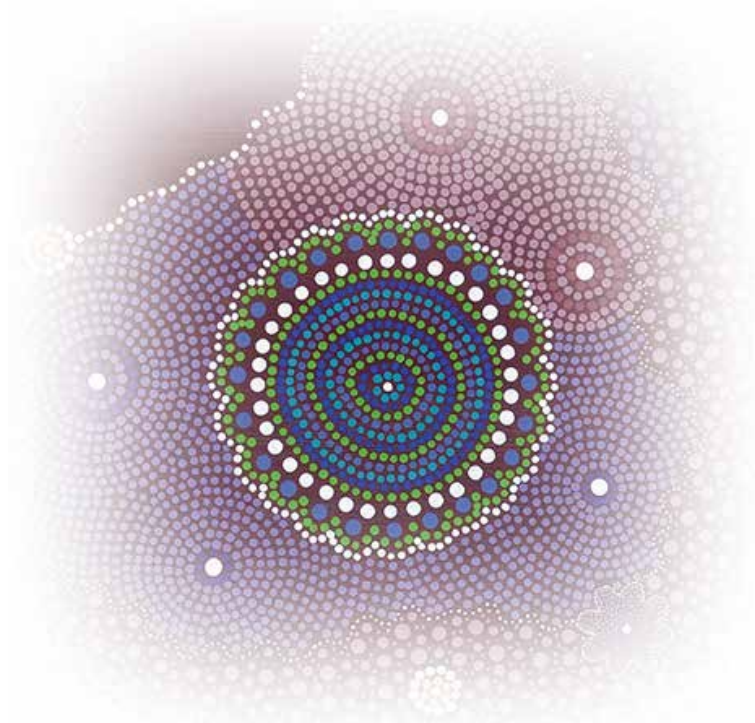
Part 1
History and Contexts

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Chapters

1 The impact of colonisation and the subsequent devastation, resistance, adaptation, resilience, racism, and struggle for equality and cultural recognition set the background to understanding people's lives within a social and emotional wellbeing and mental health context. Historical and current concepts of physical and mental health are outlined within a human rights framework along with initiatives to move forward to regain their health.

2 Examines the concepts of physical and mental health and wellbeing, as they were understood and practiced historically. The devastating consequences of the European colonisation of Australia for Aboriginal and Torres Strait Islander people are described. The chapter concludes with some innovative thinking from Australia and overseas that may assist Aboriginal Australians to regain their 'health' that has been so significantly lost.

3 Outlines the influences and progression of psychology from an Aboriginal and Torres Strait Islander perspective and how the discipline and practice of psychology had a negative impact historically. Thereon, events heralding the empowerment and inclusion of Aboriginal and Torres Strait Islander peoples at all levels of mental health service provision are acclaimed.

4 Explores determinants that have shaped Aboriginal and Torres Strait Islander social and emotional wellbeing outcomes and examines the relationship between social and emotional wellbeing and mental health from an Aboriginal and Torres Strait Islander perspective. Cultural domains and guiding principles characterising social and emotional wellbeing are outlined and placed in a framework that is discussed.

5 Discusses the development of policy that is setting directions for, and achieving change in, Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing. Key national policies, frameworks, reports and inquiries are presented, some historical milestones noted, and developments that have shaped culturally specific policy reform are described.

1

Aboriginal Social, Cultural and Historical Contexts

Pat Dudgeon, Michael Wright, Yin Paradies, Darren Garvey and Iain Walker

OVERVIEW

To understand the contemporary life of Aboriginal and Torres Strait Islander Australians, a historical and cultural background is essential. This chapter sets the context for further discussions about Aboriginal and Torres Strait Islander peoples and issues related to their social and emotional wellbeing and mental health. The history of colonisation is addressed, the subsequent devastation of Aboriginal and Torres Strait Islander Australians, and their resilience and struggle to claim equality and cultural recognition, and to shape the present is examined. Indigenous Australia is made up of two cultural groups who have shared the same struggle; yet often when using the term Indigenous, a Torres Strait Islander history is absent. In this chapter both cultures are equally presented. Brief overviews are given of pre-contact times, colonisation, resistance and adaptation, shifting government policies, and the struggle for recognition. Indigenous identity and meanings of belonging in country, community and family are also briefly covered. Contemporary issues confronting Aboriginal and Torres Strait Islander peoples are included, with particular attention to racism. To appreciate the contemporary realities of Aboriginal and Torres Strait Islander Australians, their cultural ways of life need to be understood.

INTRODUCTION—CONTEMPORARY CIRCUMSTANCE

The Australian Bureau of Statistics (ABS) estimated that in 2011[1] there were 548,370 Aboriginal and Torres Strait Islander peoples living in Australia, approximately two and a half per cent of the total Australian population.[1] It is estimated that 90 per cent (493,533 people) were of Aboriginal origin, six per cent (32,902 people) of Torres Strait Islander origin and four per cent (21,934 people) identified as being of both Aboriginal and Torres Strait Islander origin.[1] These proportions have changed very little in the last 10 years.[1]

In 2006, 32 per cent of Aboriginal people lived in major cities, with 21 per cent in inner regional areas and 22 per cent in outer regional areas, while nine per cent lived in remote areas and 15 per cent lived in very remote areas.[2] While the majority of Aboriginal people live in urban settings, the Aboriginal population is much more widely dispersed across the country than is the rest of the population, constituting a much higher proportion of the population in Northern Australia and more remote areas.[2] Updated figures for distribution of the Australian population were released by the ABS in September 2013.

ABORIGINAL CULTURE AND HISTORY

In recent decades there has been a strong renaissance of Aboriginal culture and forms of creative expression, and a reconnection and reclaiming of cultural life. Aboriginal culture has roots deep in the past. Australia's Aboriginal cultural traditions have a history and continuity unrivalled in the world.

Far from signifying the end of Aboriginal traditions, new forms of adaptation are bringing new vitality to older cultural themes and values that need to be addressed. Contemporary Aboriginal Australia presents new challenges, issues and options for reconciliation. Aboriginal people have been in Australia for between 50,000 and 120,000 years. They were a hunter-gatherer people who had adapted well to the environment. There were between 300,000 to 950,000 Aboriginal people living in Australia when the British arrived in 1788.[3] At that time there were approximately 260 distinct language groups and 500 dialects.

Aboriginal people lived in small family groups and were semi-nomadic, with each family group living in a defined territory, systematically moving across a defined area following seasonal changes. Groups had their own distinct history and culture. At certain times, family groups would come together for social, ceremonial and trade purposes. It is estimated that up to 500 people gathered at the one time. Membership within each family or language group was based on birthright, shared language, and cultural obligations and responsibilities. Relationships within groups predetermined categories of responsibilities and obligations to the group and to family. Aboriginal people built semi-permanent dwellings; as a nomadic society emphasis was on relationships to family, group and country rather than the development of an agrarian society. Being semi-nomadic meant that Aboriginal people were also relatively non-materialistic. Greater emphasis was placed on the social, religious and spiritual activities. The environment was controlled by spiritual rather than physical means and religion was deeply tied to country.[4,5]

According to Aboriginal beliefs, the physical environment of each local area was created and shaped by the actions of spiritual ancestors who travelled across the landscape. Living and non-living things existed as a consequence of the actions of the Dreaming ancestors. Helen Milroy speaks about the importance of land as part of the Dreaming:

> *We are part of the Dreaming. We have been in the Dreaming for a long time before we are born on this earth and we will return to this vast landscape at the end of our days. It provides for us during our time on earth, a place to heal, to restore purpose and hope, and to continue our destiny.*[6(p414)]

Land is fundamental to Indigenous people, both individually and collectively. Concepts of Indigenous land ownership were, and are, different from European legal systems. Boundaries were fixed and validated by the Dreaming creation stories. Each individual belonged to certain territories within the family group and had spiritual connections and obligations to particular country. Hence land was not owned; one belonged to the land. Aboriginal people experience the land as a richly symbolic and spiritual landscape rather than merely a physical environment. Religion was based on a philosophy of oneness with the natural environment. Both men and women were involved in the spiritual life of the group. While men have been acknowledged as having the overarching responsibilities for the spiritual activities of the groups, past scholars studying Aboriginal cultures have neglected women's roles. Women's roles in traditional contexts, how these were disrupted during colonisation, and the misrepresentation of these roles, have become important issues.

Kinship Systems

Complex and sophisticated kinship systems placed each person in relationship to every other person in the group and determined the behaviour of an individual to each person. The kinship system also took into account people external to the group according to their relationship. This practice became important during colonisation, when Aboriginal people attempted to bring outsiders into their kinship systems, particularly through relationships with women. Kinship systems determined exactly how one should behave towards every other person according to their relationship, so there were codes of behaviour between each person outlining their responsibilities and obligations towards others. For instance, a man had responsibilities to his nephews—he taught them hunting skills and led them through initiation. Kinship relations determined how food and gifts should be divided, who were one's teachers, who one could marry. In a sense, kinship systems placed each person securely in the group.[4]

People had defined roles according to age and gender. For example, a man's role involved skills in hunting as well as cultural obligations that were important to the cohesion of the group. Likewise, a woman also had an important role—she provided most of the food for the group, was responsible for early child rearing, and also had cultural obligations. Reciprocity and sharing were, and still are, important characteristics in Aboriginal society. Sharing along the lines of kinship and family remains an important cultural value.[4]

Descent, Country and Kinship

Descent is about belonging to a people and a place. This involves kinship—that is, relationships and obligations to other people and place or 'country'. A notion of 'country' is fundamental to Aboriginal identity. With the advent of Native Title and Land Rights, the notion of country has had a more urgent imperative, but it has always been of utmost importance from traditional times, throughout the processes of colonisation, and in contemporary times. Where one is from, and the people one belongs to, have always been and will always remain important. Demonstrating where one is from, what 'country' and group/people they belong to, is critical to any Indigenous person in their self-identity and when introducing oneself to other Indigenous people.[7]

> There is agreement that Aboriginal identity is predicated upon descent and country of origin, about knowing and being a part of an Indigenous community and perceiving oneself as Indigenous. Descent does not necessarily pertain 'to genetics as inherited essential characteristics but to the historical connection that leads back to the land and which claims a particular history'.[8]

Connection to Country

The relationship Aboriginal people have to their country is a deep spiritual connection that is different from the relationship held by other Australians.[9] Several texts articulate the spiritual feeling of country for Aboriginal people—for example, Paddy Roe in *Reading the country,*[10] Sunfly Tjuperla in *Two men dreaming,*[11] David Mowaljarlai in *Yorro Yorro: Everything standing up alive*[12] and Bill Neidjie in *Story about feeling.*[13] These texts capture the relationship with country in different ways. This could be described as a spiritual, bodily connectedness. As Neidjie puts it:

> Listen carefully, careful and this spirit e [he] come in your feeling and you Will feel it … anyone that, I feel it … my body same as you. I am telling you this because the land for us never change round. Places for us, Earth for us, star, moon, tree, animal. No-matter what sort of animal, Bird snake … all that animal like us. Our friend that.[13(p182)]

The need to be able to describe relationships to land in different ways has been taken up by Moreton-Robinson.[14] Here, Indigenous relationships with land are described as forming an 'ontological belonging'. Indigenous people's spiritual beliefs are based on ancient systems that tie one into the land, to other members of the group, and to all things of nature. This relationship with the country means that there is an incommensurable difference between sense of self, home and belonging to place. 'Our ontological relationship to land, the ways that country is constitutive of us, and therefore the inalienable nature of our relation to land, marks a radical, indeed incommensurable, difference between us and the non-Indigenous.'[14(p31)] Most Aboriginal people living away from their homelands, towns or cities express a desire to be buried in their country of origin. Serious legal disputes can erupt over where a deceased person is to be buried, should different 'country' groups feel that they have connections and claims to the person.

Being Aboriginal

Being part of an Aboriginal community is another facet of Aboriginal identity; other Aboriginal people know who you are and what family you belong to.[15] The concept of a community has a political agenda for the state, whereby Aboriginal people were moved into sites such as reserves, missions and fringe camps as part of the processes of colonisation, dispossession and dispersal, and later for bureaucratic convenience. However, there still is a strong Aboriginal sense of what it means to belong to a community. Overall, Aboriginal society is structured around the community. Within or forming the community are strong kinship and family ties and networks.

For some Aboriginal people, the cultural and political dimensions of the concept are inextricably enmeshed. Nyungar spokesperson and academic Ted Wilkes stated:

> The Aboriginal community can be interpreted as geographical, social and political. It places Aboriginal people as part of, but different from, the rest of Australian society. Aboriginal people identify themselves with the idea of being part of 'community'; it gives us a sense of unity and strength. Sometimes issues based groups are perceived as a community—but that is not the case, it is a re-configuration of some parts of the existing community. I think of all of us together, as a political and cultural group. It includes everyone, no matter what 'faction' or local group they are affiliated with, or which part of our diversity they live in. It is [also] a national concept.[15(p248)]

Aboriginal people have created communities of significance and meaning for themselves, and membership still includes Aboriginal descent. It should be noted that Western and Aboriginal notions of community differ in that the Aboriginal notion includes the criterion that, to be a member of the community, one has to be Aboriginal, identify as such and be known to the group. For Aboriginal people there are various obligations and commitments that one has as a member in the community. Being part of the community may have various responsibilities and obligations that confirm and reinforce membership. These include obligations to (extended) family, responsibilities to be seen to be involved and active in various community functions and initiatives, and representation in various political issues.

The definition of Aboriginal identity is generally accepted as a person who is a descendant of an Aboriginal inhabitant of Australia, who identifies as an Aboriginal person, and who is recognised as Aboriginal by members of the community where they live. Aboriginal identity is not about the colour of a person's skin or the percentage of 'blood' they have. Many Aboriginal people have both Aboriginal and non-Aboriginal ancestry but this does not make them any less Aboriginal. Aboriginality is about descent, culture, upbringing and life experiences.

There has been considerable discussion about how Aboriginal identity has been constructed and imposed, manipulated and used in the creation of assimilationist policies and other destructive practices such as the removal of so-called 'half-caste' children. Part of the decolonising project for Aboriginal peoples is to challenge previously held assumptions about them and work

towards creating new constructions of identity. Many Aboriginal authors have written about identity and discussed the lived experience of being an Aboriginal person.[16,17]

> *This lived experience is the essential, perennial, excruciating, exhilarating, burdensome, volatile, dramatic source of prejudice and pride that sets us apart. It refers to that specialness in identity, the experiential existence of Aboriginal people accrued through the living of our daily lives, from 'womb to tombs' as it were, in which our individual and shared feelings, fears, desires, initiatives, hostilities, learning, actions, reactions, behaviours and relationships exist in a unique and specific attachment to us, individually and collectively, because and only because, we are Aboriginal people(s).*[16(p139)]

COLONISATION: RESISTANCE AND ADAPTATION

European settlement moved from Botany Bay outwards, as settlers claimed land for economic purposes. The pastoral industry escalated the expansion, bringing increases in British immigrants. Broome calls the rapidly moving frontier of the mid-1800s the most 'fantastic land grab which was never again to be equalled'.[5(p37)] Many Aboriginal groups took livestock from European flocks. Reprisals followed, which escalated to full war over land because Europeans saw this as stealing. Aborigines fought with guerrilla tactics, destroying livestock, raiding shepherds and their flocks and homesteads. Small pitched battles were common. European retribution followed, mainly by the military but also by civilians, with massacres not only of warriors but also of women and children.[18] In some parts of the country, the objective of the colonisation was to clear the lands of Aboriginal people to enable development of the land. Poisoned flour was distributed to Aboriginal people, and introduced diseases (sometimes deliberate) such as measles, chicken pox and influenza had dramatic effects on people who did not have the immunity to such viruses common to Europeans. Smallpox was particularly devastating—entire tribes were wiped out.[19] Aboriginal fighting and warfare skills were small in scale because there had never been the need to engage in large-scale military tactics. The Europeans had guns, horses and organised military forces, and with this superior advantage they won the war for the land. Historical accounts of Aboriginal resistance to colonisation have only emerged in recent years.[5,18] There has been a recent proliferation of significant texts that include detailed accounts of Aboriginal resistances and warfare.[20] Military analyses of frontier warfare between Aboriginal people and the British[21] have been complemented by local histories with an Aboriginal perspective.[22]

As their lands became increasingly occupied, Aboriginal people gravitated towards European settlements because their own food supplies were disrupted and because of the convenience of European foods, tobacco and implements. They attempted to use their own kinship systems to exchange labour for goods. However, the settlers perceived the exchanges differently. They saw labour as an individual exchange rather than a gift to be reciprocated by providing food for the whole group. Extremely high death rates and low birth rates led to an estimated Aboriginal population of just 75,000 people at the turn of the 20th century.[5] Disruptions to traditional life led to many Aboriginal people becoming fringe dwellers to white society. They were perceived by the dominant society as hopeless remnants, clinging to what was left of their cultures and merely surviving. In some states, relatively high proportions of Aboriginal people survived the violence of initial colonial contact,[23] and there are many examples of Aboriginal groups across the country successfully adapting to colonisation and making new independent lives amid this immense change.[5,24] However, Aboriginal people were then subjected to government policies that attempted over time to displace, 'protect', disperse, convert and eventually assimilate them.

Oppressive Legislation

At Federation, Australian states and territories had control and responsibility for Aboriginal Australians. Each state of the newly formed Federation framed and enacted suites of legislations and policies that were punitive and restrictive towards Aboriginal peoples. New South Wales established the Aboriginal Protection Board in 1883, granting legal power to the Board with the introduction of the *Aborigines Protection Act 1909*.[25] Other states passed similar legislation in an attempt to control Aboriginal people:[23] in South Australia the *1911 Aboriginal Protection Act*;[26] the *Cape Barren Island Act 1912* in Tasmania;[27] the Queensland *Aboriginals Protection and Restriction of the Sale of Opium Act 1897*;[27] the *Northern Territory Aboriginal Ordinance of 1911* and the *Welfare Ordinance 1953*.[27] Victoria introduced the *Aborigines Act 1869*, before Federation in 1901.[27] The intention underlying these punitive and restrictive laws was clear, for under the pretence of *for their own good*, the effects were a form of cultural genocide of Aboriginal Australians, through the loss of language, family dispersion and the cessation of cultural practices.[28]

The Western Australian *Aborigines Act 1905* [27] has special connotations today because of its gross erosion of rights, resulting in forcible removal of children and internment of Aboriginal people in bleak reserves, to live in servitude and despair. It marked the start of a period of formidable surveillance and oppression of Aboriginal people. The WA *Aborigines Act 1905* made the Chief Protector of Aborigines the legal guardian of every Aboriginal person and of 'half-caste' children. At the local level, police constables or pastoralists were delegated powers as Protectors of Aborigines. 'Half-caste' children were to be removed from their families so that they could have 'opportunities for a better life', away from the contaminating influence of Aboriginal environments. Missions and reserves were established. The Chief Protector also had the power to remove any Aboriginal person from one reserve or district to another and to be kept there. Aboriginal people were forbidden from entering towns without permission and the cohabitation of Aboriginal women with non-Aboriginal men was prohibited. Local Protectors implemented these new regulations.

While the *Native Administration Act 1936* consolidated the absolute rights of the State over Aboriginal people, the 1905 Act is symbolic of Aboriginal oppression, just as the 1967 National Referendum, when Aboriginal rights were won back, is symbolic of emancipation.

This history demonstrates how racist beliefs became legislation. Aboriginal people were believed to be less than human, and legislation was used to control them and confine them away from 'the public'. According to Milnes, 'The pauperisation of Aboriginal peoples was sealed by legislation. The *Aborigines Act 1905* was not a protection for Aboriginal peoples, but allowed for an instrument of ruthless control'.[29(p32)] Such legislation was finally repealed in 1967, but by then the damage was done. Very few Aboriginal people escaped the direct and indirect effects of the legislation that controlled and governed their lives.[30,31]

State control of, and intervention in, the lives of Aboriginal people was extreme. Not one Aboriginal person was untouched by the legislation implemented across the country. Such legislation reflected the dominant society's perceptions of Aboriginal people and how they ought to be treated. These perceptions were underpinned by the influences of social Darwinism, where cultural groups or 'races' were seen to be at different stages of evolution, and within which Aboriginal people were thought to be primitive and childish. This period of colonisation profoundly affected the lives and self-perceptions of Aboriginal people. However, Aboriginal people and white supporters have continued to resist and struggle for justice since colonisation. The Aboriginal rights movement began in the 1920s, with the establishment of Aboriginal political organisations, including the Australian Aborigines League led by William Cooper, and the Aborigines Progressive Association led by William Ferguson.[32] Over time, various Aboriginal political and support groups were established across the country.

The 1967 Commonwealth Referendum

The 1967 Commonwealth Referendum symbolises the granting of citizenship rights to Australian Aboriginal peoples. However, as well as striving towards political equality and self-determination, the quest for a cultural identity gained new significance.[33] Despite continual difficulties with racism and disadvantage, many Aboriginal people have written of the need to recover, regain and reconstruct identities, and to reject negative white stereotypes.

Although the conception of Aboriginal rights had changed significantly since the 1960s, the formal Commonwealth and state restrictions that had denied Aboriginal people meaningful status as citizens had started to dismantle before the 1967 referendum. Legal changes from that time reflected changing government attitudes towards Indigenous peoples. This period also saw a change from an emphasis on civil rights to one on Aboriginal rights, acknowledging that Aboriginal people possessed certain rights that did not pertain to other Australians. These changes involved:

- the prohibition on racial discrimination;

- land rights; and

- the facilitation of self-determination.[34]

Around this time, key events such as the Gurindji people's walk-off from the Wave Hill cattle station in 1966 heralded the fight for land rights. Aboriginal activists gained national attention, leading public protests, rallies and political agitation.[35] The 1960s and 1970s saw significant achievements that have become historical moments in the struggle for Aboriginal rights. These include:

- the establishment of the Aboriginal Tent Embassy in Canberra;

- the creation of the Aboriginal flag by Harold Thomas in 1971; and

- the beginning of civil rights and land rights legislation.

Aboriginal people in Australia are still grappling with the effects of colonisation. Thirty years ago, Kevin Gilbert, in *Living Black*, stated that as invasion occurred, Aboriginal people began to sicken physically and psychologically:

> [T]hey were hit by the full blight of an alien way of thinking. They were hit by the intolerance and uncomprehending barbarism of a people intent only on progress in material terms, a people who never credited that there could be cathedrals of the spirit as well as stone. Their view of Aborigines as the most miserable people on earth was seared into Aboriginal thinking because they now controlled the provisions that allowed blacks to continue to exist at all. Independence from them was not possible … It is my thesis that Aboriginal Australia underwent a rape of the soul so profound that the blight continues in the minds of most blacks today. It is this psychological blight, more than anything else, that causes the conditions that we see on the reserves and missions. And it is repeated down the generations.[36(p2)]

Aboriginal intellectuals have been writing about oppression for some time. Gilbert in his book had particularly identified cultural racism, internalised racism and intergenerational trauma as the psychological issues for Aboriginal people. These accounts have been silenced until recent times. Many of the chapters in this book reaffirm the 'transgenerational, psychological blight' identified by Gilbert that still impacts upon the lives of many Aboriginal people.

Aboriginal people were hunter-gathering people who lived in close connection to their country. The world, the earth and the waters, the flora and fauna and other humans were understood and spiritually connected. Colonisation bought dramatic change and the destruction of

Aboriginal people and their cultures. However, a process of rapid adaptation was derailed with the introduction of oppressive legislation across all states and territories, stripping people of their human rights, and a period of absolute state control was put in motion. People were dispersed into government reserves and missions and the effects of this was a form of cultural genocide of Aboriginal Australians through the loss of language, family dispersion and the cessation of cultural practices. Throughout these times, Aboriginal people have continually resisted invasion and oppression. An ongoing struggle for equality and Aboriginal rights is part of Aboriginal history. Aboriginal people have retained their cultures and these have been strengthened in recent times.

TORRES STRAIT ISLANDER CULTURE AND HISTORY

Introduction

The following section provides a brief overview of Torres Strait Islander culture and history—a history that is distinctive yet inseparable from the broader Aboriginal story.

The Torres Strait is the seaway between Cape York and Papua New Guinea, and is the only part of Australia that shares an international border with another country. The Torres Strait bears the name of the Spanish explorer Luis Vaez de Torres, who sailed through the area en route to the Philippines in 1606. Voyages by British explorers Cook, Bligh, Flinders and others charted the channels through Torres Strait in the late 1700s–early 1800s.

From 1800 to 1850, only a few ships stopped in Torres Strait to take on water, to trade with Islanders, or to carry out repairs; many were also wrecked on the numerous reefs. The Torres Strait remains an important shipping route and a strategically important region of the Australian coastline.

There are approximately 270 islands in the Torres Strait, remnants of the Sahul Shelf, a now submerged land-bridge that linked the Australian mainland and Papua New Guinea between 80,000 and 9,000 years ago.[37] Torres Strait Islanders live permanently in 20 communities on 17 of the islands, as well as in locations in every Australian state. Two communities, Seisia and Bamaga, sit on the Queensland coast as part of the Northern Peninsula Area (NPA). At 30 June 2006, the estimated resident Torres Strait Islander population was 54,836 people, or 0.3 per cent of the total Australian population.[38] Torres Strait Islander people comprise 10 per cent of the total Aboriginal and Torres Strait Islander population nationally. Queensland has the highest population of people identifying as Torres Strait Islanders, followed by NSW and Victoria.[2]

A Minority Within a Minority?

Torres Strait Islander culture has a unique identity and associated territorial claim, although their culture and people are often conflated with Aboriginal people.[39,40] Torres Strait Islanders are not mainland Aboriginal people who inhabit the Torres Strait.[41] The Torres Strait Regional Authority notes that the traditional people of Torres Strait are of Melanesian origin and speak two distinct languages.[42] In the Eastern Islands (Erub, Mer and Ugar) the traditional language is Meriam Mir, while the Western and Central Island groups speak either Kala Lagaw Ya or Kala Kawa Ya, which are dialects of the same language. Another widely used language is referred to as Torres Strait Kriol.[38] Torres Strait English, a regional version of Standard Australian English, is also spoken by Islanders in the Strait and on mainland Australia.[41] The array of languages and their variants means that many Islanders are multilingual and, while Standard English may be included in this repertoire, it is advisable to assess the extent to which it is understood and practised if that is to be the language of choice in any working relationship.[43]

History

Early historical accounts point to the diversity of Islander people, reflecting both the differing conditions of the various island locations, and the social and spiritual material incorporated by them. Competition for resources would sometimes override long-standing trade and familial ties between islands, producing relationships that were at times cordial and at other times tense.[44] Torres Strait Islanders have close contact with both Papua New Guinean communities to the north and with mainland Aboriginal communities around Cape York Peninsula.[44] This might be characterised as a predominantly separate yet neighbourly relationship between Torres Strait Islanders and their neighbours to the north and south.

The economy of the Torres Strait was based on subsistence agriculture and fishing. An established communal and village life existed, revolving around hunting, fishing, gardening and trading. Inter-island trading was of food, weapons and artefacts and represented a key aspect of intergroup relationships.[40] Some islands were better able to support gardening and crops and, for others, fishing provided the main food source. Other islands, due to their size and vegetation, provided wildlife and game. Thus Islanders were, and continue to be, gardeners, fishers and hunters, as well as warriors. They were also expert sailors and navigators, with reference to this important traditional and contemporary skill of using the stars for navigation, symbolised in the flag of the Torres Strait.

Much of the early recorded history between Europeans and Islanders suggests that the interaction was punctuated by attacks and reprisals.[45] Mosby posits that Europeans' attitudes towards Islander territory and custom reflected their 'masters of the situation' mentality, disregarding Islander ways. Today, many resources aimed at facilitating good working relationships with Torres Strait Islanders focus on the need for visitors to respect *Ilan Pasin* and Islander ways of working, rather than assume certain privileges or levels of access.[40,46-48] See also Chapter 15 (Dudgeon and Ugle) on communication and engagement.

The Coming of the Light

While the Strait was seen as a strategic waterway in terms of trade and natural resources, the population was also seen as valuable to the efforts of Christian missionaries, in particular the London Missionary Society which targeted Torres Strait Islanders and other groups in the area for conversion to Christianity.[49] Their arrival at Darnley Island on 1 July 1871 has become known as the 'Coming of the Light' whereby the light of Christ was brought into the 'heathen' darkness of the Torres Strait.[45]

There are mixed opinions about the introduction of Christian religion and other influences to the Straits. While the conduct of anthropological, psychological and other research activities such as the Cambridge expedition (led by Haddon, 1912) (including the collection and removal of artefacts) were carried out as scientific imperatives of the time, recently authors suggest this period helped define the prevailing Islanders as 'souls needing to be rescued'.[49(p15)] While there were many disadvantages of missionary influences, such as the destruction of traditional cultural practices, responses to its encroachment varied.[50]

From the mid-19th century onwards, Torres Strait Islanders experienced momentous change from their increasing contact with Europeans. The emerging maritime industries of fishing, pearling and beche-de-mer (sea slug) collection were attractions. Islanders adjusted to the new lifestyle being introduced to the region through maritime industries, religion and government administration. The development of trade and industries also brought an influx of workers whose cultural diversity has helped shape Islander culture and identity.

In 1879, the Torres Strait was annexed and as such was considered part of Queensland when the islands became Crown land. At Federation, Islanders became Australian citizens although, like mainland Aboriginal people, they experienced restricted access to many of the rights their fellow Australians took for granted.[41]

Indeed, there are numerous examples of Torres Strait Islander peoples' endeavours and achievements, as well as symbols of solidarity and unity.[41] Some of these have had repercussions that extend beyond the Islanders involved, such as the case of Mabo. This has affected the very foundations of the nation's story. The historical significance of the High Court decision in the case of *Mabo and Others v the State of Queensland* lay in the recognition, for the first time, of the common law rights and interests of Indigenous people in their lands according to their traditions, law and customs. This in effect exposed the legal fiction of terra nullius—that Australia was an empty land belonging to no-one. The repercussions of this fundamental change to how the early story of the Australian nation was told continues to be felt not only in the subsequent claims to Native Title that have ensued, but also in how prior Aboriginal occupation and management of the land challenges the previously competing claim of their non-relationship to it. Actions pursued by Islanders have had repercussions beyond the Torres Strait.

While Torres Strait Islander history and culture is characterised in many ways by cultural adaptation and migration, the essence and origins of Islander identity—the psychological and the geographical—are still fought for, defended and celebrated with pride today.[41] Into the future, along with an increasing awareness of the circumstances of Torres Strait Islanders based on conduct respecting Islander needs and aspirations, it is likely that the label of 'voiceless minority' will become a less accurate description of Torres Strait Islanders.[46,47,49]

SIGNIFICANT CONTEMPORARY ISSUES

The next section focuses on some of the significant contemporary issues in Aboriginal and Torres Strait Islander society. The following are highlighted to give greater understanding of issues that are of key significance in this moment of Aboriginal and Torres Strait Islander history.

THE STOLEN GENERATIONS

Colonisation has had many negative consequences. One of the most profound has been the removal of Aboriginal children from their families. Most Aboriginal families have experienced removal of children or displacement of entire families into missions, reserves or other institutions. As many as one-in-ten Aboriginal and Torres Strait Islander children were forcibly removed from their families and communities in the first half of the 20th century. Various reports such as *Bringing Them Home* have shown that in certain regions at different times the figure may have been much more. In that time, not many Aboriginal and Torres Strait Islander families escaped the effects of forcible removal, and most families have been affected over one or more generations.[30] Drawing on her research in the Northern Territory, McGrath described these policies for the removal of children as 'the ultimate racist act'.[51] Her statement can be generalised to the rest of Australia. (See Chapter 29, Peeters and colleagues, for a comprehensive discussion of the impacts of colonisation on the Stolen Generations.) Haebich describes the removal of children as a process stretching from colonisation to the present.[52] This process and its consequences are part of Aboriginal identity and have wide-ranging implications that are discussed in several chapters in the book.

Forcible removals of children and their subsequent effects have been, and still are, a profound part of the Australian Aboriginal story. The removal of children of 'part-Aboriginal' descent from families and communities to give them an opportunity to assimilate into the white world, and later for reasons that included welfare of the children, was common practice from the beginning of the 20th century even until the 1980s. As well as interning children, in many instances they were housed in various institutions according to the predominance of white blood they were thought to have. Sister Kate's Home in Perth is an example of children being referred to a home on the basis of being light-coloured.[53] This practice was widespread in

the global colonisation project. Sissons (2005) states that, in settler nations such as Australia, Canada, New Zealand and the USA, the practice of removing Aboriginal children from families and communities was not only driven by an aim of assimilation, but also aimed to achieve the disintegration of Aboriginal communities, and to transform the relationship between Aboriginal people and their environment.[54]

The transgenerational effects of the policies of forced removal of Aboriginal children on Aboriginal emotional and social wellbeing are profound and enduring, and are discussed in Chapter 29 (Peeters and colleagues) and Chapter 17 (Atkinson and colleagues).

HEALTH AND SOCIAL AND EMOTIONAL WELLBEING

Aboriginal and Torres Strait Islander peoples are the most disadvantaged group in Australia.[55] Aboriginal and Torres Strait Islander children and adults:

- experience poorer health outcomes than others;
- have twice the mortality rates for Aboriginal children (less than five years of age) and adults are twice that of non-Aboriginal people;
- have a shorter life expectancy than others (11.5 years less for males and 10 years less for females).

In mental health and substance abuse:

- Aboriginal people report experiencing psychological distress at two and a half times the rate of other people;
- Aboriginal people are hospitalised for mental health and behavioural disorders at around 1.7 times the rate of non-Aboriginal people;
- Aboriginal people are hospitalised for non-fatal self-harm at two and a half times the rate of others;
- Suicide death rates for Aboriginal people are twice that of other people;
- Hospitalisation rates for alcohol related conditions for Aboriginal people are two and a half times those of other people;
- 71 per cent of Aboriginal homicides involved both the victim and offender having consumed alcohol as the time of the offence.

In education and employment:

- Only 50 per cent of Aboriginal students completed year 12—30 per cent less than other students;
- Only 25 per cent of Aboriginal students in 2008 received a year 12 certificate;
- The Aboriginal employment rate remains 20 per cent lower than for other Australians;
- The average Aboriginal income is lower than others.

In the justice system:

- The rate of child protection notifications are rising faster for Aboriginal people than for others;
- Homicide rates are six times higher for Aboriginal people;
- Hospitalisation rates for injuries caused by assault are much higher for Aboriginal people (seven times as high for men and 31 times as high for women);
- Aboriginal people experience higher rates of family violence, particularly in remote areas where family violence is 36 times higher;

- Both Aboriginal men and women experience more than double the victimisation rates of others;

- Aboriginal people were imprisoned at 14 times the rate for other Australians, with imprisonment rate increasing by 59 per cent for Aboriginal women and 35 per cent for Aboriginal men between 2000 and 2010;

- Aboriginal juveniles were detained at 23 times the rate for non-Aboriginal juveniles in 2009.[56]

The *Health and Welfare of Aboriginal and Torres Strait Islander Peoples'* report[58] offers several insights into issues relating to Torres Strait Islander social and emotional wellbeing, including the prevalence and impact of stress and discrimination. According to the Overcoming Indigenous Disadvantage Key Indicators report from 2011,[55] in 2008:

- The proportion of Torres Strait Islander people aged 18 years and over who had completed year 12 or post-secondary education (44 per cent) was higher than for Aboriginal people (34 per cent), but much lower than for non-Aboriginal people (62 per cent);

- The proportion of Torres Strait Islander people who were employed (65 per cent) was higher than Aboriginal people (56 per cent), but lower than for non-Aboriginal people (78 per cent);

- The proportions of Torres Strait Islander and Aboriginal people who lived in a home owned by a member of the household (29 per cent) were much lower than for non-Aboriginal people (65 per cent);

- There was no statistically significant difference between the individual median weekly income for Torres Strait Islander people ($550) and non-Aboriginal people ($608), but incomes for Aboriginal people were lower ($400).

While Torres Strait Islander people have their own distinctive culture, they share many of the same disadvantages as Aboriginal people.[57] The *Ways Forward Report* (1995) reported that Torres Strait Islander people:

- suffered the same disadvantages and racism as Aboriginal people;

- experienced lack of recognition of being a separate and unique cultural group;

- experienced lack of appropriate representation;

- experienced exclusion and hostility from Aboriginal groups in accessing services; and ignorance of their culture from mainstream Australia.[56]

Further the report recommended that there was a need for:

- research into Torres Strait Islander mental health;

- recognition of Torres Strait Islanders as a distinct cultural group; and

- recognition of their healing methods and healers.[56]

This list of impoverishment and disadvantage in an otherwise wealthy nation is shameful and unacceptable. The situation has many causes and no easy solutions, but it is clear that decades of colonial exploitation and a prolonged systematic attempt to destroy Aboriginal and Torres Strait Islander peoples and culture lie at the core of the causes. As noted in the Overcoming Aboriginal and Torres Strait Islander Disadvantage Report (2009), racism at individual and institutional levels continues to reproduce the impoverishment and disadvantage experienced by most Aboriginal and Torres Strait Islander Australians.[55]

RACISM

Like many former colonial countries, Australia has a long legacy of racism. Everyone is affected by this, although obviously in different ways. In this section, we provide a brief overview of the social scientific understanding of racism, discuss its prevalence in Australia and how it has changed over the years, and finally touch on some of its consequences for mental health.

Popular understandings of racism portray it as an overt rejection of other groups and their members, as hostile and malevolent, as underpinned by a belief in the superiority of one's own group over others, and as a feature of individuals. These aspects certainly characterise racism, but there is much more to racism that is omitted from this popular view. Jones (1997) proposed that contemporary racism should be considered at three different levels: the individual, institutional and cultural. These are distinguished by the interactions among psychological, behavioural, institutional, structural and cultural dynamics in the processes of racialised beliefs and practices.[59] While these occur interactively and simultaneously, they may manifest differently as society changes.

While debate about 'race' as a scientific concept has waxed and waned over the last few decades,[60] the term is also used as a way of organising our thinking about people and the groups they belong to.[61] Thus, race can be seen to be socially defined, sometimes on the basis of physical criteria. Race has been used to separate groups defined by physical and cultural difference and to assign supposed superiority and inferiority to members of those groups. Power and control were the modes by which racial definitions have been imposed to maintain and enforce the view that whites were inherently superior and correct and that blacks were inherently inferior and wrong. Race as a 'common-sense' construct persists because it 'has meaning for us in everyday life because it provides a good way to value our own group over others; to encapsulate social conflicts, and rationalise our way of handling it; and to talk about group differences, values, and social hierarchy'.[59(p364)]

While individual people are the agents of racism, it is important to appreciate how racism operates at a cultural and an institutional level.[59] Cultural racism is a part of the atmosphere of a society through tacit, assumed ways of doing things. Culture comprises all the ideas, values, beliefs and shared understandings that together allow members of a society to interact with one another in recognised and accepted customs. It refers to what is taken for granted. Cultural racism comprises the cumulative effects of a racist worldview, based on belief in essential racial differences that favour the dominant racial group over others.[59(p472)] These effects are suffused throughout the culture via institutional structures, ideological beliefs, and personal everyday actions of people in the culture, and these effects are passed on from generation to generation.[62]

One does not have to look far in contemporary Australia to find evidence of cultural racism. The public chatter in taxicabs, pubs, football matches and barbecues is replete with evidence of assumed essential racial differences, and of victim-blaming attributions for poor health, educational and employment outcomes and misconceptions about 'government hand-outs' and 'reverse racism'. Whereas cultural racism refers to the established 'common sense' that is shared by most or all members of a society, institutional racism refers more specifically to the practices and structures of a society's institutions or organisations. According to Jones they are:

> those established laws, customs, and practices which systematically reflect and produce racial inequities in American [or in our case Australian] society. If racist consequences accrue to institutional laws, customs, or practices, the institution is racist whether or not the individuals maintaining those practices have racist intentions. Institutional racism can be either overt or covert … and either intentional or unintentional.[59(p438)]

An institution can engage in racist practices without any of its members being individually racist. This situation can have damaging health and educational outcomes affecting Aboriginal people. The *de jure* and *de facto* rules of an institution, the aggregation of individual behaviours,

and institutional culture can all achieve racist outcomes in the absence of a deliberate intention to do so by any individual within the institution.

Individual racism is the form of racism most easily recognised by members of Western culture. A racist individual believes that black people as a group (or other human groups defined by essential racial characteristics) are inferior to whites because of physical (i.e. genotypical and phenotypical) traits. He or she further believes that these physical traits determine social behaviour and moral or intellectual qualities, and ultimately presumes that this inferiority is a legitimate basis for that group's inferior social treatment. An important consideration is that all judgments of superiority are based on the corresponding traits of white people as norms of comparison.[59(p417)] It is also possible for individuals to suffer from internalised racism which can both compromise their own sense of self-worth as well as leading to forms of racism such as lateral violence.[17,63-65]

Often people think that individual racism must be overt and blatant; that if it's not obvious then it's not racism. If only that were the case! Individual racism is more often than not subtle and covert, dressed in a veneer of tolerance and acceptance, but no less invidious in its consequences. Australian research has supported the conclusion from research in North America and Europe that, in the last 50 years or so, racism has progressively become less blatant and overt, and more subtle and covert.[66-68] Subtle racism can be just as damaging as blatant racism for people who are the targets of racism—and conceivably it could be more damaging in that it is harder for such people to attribute negative outcomes to racism, and harder to avoid attributing such outcomes to qualities about themselves.[69-71] Subtle racism is also much harder to change, as it is rarely recognised as racism, by the perpetuator and/or by the wider community.

Institutionalised racism is different from the repressive laws of the past that served overtly to oppress marginalised peoples. For Aboriginal people in Australia there is ample evidence of active oppression in past government legislation and practices that controlled people's lives. In contemporary times, however, institutionalised racism persists in the institutions and systems that exclude and discriminate against Aboriginal people. In contemporary times, society's institutions have the power to develop, sustain and enforce specific racialised views of people. The way that a society's economic, justice, educational and health care systems are applied can disadvantage certain groups of people when these systems do not cater for, or consider the cultural values or marginalisation of, members of those groups and thereby become forms of institutionalised racism. Institutionalised racism is embedded in these systems. In the Australian context, the high rates of unemployment, lower average income, high rates of arrest and imprisonment, of poor health, low education and low life expectancy are, in part, indicators of the consequences of entrenched institutionalised racism.[64]

The effects of racism on oppressed groups include responses such as low self-esteem, mistrust of the dominant culture, internalised racism, and denial. However, members of minority groups often, not always, have more positive self-conceptions.[59,72] Jones proposed that, whether one is conscious of racism or not, most black people, particularly those working in mixed-group or white settings, have to cope with everyday racism. He cited three propositions within which people of colour describe the effects of lived racism that are relevant to Aboriginal people. First, racism in contemporary society is a lived experience; it is real and happens in many ways. Second, racism not only hurts at the time it happens but has a cumulative effect. It becomes part of the narrative of the community in an 'us and them' perspective. Racism at different levels is seen as a natural part of life. Third, repeated experiences of racism affect a person's behaviour and understanding of life; one's life expectations, perspectives of oneself and one's groups and the dominant group, and many ways of coping with racism contribute to the psychological reality of people of colour. Living with racism becomes a central and defining element in the psychology of marginalised people and/or people of colour. Even for those who have 'made it' and have overcome obstacles, different forms of racism emerge that need to be confronted.[73]

We need to consider the different and interacting elements of how people are oppressed because of their racial background, in the past and in contemporary times. European ethnocentrism was an inextricable part of the colonising project; the belief that all things Western were superior and all things Aboriginal were inferior was initially imposed by military might and ensconced in laws specifically legislated to control the lives of Aboriginal people.[34] In turn, it has had a central influence on Aboriginal Australians' self-perceptions and, in one sense, a cultural renaissance is absolutely necessary for oppressed people to reclaim a sense of pride, dignity and self-worth as well as validating their own cultural histories and values.

Despite the considerable changes in Australian society, racism is still a reality for members of marginalised groups. Racism is invasive, pervasive and unrelenting. Racism imposes itself on daily living for people of colour. 'Race is about everything—historical, political, personal—and race is about nothing—a construct, an invention that has changed dramatically over time and historical circumstance … race has been and continues to be, encoded in all our lives.'[74(pix)]

Racism in Australia

Historical reviews of research trends suggest that prevalence rates of overtly racist views have steadily declined, but research at any time over the last six decades, including today, shows community views that could at best be described as strongly ambivalent.[68] Although relatively little research has focused on attitudes towards, and beliefs about, Aboriginal Australians, there is evidence of continued misconceptions that portray Aboriginal peoples as being welfare dependent, more likely to drink alcohol and as recipients of 'government handouts'.[75,76] Moreover, about 13 per cent of non-Aboriginal respondents agree that 'non-Aboriginal and Torres Strait Islander Australians are superior to Aboriginal and Torres Strait Islander Australians'.[77] Among 5,000 respondents in a 2001 NSW/Qld survey, 28 per cent expressed concern about a close relative marrying an Aboriginal person. This figure was 25 per cent in a similar survey of 4,000 Victorians in 2006. However, in the 2008 and 2010 Reconciliation Barometers, only 11 per cent and 13 per cent of non-Aboriginal Australians had concerns with their child marrying an Aboriginal person.[77] There has also been a range of qualitative research examining lateral violence in Aboriginal communities.[78-80]

Across a number of studies, the prevalence of self-reported racism among Aboriginal participants varies from 16 per cent to 97 per cent. This variation is due to a number of factors common to survey research, including the number of questions asked about racism, the terminology used, areas where the survey was administered, and characteristics of Aboriginal people responding to these surveys. Of the 1,073 children aged between 12 and 17 years in the 2001–02 Western Australian Aboriginal Child Health Survey (WAACHS), 22 per cent reported experiencing racism (defined as being treated badly or refused service due to being Aboriginal) in the past six months.[81] A 2001 survey found that about 30 per cent of Aboriginal peoples reported discrimination due to ethnic origin[82] while a 2003 survey found that 40 per cent of Aboriginal respondents reported being physically or emotionally upset as a result of treatment based on their race.[83] Of the 9,400 Aboriginal respondents in the 2002–03 National Aboriginal and Torres Strait Islander Social Survey, 18 per cent reported experiencing discrimination as a personal stressor in the past 12 months.[84] About 16 per cent of the 5,757 Aboriginal adults in the 2004–05 National Aboriginal and Torres Strait Islander Health Survey who were asked about their experiences of racism felt they had been treated badly because they were Aboriginal/Torres Strait Islander in the past year[85] while 32 per cent of 345 respondents in a 2006–08 survey reported experiences of racism.[86] Of more than 10,000 respondents in the 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), 27 per cent reported racism experiences[87] while almost all (97 per cent) of 755 Aboriginal respondents in the Localities Embracing and Accepting Diversity (LEAD) project reported at least one experience of racism in the past year.[88] This LEAD survey also revealed that nearly three-quarters of participants anticipated people saying or doing something racist sometimes, often or very often and nearly

two-thirds sometimes, often or very often tried to avoid specific situations because of racism. Almost 70 per cent of respondents reported sometimes, often or very often worrying about racism.[88]

Although the prevalence of systemic racism is more difficult to establish, a range of studies highlight the widespread nature of such racism in domains such as national politics,[89] media,[90] education,[91,92] employment,[93] the welfare system,[94] the provision of public housing,[95] in the legal/criminal justice systems.[96] For example, evidence from Victoria indicates that, when apprehended by police, Aboriginal youth are two to three times more likely to be arrested and charged with an offence than non-Aboriginal youth.[97,98] Several chapters help to understand some of the issues surrounding the over representation of Aboriginal people in the criminal justice system—see, for example, Chapter 10 (Heffernan and colleagues); Chapter 21 (Milroy); and Chapter 22 (Walker and colleagues).

CONCLUSION

Contemporary life is always shaped by history and culture. Since the arrival of white people in Australia in 1788, Aboriginal and Torres Strait Islander peoples have experienced displacement, been the targets of genocidal policies and practices, had families destroyed through the forcible removal of children, and continue to face the stresses of living in a world that systematically devalues their culture and people. Such experiences have profound effects on health, mental health and social and emotional wellbeing, for individuals, families and communities. These experiences have been resisted, and the histories of resistance and resilience are as much part of contemporary Aboriginal culture and identity as are the experiences of devastation. It is important to remember also that Aboriginal culture and people are diverse; there is no single culture or people. There are important differences between Aboriginal people and Torres Strait Islanders, just as there are important differences within these broad groupings as a consequence of different histories and different geographic and social circumstances.

REFLECTIVE EXERCISES

1. This history and social issues chapter has been purposely written from a particular perspective. Is this different from other histories you have read about Australia? What are those differences and why do you think the authors choose to present Aboriginal and Torres Strait Islander perspectives in the way that they have?

2. From reading this chapter, what do you think are the main differences between Aboriginal and non-Aboriginal people?

3. What are the main characteristics of Aboriginal people's concepts about identity and perceptions about community?

4. The Stolen Generations is a topical issue in Australia now. Why is this so and why didn't the matter receive such attention before?

5. What approaches could be used to address racism against Aboriginal people in Australia? How would these approaches differ for individual vs. institutional vs. cultural racism?

6. Has this chapter made you re-examine some of your own experiences, perhaps as a target of racism, perhaps as a perpetrator, or perhaps as a bystander? When you mentally replay those experiences, what would you do differently, and why?

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2

Aboriginal and Torres Strait Islander Mental Health: An Overview

Robert Parker and Helen Milroy

OVERVIEW

This chapter initially examines the concepts of physical and mental health and wellbeing for Aboriginal and Torres Strait Islander peoples as they were understood and practiced over the vast majority of the last 40,000 years or so. The devastating consequences of the European colonisation of Australia for Aboriginal and Torres Strait Islander peoples are described. Tracking global developments in human rights, the chapter concludes with some innovative thinking from Australia and overseas that may assist Aboriginal and Torres Strait Islander peoples to regain their 'health' that has been so significantly lost.

MENTAL HEALTH AS A HUMAN RIGHT

It has been well recognised in the past 40 years that health is an essential component of human development and an important ambition for individuals and their society. The 1978 International Conference on Primary Health Care at Alma-Ata[1] stated that 'health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and the attainment of the highest possible level of health is a most important worldwide goal'.[1(p1)] The 1986 Ottawa Charter for Health Promotion[2] was built on the initial foundations of the Declaration of Alma-Ata. The Ottawa Charter reported that health 'is therefore seen as a resource for everyday life, not the objective for living' and 'as a positive concept emphasising social and personal resources as well as physical capacities'.[2(p1)] The Charter went on to define the prerequisites for health as: 'peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity'.[2(p1)]

The Recovery Movement

In recent years, there has also been an increasing interest in Recovery for people affected by mental illness. Leff and Warner (2006)[3] note that:

> the [Recovery] model refers both to the subjective experiences of hope, healing, empowerment and interpersonal support experienced by people with mental illness, their carers and service providers and to the creation of recovery-oriented services that engender a positive culture of healing and a support for human rights.[3(p162)]

The authors add that, as a result of the Recovery movement, there is renewed interest in fighting the stigma that leads people with mental illness to lose their sense of self. There is an understanding of the need to provide access to the services and education that give mental health clients the knowledge and skills to manage their illness, empowering consumers to share responsibility with providers in the healing process and providing access to peer support

that validates the possibility of recovery.[3] Parker[4, 5] has suggested initiatives such as economic and public policy strategies similar to those outlined in the Ottawa Charter[2] for empowering Recovery and reducing Aboriginal disadvantage that are also closely aligned with the recent Canadian and Australian economic policy initiatives to reduce Aboriginal disadvantage discussed later in the chapter.

The concepts of health developed by the World Health Organisation (WHO) were reaffirmed in 2007 in the *United Nations Declaration on the Rights of Indigenous Peoples* through Article 7, which states: 'Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of the person'.[6(p5)]

Traditional Culture and Aboriginal Health

Archaeological evidence suggests that Aboriginal people have been present in Australia for the last 45,000–50,000 years. The ethnographic evidence from early contact suggests that Aboriginal people who survived infancy were relatively fit and disease-free.[7(p121)] Further, Australia's native foods supported a nutritious, balanced diet of protein and vegetables with adequate vitamins and minerals, with little salt, sugar and fat. Life on the move kept people physically fit.[7(p122)]

In terms of mental health, traditional Aboriginal culture had a number of strong reinforcing factors that have been well defined by Professors Helen and Jill Milroy.[8] Aboriginal sense of self was seen in a collective sense, intimately connected to all aspects of life, community, spirituality, culture and country. Their culture also provided for everyone by sharing rules and understanding relationships. Kinship was of prime importance in defining social roles. Aboriginal people were also given a sense of meaning and understanding of life experience through their connection to country and their Dreaming. Spiritual beliefs offered guidance and comfort and held a sense of connectivity and belonging despite distress, death and loss. Lore, the body of knowledge that defined the culture, was highly valued, as were the tribal Elders who contained and interpreted the Lore. Customary law defined rules and consequences. Over 200 traditional languages and other methods of communication allowed a rich expression of interaction in this social context, and formal ceremony enabled a method of dealing with life's transitions through birth, initiation and death. Men and women had defined economic and cultural roles. Children were well protected within the group with a range of aunties and older siblings able to take over the child care role if the mother was fulfilling other communal responsibilities or was stressed.

These concepts mean that Aboriginal society, before European contact, provided the optimal conditions for mental health and social and emotional wellbeing (SEWB) that have been enunciated in later documents such as *Ways Forward*. Swan and Raphael comment:

> [T]he Aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. This holistic concept does not just refer to the whole body but is in fact steeped in harmonised inter relations which constitute cultural well being. These inter relating factors can be categorised largely into spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these inter relations is disrupted, Aboriginal ill health will persist.[9(p19)]

Aboriginal Mental Health

In the context of such parameters for general mental health, reports of severe mental illness affecting Aboriginal people in traditional cultural settings do exist. For instance, in the 1970s Jones and de la Horne[10, 11] describe the occurrence of schizophrenia and mood disorders among traditional Western Desert cultures. Eastwell[12, 13] reported on a potential familial susceptibility to delusional disorder in Arnhem Land. Meggitt[14] also described Aboriginal people suffering from psychosis and a probable dissociative disorder due to severe cultural stress in the Central

Desert. However, these reports appear to indicate that the experience of severe mental illness was a rare event in traditional Aboriginal culture. It is most likely that Aboriginal society and culture afforded protection for the less severe neurotic and adjustment disorders through the cultural permission to release hostile feelings rather than bottling them up, and through ascribing unusual events such as premature death to sorcery, a concept that carried significant conviction within the culture.[15]

Torres Strait Islander Mental Health

It is thought that a population may have been present in Torres Strait for 70,000 years. Statistics suggest that there may be better health, social and educational outcomes for current Torres Strait Islander peoples who continue to reside in their own traditional country.[16] It has been suggested that a cross-border treaty between Papua New Guinea and Australia in 1985 that enhances Torres Strait Islander economic and social prospects through sharing of fishing rights may be a further contributing factor to this improved health status.[17] However, this has been complicated in recent years by residents of Papua New Guinea, including those infected by HIV, moving into the Torres Strait communities to seek treatment.

Cultural Practices and Mental Health

Ketchell[18] reports on a number of cultural mechanisms that are important for Torres Strait Islander family members to maintain their mental health. These cultural issues revolve around the role of the *Mari Gethal* (Hand of the Spirit). This is a male relative of a deceased person who has to inform relatives of a loss and make arrangements for a funeral. On the *Umau Goega* or day of the death, the Mari Gethal brings tidings of the deceased to the community. *Mai* is the mourning conducted by the community for the deceased. A significant component of this is the formal dressing of the deceased, which is an important part of healing for the deceased's family and for the community. The 'dressing' signifies embalming the deceased. At the *Murama Theodan* or burial of the deceased, the *Mari Gethal* has the role of choosing the location of the burial site and organising its decoration. The funeral ritual concludes with the *Thoerabau Ai*, the burial feast. This used to be a feast to acknowledge the work of the *Mari Gethal* but is now generally regarded as a source of 'debriefing' for the entire community.

At the feast, the *Mari Gethal* can also assess the level of community grief and devise intervention strategies. Some time after the death, there is the *Tai* or *Markai* tombstone opening. This ceremony signifies that the deceased is finally housed and official grieving ceases. There is a feast and gifts are given to people who cared for the family of the deceased. Ketchell[18] notes that it is very important for Torres Strait Islander people to be able to fulfil these duties; mental illness may result if the duties are not able to be completed or if people are denounced by the clan group because they are perceived as not having fulfilled their responsibilities adequately. In addition, Ketchell[18] reports that Torres Strait Islanders may be affected by *Murr Merr* or *Uthia Tharan*. *Murr Merr* or *Uthia Tharan* are reports from community that damage the self-esteem of individuals. In a cultural context, they may be underlying issues causing anxiety, depression and paranoia and delusional disorders. In layman's terms it is 'gossip' despite all evidence or reason for not attending ceremonials.

CONTEMPORARY HEALTH AND WELLBEING

The reports of occasional mental illness in Aboriginal and Torres Strait Islander peoples notwithstanding, as detailed in Chapter 1 (Dudgeon and colleagues), colonisation has had far reaching consequences on Aboriginal health and SEWB. The decimation of Aboriginal populations, destruction of Aboriginal culture and significant disempowerment and marginalisation following the British colonisation of Australia has resulted in widespread, devastating effects on the physical and mental health of Aboriginal and Torres Strait Islander peoples. The issue of the Stolen Generations is a particular recent example of physical and psychological deprivation visited on Aboriginal children removed from their parents.

Aboriginal Health and Wellbeing

The current significant disadvantage of Aboriginal health and social determinants is well recognised. Hospitalisation rates for cardiovascular disease in Aboriginal and Torres Strait Islanders were 67 per cent higher in 2007–08 than for other Australians.[19] In 2009, rheumatic heart disease was 25 times more common for Aboriginal and Torres Strait Islanders than for other Australians in the Northern Territory.[19(p34)] Diabetes and renal failure also figure prominently in Aboriginal health issues. In 2004–05, three times as many Aboriginal and Torres Strait Islanders were reported to have diabetes or high sugar levels compared with other Australians.[20] Aboriginal and Torres Strait Islander peoples were 3.5 times more likely to be hospitalised with diabetes than other Australians.[21] End stage renal disease, often the consequence of poorly controlled diabetes, was almost eight times higher for Aboriginal and Torres Strait Islander peoples than for other Australians.[21] Given these alarming statistics, it is not surprising that life expectancy for Aboriginal and Torres Strait Islander peoples is estimated to be 11.5 years lower for males and 9.7 years lower for females than other Australians, an issue now well recognised in the *Closing the Gap* agenda.[21]

Aboriginal and Torres Strait Islander disadvantage is also apparent in other social indices. The 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) estimated that 25 per cent of the Aboriginal and Torres Strait Islander population aged over 15 years were living in overcrowded housing. The overcrowding becomes more common and problematic in remote areas where it is estimated that 48 per cent of Aboriginal and Torres Strait Islanders live in such housing.[22] In respect to education, the retention rate in 2010 for Aboriginal and Torres Strait Islander students in Year 7/8 to Year 10 was 96 per cent compared with 100 per cent for other students. Unfortunately, the retention rate for Aboriginal and Torres Strait Islander students from Year 7/8 to Year 12 was only 47 per cent compared with 79 per cent for other students.[23] Recent surveys have shown a welcome increase in Aboriginal and Torres Strait Islander participation in education and completion of Year 12.[24]

Some of the reasons for this disparity are illuminated in the case studies in Chapter 21 (Milroy) and Chapter 22 (Walker and colleagues) which discuss the emotional and behavioural issues for Aboriginal young people. Given this trend in education, and some of the complex issues surrounding the poor education outcomes, the accompanying statistics of significant Aboriginal and Torres Strait Islander disadvantage in employment and income compared with the rest of Australia are no surprise; neither are data from the Australian criminal justice system which show that Aboriginal and Torres Strait Islander peoples are 15 times more likely to be in prison than other Australians.[25] Refer to Chapter 10 (Heffernan and colleagues) for further discussion of Aboriginal mental health and the criminal justice system.

Poverty and Racism

Poverty and racism also provide a framework for these statistics related to Aboriginal health and wellbeing. Walter and Saggers[26] point to the significant association between poverty and adverse health outcomes. They note that a significant proportion of Australia's Aboriginal population live in a situation of absolute poverty as defined by the United Nations, where they have severe deprivation of basic human needs including food, safe drinking water, sanitation facilities, health, shelter, education and information. Some diseases, such as scabies and diarrhoea, which can have long term debilitating effects, are directly related to inadequate sanitation and living conditions.[19(p101)] The issues of Aboriginal poverty appear particularly marked in rural and remote areas. In addition, the failure of a recent plethora of policies to advance Aboriginal health has been attributed to a pervasive culture of welfare colonialism, an aspect of continuing poverty. According to Anderson, welfare colonialism affects Aboriginal communities that rely heavily on the provision of public sector resources.[27] Over time, the mechanisms to deliver these public sector resources overlie the traditional methods

of Aboriginal governance, reducing the capacity of the communities to develop leadership in the solutions to their problems. In addition, the continuing experience of widespread racism against Aboriginal people generally within the Australian community appears to have a continuing negative effect, particularly on the mental health of Aboriginal people.[28]

In addition, recent data from the Australian Institute of Health and Welfare (AIHW) indicate that Aboriginal and Torres Strait Islander children are twice as likely to live in single parent families (who are more exposed to poverty) and Aboriginal and Torres Strait Islander adults were more likely to be unemployed and have higher rates of homelessness than other Australians.[21] Furthermore, overcrowding and exposure to stressful events continue to be problematic.[21]

Child Safety

A perception of safety is also a crucial element of SEWB and mental health. Surveys have shown that Aboriginal and Torres Strait Islander peoples aged over 18 years are twice as likely to report being victims of violence or threatened violence than other Australians.[19] Further, in 2006–07, the rate of substantiated child protection notifications for Aboriginal and Torres Strait Islander children was 32 per 1,000 compared with six per 1,000 for other children.[19(p112)] This alarming trend with respect to child safety appears to be continuing with the following disturbing statistics for children in care:

> *For children aged 0–17 years in 2009–10:*
>
> * *The rate of substantiated child protection notifications for Aboriginal and Torres Strait Islander children was 35 per 1,000 children, over 7 times the rate for other Australian children (4.6 per 1,000);*
>
> * *The rate of Aboriginal and Torres Strait Islander children on care and protection orders was nine times higher than the rate for other Australian children (48 versus 5.4 per 1,000 children);*
>
> * *The rate of Aboriginal and Torres Strait Islander children in out-of-home care was almost 10 times higher than the rate for other Australian children (48 versus 5.0 per 1,000 children).[21]*

Life Stressors

Aboriginal and Torres Strait Islander peoples report significantly higher levels of stress than the wider Australian community. Fifty-two per cent of respondents in the *2004–05 National Aboriginal and Torres Strait Islander Health Survey* reported at least two life stressors over the previous 12 months, while 27 per cent reported four or more life stressors over the same period.[29] Multiple stressors were more commonly experienced in remote areas. Reported stressors identified include:

* the death of a family member or close friend;

* overcrowding at home;

* alcohol or drug-related problems;

* serious illness or disability; and

* having a family member sent to jail or currently in jail.[29(p23-4)]

The significant effect of stress on Aboriginal children in Western Australia is also of concern. The Western Australian Aboriginal Child Health Survey (WAACHS) reported that a significant number of Aboriginal children aged 4–17 years were living in families where seven or more major life stress events had occurred over the preceding 12 months.[30]

Impacts of Trauma on Mental Health

Recent neuroimaging and associated studies have shown that early trauma can have long lasting effects on brain regions, such as the amygdala, which process emotion, and make affected individuals more vulnerable to mental illness such as anxiety and depression in later life.[31-33] Husain comments on resilience and vulnerability factors for children affected by trauma:

> *Many factors contribute to resiliency in a child. Positive temperaments, secure attachment during early childhood, a supportive family and a special and positive relationship with an adult are worth mentioning. Vulnerability, on the other hand, involves a wide range of child and family-related factors that may increase the risk of developing behavioural and psychiatric problems. Poverty, early bereavement, physical and sexual abuse and a broken family may increase the vulnerability of a child to mental illness.[34(p279)]*

Sadly, many Aboriginal and Torres Strait Islander children exposed to trauma appear to have the factors that predispose to vulnerability rather than resilience in the context of their continuing life experience following trauma.

This phenomenon of 'malignant grief' is the result of persistent stress experienced in Aboriginal communities. Malignant grief is a process of irresolvable, collective and cumulative grief that affects Aboriginal individuals and communities (Milroy, 2005). The grief causes individuals and communities to lose function and become progressively worse; ultimately it leads to death. This grief has invasive properties, spreading throughout the body, and many of Australia's Aboriginal people die of this grief. The issue of malignant grief should also be viewed in the context of repeated generational trauma that affects some Aboriginal and Torres Strait Islander communities and which is discussed further in Chapter 17 (Atkinson and colleagues).

Stolen Generations

The WAACHS also reports on the psychological wellbeing of members of the Stolen Generations and their families. The survey noted that members of the Stolen Generations were more likely to live in households where there were problems related to alcohol abuse and gambling. They were less likely to have a trusting relationship and were more likely to have been arrested for offences.

Members of the Stolen Generations were more likely to have had contact with mental health services. The survey commented that children of members of the Stolen Generations had much higher rates of emotional/behavioural difficulties and high rates of harmful substance use.[30(p465)]

Substance Use

Given the high levels of background stress, substance misuse also figures prominently as a background factor to mental illness. It is well recognised that Aboriginal and Torres Strait Islander peoples experience harmful rates of alcohol and other substance use and that this tends to be more pronounced in rural communities.[16] See Chapter 8 (Wilkes and colleagues) for a detailed discussion of harmful substance use and mental health.

Aboriginal and Torres Strait Islander men are hospitalised at over four times the expected rate for population with severe mental illness related to substance misuse, and over double the expected rate for severe chronic mental illnesses such as schizophrenia.[35(p112)] The rates of hospital admission for severe mental illness in Aboriginal and Torres Strait Islander women is also substantially above expected rates for their numbers in the population.[35(p112)] Hunter[36] has recently argued that very high rates of psychosis affecting Aboriginal people in Cape York is the end result of a range of significant measures of disadvantage in the neurodevelopmental environments of the affected individuals including the dramatic changes and social chaos that followed the introduction of alcohol to communities in the 1980s, in addition to factors of

significant social adversity affecting their pregnancy and childhood—refer to Chapter 20 (Hayes and colleagues).

Death rates in the Aboriginal and Torres Strait Islander population secondary to substance misuse and mental illness are alarming. The death rate for Aboriginal and Torres Strait Islander peoples from mental and behavioural disorders due to psychoactive substance use is almost 12 time the rate for the Australian population in men and almost 20 times the rate of the Australian population for women.[35(p161)] In addition, the rates of death by suicide for Aboriginal and Torres Strait Islander men are almost three times the rates for the Australian population generally, discussed further in Chapter 9 (Silburn and colleagues).[35(p169)]

POLICY INITIATIVES FOR IMPROVING MENTAL HEALTH AND WELLBEING

The International Arena

Evidence from overseas indicates that enlightened government policy and enhanced control of socioeconomic factors by Aboriginal communities in respect to their health can lead to improved health outcomes, including mental health. Strengthening of the Maori health workforce in New Zealand has led to a number of successes including Maori-led, Maori-focused and Maori-targeted interventions, consistent investment over a prolonged period, and an emphasis on the development of dual cultural and clinical competencies.[37]

In the USA, a successful Native American Health Service development in the early 1990s appears to have been shaped by enhanced federal government administration for Native American Affairs in addition to the separation of the Native American Health Service from other Native American affairs and the provision of an integrated health service.[38] Ring and Brown[39] note a recent reduction in overall death rates for Indigenous people in the USA and New Zealand. While there does not appear to be a direct correlation between improved health services for Indigenous peoples in the two countries and improved mortality, there is a notable improvement in health status generally.

Studies of community control by First Nations groups in British Columbia and suicide rates within communities appear to show a direct correlation between increased cultural control within First Nation communities and reduced suicide rates.[40]

Another example of an overseas innovative government program was the strategic leadership recently shown in Canada through the Canadian Aboriginal Horizontal Framework.[41] A government policy closely aligned with principles for health developed in the Ottawa Charter[2] was coordinated between the Canadian federal government and provincial governments to address the disadvantage in Canadian First Nation social determinants across a wide front. Leadership from the top was a key initial factor in the development of the Framework, with the then Canadian Prime Minister committing to a round table discussion with all levels of Canadian government and First Nation leaders. A policy retreat followed with members of the Canadian Committee on Aboriginal Affairs and First Nations leaders. There was also a commitment to the development of an Aboriginal report card to track progress with the Canadian health strategy.

The Canadian Aboriginal Horizontal Framework was then developed as a strategic guide to funding priorities and cooperation between the various levels of government as well as allowing the establishment of performance indicators. The Framework appears to place the pillars of health at equal value. These pillars are:

- Health;
- Lifelong Learning;
- Safe and Sustainable Communities;
- Housing;

- Economic Opportunity;

- Lands and Resources; and

- Governance and Relationships.

Each of the pillars of the Framework can then be divided into sub-pillars. As an example, Safe and Sustainable communities are divided into Community Infrastructure, Social Support and Community Wellbeing, and Community Safety and Justice.

The Australian Policy Context

The Australian policy environment has recently produced a number of innovative solutions in government approaches to Aboriginal and Torres Strait Islander disadvantage. In 2007, Henry[42] suggested a broad approach across Australian Government departments to address Aboriginal and Torres Strait Islander health disadvantage, similar to the Canadian Framework and Ottawa Charter. Henry and other secretaries in the Secretaries Group on Aboriginal and Torres Strait Islander Affairs have identified seven platforms that need to be prioritised within a framework of Aboriginal and Torres Strait Islander capacity development:

- basic protective security for women and children;

- early childhood development;

- a safe and healthy home environment;

- an accessible primary care health service;

- ensuring that incentives in the welfare system do not work against promotion of investment in human capital;

- real job prospects as a result of education and governance systems that support political freedom; and

- social opportunities for local Aboriginal people to be engaged in policy development.

Henry[42] defines social elements of poverty that all have to be overcome before a society can move forward. These elements are the capacity to live without shame, the capacity to participate in the activities of the community, and the capacity to enjoy self-respect. Henry[42] further describes three key interdependent foundations to current Aboriginal and Torres Strait Islander disadvantage in Australia: poor economic and social incentives, the underdevelopment of human capital, and an absence of effective engagement of Aboriginal and Torres Strait Islander peoples in the design of policy frameworks that might improve these incentives and capacities.

Dillon and Westbury[43] also look to a number of ways that government can strengthen capacity within Aboriginal and Torres Strait Islander communities. They outline seven directions to enhance government's role.

Strengthening Capacity in Aboriginal and Torres Strait Islander Communities: Seven Directions to Enhance the Role of Government

- Acknowledgment of the 'tough' social and cultural environment surrounding Aboriginal and Torres Strait Islander health issues and a commitment to build sustained support structures that will operate effectively.

- Investment in cross-cultural communication and governance capacity.

- Rationalisation of short-term program delivery in Aboriginal and Torres Strait Islander communities through an increasing 'connecting government' approach.

Continued . . . .

Strengthening Capacity in Aboriginal and Torres Strait Islander Communities: Seven Directions to Enhance the Role of Government (continued)
• The re-establishment of a consistent and comprehensive regional framework for program delivery in remote Australia and the increasing use of Aboriginal and Torres Strait Islander local governments.
• A national commitment to a long-term development approach to strengthen capital stock such as essential services and housing in remote regions and build strong service delivery systems.
• Replacing a myriad of 'small niche programs' within Aboriginal and Torres Strait Islander communities with negotiated priorities for funding and support, and flexible program funding arrangements.
• Retaining or increasing the inherent flexibility of mainstream programs to deal with non-standard remote exigencies, to ensure that all Aboriginal and Torres Strait Islander citizens are getting equitable access to all program allocations.

Shifting Mental Health Perspectives

In the context of this emerging policy background, the approach of the broader Australian community to address issues of Aboriginal and Torres Strait Islander mental health and illness is of interest. Professor Hunter[44] notes an evolutionary progression of thought from an ethnographic fascination with issues of mental illness in Aboriginal and Torres Strait Islander peoples in the 1950s and 1960s, to an understanding of the social determinants of Aboriginal and Torres Strait Islander ill health in the 1970s and the increasing empowerment of Aboriginal and Torres Strait Islander health organisations in the 1980s and 1990s.

Other important factors such as the Royal Commission into Aboriginal Deaths in Custody (RCIADIC), the Commission into the Separation of Aboriginal and Torres Strait Islander Children from their Families and the establishment of the National Aboriginal Community Controlled Health Organisation (NACCHO), the Office of Aboriginal and Torres Strait Islander Health and the National Congress of Australian First Peoples also form a background framework for these and other initiatives. These developments are explored in more detail in Chapter 7 (Parker and Milroy) and in Chapter 5 (Zubrick and colleagues) which examines the evolving policy.

The achievement of better mental health and wellbeing will involve a revision of government attitudes and policies towards welfare generally. In addition it will require government commitment to specific programs to improve services for Aboriginal and Torres Strait Islander SEWB and for people suffering from mental illness.

It is increasingly recognised that improving community capacity with enhanced civic participation, leadership resources and stronger inter-organisational relationships will lead to improved health generally (including mental health) within the community.[45] There are a number of successful examples of this for Aboriginal and Torres Strait Islander communities. The OXFAM 'family placed projects' in the Gulf of Carpentaria aim to enhance community resilience against the effects of substance misuse by developing safe family place houses[46]. An innovative, community-based solution to an epidemic of suicide in the Tiwi Islands emphasised education in improved communication and coping skills for men's and women's groups in the community, in addition to developing enhanced community care and empowerment for vulnerable individuals.[47]

In addition to these innovative suggestions to rebuild the social capacity of Aboriginal and Torres Strait Islander communities—an essential prerequisite for re-establishing mental health—there

have been a number of programs specifically targeted to Aboriginal and Torres Strait Islander SEWB and services for those suffering from mental illness.

The Clontarf Foundation,[48] established in Western Australia (WA) in 2000, and now operating in over 40 schools throughout Australia, has had a number of significant achievements in keeping young Aboriginal males enrolled in school and then meaningful work following school. The Foundation works by establishing 'academies' within high schools that provide mentoring and educational support for the young men who wish to participate. The Australian Football League (AFL) is used as an attraction for youth's participation in the program and a number of ex-AFL players have become mentors for the Foundation.

The Billard Blank Page Summit[49] held at the Billard Community adjacent to Beagle Bay, WA, in 2009 developed some meaningful initiatives to reduce suicide in Aboriginal communities in the region. These included communities adapting a 'Community Code of Conduct' in the way individuals behave and nurture their children, training and supporting families to be functional and safe, and developing healing tools for individuals at risk of self-harm.

The most recent *Closing the Gap*: Clearing House report[50] also mentions a number of Aboriginal and Torres Strait Islander specific programs as well as general programs that may contribute to improved SEWB.

Other culturally-specific programs include:

- *the Family Wellbeing Program*[51] developed for people in South Australia and the Northern Territory that assists individuals to deal with day-to-day stressors and to assist others;

- *the We Al-li program* developed by Professor Judy Atkinson[52] that uses cultural practices and therapeutic skills to assist individuals to recover from transgenerational trauma—refer to Chapter 17 (Atkinson and colleagues);

- *the Marumali program* developed by Lorraine Peeters to train counsellors to assist individuals removed from their family as children—refer to Chapter 29 (Peeters and colleagues);

- *a women's healing camp* where guided mediation, reconnecting with past generations, narrative therapy and individual counselling were found useful for increasing the participants' sense of self-worth and assertiveness;[53] and

- *the Aboriginal Family and Community Healing Program* that works with Aboriginal families and communities in South Australia, involving them in education programs within the high schools, including nutrition and crisis support.[54]

A major strategic direction for the progression of mental health services for Aboriginal and Torres Strait Islander peoples was the development of the *Ways Forward* document in 1995. Swan and Raphael recommended a range of initiatives to deal with the major burden of mental illness within the Aboriginal and Torres Strait Islander population.[9(p11)] Key initiatives included self-determination within Aboriginal and Torres Strait Islander mental health service development, a holistic approach to mental health, specific services for population sub-groups, improved coordination of service delivery for people within mainstream health services, Aboriginal mental health worker (AMHW) and other staff development, and improved research. Many of these themes are continued in the key strategic directions of current policy frameworks for Aboriginal and Torres Strait Islander mental health, such as the *Social and Emotional Wellbeing Framework 2004–2009*.[55] Many of these themes are examined in detail in the chapters that follow. It has also been suggested that a formal organisation such as a college of Aboriginal and Torres Strait Islander health may significantly assist in the recognition of improved credentialing of standards for health professionals working with Aboriginal and Torres Strait Islander peoples, as well as improved recognition of the role of AMHWs.[56]

From the preceding, it can be seen that Aboriginal and Torres Strait Islander peoples appeared to have had a particularly effective understanding of mental health for the 40,000 years before European contact. This chapter has described pre-contact life as well as discussing some of the major impacts of colonisation on Aboriginal and Torres Strait Islander peoples. In the current policy environment, positive mental health requires major strategic review across a range of government policies. The aim would be to enhance Aboriginal and Torres Strait Islander economic and social capital in addition to specific policies to improve SEWB, as well as culturally appropriate services for people suffering from mental illness.

Other countries and other Aboriginal cultures appear to be leading the way here at present. However, in the current social and political environment of the Formal Apology to the Stolen Generations, *Closing the Gap*, and the current agreement that the Australian Government Department of Health and Ageing (now Department of Health)(DoHA) and the NACCHO is working towards, a brighter future for mental health for Australia's Aboriginal and Torres Strait Islander peoples is probable.

RESOURCE

The *Closing the gap clearing house: Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander People,* 2013[50] outlines a range of effective Aboriginal and Torres Strait Islander specific programs and general programs that have contributed to improved SEWB.

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3

A History of Indigenous Psychology
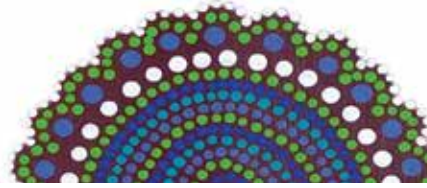
Pat Dudgeon, Debra Rickwood, Darren Garvey and Heather Gridley

OVERVIEW

This chapter discusses how the discipline and practice of psychology has been part of the colonising process influencing the mental health of Australian Aboriginal and Torres Strait Islander peoples. It outlines events where the discipline of psychology has been supportive of, and responsive to, the Aboriginal mental health movement, heralding the empowerment and inclusion of Aboriginal and Torres Strait Islander peoples at all levels of mental health service provision. The chapter identifies key milestones in psychology, pointing to positive ways in which psychologists can work together with Aboriginal Australians to improve their social, emotional and spiritual wellbeing. The chapter examines the different ways that psychology has impacted upon Aboriginal Australians—through science, practice and reflective action—and how these three domains intersect and interrelate, influencing the discipline's understanding of, and responses to, Aboriginal mental health and wellbeing.

THE DISCIPLINE OF PSYCHOLOGY

Psychology, as a science and profession, has impacted significantly on knowledge and perceptions about Aboriginal and Torres Strait Islander mental health. This review is relevant for psychologists and other practitioners working in the mental health field. 'Knowing the past' is complex, but not objective. There are multiple histories, and those that are prominent generally come from sources with the most powerful voice. All historical accounts need to be interpreted within this understanding.[1] It is with this critically reflective approach that the current chapter examines psychology's involvement with Aboriginal people.

Psychology comprises both scientific investigation and professional practice as applied to understanding human thoughts, feelings and behaviour to improve individual and community wellbeing. The mission of the Australian Psychological Society (APS), the peak professional body representing psychology in Australia, is to advance 'the discipline and profession of psychology for the benefit of our members and the communities they serve'.[2]

Nevertheless, psychology has been complicit in the colonising process and, as a dominant discourse, has been ethnocentric and has objectified, dehumanised and devalued those from culturally different groups. Furthermore, psychology has often been enlisted to enact or justify practices of assimilation and oppression.[1] Dudgeon and Pickett recommended that the discipline is well placed to support the empowerment and self-determination of Aboriginal people:

Australian psychology needs to recognise Australian Indigenous history and cultural difference, and more, to celebrate cultural difference. The understanding of Indigenous history must include awareness about contemporary Indigenous life and the diversity of Indigenous people'.[1(p86)]

PSYCHOLOGY AS SCIENCE

Psychology as a science is concerned with understanding human behaviour. Psychology has been involved with the 'race debate' and theories of race and human evolution; investigations of mental functioning and testing; and understanding racism, stereotyping and prejudice.

Human Evolution

Curiosity about the nature of the original Australians began with the first European explorers. It derived from growing European interest in the origins of life and the possibility of evolutionary development. Studies were initiated by biologists and anthropologists, but soon involved psychology. While Garvey provided a comprehensive overview of the history of psychology and Aboriginal people,[3] the current chapter addresses the key events of that history. Some of these are outlined on page 50.

Early scientific relationships with Aboriginal Australians were influenced by the dominant evolutionary views of social Darwinism[4] and social evolution,[5] which held that all things changed over time in one direction—from simple to complex and from relatively undifferentiated to more differentiated. English philosopher Herbert Spencer, who coined the phrase 'survival of the fittest', applied this theory to psychological and social processes. He maintained that just as human intellectual functioning proceeds from simple cognitions and reflex actions to more complex and general cognitions, society too becomes progressively more complex and highly organised. Spencer's theory incorporated the 'Lamarckian' notion of inheritance of acquired characteristics, so that humans acquired certain mental traits that favoured their continued existence, and these were passed on to their children.[6]

At that time, Aboriginal Australians were seen as humans at an 'early' stage of development. According to social evolution theory, all cultures evolved independently, and each went through the same necessary stages on their way to full evolutionary development. Aboriginal and Torres Strait Islander peoples attracted interest due to Australia's isolation, an island continent separated from outside influence on its flora and fauna (including human inhabitants), providing an 'untouched' environment for research into human evolution:

> *Australia represented a stage very close, as far as humanity was concerned, to that at which man had originated; the past had been miraculously preserved, and for those interested in the question of origins, here was a fleeting opportunity which needed to be grasped before it vanished inevitably under the impact of Western civilisation.*[7(p4)]

The theories of race that became human evolution theory during the late 19th century coincided with the establishment of modern science as the arbiter of truth and the emergence of psychology as a science.[8] Biological determinists argued that the behavioural, social and economic differences between human groups—races, classes and sexes—arise from inherited, inborn distinctions. Human societies were seen as an accurate reflection of biology.[9] There is a long history of bio-psychological explanations providing scientific legitimacy to dominant social values. Both the general public and psychologists accept biological explanations as scientifically objective. This has resulted in a psychological determinism that has supported a racist agenda. The hegemony of the scientific discourse also serves to manage ordinary voices of discontent and accounts of Aboriginal social realities. Psychology is committed to address these aspects of its colonial/colonising past.

An APS Position Paper[8] argued that developments in the study of the genetic basis of human diversity confirmed that the concept of race had no basis in fundamental biology and should be abandoned by scientists. At that time, genetic research revealed that there is more genetic variance observable within racial groupings than between them, and much greater overlap in the genetic inheritance shared by all human beings. Because within-group variation is greater than variation between groups, ethnic or racial membership alone cannot predict behaviours in any psychologically meaningful way.[10] Rejection of hierarchical conceptualisations of race based on genetic differences is now the dominant scientific position.

Recent advances in genomics and emerging forms of biotechnology have added considerable complexity to the ethical issues associated with such research. For example, research is now using DNA to map human migration and evolution[11] and to determine genetic risk factors for health disparities.[12] Biological bases of 'race' are again being used as explanatory frameworks. It has been noted that anti-racialism—that is, opposing racial categories—and anti-racism arguments have been used to perpetuate racist scientific agendas.[13] We need to remain vigilant to the very complex links between human scientific endeavour and implicit values placed on 'whiteness'; science is never objective, rather it is shaped by our personal and social values. Developments in the biological evidence base may be extrapolated to serve the social purposes for the dominant culture of the time.

Mental Functioning and Testing

Psychologists have long been involved in researching and testing mental functioning and intellectual capacity. To social evolutionists, the mental traits of individuals should be in line with the stage reached by their culture—for example, groups using stone tools should have simpler mental traits than those using bronze or iron. Consequently, the mental traits of a group considered to be at an early stage of cultural development should provide information on the mental functioning of all human groups at that same early stage, including the ancestors of the then fully developed groups (i.e. European). This view provided a strong impetus for the study of mental function in 'primitive man'.

Many psychologists have supported a biological determinist view with respect to the genetic underpinnings of intelligence.[14-16] In fact, it has been argued that the 'bell curve', or normal distribution, on which much of psychology is predicated, is an example of 'highly technical, statistically sophisticated, psychological research being used to support a sociopolitical agenda transparently geared toward victim blame'.[17(p41)]

Such scientific views and methods had a profound impact, and Aboriginal and Torres Strait Islander Australians were the main subjects in some influential early research studies. The Cambridge Anthropological Expedition took place in the late 19th century to study the people of the Torres Straits islands as a representation of 'primitive man'. Test scores on a number of sensorimotor functions were compared between people from Murray Island and a small number of English people. Overall, few differences were found, making it hard to interpret the results from a social Darwinist perspective, particularly those that favoured the Murray Islanders' performance.

Later, in the early 1900s, Porteus, a teacher at a special school, devised a series of maze tests to be used as a screening device for 'mentally defective' pupils. He used his test in a study of Aboriginal mission children and, later, with Aboriginal adults of the North Western and Central Australia (CA) regions.[18] He found that Aboriginal adults in these regions performed at generally lower levels than the norming samples, although there were interesting variations.[19] The Aboriginal peoples with the most exposure to Western school experience, such as the Hermannsburg people of CA, achieved a higher 'mental age' than those with less exposure, suggesting that intelligence was not biologically determined but a result of experience.

Following Porteus, over the next two decades from the 1930s, a study was undertaken by psychologists at the University of Western Australia. They tested Aboriginal men and women on stations in the Gascoyne region of Western Australia (WA) and remarked on the wide range of scores, commenting that 'some natives have intelligence of a high degree'.[19p(41-2)] The study indicated test score equivalence between Aboriginal and white Australian people, raising the question of the effects of differential experience on test performance.

Of these three studies of the first half of the 20th century, only the work of Porteus was widely reported by the press (e.g. the Adelaide Advertiser, 25 May 1929)[20] and that was interpreted as supporting the prejudice of mainstream society—that Aboriginal Australians needed 'civilising'. Such conclusions are likely to have influenced government policy to prioritise assimilationist strategies.

From the late 1950s, McElwain conducted a series of investigations of cognitive ability using the Queensland Test (QT) with over 1,000 Aboriginal children and adults who had varying degrees of contact with white Australian culture. It was concluded that:

> *the Aboriginal groups are inferior to Europeans, and in approximately the same degree as they have lacked contact with European groups … It seems clear that test results are dependent to a considerable degree upon contact or some variable related to contact.[21(p47)]*

Despite concerted efforts to modify the QT to be non-verbal and culture-neutral, this research clearly demonstrated that it is not possible to create a culture-free test unaffected by Western cultural experience on the test performance of non-Western children. Indeed, many tests appear to be measures of Western learning, a finding that strikes at the validity of instruments developed with other populations, and poses questions about the assumed universality of psychological phenomena that permits the application and authority of the tests in the first place. See Chapter 16 (Adams and colleagues) for further discussion of assessment and testing issues.

The intelligence-testing movement pioneered by Porteus supported educational, vocational and social policies that have oppressed Aboriginal people.[22, 23] In much of this debate, too little attention has been given to issues such as:

- differences in how 'intelligence' is constructed and expressed in different cultural settings;
- cultural biases in assessment instruments developed and normed in Western societies; and
- the different health, educational, community and cultural contexts of the groups involved.

As one commentator noted:

> *Although hundreds of tests and assessment procedures work reasonably well in the Western world, it must be proven and not assumed that they will work equally well in cultures where they were not developed.[24(p56)]*

From the mid-1960s, a number of researchers undertook Piagetian studies with Aboriginal children in remote areas. These studies revealed consistently later than 'average' development of the concepts under study, particularly for the concept of conservation.[25] Again, greater Western culture contact, particularly Western schooling, influenced higher Aboriginal scores.

The wide coverage of these results regarding Aboriginal deficits in Australia and abroad, is likely to have influenced the perceptions teachers held of the cognitive ability of Aboriginal pupils. The emphasis on developmental stages, which permeated early childhood and primary school education training courses would not have helped raise teachers' expectations of Aboriginal children. The Piagetian research may seem to be partly responsible for 'deficit' views, that Aboriginal children needed to change (or be changed) to fit better into Western education.[25] The basic assumption of cultural deficit or 'deprivation' was that, if a child's cultural learning

had not been that of Western children, it was deficient. It appears the imperative was to measure Aboriginal people prior to their predicted assimilation (or annihilation). At this point, the imperative had changed to ensure they were sufficiently assimilated.

In the lead-up to, and aftermath of, the nation-defining 1967 Referendum to count Aboriginal Australians in the national census, the 1960s–70s proved to be a watershed era in changing regard for Aboriginal Australians. The first Australian psychology volume focusing on Aboriginal people was published in 1973,[26] followed by an edited volume of a symposium held at the Australian Institute of Aboriginal Studies.[27] In 1981, Judith Kearins proposed that Aboriginal Australians have different cognitive strengths from other Australians.[28] Then, in 1985, the First Australian Conference on Testing and Assessment of Ethnic Minority Groups was held in Darwin, where psychologists and educators from around Australia discussed Aboriginal and other cultural group issues in education.[29]

This gradual shift in representations of Aboriginal Australians in psychological literature pre-1988, demonstrates an attempt to understand and categorise people who did not necessarily 'fit' easily into established categories, or who in other ways defied conventional understanding. Aboriginal and Torres Strait Islander peoples challenged many of the basic tenets of the profession. Most of this literature reflected the Western scientific paradigm and was aimed at addressing the 'Aboriginal problem'—the 'subjects of' and 'subject to' psychological research and intervention. Up to this time, non-Aboriginal psychologists led the revised approaches to mental functioning and testing of Aboriginal Australians. It was not until the 1990s that a small group of Aboriginal and Torres Strait Islander psychologists claimed a space in the emerging mental health movement to develop culturally appropriate assessment tools for their own people.

Stereotyping and Prejudice

Social psychology has had a critical impact on our understanding of prejudice and racism, and has at times supported institutionalised racism by representing prejudice as a 'natural' human process and by locating the origins of prejudice within the individual rather than in society. Contemporary social psychology argues that people categorise people into social groups and then stereotype on the basis of group membership. Social categorisation is primarily based on salient and identifiable features of a person such as their age, gender, race, ethnicity and social status. Stereotypes, as generalised descriptions of a group and its members, emerge from this categorisation process. Both categorisation and stereotyping are adaptive in that they simplify the complexity of the social world and provide us with cognitive shortcuts to help negotiate social reality.[30]

The dual processes of social categorisation and stereotyping can lead to prejudice, by favouring one's own group (ingroup) and discriminating against groups to which one does not belong (outgroups). Many laboratory and field studies have shown that the mere act of categorising individuals into distinct groups is sufficient to trigger ingroup favouritism and outgroup discrimination.[31] The centrality of social categorisation and stereotyping to human cognition has led many social psychologists to conclude that prejudice is a natural and inevitable consequence of these normal cognitive processes.

Other social psychologists have argued that affective or motivational factors are equally important in the manifestations of prejudice which are learned dispositions, and not necessarily derived from cognitive categorisation.[32] Developmental psychology and social learning theory maintain that there are mechanisms by which children acquire stereotypes of their culture. For example, they may receive direct instruction that particular racial groups are 'dirty' or 'can't be trusted'. They are also likely to make unconscious inferences from the behaviour and attitudes they observe exhibited by people around them; in early childhood, this usually means parents,

but as the child grows it includes teachers, peers and the media. It has been demonstrated that, if ingroup/outgroup distinctions are de-emphasised in the child's social world, positive models are provided, and the social distance between the child's group and other groups is reduced, then the development of prejudicial attitudes and discriminatory behaviour can be significantly reduced.[33]

The view that prejudice is an individual phenomenon or a personal pathology, rather than a social construction, has been supported by some psychological research approaches. An extensive literature on the 'authoritarian personality' maintained that some individuals are predisposed to prejudice as a result of personality tendencies to be politically conservative and fascist.[34, 35] The 'authoritarian personality' has not been widely accepted as a wholly credible account of the origins of prejudice, however, and a more contemporary and consensual view is that, while personality factors undoubtedly play a role in prejudice, the roots of prejudice primarily involve processes of social learning and social categorisation.

A particularly useful contribution of social psychology has been in understanding how marginalised social groups internalise prejudice and oppression.[36-38] Internalised oppression has been defined as the incorporation and acceptance by individuals within an oppressed group of the prejudices against them within the dominant society. Internalisation of their devalued status and feelings of oppression can lead to the adoption of denigrating views and judgments both about themselves and about others in their racial or ethnic group. This process is actively encouraged and reinforced by the dominant group's own process of internalised domination. This tendency of oppressed groups to take out their frustration and rage on each other is termed lateral violence.[39] Such outcomes support the urgent need to focus on empowerment and self-determination for Aboriginal and Torres Strait Islander Australians.

A powerful and positive example of an Aboriginal-led initiative was the 2009 National Research Roundtable on Racism Towards Indigenous Australians. The APS, with the Australian Indigenous Psychologists Association (AIPA) and the Centre for Research Excellence in Aboriginal Health and Wellbeing, co-hosted the Roundtable alongside several other key organisations. The roundtable was initiated by then AIPA Chair, Pat Dudgeon, as one way to renew the momentum generated a decade previously for psychology to take an active role in combating racism.[40]

The pervasive effects of cultural and institutionalised racism exist within professions, disciplines and institutions—they are often invisible, with the dominant group being seen as normal or the standard against which all else are judged, while those not part of the dominant group are viewed as abnormal or inferior and in need of correction. All disciplines need to examine their role within the social and political structures and systems that give rise to, and perpetuate, racism. It is in this vein that Reconciliation Australia advocates for organisations, corporations and professional bodies to develop their own Reconciliation Action Plans (RAP).[41] A RAP publicly formalises an organisation's contribution to reconciliation and to actions that embed cultural change, in consultation or partnership with Aboriginal and Torres Strait Islander communities, organisations and leaders. Psychology has enacted institutionalised racism, but it has also used its science, practice and advocacy in ways that 'work with' rather than 'work on' Aboriginal and Torres Strait Islander Australians.

PSYCHOLOGY AS PROFESSIONAL PRACTICE

The practice of psychology has had a profound impact on mental health interventions, and also on broader health and human welfare service delivery. The negative impact of psychology has been evident through an emphasis on a deficits model, intervening through mainstream assimilation approaches, and the provision of assumed 'expertise'. Positive impacts have been through more recent support for the empowerment of self-determinism of Aboriginal

and Torres Strait Islander peoples, and the input of community and health psychology to understanding the social determinants of health and wellbeing, particulary the social disadvantage and fundamental importance of empowerment.

It is not possible to determine the distinct impact of psychology as a profession in the early years of the previous century, because the profession was not clearly established. However, during the period up to the 1970s, there was a pervasive influence of mainstream scientific views to which psychology contributed in the policies of the day. Notably, the policies of 'Aboriginal protection' derived from the prevailing scientific views that applied inferior normative comparisons and deficit models to Aboriginal peoples, and adopted a victim-blaming orientation.

These views culminated in the Stolen Generations through the removal of Aboriginal children under child protection laws, which took place mostly between 1869 and 1972. These policies operated across Australia until (and even beyond) the growing focus in mainstream developmental psychology on attachment theory and the essential nature of mother-infant bonding began to prevail.[42-44] Consequently, Aboriginal and Torres Strait Islander peoples experienced a long history of mistreatment by mainstream health and welfare services, and have become understandably mistrustful and fearful of contact with such services. Historically, diagnoses of mental illness or mental health problems have been used to disempower and disadvantage those from marginalised groups, and this gives Aboriginal people a strong reason to avoid contact with mental health services.

The mental health system (psychiatry in particular) received considerable criticism from the Royal Commission into Aboriginal Deaths in Custody (RCIADIC).[45] Similarly, analyses under the National Aboriginal Health Strategy (NAHS) revealed pervasive indifference on the part of health professionals to the disadvantage experienced by Aboriginal and Torres Strait Islander peoples within the mental health system.[46] The ethnocentric 'expertise' of mainstream mental health services negated awareness of the unique needs of, and impeded acknowledgment of the profound impact of invasion and colonisation through grief, trauma, and social and emotional distress in, Aboriginal and Torres Strait Islander communities.[47] Misdiagnosis has been common because of a failure to recognise and understand the social and emotional context of presenting problems for Aboriginal Australians. Concomitantly, stigma and lack of cultural understanding have inhibited acknowledgment of mental health problems. Significant inroads are being made in this area. Notable are mental health assessment measures developed by Aboriginal psychologist Tracy Westerman, and other culturally appropriate assessment tools[48]— see Chapter 16 (Adams and colleagues).

Recent approaches to cultural competence training developed by the AIPA for psychologists and other mental health professionals have taken Indigenous realities as their starting point, by working within a social and emotional wellbeing framework rather than assuming a more traditional psycho-medical paradigm.

THE ABORIGINAL MENTAL HEALTH MOVEMENT

Over the decades leading to the 1990s, a groundswell of activity by Aboriginal mental health professionals established a voice in mental health issues of Aboriginal Torres Strait Islander Australians. It was not until *200 Years of Unfinished Business* was published in 1988 by an Aboriginal mental health professional Pat Swan, that changes emerged. This text was the main reference in the NAHS (1989)[49] and was heavily quoted by RCIADIC (1991)[50] which led to the Ways Forward Report (1995).[51] The Ways Forward Report was a result of a national consultation that ended in the National Aboriginal Mental Health Conference in Sydney in November 1993, drawing together more than 900 people, and the *Bringing Them Home* Report *(1997)*[52] and other relevant texts and policies. See Chapter 5 (Zubrick and colleagues) for a discussion of these policies and reports.

Perceptions of Aboriginal and Torres Strait Islander mental health changed to prioritise wellness, holistic health, and culturally informed and appropriate approaches over the 'disease model' perspective.

Dudgeon and Pickett described these changes in perceptions towards Aboriginal and Torres Strait Islander mental health as underpinned by a philosophical approach of empowerment and self-determination in the provision of mental health services for Aboriginal people.[1] Self-determination means that services need to ensure that mechanisms are in place for collaboration and direction from the client groups, and Aboriginal people need to be fully involved in any mental health activity aimed at them. Aboriginal and Torres Strait Islanders themselves need to direct the engagement at all levels, whether this is an interaction between a psychologist and a client, or establishing services and developing policy. Psychologists have gradually acknowledged this changed perspective, although many challenges remain and Aboriginal psychologists continue to call for appropriate inclusion of Aboriginal people: 'Professionals, their organisations and management groups in the mental health field need to learn to work with Aboriginal people and not to continue to work on them'.[53(p.7)]

As well as facilitating a culturally competent profession, an Aboriginal mental health workforce needs to be a priority. The number of Aboriginal psychologists has grown since 2000 from less than twelve, to at least 50 in 2012. However, AIPA has estimated that if the proportion of Aboriginal and Torres Strait Islander psychologists matched that in the general population (2.5 per cent), there would be 625 Aboriginal and Torres Strait Islander psychologists, showing there is still a long way to go to achieve adequate representation in the profession.[54]

Between the national soul-searching of the 1988 bicentennial and Prime Minister Paul Keating's Redfern speech in 1992, powerful counter-narratives emerged that foregrounded Aboriginal voices and perspectives on a whole range of issues, including health, justice, native title and education. In this space, the Australian governments initiated the National Mental Health Strategy in 1992 to correct decades of neglect and assure the rights of people with mental illness.

The Burdekin Report that came from this, exposed the devastating personal consequences of inadequate mental health and welfare services. One chapter focused on Aboriginal and Torres Strait Islander mental health. This captured the concerns about a range of issues—the need for inclusion of historical, social and political contexts, the need for a human rights approach, the need for culturally appropriate approaches, services and workforce, and the importance of self-determination. This meant providing Aboriginal people with the training, power and resources to determine their own mental health services and programs within their own terms of reference.

> *…the bald fact is that the symptoms will not go away even with the best service provision until there is real progress on the fundamental cause, which is to ensure access to Aboriginal mental health through Aboriginal self-determination in all aspects of life to make possible a dignified Aboriginal life which is viable and meaningful as seen and experienced and constructed by Aboriginal people themselves.[55(p315)]*

PSYCHOLOGY CONFRONTING CHANGE

Psychology has a fairly recent history in relation to Aboriginal and Torres Strait Islander mental health and wellbeing. Although the APS has been involved in Aboriginal issues since the 1960s—when a Queensland group sent submissions to government on secondary education, child welfare and Aboriginal welfare—a major turning point was in 1988, a significant year for two reasons. First, it was the bicentennial of European settlement/invasion of the Australian continent by the English colonisers. Second, it was the year when about 4,000 psychologists from around the world gathered in Sydney for the 24th International Congress of Psychology; many Australian psychologists felt that Australian psychology had come of age with this conference.

Yet, despite the bicentennial being a catalyst for many Anglo-European Australians to become aware of their ignorance about the destructive effects of official policies of 'separation', 'protection', 'assimilation' and 'integration' as legacies of an inherently racist society, as well as of the ongoing effects of common prejudice and discrimination in everyday life, there was a complete absence of Aboriginal content or discussion as part of the program.

The only Aboriginal representation was a photographic exhibition with a section on 'Indigenous Aspects of Australian Psychology', which included photographs of Aboriginal skulls collected by 'craniometrists, anthropometrists and psychometrists',[56] displayed without apology or apparent recognition of the insensitivity of such a display. Significantly, 22 years later at the next international congress hosted in Australia, ICAP 2010, Garvey presented a paper reflecting on these events[57] and on the parallel publication in the Annual Review of Psychology Bicentennial and International Congress of an article by Taft and Day on Psychology in Australia, which was equally insensitive in its reference to Aboriginal people.[58]

Shared concerns about these representations and omissions led to what was then the APS Board of Community Psychologists to embark on a consciousness-raising process, using the annual APS conferences as a major vehicle. A symposium on the Psychology of Indigenous People at the 25th Annual Conference of the APS was held in Melbourne in 1990. The symposium featured the first ever presentations by Aboriginal speakers, with Tracey Bunda presenting a paper about Aboriginal identity written by Dudgeon and Oxenham.[36] Following the conference, a group of 28 delegates set off on the Maralinga Workshop, a seven-day journey to meet with Elders of the Maralinga Tjarutja community in the South Australian desert. This was the first activity of its kind designed for psychologists to learn of, and highlight first-hand, the issues of social (in)justice and their effects on Aboriginal people.[59]

At the 26th Annual Conference in Adelaide in 1991, the APS Interest Group on Aboriginal Issues, Aboriginal People and Psychology was formed, as a principal advocate on Aboriginal and Torres Strait Islander issues from the Board of Community Psychologists. The Interest Group has continued to prioritise these issues at the APS annual conferences; organised mini-conferences in Perth (1993 and 1998); run professional development programs with psychologists and other professionals, including Aboriginal Health Workers (AHWs), in several states; contributed to APS Position Papers and submissions to national inquiries; and mentored Aboriginal psychology students.[60] In 2012, the group, now the Aboriginal and Torres Strait Islander Peoples and Psychology Interest Group (ATSIPP), celebrated its 21st anniversary with a retrospective issue of its online newsletter, noting the shift in its role following the emergence of AIPA. ATSIPP continues to progress the aims of Reconciliation within and beyond the profession.

> *The 1990s witnessed a change in the quality and quantity of literature produced, much of it a reflective exercise devoted to the ethical, practical and political concerns of Indigenous people vis-a-vis psychology, an increasing corpus of which was produced by Indigenous people themselves.*[57(p9)]

In 1993, the APS established a working party to prepare guidelines to assist psychologists who work with Aboriginal people.[61] The resulting Guidelines for the provision of psychological services for, and the conduct of, psychological research with Aboriginal and Torres Strait Islander peoples of Australia now form part of the Ethical Guidelines companion booklet to the APS Code of Ethics, by which all APS psychologists are required to abide. Adoption of the Guidelines prompted the inclusion in the APS Code of Ethics of a General Principle III(b) requiring that psychologists:

> *must be sensitive to cultural, contextual, gender, and role differences and the impact of those on their professional practice on clients. [Psychologists] must not act in a discriminatory manner nor condone discriminatory practices against clients on the basis of those differences.* [62(p1)]

The inclusion of this General Principle acknowledged the pluralistic context of research and professional practice in Australia, and expanded the definition of professional competence to incorporate cultural competence. The notion of cultural competence is also embodied in the *National Practice Standards for the Mental Health Workforce (2013)*[63] which cover all five professions as well as recommendations to inform the mental health curriculum. See Chapter 12 (Walker and colleagues) for a discussion of strategies for becoming culturally competent practitioners. The most recent revision of the Code goes further, affirming all people's 'right to linguistically and culturally appropriate services' and incorporating an advocacy role when psychologists become aware of discriminatory practices or systems experienced by their clients.[64(p11)]

Since 1995, the APS annual conference has included a specific program for Aboriginal and Torres Strait Islander mental health professionals presenting papers. The 30th APS Annual Conference in Perth that year marked a significant change. There were numerous sessions in the program including the first Aboriginal welcome to country at the opening, and many cultural activities. Importantly, there was the first Aboriginal keynote presentation by Rob Riley who made a 'Charge' to Psychologists at the end of his paper which still remains relevant today.[65(p15-16)] See page xvi for an extract from that paper.

In 1997, the APS Position paper on racism and prejudice reviewed recent Australian research in the area.[8, 40] This was a significant step towards formally recognising that racial and ethnic prejudice still exists in Australia, increasing psychologists' sensitivity to their effects on Aboriginal people, and reducing professional ignorance about various forms of present-day racism. These steps contrasted with Davidson and Sanson's observation two years earlier that:

> *Failure to speak about, or engage in social action against, social practices when evidence is available to psychologists that these infringe against rights and discriminate against persons may be construed as condoning these practices.*[66(p3)]

In 1998, the Centre for Aboriginal Studies led by Pat Dudgeon, and the School of Psychology at Curtin University convened a mini-conference to overview and discuss Aboriginalising the psychology curriculum. Some of these educational activities were presented in a special issue of the Australian Psychologist.[67, 68] This volume was unprecedented in its focus and in its genuine collaboration between Aboriginal and Torres Strait Islander and other mental health professionals.

The APS is now committed to enabling the profession and discipline of psychology to acknowledge and support the social and emotional wellbeing of Aboriginal and Torres Strait Islander Australians, as described in Chapter 4 (Gee and colleagues). This commitment includes teaching Aboriginal content in undergraduate psychology courses, offering bursaries and other supports to encourage and enable Aboriginal people to pursue careers in psychology, as well as ongoing examination of the role and impact of the profession in this field to ensure both cultural relevance and affirmation in both teaching and practice through ATSIPP and other mechanisms of the APS.

In 2011, the APS formally committed to the development of a Reconciliation Action Plan (RAP) in partnership with AIPA, as a means of 'building respect, relationships and understanding between Indigenous and other Australians to close the gap in mental health and wellbeing outcomes'.[69(p9)] The plan identified four broad areas as priorities for action:

- respectful relationships;
- governance;
- cultural competence; and
- Aboriginal and Torres Strait Islander education and employment.

The RAP recognises the UN Declaration of the Rights of Indigenous Peoples, and represents the development of a greater awareness and responsibility within the discipline and profession. However, these developments have so far been located almost entirely within the APS. Bodies such as the Psychology Board of Australia, the Australian Psychology Accreditation Council, and the Heads of Departments and Schools of Psychology Association also have key roles to play in any genuine and sustainable transformation of the discipline and profession.

One of the most significant developments has been the formation of AIPA in March 2008 under the auspices of the APS. AIPA members are in demand individually and as a group for media comment, student mentoring, cultural competence training and partnerships with local communities. The invitation by the Australian Human Rights Commission for AIPA to join the leadership group of the *Close the Gap* campaign placed psychology and mental health firmly on the agenda of the major national Aboriginal and Torres Strait Islander health equality campaign. AIPA provides the secretariat for the Aboriginal and Torres Strait Islander Mental Health Suicide Prevention Advisory Group (ATSIMHSPAG), a ministerial advisory group established by the Federal Ministers for Mental Health and for Aboriginal and Torres Strait Islander Health, with Pat Dudgeon and Tom Calma as co-chairs. The group's membership includes 20 representatives of key stakeholder bodies from around the country. ATSIMHSPAG advises the Ministers on the design and implementation of measures in the Government's Delivering National Mental Health Reform package, the National Aboriginal and Torres Strait Islander Health Suicide Prevention Strategy and the renewed national Social and Emotional Wellbeing Framework. Significantly, Pat Dudgeon was also the only psychologist appointed to the inaugural Mental Health Commission established in 2011.

CONCLUSION

This Chapter has tracked the role of psychology in contributing to cultural and institutionalised racism. Acknowledging and owning this history enables us to learn from the mistakes of the past and move forward. Awareness of this history will help psychologists to understand Aboriginal and Torres Strait Islander peoples' suspicion of, and reluctance to engage with, psychology as a profession. Historically, the science and practice of psychology reflect and influence mainstream Western scientific values that have perpetuated and excused racism. While the discipline and profession have matured to acknowledge their role in this history, there must be ongoing reflection and action regarding the cultural relevance and utility of theories, research methodologies and professional practice. It is essential that psychology continues to work towards the goal to 'train members of our profession to be part of the multiple solutions to racism and Aboriginal disadvantage, rather than part of the problem'.[70(p6)] Doing so will align our actions with the Apology delivered by the Prime Minister on behalf of Australian peoples in February 2008, which recognised the harm caused by the mistreatment of Aboriginal Australians through the policies and practices of past governments. It will also enable psychologists to take up 'the Charge' by Rob Riley that psychology acknowledge its past and look towards new solutions and approaches and commit to principles of mutual respect, inclusion and shared responsibility in moving forward to a better future.[65] As Pat Dudgeon declared in launching the APS RAP:

> *Reconciliation is a two way process, it gives us all the chance to learn, value and respect new and different forms of knowledge and healing. It enables us to learn about how best to work in ways that will assist Aboriginal and Torres Strait Islander peoples to heal, and go on feeling worthwhile and healthy in their lives. It also provides an opportunity to enhance our profession through the wisdom of Aboriginal and Torres Strait Islander cultures and experiences.[69(p6)]*

Timeline of the History of Psychology and Aboriginal People

Psychology Events		Aboriginal Responses
	1986	- Ottawa Charter for Health Promotion
24th International Congress of Psychology, Sydney Review of psychology in Australia	**1988**	- Bicentennary 'Celebration of the Nation'
	1989	- A National Aboriginal Health Strategy
25th Annual APS Conference, Melbourne 'The Psychology of Indigenous People' Symposium	**1990**	
26th Annual APS Conference, 'Aboriginal Issues' Aboriginal People and Psychology Interest Group formed	**1991**	- Royal Commission into Aboriginal Deaths in Custody Council for Aboriginal Reconciliation Act
Psychology Program Workshop, Cairns APS Working Party was established Mini-conference was held in Perth	**1992**	- Mabo Decision - Social Justice Commissioner appointed as part of HREOC - Paul Keating Redfern speech

	1993	- National HREOC Inquiry into Human Rights and Mental
		  Illness
		- First National Aboriginal Mental Health Conference 'Our
		  Way'
		- International Year of Indigenous Peoples

Representations of psychology in Aboriginal Australia	**1994**	- International Decade for the World's Indigenous Peoples
Guidelines for the provision of psychological services	**1995**	- Ways Forward Consultancy Report
30th Annual APS Conference, Perth	**1996**	- Rob Riley's keynote address at the APS Conference, Perth - First National Reconciliation Week

Racisim and Prejudice: Psychological Perspectives - APS Position Paper	**1997**	- Bringing Them Home Report of the National Inquiry into
		  the Separation of Aboriginal and Torres Strait Islander
		  children from their families

32nd Annual APS Conference, Cairns Mini-conference held in Perth	**1998**	- Aboriginal Reconciliation Convention
	1999	- National Statement on Ethical Conduct in Research involving Humans
Working with Indigenous Australians: A Handbook for Psychologists (Dudgeon et al)	**2000**	- Decade of Reconciliation
National Workshop on psychology and Indigenous Australians, UniSA	**2001**	
	2002	- The NHMRC Road Map: A strategic framework for improving Aboriginal and Torres Strait Islander health through research

	2003	- Values and Ethics: Guidelines for Aboriginal and Torres Strait
		  Islander Health Research
		- National Framework for Aboriginal and Torres Strait Islander
		  Social and Emotional Wellbeing
		- National Coalition of Aboriginal and Torres Strait Islander
		  Social Workers Association first National Conference

	2005	- Social Justice Report - WA Aboriginal Child Health Survey: Vol 2, SEWB
	2007	- UN Declaration on the Rights of Indigenous People
43rd Annual APS Conference Formation of AIPA	**2008**	- 'Close the Gap' campaign launched - Kevin Rudd's Apology to the Stolen Generations
National Research Roundtable on Racisim towards Indigenous Australians	**2009**	- Billard Blank Page Summit - Boatshed Declaration against Racism initiated by AIPA, Perth - Living on the Edge, AIPA
27th International Congress of Applied Psychology	**2010**	- Working Together Book (First Edition)
Development of a Reconciliation Action Plan (RAP) with AIPA	**2011**	
ATSIPP celebrated its 21st anniversary	**2012**	- Formation of Aboriginal and Torres Strait Islander Mental Health and Advisory Group
	2013	- Formation of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group

Design: Chrissie Easton

REFLECTIVE EXERCISES

1. This chapter gives a particular perspective on the historical impact and potential role of psychology in Aboriginal and Torres Strait Islander mental health including a timeline of key events empowerment. Consider your lifeline and how it overlaps with the timeline— what key events have shaped your values in relation to science, practice and advocacy?

2. Why is it important for mental health professions to 'know the past'?

3. What roles could Aboriginal and non-Aboriginal psychologists have in Aboriginal and Torres Strait Islander mental health? When should these be different? When should they be the same?

4. What key factors in psychology supported the Aboriginal mental health movement, and what more is needed to sustain or accelerate change going forward?

5. What actions towards Reconciliation could set your practice, your workplace, your university, and/or psychology apart from other organisations and professions?

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4

Aboriginal and Torres Strait Islander Social and Emotional Wellbeing

Graham Gee, Pat Dudgeon, Clinton Schultz, Amanda Hart and Kerrie Kelly

OVERVIEW

This chapter examines understandings of social and emotional wellbeing (SEWB) with the aim of clarifying the relationship between SEWB, mental health and mental health disorders from an Aboriginal and Torres Strait Islanders' perspective. The chapter begins with a brief historical overview of how the term 'social and emotional wellbeing' emerged as a signifier of Aboriginal and Torres Strait Islander concepts of health. We define SEWB as a multidimensional concept of health that includes mental health, but which also encompasses domains of health and wellbeing such as connection to land or 'country', culture, spirituality, ancestry, family, and community.[1] The domains and guiding principles that typically characterise SEWB are outlined and situated within a framework that places Aboriginal and Torres Strait Islander world views and culture as central. The importance of recognising social, cultural, historical and political determinants in shaping Aboriginal and Torres Strait Islander SEWB is also discussed. We suggest that working within a SEWB framework involves developing an understanding of how these principles, domains and determinants manifest and operate at a local level, and explore how to apply these in a practical setting.

INTRODUCTION

Health and wellbeing are complex concepts and there is no clear consensus across or within cultures as to how these constructs should be defined.[2, 3] Policy makers, researchers and practitioners working to improve the SEWB and mental health of Aboriginal and Torres Strait Islander peoples in Australia have to grapple with the task of defining these health concepts in terms that are relevant and consistent with Aboriginal and Torres Strait Islander understandings and experiences. The linguistic and cultural diversity that exists within Aboriginal and Torres Strait Islander cultures needs to be acknowledged from the outset, as there are significant differences in the way SEWB, mental health and mental health disorders are understood within different Aboriginal and Torres Strait Islander communities across Australia. Similarly, the variation in other Australian understandings of what constitutes mental health and mental health disorder also needs to be recognised.

SEWB WITHIN ABORIGINAL AND TORRES STRAIT ISLANDER CONTEXTS

The World Health Organisation's (WHO's) Alma Ata Declaration on Primary Health Care (1978)[4] signalled a shift in thinking about health that mobilised a movement to tackle 'politically, socially and economically unacceptable' health inequalities through the delivery of comprehensive primary health care.[4] At the time, these global shifts in approach to health care were seen to be consistent with the views of Aboriginal people and the establishment of

Aboriginal Community Controlled Health Organisations (ACCHOs) that began in the 1970s. The uptake of the term 'SEWB' to reflect holistic Aboriginal and Torres Strait Islander concepts of health can be traced to the early efforts of these organisations to define health from an Aboriginal perspective. In 1979, the National Aboriginal and Islander Health Organisation (now the National Aboriginal Community Controlled Health Organisation) adopted the following definition of health:

> *Aboriginal health does not mean the physical wellbeing of an individual, but refers to the social, emotional, and cultural wellbeing of the whole community. For Aboriginal people this is seen in terms of the whole-life-view. Health care services should strive to achieve the state where every individual is able to achieve their full potential as human beings, and must bring about the total wellbeing of their communities.*

This definition was used in the first National Aboriginal Health Strategy (NAHS).[5] In the section devoted to mental health, the NAHS Working Party held a strong line, arguing that 'mental health services are designed and controlled by the dominant society for the dominant society' and that the health system had failed 'to recognise or adapt programs to Aboriginal beliefs or law, causing a huge gap between service provider and user'.[5] One of the strategy's key recommendations was for a health framework to be developed by Aboriginal and Torres Strait Islander peoples that recognised the importance of culture and history, and which defined health and illness from an Aboriginal and Torres Strait Islander perspective. The Royal Commission Into Aboriginal Deaths In Custody (RCIADIC)[6] closely followed the release of the NAHS (1989),[5] and implementation of the strategy was one of the commission's recommendations, as was the need for a national consultancy on Aboriginal and Torres Strait Islander mental health. The latter culminated in the landmark *Ways Forward* National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health.[7] As detailed by Zubrick and colleagues in Chapter 5, the subsequent national efforts for policy reform led to the development of successive national action plans and frameworks, including the most recent National Strategic Framework for Aboriginal and Torres Straits Islander People's Mental Health and Social and Emotional Well Being 2004-09 (hereafter referred to as the 2004 SEWB framework).[1] Though now defunct, and with current efforts underway to renew this framework, it remains the guiding national document for defining Aboriginal and Torres Straits Islander-specific understandings of SEWB. Despite the limited implementation of past action plans and frameworks, the development of the SEWB concept at a nationwide level has been important to the process of reclaiming and renewing Aboriginal and Torres Strait Islander understandings of health and wellbeing, and legitimising and disseminating these understandings within the current health policy landscape.[8, 9]

DEFINING SEWB AND MENTAL HEALTH

The synergies with Aboriginal and Torres Strait Islander mental health reform and the development and advocacy of SEWB as a guiding health concept have not necessarily translated into a clear and concise conceptualisation of the differences in understandings of SEWB and mental health, nor widespread agreement about how these concepts ought to coexist or intersect at the level of theory and practice.[10,11]

Most of the Aboriginal and Torres Strait Islander SEWB and mental health literature draws upon the NAHS (1989)[5] or the *Ways Forward* report (1995)[7] to adopt a broad, holistic definition of health and wellbeing.[12, 13] Beyond that, as supported in the literature there is some divergence in understanding of the terms 'social and emotional wellbeing' and 'mental health' and what they mean. In some of the literature the terms have been used interchangeably, either as an attempt to subvert the stigma associated with mental illness or to try and move away from biomedical perspectives of mental health and mental illness.[14, 15] Kelly and colleagues[16] suggest that the term SEWB signifies an Aboriginal and Torres Strait Islander concept of wellbeing that differs in important ways to Western concepts of mental health. We suggest that, within the Aboriginal and Torres Strait Islander SEWB and mental health landscape, SEWB signifies a relatively distinct set

of wellbeing domains and principles, and an increasingly documented set of culturally informed practices that differ in important ways with how the term is understood and used within Western health discourse, discussed in Chapter 6 (Zubrick and colleagues) and Westerman.[17]

Guiding Principles of Social and Emotional Wellbeing

The 2004 SEWB framework[1] sets out nine guiding principles that were developed during the *Ways Forward* national consultancy[7]. These guiding principles shape the SEWB concept and describe a number of core Aboriginal and Torres Strait Islander cultural values that are detailed on page xxiv.

Nine guiding principles that underpin SEWB

1. Health as holistic
2. The right to self-determination
3. The need for cultural understanding
4. The impact of history in trauma and loss
5. Recognition of human rights
6. The impact of racism and stigma
7. Recognition of the centrality of kinship
8. Recognition of cultural diversity
9. Recognition of Aboriginal strengths

Created by SHRG,[1] adapted from Swan and Raphael[7]

Cultural Domains of Social and Emotional Wellbeing

Members of the Australian Indigenous Psychologists Association (AIPA) have endeavoured to link some of these areas of SEWB in a way that has utility for mental health practitioners (AIPA cultural competence SEWB workshop module).[16, 18] Figure 4.1 shows some of the domains of wellbeing that typically characterise Aboriginal and Torres Strait Islander definitions of SEWB.[1, 14, 16, 19-21]

Figure 4.1: Social and Emotional Wellbeing from an Aboriginal and Torres Strait Islanders' Perspective
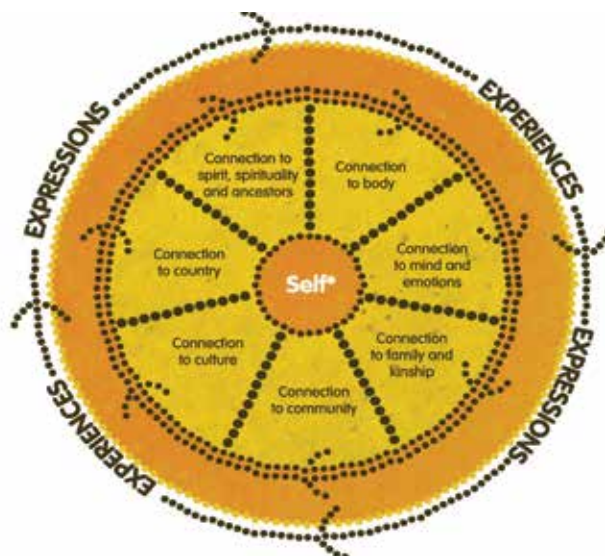
*This conception of self is grounded within a collectivist perspective that views the self as inseparable from, and embedded within, family and community.

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Artist: Tristan Schultz, RelativeCreative.

We note the somewhat artificial separation of these areas of SEWB, and recognise that the cultural diversity that exists amongst Aboriginal and Torres Strait Islander peoples means that no single grouping is necessarily applicable or relevant for every individual, family or community. Whilst cognisant of the dangers in essentialising Aboriginal and Torres Strait Islander SEWB, it is evident that there is considerable uncertainty amongst many practitioners about how to approach working in this area. Consequently, it is useful to make clear some of the guiding principles[1] and broad areas of wellbeing that need to be considered when working in this field.

The diagram shows that the SEWB of individuals, families and communities are shaped by connections to body, mind and emotions, family and kinship, community, culture, land and spirituality (the important role of broader level determinants is also addressed below). The term 'connection' refers to the diverse ways in which people experience and express these various domains of SEWB throughout their lives. People may experience healthy connections and a sense of resilience in some domains, while experiencing difficulty and/or the need for healing in others. In addition, the nature of these connections will vary across the lifespan according to the different needs of childhood, youth, adulthood and old age.

If these connections are disrupted, and for many Aboriginal and Torres Strait Islander peoples and families some of these connections have been significantly disrupted in multiple ways as a result of past government policies associated with colonisation, then they are likely to experience poorer SEWB. Conversely, restoring or strengthening connections to these domains will be associated with increased SEWB. We briefly describe each of these domains below and discuss how to apply some of the guiding SEWB principles in a practical setting.

Encouragingly, the arrangement of domains in Figure 4.1 has been presented and collectively discussed with, and supported by, over 300 SEWB members during National and State SEWB conferences held in 2012 and 2013.[22, 23] An early version of the diagram was also used in the national consultation phase of the development of the renewed Framework for Aboriginal and Torres Strait Islander Social and Emotional Wellbeing (Social Policy Research Centre, 2013). The current diagrammatic representation incorporates feedback from the extensive community consultations that were held in 2013.

Connection to Body, Mind and Emotions

The wellbeing domains we have termed connection to body, and mind and emotions, refer to those aspects of health and wellbeing that are rooted in bodily, individual or intrapersonal experience.[24]

Connection to Body

Connection to body is about physical wellbeing and includes all of the normal biological markers and indices that reflect the physical health of a person (i.e. age, weight, nutrition, illness and disability, mortality).

Connection to Mind and Emotions

Connection to mind and emotions refers not only to an individual's experience of mental wellbeing (or mental ill-health) but also the whole spectrum of basic cognitive, emotional and psychological human experience, including fundamental human needs such as: the experience of safety and security, a sense of belonging, control or mastery, self-esteem, meaning making, values and motivation, and the need for secure relationships. The 2008 National Aboriginal and Torres Strait Islander Social Survey[25] found that the majority of adults reported feeling happy, calm and peaceful, and full of life, all or most of the time. However, nearly one-third of adults reported experiencing high to very high levels of psychological distress (more than twice the rate for other Australians) and Aboriginal and Torres Strait Islander women are 31 times—and men 25 times— more likely than other Australians to be admitted to hospital as a result of family violence-related assaults.[26] Given these alarming statistics, we stress the primacy of personal safety and freedom from abuse as a most fundamental human right and determinant of SEWB. For further discussion see Chapter 17 (Atkinson and colleagues), Chapter 23 (Cripps and Adams) and McGlade.[27]

In relation to working with mental health and SEWB, general recommendations in the literature include the need to:

- collaborate and build relationships within community
- have prior knowledge of appropriate referral pathways
- coordinate work with other service agencies
- have access to a cultural mentor or consultant
- carefully consider the meaning of the signs and symptoms of distress experienced by clients.[28, 29]

Recognising Cultural Differences in Mental Health Diagnoses

From a practitioner perspective, it is important not to rely solely on Western psychiatric classification systems when trying to identify, understand, and work with symptom patterns of distress in Aboriginal and Torres Strait Islander populations. Westerman[17] has written about some of the implications of cultural differences within an Aboriginal and Torres Strait Islander mental health context, identifying the need to recognise culture-bound disorders (for example, longing for country) that 'often mimic mental health disorders, however, the triggers and maintaining factors lie with the cultural beliefs of the client, and therefore resolution often needs to occur at the cultural level'.[17(p4)] Brown's[30] work on depression and Aboriginal men in central Australia documents the unique determinants and ways in which the expression of depression differs from mainstream populations (for example, the presence of weakened spirit, anger and worry). Atkinson's[31] research into post-traumatic stress identifies a wider range of associated cultural and interpersonal trauma symptoms that require assessment and attention, including fragmented identity construction, community disconnection and difficulties in maintaining close relationships.

The common denominator amongst their findings is that, while there are specific symptom patterns congruent with Western mental health diagnoses that can be detected in Aboriginal and Torres Strait Islander clients (making it all too easy for practitioners to simply tick the box), there are additional symptom patterns of distress that need to be recognised. The meanings, determinants and causal theories attributed to these distress patterns can often differ dramatically. Therefore, practitioners also need to consider the pathways of healing and recovery that are most congruent with the client's needs and world views. For example, traditional healing methods may be a preferred option for a client, or they may wish to use such practices in conjunction with the services offered by the practitioner. It is important not to assume that self-disclosure or emotional expression is necessarily valued by the client as a healing mechanism, as is often the case in Western therapies.

Connection to Family, Kinships and Community

The SEWB domains of connection to family and kinship, and community, refer to aspects of wellbeing that are rooted in interpersonal interaction.

Family and Kinship

Family and kinship systems have always been central to the functioning of traditional and contemporary Aboriginal and Torres Strait Islander societies. These systems are complex and diverse, and serve to maintain interconnectedness through cultural ties and reciprocal relationships.[32, 33] Milroy states:

> *These systems locate individuals in the community and neighbouring clans within relationships of caring, sharing, obligation and reciprocity. Essentially, the kinship system provided a very secure attachment system that established caring relationships, so that everyone grew up with multiple carers and attachment figures and, in turn, provided care for others.[12(p126-127)]*

She also notes that in contemporary society, kinship and cultural obligations can place significant burdens on members of the family. Grandmothers, for example, may not have the adequate levels of support and resources necessary to care for large numbers of family. It is important that practitioners develop an understanding of the different language and family groups of the communities they work in.[17] In traditional regions, this usually includes moiety or skin group systems that can entail complex avoidance relationships that determine the nature and extent of interaction between different family and kin members.

Community

The concept of community has been described as fundamental to identity and concepts of self within Aboriginal cultures (see Dudgeon and colleagues, Chapter 1), a collective space where building a sense of identity and participating in family and kinship networks occurs, and where personal connections and sociocultural norms are maintained.[34, 35] The establishment of ACCHOs has been found to play an important role in strengthening cultural identity and fostering a sense of ownership, cultural pride and belonging for some communities.[36, 37]

Connection to Spirituality, Land and Culture

Spirituality

Many Aboriginal and Torres Strait Islander peoples' cultural worldviews include beliefs and experiences that are grounded in a connection to spirituality.[20] Within traditional contexts, the essence of spirituality has been most popularly translated and depicted as '*The Dreaming*' or '*The Dreamtime*', which has become an iconic referent for Aboriginal metaphysical world views, though in reality Aboriginal and Torres Strait Islander nations and language groups have different terms, practices and epistemologies that reflect these world views. These understandings of spirituality broadly refer to a cultural group's traditional systems of knowledge left by the ancestral beings that typically include all of the stories, rituals, ceremonies and cultural praxis that connect person, land and place. In ceremony, the critical transitions from childhood to adulthood, and other life stages, are marked through specific rights of passage. It is through ceremony and everyday cultural praxis that children, women and men of the community learn about their culture's systems of moral and ethical practices that guide behaviour, and determine their personal, familial and cultural rights, obligations, and responsibilities.[21, 38]

Perhaps here, in the connection to spirit and spiritualty, the consequences of colonisation for many Aboriginal and Torres Strait Islander peoples are most keenly felt, because for many this has involved a permanent severance of the links to their traditional customs, leaving a cultural void and an unfulfilled longing and need for recreating and redefining the spiritual. It is not surprising then, that Poroch and colleagues[21] in their review of spirituality and Aboriginal SEWB have found that spirituality is an evolving expression of Indigeneity that in contemporary Aboriginal cultures is experienced in a multitude of ways. They note that spirituality for many Aboriginal and Torres Strait Islander peoples today has been transformed by engagement with other cultures, and is now experienced in multiple contexts, including in combination with and alongside other religions; in contemporary Aboriginal healing practice settings; and as an ethos related to a holistic philosophy of care that underpins community-controlled health centres and other types of Aboriginal organisations.[21]

Land or 'Country'

For many Aboriginal and Torres Strait Islander peoples, spirituality is closely tied to their connection to land or 'country'. Country or land has been described as an area to which people have a traditional or spiritual association,[39] and the sense of connection as a deep experience, belief or feeling of belonging to country—see Chapter 1 (Dudgeon and colleagues).

Connection to country and land extends beyond traditional cultural contexts, however, and the SEWB literature documents the importance of country across the whole spectrum of diverse Aboriginal and Torres Strait Islander cultural groups around Australia.[39-41]

Culture

Connection to culture, as we use the term here, refers to Aboriginal and Torres Strait Islander peoples' capacity and opportunity to sustain and (re) create a healthy, strong relationship to their Aboriginal or Torres Strait Islander heritage. This includes all of the associated systems of knowledge, law and practices that comprise this heritage. Culture is, of course, a complex concept to try and define or articulate. We ascribe to Hovane and colleagues (2013) articulation of Aboriginal culture as constituting a body of collectively shared values, principals, practices and customs and traditions—Chapter 30 (Hovane, Dalton and Smith). Within this context, maintaining or restoring SEWB is about supporting Aboriginal and Torres Strait Islander peoples to maintain a secure sense of cultural identity and cultural values, and to participate in cultural practices that allow them to exercise their cultural rights and responsibilities.

This can be deeply rooted in areas of wellbeing such as connection to spirituality and land, but also might not be due to the large variation and increasing complexity of Aboriginal identity.[42] We suggest that important roles for practitioners include, for example, supporting people to develop and strengthen a sense of continuity and security in their Indigenous identity, supporting people to re-affirm and strengthen their cultural values, and assisting them to develop effective strategies to respond to racial discrimination, which has been shown to be associated with depression, anxiety and other mental health difficulties.[43]

The wellbeing domains of spirituality, land and culture can be sensitive and complex areas to work with. For some Aboriginal and Torres Strait Islander families and communities, the extent of cultural loss associated with colonisation has been profound. Many members of the Stolen Generations and their descendants continue to experience a deep grief and a longing to reconnect with their cultural heritage and ancestry. With appropriate cultural supervision, and in the right circumstances, it is important for practitioners to be able to provide clients with an opportunity to discuss whether issues such as cultural loss, identity and belonging are in any way linked to their current difficulties, and whether personal work in this area is important for their healing process. Practitioners need to make sure they have a sound knowledge of the appropriate cultural services available in the community—for example, the availability of traditional healers, the nearest *Link Up* and *Bringing Them Home* services, and the availability of any local healing programs. Across the country, community-driven healing programs that have a focus on cultural healing and cultural renewal have gained greater prominence.[44] The Aboriginal and Torres Strait Islander Healing Foundation, for example, with a focus on the Stolen Generations and the intergenerational trauma impacting many families and communities, now funds over 97 community designed programs across Australia. These include healing programs, education and training programs centred on healing and trauma recovery, and research and evaluation programs that include measures of cultural wellbeing developed by communities themselves.

SOCIAL, CULTURAL, POLITICAL AND HISTORICAL DETERMINANTS

It is also important to consider SEWB connections within broader social, cultural, political and historical contexts. Zubrick and colleagues in Chapter 6 show that the social determinants of mental health and SEWB for Aboriginal and Torres Islander people include such things as socioeconomic status and the impact of poverty, unemployment, housing, educational attainment, racial discrimination, exposure to violence, trauma and stressful life events, and access to community resources. Importantly, they note these social determinants do not occur in isolation, but rather impact SEWB concurrently and cumulatively. For practitioners, this often translates into complex client and family presentations that involve multiple stressors and issues. Solutions to these types of issues often lie outside the health sector, and require accessing services related to housing and community infrastructure, education, employment, welfare services, family and children's services, and building community capacity. Swan and Raphael[7] and the Social Health Reference Group (SHRG)[1] highlight the need to incorporate two additional dimensions in relationship to Aboriginal and Torres Strait Islander SEWB. The first is the historical context of colonisation and its legacy, which we have termed 'historical determinants' in the diagram. Historical determinants refers to the impact of past government policies and the extent of historical oppression and cultural displacement experienced by individuals, families and communities or, conversely, the extent to which communities have managed to accommodate cultural displacement (i.e. communities consisting of many language groups), and build capacity for self-governance that helps to maintain or renew cultural continuity and control. The second, which we term 'political determinants' refers to:

> *the unresolved issues of land, control of resources, cultural security, and the rights of self-determination and sovereignty, which are recognised as contributing to health and wellbeing and reducing health inequities for Aboriginal and Torres Strait Islander peoples.*[1(p7), 45, 46]

These individual and collective rights of Indigenous people are provided under the United Nations Declaration on the Rights of Indigenous People.

Historical and political determinants are an important part of the broader level of cultural determinants that help shape the environment and circumstances in which Aboriginal and Torres Strait Islander peoples are born into. These critical factors—such as a community's local history of colonisation and the extent to which a cultural group is able to resist assimilation, maintain cultural continuity, and retain the right of self-determination and sovereignty—will all significantly influence a community's capacity to retain their cultural values, principals, practices, and traditions. This, in turn, will differentially empower or impinge upon individual and family SEWB.

To develop awareness and engage practically with historical, political and cultural determinants involves practitioners developing a basic knowledge of the history of the traditional owner groups in the community they work in, and thinking about the ways in which colonisation has impacted the community. This includes being able to identify who the traditional owner families and clans are, as well as other Aboriginal and Torres Strait Islander families who are an integral part of the community but who may not have traditional links. Practitioners also need to be able to develop an awareness of the extent of self-governance and community control of resources that exists in this community (or lack of), and this often includes locating and making links with community-controlled organisations and other key stakeholders in the community.
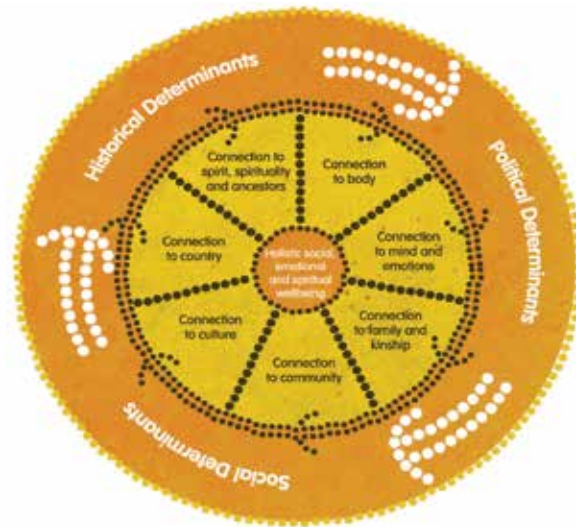
© Gee, Dudgeon, Schultz, Hart and Kelly, 2013
Artist: Tristan Schultz, RelativeCreative.

THE RELATIONSHIP BETWEEN SEWB AND MENTAL HEALTH

Our interpretation and description of the principles and domains of SEWB outlined in this chapter suggests that, within an Aboriginal and Torres Strait Islander health context, SEWB is a complex, multidimensional concept of health that includes but extends beyond conventional understandings of mental health and mental disorder. Mental health and wellbeing is an important component of SEWB, but needs to be viewed as only one component of health that is inextricably linked to the social, emotional, physical, cultural and spiritual dimensions of wellbeing. The 2004 SEWB framework[1] describes an interactive relationship between SEWB and mental health, where the two may influence each other and where a person can experience relatively good SEWB and yet still experience mental health problems, or vice-versa. SEWB problems include a wide range of issues, such as: 'grief, loss, trauma, abuse, violence, substance misuse, physical health problems, child development problems, gender identity issues, child removals, incarceration, cultural dislocation, racism and social disadvantage … while mental health problems may include crisis reactions, anxiety, states, depression, post-traumatic stress, self-harm, and psychosis'.[1(p3)] Many of the issues identified as SEWB problems, such as abuse, violence, racism and social disadvantage are also well-established risk factors for various mental health disorders. For further discussion, see Chapter 2 (Parker and Milroy), suggesting that in some cases mental health disorders are likely to be symptomatic of greater SEWB disturbance. The framework also emphasises that cultural and spiritual factors can have a significant impact on the ways mental health problems develop, by influencing the presentation of symptoms and psychological distress, the meaning attributed to this distress, and the appropriateness of different therapeutic approaches and expected outcomes.[1]

Other Considerations

We see a number of advantages to viewing mental health and mental health disorders as being positioned *within* a larger SEWB framework, rather than equated *with* SEWB. The first is that placing mental health within a broader SEWB framework helps to make explicit that, for many Aboriginal and Torres Strait Islander peoples and communities, mental health issues are still entwined with the past injustices associated with colonisation. The guiding principles and domains that define a SEWB framework as outlined in this chapter highlight the need to be

attendant to both mental health and social justice issues when working to improve the SEWB of Aboriginal and Torres Strait Islander individuals, families and communities.

Practitioners working in Aboriginal and Torres Strait Islander communities are often confronted with extremely complicated client presentations. It is not unusual to work with help seeking community members who simultaneously experience mental health issues, historical loss and cultural disconnection issues, multiple stressors in the form of poverty, child removal, or housing and other issues, as well as social and emotional difficulties such as trauma, abuse and loss. This level of complexity requires new approaches, different models of engagement, and new ways of thinking about working with Aboriginal and Torres Strait Islander mental health and SEWB. In circumstances where clients experience multiple SEWB and mental health issues and the negative impact of social determinants, it is often appropriate to begin with case management and problem solving approaches to address these issues, and support clients to establish safety, security and stability before focusing on other healing processes. It is also important to incorporate a trauma-informed approach to therapeutic practice, as often families and communities may have experienced multiple types of trauma (e.g. historical and intergenerational trauma associated with cultural dislocation and loss of identity and practices, direct interpersonal trauma such as physical or sexual assault/abuse, and within-community lateral violence). Strategies for addressing the associated trauma, grief and loss associated with the legacy of colonisation are discussed in several chapters of this book—see Chapter 17 (Atkinson and colleagues); Chapter 28 (Wanganeen); and Chapter 29 (Peeters and colleagues).

KEY ISSUES AROUND EFFECTIVE CLINICAL PRACTICE

There is a small but important literature base that documents some of the key issues around effective clinical practice, including knowledge related to: cultural disparities and gender differences between client and practitioner;[17] the use of cultural mentors and supervisors[47]; issues in mental health and psychiatric assessment—see Chapter 16 (Adams and colleagues); culturally appropriate counselling techniques;[17] culture-bound syndromes;[31] and the importance of accessing traditional and contemporary Indigenous healing models, programs and trainings developed by Aboriginal and Torres Strait Islander peoples themselves (refer to Part 6 of this book).

Finally, despite contemporary definitions of 'mental health' incorporating the notion of being 'not simply the absence of mental illness' and existing along a spectrum that includes 'positive mental health',[48] currently the discipline is still predominantly focussed on psychopathology and mental health disorders, with the notion of positive mental wellbeing yet to be really well defined.

We believe that situating mental health within an Aboriginal and Torres Strait Islander SEWB framework is more consistent with the view that Aboriginal and Torres Strait Islander concepts of health and wellbeing prioritise and emphasise wellness, harmony and balance rather than illness and symptom reduction.[12] This does not obviate the importance of addressing mental illness in our communities as a critical component of SEWB. However, the reduction of symptoms associated with mental health disorders should not be equated with experiencing a sense of wholeness or connectedness to the totality of SEWB as described in this chapter. In both research and at the therapeutic level, more priority needs to be given to understanding and promoting the kinds of strengths and resources that have assisted Aboriginal and Torres Strait Islander peopless, families and communities to maintain resilience and survive multiple and widespread adverse life events over several generations.

In the 1994 Wentworth lecture, Professor Mick Dodson, did well to remind us all that:

> 'Our people have left us deep roots, which empowered us to endure the violence of oppression. They are the roots of survival, but not of constriction. They are the roots of which all growth is possible. They are the roots that protected our end from the beginning'.[49(p11)]

CONCLUSION

The aim of this chapter has been to define SEWB from an Aboriginal and Torres Strait Islander perspective. We have provided an overview of the guiding principles and broad domains of health and wellbeing that typically characterise SEWB, and highlighted the importance of social, cultural, historical and political determinants in shaping SEWB and mental health outcomes. The chapter has provided only the broadest of brush strokes in terms of identifying principles and domains of SEWB that may be relevant to Aboriginal and Torres Strait Islander peoples and communities. This is as it should be, because the concept of SEWB as we have defined it, is a cultural construct that describes general level features or characteristics of SEWB that are proposed to be 'similar enough' across different Aboriginal and Torres Strait Islander peoples and communities as to hold conceptual value and meaning.

We recognise and accept this limitation, as it underscores the important point that for health professionals to gain an in-depth, genuine understanding of mental health and SEWB as it relates to their local Aboriginal or Torres Strait Islander community, they must engage with that community in a meaningful way. This involves developing relationships with Elders, families and leaders of the community over time. There are no alternatives or short cuts to bypassing this need. A broad and coherent understanding of the SEWB concept and its relation to mental health should help to orientate health professionals and practitioners in their work. If practitioners can use this general knowledge within the context of developing meaningful relationships at a local level, then they will be able to work more effectively with Aboriginal and Torres Strait Islander peoples, families and communities in the areas of SEWB and mental health.

REFLECTIVE EXERCISES

1. Thinking about the concept of social and emotional wellbeing outlined in this chapter, and the holistic definition of health and wellbeing offered by NAHS, how might these understandings change the way someone works within the discipline of mental health?

2. If an Aboriginal and/or Torres Strait Islander client came to you presenting with mental health, social justice, and social disadvantage issues, what do you think would be some of most difficult challenges and tensions involved in trying to balance their needs? How would you try to address these challenges and tensions?

3. Connection to spirituality, land, culture and identity/belonging, can all be sensitive, complex areas of social and emotional wellbeing to work with due to the historical impact of colonisation and the cultural disparity that can exist between the client and the practitioner. What are some strategies you could use and things you could do (both face to face and when not directly engaged with the client) in order to feel more confident that your work is of value to the client (and culturally safe)?

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5

The Evolving Policy Context in Mental Health and Wellbeing

Stephen R. Zubrick, Christopher Holland, Kerrie Kelly, Tom Calma and Roz Walker

OVERVIEW

This chapter outlines the role of policy in setting directions for, and achieving change in, Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing. Key national policies, frameworks and reports addressing mental health and social and emotional wellbeing up until mid 2013 are presented. Historical milestones surrounding key policies together with their effects on individual and community health and mental health outcomes and circumstances are described. These include the specific aims of key policies or reports; why they were developed and by whom; what they intended to achieve; and whether any programs, services, practices or processes were implemented and/or influenced. Policy development and implementation can be a piecemeal and at times ad hoc 'action-response-action' process to address a perceived issue or need, lacking any coherent strategic purpose. Changes in policies tend to be underpinned by assumptions regarding the policy process and the reasons for success or failure in policy or program implementation. This chapter focuses on the policies intended to specifically address mental health and SEWB as well as the relevant reports and commissioned inquiries that influenced these policies. As policies and priorities are determined by Australian, state and territory governments of the day, those identifed in this chapter may not necessarily reflect the policy direction of current governments.

THE CHANGING POLICY CONTEXT

In the last 15 years there has been a growing focus on Aboriginal and Torres Strait Islander social and emotional wellbeing (SEWB) as evident in several key policy documents discussed in this chapter. Increasingly, it is recognised that policy areas relevant to SEWB extend well beyond the influence of health and mental health systems to encompass education, law and justice, human rights, Native Title, and families and communities. Thus, coordinating policy inputs across multiple sectors to guide planning and services to address mental health and encourage interagency collaboration remains a complex and daunting task.

In addition, the term 'mental health' has proved particularly problematic in the Aboriginal context. Most mainstream mental health services tend to focus primarily on treating mental illness and/or psychiatric care. Efforts to broaden community understanding about the promotion of mentally healthy behaviour and the prevention of mental illness, are limited by negative connotations and stigma about mental illness, psychiatric treatment and people needing mental health care.[1] It is not surprising then that attempts to transpose current mental health practices into Aboriginal health services have been widely resisted.

Over the last 15 years, Aboriginal people have advocated for a more culturally appropriate, holistic policy position and program implementation governing SEWB and mental health. This

has resulted in recognition of a definition of mental health that more appropriately reflects such philosophies and views. During the same period the mental health system has undergone a sustained process of reform, with a greater focus on prevention and promotion in mental health policy. There is now a greater recognition in mainstream policies of positive mental health—as opposed to mental illness—that is more in accord with an Aboriginal emphasis on SEWB. A current definition of mental health is:

> *A state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential. It includes being able to work productively and contribute to community life. Mental health describes the capacity of individuals and groups to interact, inclusively and equitably, with one another and with their environment in ways that promote subjective wellbeing, and optimise opportunities for development and the use of mental abilities. Mental health is not just the absence of mental illness.[2(pp7-8)]*

The concept of mental health comes more from an illness or clinical perspective and its focus is more on the individual and their level of functioning in their environment. The following definition better reflects the Aboriginal perceptions of SEWB described below:

> *This definition is about being well and being able to grow and develop within the context of family, community, culture and broader society to achieve optimal potential and balance in life. From the Aboriginal and Torres Strait Islander view, it must also incorporate a strengths approach, recognising the importance of connection to land, culture, spirituality, ancestry, family and community. Also, acknowledging the inherent resilience in surviving profound and ongoing adversity—yet retaining a sense of integrity, commitment to family, humour, compassion and respect for humanity.[3(p8)]*

SEWB covers a broad range of factors that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage. This definition encompasses a range of determinants influencing Aboriginal SEWB and mental health. For further discussion of SEWB, see Chapter 4 (Gee and colleagues) and Chapter 6 (Zubrick and colleagues).

POLICY INITIATIVES AND FRAMEWORKS

Policy developed by the Council of Australian Governments (COAG) provides the context for both Aboriginal and Torres Strait Islander-specific and general population mental health policy at the commonwealth, state and territory levels. It is at this level that shifts in international thinking around Indigenous and human rights, mental health and recovery approaches shapes domestic policy.

National COAG Policy Initiatives

Key developments at the COAG level include:

- The *National Mental Health Strategy 1992*, revised in 1998, and a succession of four national mental health plans;
- The *National Suicide Prevention Strategy 1999* with four components including the *Living is for Everyone, a Framework for the Prevention of Suicide in Australia* (2007);
- The *National Action Plan on Mental Health 2006–2011* is a multi-billion dollar COAG mental health package initiative increasing the role of Medicare and general practitioners within the mental health system;
- The *Fourth National Mental Health Plan 2009-2014* which sets an agenda for collaborative government action in mental health;
- The *National Mental Health Workforce Strategy 2011.* The Australian Health Ministers' Advisory Council (AHMAC), Mental Health Standing Committee (MHSC),
- The *COAG Roadmap for National Mental Health Reform 2012–2022.*

Aboriginal and Torres Strait Islander-specific Initiatives

COAG provides the context for Aboriginal policy at all levels of government. Key developments include:

- The COAG *Reconciliation* Framework (2000);
- The *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013*. Key Result Area (KRA) four addresses mental health and SEWB;
- The *COAG Indigenous Reform Agenda* in which *Closing the Gap* is a national priority (2008);
- *The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2011–2015)* prepared for AHMAC by its Aboriginal and Torres Strait Islander Health Workforce Working Group.

Commonwealth Government Mental Health Related Initiatives

In addition to driving reform through COAG, the Commonwealth has increased its involvement in the mental health and related spaces in other ways:

- The establishment of the Health and Hospitals Network built, in part, around Medicare Locals, to oversee the delivery of some mental health services—particularly those delivered by, or through, General Practitioners (such as the Access to Allied Psychological Services (ATAPS) Program) and support programs within their jurisdictions (2010);
- The appointment of a National Mental Health Commission (NMHC) and a National Mental Health Consumer and Carer Forum (NMHCCF) in 2012;
- A *National Anti-Racism Strategy* (2012);
- The Disability Care Australia (2013) (formerly known as the National Disability Insurance Scheme (NDIS)).

Despite the Commonwealth's increasing profile in this space, the primary responsibility for funding, policy development and delivering mental health services still rests with the states and territories. New South Wales (NSW) and Western Australia (WA) have established mental health commissions and several jurisdictions have appointed ministers for mental health.

Commonwealth Government and Aboriginal Mental Health Initiatives

The key Aboriginal-specific health and mental health policies and initiatives are:

- *The National Aboriginal Health Strategy (1989)*;
- *The Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan (1996)*;
- *Ways Forward*: *National Aboriginal and Torres Strait Islander Mental Health Policy (1995)*;
- *National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003–2006*;
- The *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–13*;
- The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009*. A renewed Framework is currently in development.
- The Commonwealth's Northern Territory (NT) Emergency Response to the *Ampe Akelyernemane Meke Mekarle 'Little Children are Sacred'* report (2007);
- National Apology to Australia's Indigenous peoples ('National Apology' February 2008);
- The *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (May 2013)*;
- The *National Aboriginal and Torres Strait Islander Health Plan (July 2013)*.

Two initiatives of significance to the Aboriginal social and emotional wellbeing policy arena include the establishment of Aboriginal Community Controlled Health Organisations (ACCHOs) and the National Apology to Australia's Indigenous people.

Since the 1970's the Commonwealth has funded ACCHOs to deliver primary health care services. These services initiated by Aboriginal peoples in response to market and government failure to meet their health needs are operated by local Aboriginal communities to deliver holistic, culturally appropriate care. There are approximately 150 ACCHOs across Australia providing SEWB and drug and alcohol services. The National Aboriginal Community Controlled Health Organisation (NACCHO) is the peak body representing these Aboriginal controlled services.[4]

On 13 February 2008, the Prime Minister, the Hon. Kevin Rudd MP, apologised to the Aboriginal and Torres Strait Islander Stolen Generations and their families on behalf of the Australian Government and the parliament. The significance of the apology and the use of the word 'sorry' to Stolen Generations survivors cannot be underestimated in the healing process. This landmark event has great significance for the SEWB of all Aboriginal people. In September 2008, approximately 60 delegates including Aboriginal practitioners and organisations working in healing and key government agencies met in Canberra to discuss strategic policy directions to address issues identified by the Stolen Generations. They recommended the establishment of a Healing Foundation, an initiative which has subsequently proved effective in supporting Stolen Generations.

State and Territory Initiatives

Aboriginal-specific mental health services, policies and bodies at state/territory levels include:

- The *NSW Aboriginal Mental Health and Wellbeing Plan 2006–2010* and the NSW Aboriginal Mental Health Worker Training Program;
- The WA Statewide Specialist Aboriginal Mental Health Service (2010);
- *Victorian Aboriginal Suicide Prevention and Response Action Plan 2010–2015;*
- State and territory health plans and frameworks. For example, the *Victorian Indigenous Affairs Framework 2013–2018* addresses psychological distress.

THE ESTABLISHMENT OF NATIONAL ABORIGINAL ADVISORY BODIES

Since 2007, Aboriginal service providers and advisory and representative bodies have played an important role in driving policy reform at the national level. These include:

- The National Indigenous Drug and Alcohol Committee (NIDAC) to the Australian National Council on Drugs, established in 1998;
- The Australian Indigenous Psychologists Association (AIPA) (2008);
- The National Aboriginal and Torres Strait Islander Health Equality Council (NATSIHEC), an advisory body to the Commonwealth Minister for Indigenous Health (2008);
- The National Aboriginal and Torres Strait Islander Healing Foundation (Healing Foundation)—to support culturally strong, community-led programs and fund education and research on healing (2009);
- The National Congress of Australia's First Peoples (NCAFP)—to provide a platform for the National Heath Leadership Forum (NHLF) to speak on health and mental health and SEWB. The NHLF comprises representatives of the health professional bodies listed above and was established in 2011;
- The First Peoples' Disability Network (FPDN)Australia in 2012;
- The establishment of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) in 2013 reporting to the then Commonwealth Ministers for Mental Health and Indigenous Health.

REPORTS AND INQUIRIES

As described by Dudgeon and colleagues in Chapter 1, the policies and actions since colonisation have had a profound and enduring impact on the lives of Aboriginal and Torres Islanders individually and collectively. Many previous policies have had a detrimental effect on the health, SEWB and survival of Aboriginal peoples, and have limited their capacity to control and direct their future development. Several important inquiries have examined the impact of past polices on Aboriginal people and these have influenced the policy response to the stark health and mental health disparities and social circumstances between Aboriginal peoples and other Australians. These reports include:

- *The Royal Commission into Aboriginal Deaths in Custody Report (RCIADIC)*(1991);[5]
- *Human Rights and Mental Illness: Report of the National Inquiry into Human Rights and Mental Illness* (the Burdekin Report) (1993);[6]
- *Ways Forward: National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health* (1995);[9]
- *National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (1995) and the subsequent *Bringing Them Home* Report (1997).[7]

Royal Commission into Aboriginal Deaths in Custody Report (1991)

The RCIADIC was a landmark report that has had a significant influence on Aboriginal mental health policy in the last 20 years. The report highlighted the urgent need to address Aboriginal mental health, given its links to overrepresentation in the criminal justice system and suicides in custody. The RCIADIC argued that approaches to mental health needed to acknowledge and be respectful and sensitive to the legacy of Australia's colonial history. The report stressed the importance of law reform and changes in policing strategies.[5] Importantly, the report made a number of recommendations that have been a major milestone in addressing Aboriginal mental health issues.

The Burdekin Report (1993)

In 1992, the National Mental Health Strategy was initiated by all Australian Governments as part of a reform of treatment for people with mental illness. *The Human Rights and Mental Illness: Report of the National Inquiry into Human Rights and Mental Illness* known as the 'Burdekin Report',[6] (1993) 'exposed the devastating personal consequences of inadequate mental health and welfare services'. This report resulted in major changes to mental health policy in Australia in line with changing views globally, including deinstitutionalisation and protection of rights of those with a mental illness. The report identified widespread ignorance in the community regarding the nature and prevalence of mental illness and the extent to which people with a mental illness are dangerous. There was widespread misconception that few people with mental illness recover. While the report resulted in sweeping reforms, a Human Rights and Equal Opportunities Commission (HREOC)[11] Submission to the *Senate Inquiry on Mental Health* in 2005 found that many of the goals have not yet been met.

Ways Forward: National Consultancy Report (1995)

Throughout 1994 and 1995, Swan and Raphael consulted widely with Aboriginal people and key stakeholders and reviewed all previous relevant reports. Their *Ways Forward*: *National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health*[9] was the first national analysis to report specifically on Aboriginal and Torres Strait Islander mental health and to generate a specific plan of action.[9] The report confirmed previous findings—that the devastating impact of forced removal of children from their families, the dispossession from land, and continuing social and economic disadvantage have contributed to widespread SEWB and mental health problems. Noting the connection between historical factors and

contemporary social issues, the report stated:

> 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; and the loss of culture and identity; plus the impact of social inequity, stigma, racism and ongoing losses.[9(p2)]

Importantly, the findings highlighted the need for:

- greater understanding among health professionals about the influences upon, and extent of, mental illness among Aboriginal people;
- mental health services to address the underlying grief and emotional distress experienced by Aboriginal people;
- greater cultural competence within mainstream services and among mental health professionals to overcome misdiagnosis and inappropriate treatment;
- priority to be given to training Aboriginal Health Workers (AHWs) and other Mental Health Workers (MHWs); and
- tertiary courses for health professionals (particularly psychiatrists and nurses) that include material on Aboriginal history and contemporary Aboriginal society.[9]

This seminal wide-reaching *Ways Forward* report emphasised the need for mental health policy, planning and program delivery to be developed in *consultation* with Aboriginal people. Sixteen key policy elements were identified reinforcing the importance of self determination and holistic approaches to Aboriginal mental health . Some of the elements such as suicide and self harm and alcohol and drugs have their own policy frameworks. Some of the other elements highlight the need for mechanisms for effective implementation including research and evaluation, data and information systems, intersectoral programs and personnel development.

Bringing Them Home Report (1997)

Another landmark report, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, has been equally influential in the evolution of Aboriginal mental health and SEWB policy.[7] It provides a comprehensive review of the testimonies of Aboriginal people removed under government forced removal policies, and discusses their effects and the actions needed to commence healing for survivors and their families. The report confirms the links between past government policies of forced removal, human rights abuses and current social and health concerns for Aboriginal people.[1]

In particular, the findings highlighted the mental health consequences of child removal policies and the inaccessibility and inadequacy of existing mental health services to deal with these issues. Further, the report found that racial discrimination, cultural incompetence and the inability to recognise or understand the complex causes for mental health among Aboriginal people remain a predominant concern among practitioners and the wider society. It described the impact of forcible removal of children and the continuing effects on thousands of Stolen Generations survivors today. It set out 54 recommendations which have not yet been fully implemented.[7]

Nevertheless, there have been significant symbolic and practical responses to the report. On a practical level, government have provided funding for a range of programs and services to support Stolen Generations survivors, most of which are still funded. On a symbolic level, on 26 May 1998, the anniversary of the *Bringing Them Home* report saw the inaugural Sorry Day introduced as a national day of recognition and reconciliation.[7] The National Apology was was one of the 54 recommendations outlined in the report. A National Sorry Day Committee

(NSDC) was established to organise a range of activities across Australia.[8] The majority of Stolen Generations survivors are now Elders and senior citizens. The NSDC coordinates the National Sorry Day events which, for 2013, is *Still Living on Borrowed Time!* The National Stolen Generations Alliance (NSGA) was formed with three basic principles as the foundations for its work—Truth, Justice and Healing. The NSGA believes that all Australians can respect these principles and many individuals, community and government organisations made a commitment to honour these principles in some way already.

The 2011 Australian Government budget consolidated existing counselling, family tracing and reunion support services into a flexible model of service delivery and workforce support supplemented by national coordination and delivered through the *Social and Emotional Wellbeing Program*. The program is implemented through: a network of eight *Link-Up* services providing reunion and counselling services to members of the Stolen Generations across Australia; SEWB and mental health counselling services, prioritising members of the Stolen Generations, located in over 90 ACCHOs; and workforce support and training through a national network of Workforce Support Units and Indigenous Registered Training Organisations nationally.

POLICY FRAMEWORKS AND ACTION PLANS

Although it has taken considerable time for the recommendations from both the *Bringing Them Home* report and the *Ways Forward* report to be implemented, the findings and guiding principles continue to influence contemporary policy initiatives, frameworks and action plans, with a stronger focus on partnership rather than consultation as oulined in the section below.

Emotional and Social Wellbeing Action Plan 1996–2000

The *Aboriginal and Torres Strait Islander Emotional and Social Wellbeing (Mental Health) Action Plan 1996–2000* was a response to findings and recommendations of the *Ways Forward* report (1995), the RCIADIC (1991) and the Burdekin Report. Reporting on deaths in custody, youth suicide, transgenerational loss and trauma, these documents highlighted the need for culturally appropriate and accessible Aboriginal mental health services to address these critical issues.[10] The Action Plan aimed to provide an integrated and consistent approach to mental health that acknowledged and acted upon Aboriginal perspectives outlined in these key reports.

The Action Plan was informed by nine guiding principles (detailed on page xxiv).

Nine Guiding Principles of the Action Plan 1996–2000

1. Holistic health, encompassing mental health, physical, cultural and spiritual health;
2. Self-determination;
3. Culturally valid understandings;
4. Recognition that the experiences of trauma and loss have intergenerational effects;
5. Recognition and respect of human rights;
6. Racism, stigma, environmental adversity and social disadvantage have negative impacts;
7. The centrality of family and kinship and the bonds of reciprocal affection, responsibility and sharing;
8. Recognition of individual and community diversity;
9. Great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment.

The Action Plan was the first national initiative to recognise and address the SEWB of Aboriginal people. It set out priority areas for Commonwealth expenditure for mental health initiatives as well as creating a policy framework that aimed to ensure a coordinated approach to service delivery between the Australian and state/territory governments. It proposed to establish a Framework Agreement as:

> a mechanism to inform policy development, planning and priority setting. State and territory forums will also be established under the Agreements, which will be encouraged to set and achieve targets for access by Aboriginal and Torres Strait Islander peoples to mental health services.[11]

The key goals and intended outcomes of the Action Plan were to:

- enhance the appropriateness and effectiveness of both mainstream mental health organisations and culturally-specific primary health care services for Aboriginal people with mental health needs;
- improve access to culturally appropriate, high-quality health care and improve mental health outcomes; and
- reduce the rate of suicide by young people by ensuring the availability of culturally appropriate and high-quality mental health services and support mechanisms.

The Action Plan priority areas discussed in this and other chapters within this book include:

- youth suicide;
- trauma and grief counselling;
- communications;
- development of a range of culturally appropriate mental health case models;
- intersectoral activity;
- specialist regional centres in mental health training and service delivery;
- data collection;
- research and evaluation;
- funding.

Other Aboriginal-led Innovative Initiatives

The Action Plan also led to a range of innovative initiatives being developed by Aboriginal -led initiatives including the development of culturally appropriate mental health models and therapies such as the We Al-li Indigenous Therapies in Lismore; and the establishment of Social Health Teams in ACCHOs to provide SEWB counselling. Many of these innovative, culturally appropriate programs have proven to be sustainable best practice. Examples include: Wuchopperen Health Service in Cairns; Gallang Place in Brisbane; Nunkuwarrin Yunti in Adelaide; Biripi Aboriginal Corporation in Taree; and the Koori Kids program at the Victorian Aboriginal Health Service Cooperative. Other projects include theatre and storytelling as counselling, such as HEATworks/Kimberley Aboriginal Medical Services Centre, and the establishment of *Deadly Vibe Magazine.* The Action Plan helped to consolidate and elevate the importance of SEWB for Aboriginal Australians that had previously been neglected or underestimated by government.

National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013

In 2003 the *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for Action by Governments (The Framework)* was developed for the delivery of health services to Aboriginal people. The Australian, state and territory governments subsequently developed implementation plans for the strategic action areas outlined in the *Framework* which identifies SEWB as one of the nine Key Result Areas (KRAs) for government action. In particular, mental health, suicide, alcohol and substance misuse, family violence issues including child abuse, and male health were targeted as priority areas.[12]

Australian Government Implementation Plan 2007–2013

The *Australian Government Implementation Plan 2007–2013 (the Implementation Plan)[13]* was developed by the previous Department of Health and Ageing (DoHA) in consultation with all relevant Australian Government agencies and the National Aboriginal and Torres Strait Islander Health Council (NATSIHC). It emphasises a whole-of-government approach to address the key priorities identified; is consistent with the *National Strategic Framework's Goal, Aims and Priorities;* and retains the same structure of nine Key Result Areas.

Key Result Area Four: 'Social and Emotional Wellbeing' of the implementation plan is relevant here.

Reporting against these action items occurs through qualitative reporting against the Implementation Plan and quantitative reporting through the *Aboriginal and Torres Strait Islander Health Performance Framework (HPF).*[14] KRA four contains actions that align with the *Overcoming Indigenous Disadvantage (OID) Framework's* 'Substance use and misuse' and 'Functional and resilient families and communities' strategic areas for action in the 2007 OID Report[16] and *Healthy lives* in the 2009 OID report.[15]

Social and Emotional Wellbeing Framework 2004–2009

The *Social and Emotional Wellbeing Framework: a National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004–2009*[3] *(the Framework)* endorsed by AHMAC in 2004 complements the National Mental Health Plan and the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013 and the Australian Government Implementation Plan 2007–2013.[13]

Part One of the *Framework* sets out the guiding principles and policy thinking underpinning the concept of SEWB.

Part Two sets out Strategic Directions in five key areas:

1. Focus on children, young people, families and communities.
2. Strengthen Aboriginal community-controlled health services.
3. Improve access and responsiveness of mental health care.
4. Coordinate resources, programs, initiatives and planning.
5. Improve quality, data and research.

The Key Strategic Directions aim to achieve three fundamental elements of care for each Aboriginal and Torres Strait Islander community:

1. Action across all sectors to recognise and build on existing resilience and strength to enhance SEWB, to promote mental health, and to reduce risk.
2. Access to primary health care services providing expert SEWB and mental health primary care, including Social Health Teams.
3. Responsive and accessible mental health services with access to cultural expertise.

Part Three sets out roles, responsibilities and timeframes for the implementation, monitoring and evaluation of the *Framework.*

Overall, the *Framework 2004–2009*[3] has provided an important reference point informing the development of policy and programs in both the government and community sector, including the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013* and the *Australian Government Implementation Plan 2007–2013*.[13] The SEWB Framework is currently being revised.

RELATED POLICY DEVELOPMENTS

A number of related policy developments in Aboriginal and Torres Strait Islander affairs over the last 20 years continue to shape the evolution of Aboriginal mental health policy:

The COAG Reconciliation Framework 2000

The *COAG Reconciliation Framework* acknowledges Government's responsibility for addressing social and economic disadvantage and for improving the way agencies do business with communities to get better outcomes; provides the basis for governments to work together and become more responsive in addressing the needs of Aboriginal people through community

partnerships; provides governments with a solid foundation for measuring any improvements and ensuring that changes are structurally based and sustainable.[17] As Zubrick et al, point out the Government endorsed three priority areas to improve health and wellbeing outcomes:

1. *Investing in community leadership and governance issues;*

2. *Reviewing and re-engineering programs and services to ensure they deliver practical measures that support families, children and young people; and measures for tackling family violence, drug and alcohol dependency and other symptoms of community dysfunction;*

3. *Forging greater links between the business sector and Aboriginal communities to help promote economic independence.*[18 (p564)]

The COAG Steering Committee for the Review of Commonwealth/State Service Provision released its report whichoutlined a vision of an Australia where *Indigenous people will one day enjoy the same overall standard of living as other Australians. They will be as healthy, live as long and participate as fully in the social and economic life of the nation.*[19 (p1.1-1.2)] The endorsement of the report marks the commitment of Australian governments to tackle the root causes of Aboriginal disadvantage and to systematically monitor the outcomes across jurisdictional and portfolio boundaries.

The 'Close the Gap' Campaign

In 2005, the Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma, proposed aligning Australian governments' responses to Aboriginal health inequality with the international human rights framework (and the right to health in particular). He proposed a national effort to achieve health and life expectancy equality for Aboriginal and Torres Strait Islander peoples by 2030. This effort included the adoption of ambitious, yet realistic targets and a partnership approach in which Aboriginal people and their representatives worked as **equal partners** with Australian governments in planning and implementation. These two elements became the hallmarks of the subsequent *Close the Gap Campaign* whose Steering Committee comprised a leadership group including the Healing Foundation, NACCHO, NIDA,CAIPA and the major general population peak health and professional bodies.

The Close the Gap Campaign Steering Committee hosted a *National Indigenous Health Equality Summit* in March 2008. It culminated in the Prime Minister, the Minister for Health and Ageing, the Minister for Families, Housing, Community Services and Indigenous Affairs (FAHCSIA), and the Federal Opposition Leader signing the *Close the Gap Statement of Intent* with Aboriginal health leaders. The Governments and Oppositions of WA, Queensland (Qld), Victoria, the Australian Capital Territory (ACT), NSW and South Australia (SA) have since signed a commitment to partnership and planning for health equality by 2030.

The COAG 'Closing the Gap' National Reform Agenda

In 2007, there was bipartisan support for *Close the Gap Campaign* and, after the election with a new government, 'closing the gap' entered the policy lexicon. In December 2007, COAG adopted a *Closing the Gap* target to achieve life expectancy equality for Aboriginal people within a generation.

By mid-2009, six long-term 'Closing the Gap' targets on life expectancy, health, early childhood development, education, housing, and economic outcomes had been agreed through a National Indigenous Reform Agreement (NIRA).[20] The NIRA also provided the overarching framework for achieving the targets, as well as key performance indicators and benchmarks that the COAG Reform Council used to monitor progress through annual public reporting and analysis.

The NIRA recognises that a multifaceted and sustained approach addressing factors, both within and beyond the health system, is required to address Aboriginal disadvantage and inequality. It identifies seven 'building blocks' which integrates policy reforms and implementation to comprehensively address Aboriginal disadvantage. They include: healthy homes; safe communities; health; early childhood; schooling; economic participation; governance and leadership.[20]

Six National Partnership Agreements, are the 'engine' that drives COAG's *Closing the Gap* Agenda. The *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* (2009–2013) (approximately $1.6 billion funding) and *National Partnership Agreement for Indigenous Early Childhood Development* ($550 million) are most relevant to mental health and SEWB. Through the former, for example, the WA Statewide Specialist Aboriginal Mental Health Service has been established, and it is expected that the renewal of the agreements (taking place at the time of writing) will reflect a growing understanding of the importance of mental health and SEWB to increased life expectancy. Aside from its generative role in COAG'S *Closing the Gap* Agenda, two major outcomes of the *Close the Gap* Campaign are a partnership vehicle for achieving health equality and the development of the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023.*

SOURCES OF DATA, MONITORING AND ACCOUNTABILITY

Zubrick et al. confirm the need to collect data related to the mental health morbidity and mental health care of the Aboriginal and Torres Strait Islander population.[18] However, they are critical that the existing indicators of mental health and SEWB tend to focus on the measurement of severe mental health outcomes—rates of hospitalisation for anxiety, depression, self harm and child abuse substantiations.[18(p564)] The emphasis on these aspects can inadvertently limit the funding and development of programs and services that focus on more holistic approaches to Aboriginal SEWB including mental health, which encompasses social justice, self-determination, sense of connectedness with culture, family and country (see Chapter 4, Gee and colleagues).

Primary Sources

The first national survey of Aboriginal and Torres Strait Islander peoples was conducted in 1994[21], in response to the RCIADIC(1991)[5] recommendations. The survey included questions on health and other determinants. Since then the quantity, timeliness and quality of information relevant to the health and SEWB of Aboriginal and Torres Strait Islander populations has improved considerably. Both the *National Health Surveys* (NHSs)and *National Aboriginal and Torres Strait Islander Social Surveys* (NATSISSs) contain valuable information about Aboriginal mental health and SEWB, and Stolen Generations survivors and experiences of racism and other stressors. The appropriateness of SEWB indicators used in these surveys, in relation to cultural participation, is the subject of ongoing review and debate. The five-yearly Census of Population and Housing also reports on housing, income, education and other health and mental health determinants for Aboriginal and Torres Strait Islander peoples.

Additionally, *Footprints in Time: the Longitudinal Study of Indigenous Children*, funded by the Australian government, provides the first comprehensive longitudinal data on the development of Australian Aboriginal children. This survey, along with the *Western Australian Aboriginal Child Health Survey (WAACHS)*,[18] represents significant milestones in gathering data for and about Aboriginal people. The findings and recommendations of these studies continue to inform actions and initiatives to address the difficulties experienced by Aboriginal people.

The *Aboriginal and Torres Strait Islander Health Performance Framework* (HPF)[14] is a foundation document for informing COAG performance indicators as well as the data sources and development requirements for them and many Indigenous-specific agreements relating to

health. It presents information gathered from a number of different administrative data sets and surveys, including information relevant to SEWB. The substantial HPF data development work is informing the data sources and development requirements for the COAG performance indicators. The HPF biennial report is critical for measuring progress towards the COAG *Close the Gap* agenda. It is designed to inform policy analysis, planning and program implementation by providing a ready reference to verified data and research. The data in the HPF is compiled from approximately 50 data sets and is reported against biennially, for 71 measures in three domains:

1. Health status and outcomes (including social and emotional wellbeing).

2. Determinants of health including socioeconomic and behaviours factors.

3. Health system performance.

Each of these domains encompass determinants that influence mental health and wellbeing. In Chapter 4 (Gee and colleagues) and Chapter 6 (Zubrick and colleagues) the main underlying determinants of SEWB and ways to modify their effects are described.

Reporting on Health Care Services

The Australian Government produce an annual report on Primary Health Care Services that includes the ACCHOs. This contains information about SEWB and drug and alcohol services provided by this sector. The National Health Performance Authority (NHPA) was established in 2011 to provide nationally consistent information on the performance of health care organisations and health systems. The NHPA, when fully operational, will draw on nearly 50 indicators agreed by COAG to measure the performance of hospitals, and health and mental health services.

Mental Health Reports and Summaries

The NMHC published its first report on the mental health system in October 2012. It includes a dedicated chapter on mental health of Aboriginal people. The report calls for mental health and SEWB to be prioritised within the COAG *Closing the Gap* Agenda, including the adoption of a mental health target.

The COAG Reform Council provides an annual report on progress against the COAG *Closing the Gap* Targets based on existing data sources and since 2009, the Prime Minister has provided an annual report on this to Parliament in its opening session. The *Close the Gap* Campaign Steering Committee produce an annual *shadow report* that provides an independent evaluation.

Biennial summary reports on the health and welfare of Aboriginal Australians that draw on many of the above sources are produced by the Australian Institute of Health and Welfare (AIHW). The Productivity Commission also produces a biennial report against the OID Indicators drawing on existing data sources. In 2010, the indicators were aligned to the COAG *Closing the Gap* targets.

RECENT NATIONAL MENTAL HEALTH POLICY REFORM INITIATIVES

Over the past three years a number of national health reform initiatives have resulted in allocations of significant resources to improve mental health services for Aboriginal and Torres Strait Islander peoples and the wider population.

COAG National Action Plan on Mental Health 2006–2011

In February 2006, COAG committed to $1.9 billion to improve mental health services nationally. It involves a five-year action plan and a series of measures by both state and Australian governments to improve services to people with a mental illness. The Australian Government provides funds to support:

- a major increase in clinical and health services available in the community and new team work arrangements for psychiatrists, general medical practitioners, psychologists and mental health nurses;
- new non-clinical and respite services for people with mental illness and their families and carers;
- an increase in the mental health workforce; and
- new programs for community awareness.

States and territories will be enhancing services in their key areas of responsibility, including the provision of emergency and crisis responses; mental health treatment services by public hospitals and community-based teams; mental health services for people in contact with the justice system; and supported accommodation.

In addition, the Commonwealth, states and territories have invested in areas of common action including:

- promotion and prevention programs including suicide prevention;
- school-based early intervention programs targeting children and young people;
- community-based mental health treatment services, particularly for people with mental illness and drug and alcohol issues;
- mental health services in rural and remote areas;
- support for people with more severe mental illness to gain living skills and work readiness;
- clinical rehabilitation services;
- telephone counselling and advisory services, for example through the National Health Call Centre Network; and
- support for families and carers such as respite care.

Each government has signed Individual Implementation Plans that set out the additional investment they will make to achieve the outcomes and policy directions.

Aboriginal and Torres Strait Islander Initiatives

Initiatives delivered through the COAG National Action Plan on Mental Health 2006–2011 included $20.8 million Commonwealth funding for '*Improving the Capacity of Workers in Indigenous Communities*' program. This included a mental health training program targeting 840 AHWs, and a culturally appropriate mental health first aid (MHFA) training program for 350 transport and administration workers in Aboriginal-specific health services. AHWs, counsellors and clinic staff were trained to identify and address mental illness and associated substance use issues in Aboriginal communities, to recognise the early signs of mental illness and make referrals for treatment where appropriate. Specific projects to enhance Aboriginal mental health included:

- a training program to recognise and address mental illness;
- provision of MHFA training to increase mental health literacy;
- ten new mental health worker positions and associated infrastructure;
- a mental health toolkit;
- the development of the first edition of this mental health textbook; and
- culturally appropriate mental health assessment tools.

Mental health reform is a long term, cumulative and evolutionary process that requires continued government commitment and renewal beyond the expiry of The Action Plan in 2011. Recognition of this is evident in the agreement by Ministers to a new National Mental Health Policy 2008 in December 2008, and the Fourth National Mental Health Plan 2009–14 in November 2009 through which many of the programs in *The Action Plan* are extended beyond 2011. In turn, the programs in these documents are extended by the *The Roadmap for National Mental Health Reform 2012–22* discussed above to further guide whole-of-government mental health reform over the next 10 years.

National Mental Health Policy 2008

In December 2008, a new *National Mental Health Policy* was endorsed by Australian Health Ministers. The Policy provides an overarching vision and intent for the mental health system in Australia and embeds a whole-of-government approach to mental health. The Policy represents a renewed commitment to the continual improvement of Australia's mental health system to ensure that it detects and intervenes early in illness, promotes recovery, and ensures that all Australians with a mental illness have access to effective and appropriate treatment and community supports to enable them to participate fully in the community. The Policy aims to:

- promote the mental health and wellbeing of the Australian community and, where possible, prevent the development of mental health problems and mental illness;
- reduce the impact of mental health problems and mental illness, including the effects of stigma, on individuals, families and community;
- promote recovery from mental health problems and mental illness; and
- ensure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.

The Policy recognises that certain groups in the community, including Aboriginal and Torres Strait Islander peoples, homeless and disadvantaged people, those exposed to traumatic events, and those with serious or chronic health problems are at heightened risk of mental health problems and mental illness.

Fourth National Mental Health Plan 2009–2014

The *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009–2014* has been developed to further guide reform and identify key actions that can make meaningful progress towards fulfilling the vision of the Policy.[21] The Plan has five priority areas for government action in mental health:

1. Social inclusion and recovery
2. Prevention and early intervention
3. Service access, coordination and continuity of care
4. Quality improvement and innovation
5. Accountability - measuring and reporting progress.

The Plan takes a whole-of-government, intersectoral partnership approach to achieve the best mental health outcomes. It is envisaged that the *Fourth Mental Health Plan* will provide a basis for governments to include mental health responsibilities in policy and practice in a more integrated way, recognising that many sectors can contribute to better outcomes for people living with mental illness.

The COAG Roadmap for National Mental Health Reform 2012–22

The COAG Roadmap was developed as a part of a $2.2 billion mental health package announced by the Commonwealth over the 2010–11 and 2011–12 Federal Budgets.[23] It is intended to provide a framework for the renewal of the *National Mental Health Policy* and the *Fifth National Mental Health Plan*. The COAG Roadmap contains six priorities:

1. Promote person-centred approaches.
2. Improve the mental health and SEWB of all Australians.
3. Prevent mental illness.
4. Focus on early detection and intervention.
5. Improve access to high quality services and supports.
6. Improve the social and economic participation of people with mental illness.

Forty-five strategies are proposed to achieve these priorities. In the development of the Roadmap there were calls for a seventh priority specifically to address Aboriginal and Torres Strait Islander mental health. While this did not occur, 10 of the 45 strategies are '*Targeted strategies for Aboriginal and Torres Strait Islander peoples*.

Table 5.1: COAG Roadmap: 10 Targeted Strategies

1. Increase the involvement of Aboriginal and Torres Strait Islander peoples and their families, carers and service providers in developing culturally appropriate mental health and social and emotional wellbeing programs (**Strategy 5**).
2. Renew and implement the *National Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework* (**Strategy 11**).
3. Complete and implement the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* (**Strategy 12**).
4. Support the implementation of community led healing programs (**Strategy 13**).
5. Recognise and address the impact that trauma, grief and loss related to past government policies, including the removal of children from their parents, can have on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples *(Strategy 18)*
6. Strengthen the cultural competency of frontline professionals, including police, education and early childhood providers and health care professionals to detect and appropriately intervene in mental health concerns for Aboriginal and Torres Strait Islander peoples (**Strategy 25**).
7. Enhance the cultural competence and training of those providing mental health services and supports to Aboriginal and Torres Strait Islander peoples *(Strategy 36)*.
8. Establish protocols for service providers working with interpreters for Aboriginal and Torres Strait Islander peoples *(Strategy 37)*.
9. Increase and promote employment opportunities for Aboriginal and Torres Strait Islander peoples in mental health and social and emotional wellbeing service areas *(Strategy 38)*.
10. Expand the availability, and ensure a range, of high quality and culturally appropriate mental health services and supports for Aboriginal and Torres Strait Islander peoples with a mental health issue to enable their participation in education, employment and their community *(Strategy 45)*.

The Roadmap also contains preliminary indicators and targets to measure progress.

The National Aboriginal and Torres Strait Islander Health Plan 2013 - 2023

The National Aboriginal and Torres Strait Islander Health Plan (the Health Plan) is an evidence-based policy framework to guide policies and programs to improve Aboriginal health access, care and outcomes over the next 10 years. A supporting Companion Document outlines Commonwealth activity in Aboriginal health and the social determinants of health, as at 1 July 2013.

The Health Plan addresses strategic points of intersection between health, mental health and social and emotional wellbeing (SEWB), and provides a patient-centred platform for different agencies, organisations, government, stakeholders including communities to work together to plan and deliver better coordinated and focused programs.

The Health Plan adopts an integrated approach encompassing the strengthening of community functioning, reinforcing positive behaviours, improving education participation, regional economic development, housing and environmental health, and spiritual healing communities and individuals to be empowered and to translate their knowledge, skills, understanding and experiences into action. Improvements in Aboriginal health and mental health require effective strategies that address environmental, economic and social inequalities to achieve health equality.

Furthermore, implementing a whole-of-life perspective recognises the different stages in life, highlights key transition periods for individuals and provides strategic points of intersection between health and mental health and SEWB to help overcome health inequalities.

Principles

The new Health Plan is underpinned by the following principles:

Health Equality and a Human Rights Approach

The principles of the United Nations Declaration on the Rights of Indigenous Peoples and other human rights instruments support Aboriginal and Torres Strait Islander people in attaining the highest standard of physical and mental and social health.

Aboriginal and Torres Strait Islander Community Control and Engagement

There is a full and ongoing participation by Aboriginal and Torres Strait Islander people and organisations in all levels of decision-making affecting their health needs.

Partnership

Partnership and shared ownership between Aboriginal and Torres Strait Islander people, governments and service providers at all levels of health planning and delivery.

Accountability

Structures are in place for the regular monitoring and review of implementation as measured against indicators of success, with processes to share knowledge on what works.

Goals

Goals to ensure Aboriginal and Torres Strait Islander people have the best possible mental health and social and emotional wellbeing are included in the plan and strategies are integrated in all health care service delivery and health promotion strategies.

Mental health and social and emotional wellbeing

The Health Plan recognises that social and emotional wellbeing problems are distinct from mental illness, although the two interact and influence each other. People with good social and emotional wellbeing people can still experience mental illness, and people with a mental health issues can experience social and emotional wellbeing with adequate support.

The Health Plan encompasses a definition of Social and Emotional Wellbeing that is consistent with the approach as outlined in the book. SEWB is defined as a holistic concept which recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual. It also acknowledges the influence of the social determinants on SEWB including: homelessness; education; unemployment; problems resulting from intergenerational trauma; grief and loss; abuse, violence; removal from family and cultural

dislocation; substance misuse; racism and discrimination and social disadvantage. Culture and cultural identity, individual and community control, dignity and self-esteem, and respect for Indigenous rights and a perception of just and fair treatment is also important to social and emotional wellbeing. These issues are discussed in individual chapters throughout the book.

National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013

Australia's first national *Aboriginal and Torres Strait Islander Suicide Prevention Strategy (the Strategy)* has been informed by an extensive national community consultation and guided by the ATSISPAG. As with other recent policy initiatives the Strategy is informed by a holistic view of health that encompasses mental, physical, cultural and spiritual health. Community consultations reaffirmed the need for community-focused, holistic and integrated approaches to suicide prevention with an emphasis on 'upstream' efforts to build community, family and individual resilience and on restoring SEWB.

Strategy Objective and Goals

The overarching objective of the Strategy is to reduce the cause, prevalence and impact of suicide on individuals, their families and communities.

Six goals underpin this objective:

1. Reduce the incidence and impact of suicide and suicidal behaviour in the Aboriginal and Torres Strait Islander population and in specific communities affected by suicide.

2. Ensure that Aboriginal and Torres Strait Islander communities and populations are supported within available resources to respond to high levels of suicide and/or self-harming behaviour with effective prevention strategies.

3. Implement effective activities that reduce the presence and impact of risk factors that contribute to suicide outcomes in the short, medium and long term and across the lifespan.

4. Build the participation of Aboriginal and Torres Strait Islander peoples in the workforce in fields related to suicide prevention, early intervention and social and emotional wellbeing through the provision of training, skills and professional qualifications at all levels.

5. Build the evidence base to support effective action and to evaluate the outcomes of suicide prevention activity at local, regional and national levels.

6. Make high quality resources, information and methods to support suicide prevention for Aboriginal and Torres Strait Islander peoples available across all contexts and circumstances.

Action areas

Action area 1: Building strengths and capacity in Aboriginal and Torres Strait Islander communities.

This action area focuses on strategies to support community leadership, action and responsibility for suicide prevention; and the development, implementation and improvement of preventive services and interventions for communities and their members.

Action area 2: Building strengths and resilience in individuals and families.

This action area focuses on work with universal services—child and family services, schools, health services—to help build strengths and competencies and to protect against sources of risk and adversity later life. The focus is also on activities directly with families or with children in schools to develop the social and emotional competencies to promote resilience across the lifespan.

Action area 3: Targeted suicide prevention services.

This action area focuses on targeted services for individuals and families at a higher level of risk including those with mental illness, a prior history of self-harm, alcohol and drug abuse or domestic violence, neglect and abuse; people in, or discharged from, custody. Services need to coordinated and culturally appropriate and linked with culturally competent community-based preventive services

Action area 4: Coordinating approaches to prevention.

This action area relates to the importance of coordinated action across all government sectors and departments—health, schools, justice, child and family services, child protection and housing—and ensure capacity within local Aboriginal organisations to provide preventive services.

Action area 5: Building the evidence base and disseminating information.

This area focuses on developing a body of research and obtaining adequate data on self-harm and suicide in communities as a high priority.

Action area 6: Standards and quality in suicide prevention.

This action area focuses on strategies to ensure consistency in standards of practice and high quality service delivery through: 1) Aboriginal participation in the workforce; 2) Quality controls to strengthen preventive activity in primary health care and other service sectors; and 3) Evaluation to support quality implementation of programs and to evaluate their outcomes.

Community Generated Policy and Initiatives

Since the 1970s, with placement of restrictions on the sale, possession and consumption of alcohol, Aboriginal and Torres Strait Islander communities have developed community level policy as part of their right to self-determination, self-governance, and cultural maintenance. In some cases, these are now reflected in national policy developments—such as the minimum standards in relation to alcohol restrictions in the Commonwealth's Stronger Futures Legislation (with impact in the NT). The work in the Fitzroy Valley in the Kimberley to tackle alcohol misuse and prevent suicide. See Chapter 20 (Hayes and colleagues) for further discussion.

Other community-generated initiatives include the National Empowerment Project which grew out of the Kimberley empowerment project, (Hear Our Voices project). This initiative confirms that, to be effective, programs and services addressing Aboriginal mental health and wellbeing need to be culturally-based and incorporate cultural elements. For further dicussion of this project see Chapter 25 (Dudgeon and colleagues).

CONCLUSION

This chapter has mapped the policy developments relating to Aboriginal and Torres Strait Islander mental health and SEWB. Different ways of approaching the policy formulation and implementation process have influenced several successive policy reforms over the past 25 years.

These policy reforms have been shaped firstly, by national mental health policy and a relatively small component of the $1.6 billion commitment to Australia's mental health; secondly, by a broader Aboriginal health movement that evolved in the 1960s with the founding of the first ACCHOs to the current *Close the Gap* Campaign. Throughout this time, Aboriginal people have asserted the need for Aboriginal leadership and genuine partnership in policy making which is reflected in the new Aboriginal and Torres Strait Islander health policy 2013-2023.

Equally importantly, policies have also been shaped by the need to address the unique factors of mental health and continuing impacts of colonisation and past practices—notably those that led to the Stolen Generations. Critically, all of these factors has led to the the development of a

culturally specific mental health and social and emotional wellbeing policy—acknowledging the holistic concept of Aboriginal health and the assertion of an Indigenous conception of SEWB and the need for more culturally appropriate service delivery and an increase in the Aboriginal mental health workforce. Working in partnership with Australian governments, future Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing policy is now being guided and developed by these movements and the advisory groups associated with them.

REFLECTIVE EXERCISES

1. In what ways are Aboriginal and Torres Strait Islander peoples and their representatives and communities contributing to the development of mental health policy in Australia? Why is this important?

2. Select one of the policy initiatives in the chapter to answer the **questions** below:

   What has influenced the development of the policy?

   What are the key aims of the policy?

   What are the issues it aims to address, i.e. suicide, depression, drugs and alcohol?

   What initiatives have been successful?

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Part 2

Issues and Influences

Describes various issues and influences on people's mental health and social and emotional wellbeing, including a clinical description and diagnosis of mental health. Substance misuse, suicide and the over-representation of people in the criminal justice system are viewed as most significantly impacting on individuals and communities.
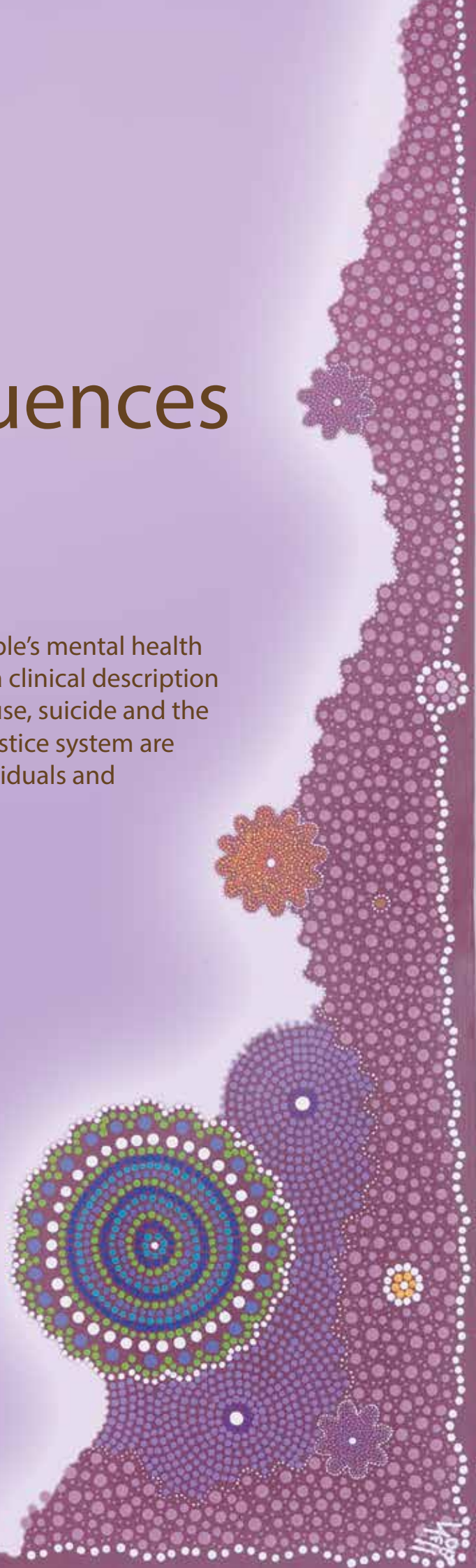
Chapters

6 Social determinants of social and emotional wellbeing are interconnected and develop and act across the life course. Theoretical frameworks linking social factors to health and examining how social and emotional wellbeing develops, is facilitated or constrained are described. Concepts reflecting the broader, holistic view of health that is an intrinsic part of culture and the importance of connection to land, spirituality, ancestry, family and community are discussed.

7 Mental illness is associated with a clinically significant behavioural or psychological syndrome and significant distress and disability. Common types of mental disorders are discussed in both traditional and current contexts. Appropriate diagnosis to ensure accurate assessement, with recognition of cultural relevance in addition to the recognised availability of adjunctive therapeutic supports such as social and emotional wellbeing counsellors is highlighted. Standard resources and assessment tools are defined.

8 Harmful substance use, comorbidity, social and emotional wellbeing and mental health are explored. Services developed through the National Drug Strategy's framework are outlined. A multi-systemic strategy addressing cultural security, evidence-based practice, service coordination, development of an Aboriginal substance use and mental health workforce, working with or alongside local, culturally appropriate, interventions are discussed.

9 The historical and social aetiology of suicide, the nature of its occurrence and consequences within communities provide insights into the group, community, situational and inter-generational factors associated with the likelihood of suicide and suicidal behaviour. Lifecourse studies help explain vulnerabilities to stresses triggering or escalating suicidal behaviour.

10 Mental disorder and cognitive disability amongst people in contact with the criminal justice system and how these issues impact on individuals, families and communities is reviewed. Evidence supports mental disorders and cognitive disability as significant health challenges for people in contact with the criminal justice system. Consideration of the complex implications for mental health and disability services in meeting the needs of these people are explored.

6

Social Determinants of Social and Emotional Wellbeing

Stephen R. Zubrick, Carrington CJ Shepherd, Pat Dudgeon, Graham Gee, Yin Paradies, Clair Scrine and Roz Walker

OVERVIEW

This chapter explores current understandings of the social determinants of Aboriginal and Torres Strait Islander social and emotional wellbeing and its development. We show that the determinants of this wellbeing are multiple, interconnected, and develop and act across the lifecourse from conception to late life. This chapter firstly focuses on the theoretical frameworks linking social factors to health and their applicability in Aboriginal population contexts. It then examines how social and emotional wellbeing develops in individuals, with a specific focus on the broad mechanisms that prompt, facilitate or constrain social and emotional wellbeing in all individuals. The chapter then discusses the social determinants and processes that pose a risk to the development of poor outcomes among Aboriginal and Torres Strait Islander peoples as well as the factors that promote or protect positive wellbeing. We highlight that there are a unique set of protective factors contained within Indigenous cultures and communities that serve as sources of strength and resilience.

It should be noted that this chapter primarily examines and refers to 'social and emotional wellbeing', as opposed to the terms 'mental health' or 'mental illness'. The social and emotional wellbeing concept reflects the broader, holistic view of health that is an intrinsic part of Aboriginal and Torres Strait Islander (herein referred to as 'Aboriginal') culture. It recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect individual's wellbeing.[1]

INTRODUCTION

What can be done to promote and protect the development of optimal social and emotional wellbeing (SEWB) among Aboriginal peoples? How is the development of poor SEWB prevented or reduced? To begin to address these questions it is necessary to have an understanding of the key determinants of the wellbeing of populations.

THE IMPORTANCE OF SOCIAL FACTORS TO POPULATION HEALTH

The health and development of individuals is shaped by an array of factors over time and by place and lifecourse stage. Genetic history, biology and environmental exposures can all have a marked impact on health, and form part of the complex aetiologies of physical and mental health problems.[2, 3]

In recent decades there has been an increased acknowledgment of the role of social factors in determining health outcomes. There is now a robust international literature

that consistently affirms that social factors have a marked influence on the health of populations. The quantitative and qualitative evidence base now widely supports the notion that health inequalities, such as those that exist between Aboriginal and non-Aboriginal Australians, are the result of factors and processes that fall outside of the traditional domains of health. They are heavily influenced by the structures of society and the social conditions in which people grow, live, work and age—or what are now popularly known as the social determinants of health.[4]
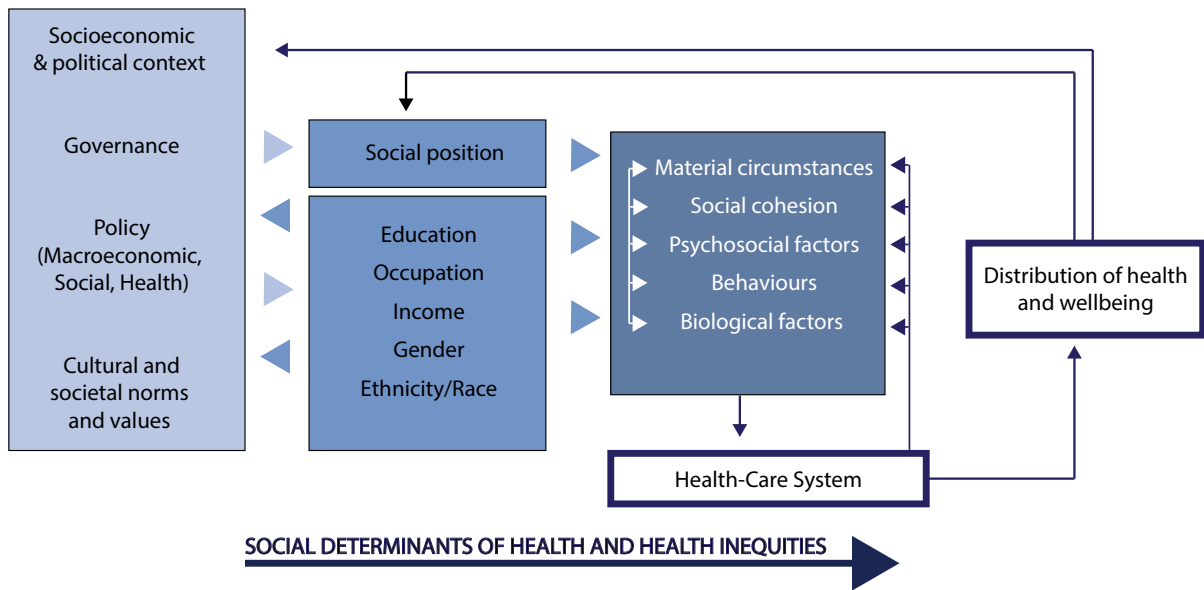
These social determinants of health comprise a wide range of factors, including those that describe the material and social environment of families and the communities in which they live, and the psychosocial conditions of life. These factors extend to income, employment, occupation, poverty, housing, education, access to community resources, and demographic factors such as gender, age and ethnicity.[5]

There are a number of theoretical frameworks that attempt to describe the relationship between health and their social determinants. Most place an emphasis on either psychosocial processes that increase an individual's susceptibility to illness (for example, lower social standing that causes stress, leading to alcohol misuse and a perceived loss of control over one's life, and consequent poor health), or broader economic and political influences that have an indirect effect on health via their impact on material wellbeing (for example, financial strain that results in restricted access to health care services), or both. Importantly, most determinants do not occur in isolation from others. Many pose a risk to health concurrently and many accumulate as time goes on. The number and type of risks (or protective factors) faced by an individual, and their timing, intensity and duration of exposure all influence the level of wellbeing experienced at any point in time.

The framework posed by the World Health Organisation's Commission on Social Determinants of Health (WHO CSDH) is a prominent example of an organising framework that implicates the circumstances of daily life and the broader structures of society as important health determinants.[6] It highlights that inequalities in society lead to inequalities in physical and mental health.[7] The elements of the WHO CSDH framework were determined on the basis of the empirical evidence globally and features determinants that have been shown to be amenable to policy intervention. In other words, the generally accepted social determinants of health are modifiable—that is, they can be influenced or controlled in ways that either reduce the incidence and/or prevalence of ill health and disease, or promote the likelihood of positive physical and mental health and wellbeing.

The WHO CSDH framework and its components are likely to have applicability to Aboriginal populations,[7-9] although it should be recognised that while the framework makes reference to ethnicity and race as a key determinant of health, they are not a central tenet. Models that consider specific population groups tend to place greater emphasis on characteristics of culture and historical circumstances. The model proposed by Williams (1997), for example, considers culture as a basic cause of health status and places aspects of racism, geographic origins and culture as central in understanding how health is formed.[10] The underlying message here is that we are still unsure about the saliency of conventional social determinants to the health of Aboriginal population groups—this is because there has been relatively little scrutiny of the relationship between social factors and Aboriginal health in general,[11] and SEWB specifically.[12]

Figure 6.1: Commission on Social Determinants of Health Conceptual Framework

Source: *Amended from Solar & Irwin (2007) by Commission on Social Determinants of Health (2008),[6] used with permission.*

THE DEVELOPMENT OF SOCIAL AND EMOTIONAL WELLBEING

It is important to recognise that children's development—including the development of SEWB—is influenced not just by what happens in childhood but also by processes that take place in-utero and prior to conception. For example, maternal drug use can have a marked negative effect on early brain development. This, in turn, may restrict early learning experiences and further limit early cognitive development and emotional and behavioural regulation—and all of these experiences and outcomes are likely to have consequences for health throughout life.[2] As such, thinking about determinants needs to be done in the context of how humans develop through the lifecourse. Before we consider some *specific* determinants of social and emotional development, we present here some broad concepts about the development of SEWB.

The evidence in the child development literature suggests that the development of SEWB is shaped by a small set of mechanisms. These mechanisms either prompt, facilitate or constrain the development of skills, capabilities and strengths in early life, and can have a lasting impact on all facets of life. The term *prompts* refers to those mechanisms that require or cause development in wellbeing to occur at particular times or in response to specific circumstances. *Facilitators* are those factors that assist, or make easier, the growth, establishment, elaboration and maintenance of wellbeing. *Constraints*, not surprisingly, inhibit, delay or prevent the development of wellbeing.[13] These mechanisms operate similarly in Aboriginal and non-Aboriginal populations, albeit in vastly different population contexts. They also operate across the lifecourse. Figure 6.2 offers a lifecourse perspective on the development of SEWB in the context of a selection of global and national events (from the end of WWII to the present day) that are known to have had an impact on Aboriginal Australia, and highlights the hypothetical variation in SEWB from birth to late life. The variation in the status of SEWB can be thought of as the variation in the lifecourse of an individual life or as a time series of the population estimate over the relevant period. The figure features a range of family, community and society-level contexts and exposures. This includes important developmental facilitators such as educational experience and transitions, and a selection of developmental constraints that are, too often, part of the lives of Aboriginal children (parental separation, the death of family members and Elders, and community closures). All of these exposures (and SEWB outcomes)

can be influenced by broader factors—these include global and national events that occur over time.[14] For example, the establishment of the Federal Council for the Advancement of Aborigines and Torres Strait Islanders in 1958 provided a stimulus to anti-racism and equality campaigns across Australian states and territories. This activity culminated in the successful 1967 Referendum that provided the Commonwealth government with the power to legislate on issues directly affecting Aboriginal people and ensured Aboriginal people were included in the national Census.[15] Moreover, the Referendum was interpreted as recognition of Aboriginal citizenship rights and expected to spark substantial improvements in the welfare of Aboriginal peoples. These outcomes are likely to have provided direct benefits to the SEWB of individuals and communities around the time of the Referendum and indirect benefits over time, coinciding with a stronger push for Indigenous rights in Australia in the ensuing decades.

Figure 6.2: Child development in the context of the lifecourse, with an Aboriginal perspective
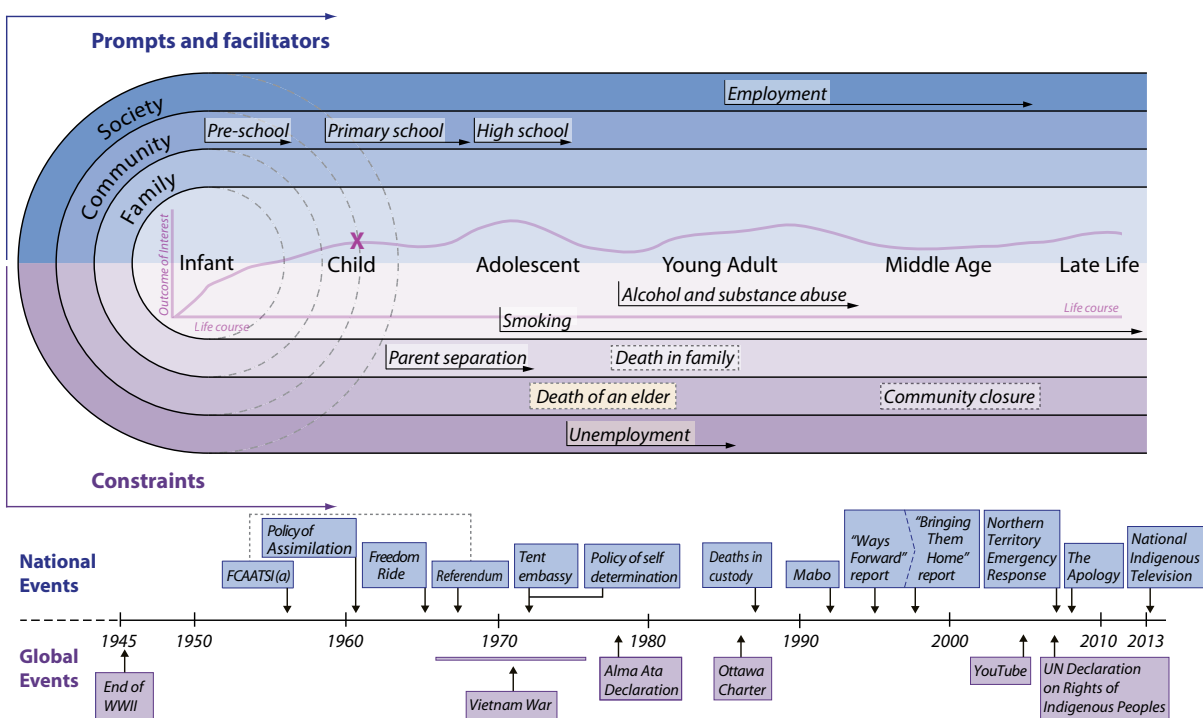
(a) Federal Council for the Advancement of Aborigines and Torres Strait Islanders

Source: Zubrick et al. (2009),[14] adapted with permission.

Prompts for the Development of Social and Emotional Wellbeing

The three major prompts of optimal SEWB are biology, expectations and opportunities.

Biology

Key biological processes form an important determinant of social and economic wellbeing. Biology prompts development in the form of milestones—crawling, walking and talking—and it prompts physical development and sexual maturation during early adolescence.

Expectations

The social and emotional capacities in children are prompted by parent/carer expectations about the capacities of their children. Carers have expectations about the development of their children, some of which are explicitly acknowledged and others of which are not.

These expectations come in the form of carer values, attitudes and beliefs. Some of these are revealed in the encouragement given when parents respond to a child's first steps or words—or when they express concern about delays in these milestones. Other expectations are revealed in requests, demands and rules that govern such things as picking up after yourself, cleaning your room, making your bed, doing chores, doing your homework, reporting in, being home on time and being polite. Evidence shows an important relationship between carer expectations in the form of their parenting styles and practices and the wellbeing of their children.[13]

Opportunities

The social, emotional and cognitive development of children is promoted by the opportunities they have to engage in stimulating activities. Providing opportunities to talk, play, interact and read, particularly for very young children, can have significant onward developmental benefits for the child, in the form of both improved academic achievement and improved social and emotional capacities.[16, 17]

Facilitators of Social and Emotional Wellbeing

The three major facilitators of optimal wellbeing in children and young people are intellectual flexibility coupled with an outgoing, easy temperament; good language development; and emotional support, especially in the face of challenge.

Intellectual Flexibility

SEWB is facilitated by intellectual flexibility and an outgoing personality, easy temperament and tolerance of new situations.[18]

Good Language Development

Survey data indicate that speech problems increase the risk of clinically significant emotional or behavioural difficulties in children.[13]

Emotional Support

Some examples of emotional support include encouraging young children to explore, to celebrate developmental milestones, providing guided rehearsal and extension of new skills, and protection from inappropriate disapproval, teasing or punishment.[19] Most parents want their children to succeed and generally protect them from excessively adverse experiences. For many children, encouragement in the face of difficulty, support in failure, and celebration of success can aid the development of secure relationships with their parents and their longer-term social development, and are critical facilitators of their SEWB.[20]

Constraints on the Development of Social and Emotional Wellbeing

The four main constraints on optimal wellbeing in children and young people are stress that accumulates and overwhelms, chaos, social exclusion (including racism), and social inequality.

Stress

Stress is defined as 'environmental circumstances or conditions that threaten, challenge, exceed or harm the psychological or biological capacities of the individual'.[21] When stress events occur often enough in early life they can have a damaging effect on the developing brain of a child and alter the functioning of important bodily systems, with negative consequences for cognitive, emotional, and systemic disorders throughout life.[22, 23] At the same time, stress can also affect the ability of adults to perform their role as parents in addition to disrupting community cohesion and the wider supports for optimal child development.

Chaos

As Zubrick et al. (2005) note:

> [I]n 1996 Bronfenbrenner and colleagues reviewed what they termed 'growing chaos' in families, schools, unsupervised peer groups and other settings in which children and young people spend extended periods of time. They noted the damaging and disorganising effects of frenetic activity, lack of structure, unpredictability in everyday activities and high levels of ambient stimulation on the development of social and emotional capacities in children.[24(p.559)]

Not only do such contexts disrupt SEWB, but they have the potential to establish alternative developmental processes that lead to poor outcomes.[25] Chaotic systems disrupt attachment, emotional regulation and autonomy.[26] Violence is a prime example of a disorganising influence on human development. Abuse, physical punishment, harsh parenting, bullying and other forms of harassment are harmful to human development and may be particularly damaging for individuals who are vulnerable to such harm.[13, 27]

Social Exclusion

Social exclusion can take many forms ranging from racism and vilification to bullying and more subtle experiences that entail refusals of friendship and non-recognition, all of which constrain wellbeing. These actions also span multiple settings and occur at home, at school, in the workplace, and in day-to-day social exchanges and transactions. Such experiences have the potential to establish reciprocal patterns of socialisation that weaken individual capacities, disrupt social cohesion and alienate groups. There is good evidence that racial discrimination is associated with a range of adverse health conditions including poor physical and mental health (especially depression and anxiety), as well as unhealthy behaviours such as smoking, alcohol and drug use.[28-30] Racism has been identified as a determinant of SEWB in its own right[28, 31, 32] and is discussed in greater detail below.

Racism

There are six main pathways through which racism can lead to ill health: reduced access to the societal resources required for health (e.g. employment, education, housing, health care) and increased exposure to health risks (e.g. unnecessary contact with the criminal justice system); negative self-esteem and self-worth leading to mental ill health; stress and negative emotion reactions which lead to mental ill health as well as affecting the immune, endocrine and cardiovascular systems; disengaging from healthy activities (e.g. exercise, adequate sleep, taking medications); maladaptive responses to racism such as smoking, alcohol and other drug use; and injury through racially motivated assault, resulting in further negative physical and mental health outcomes.[33]

There is strong evidence that systemic racism leads to reduced opportunities to access societal resources required for health, and hence that it contributes to socioeconomic disadvantage.[33] Systemic racism is the inherent ways in which policies, practices and processes of institutions— such as education providers, government agencies or the police—operate, leading to systematic, entrenched inequality between racial groups. While often viewed as neutral and sometimes acceptable, the application of beliefs, values, structures and processes by the institutions of society (economic, political, social) result in differential and unfair outcomes for particular groups. Policy and practices that discriminate unfairly in their effect, impact or outcome, irrespective of the motive or intention, amount to unfair discrimination.

Social Inequality

Social inequality results in the unequal distribution of, and access to, resources required for the development and SEWB of adults and children. These resources include human, psychological and social capital resources as well as income and wealth. This inequality may arise from inadequacies

in the laws and regulations for the redistribution of wealth and social benefit, differences in the use and accumulation of wealth by individuals and groups, and lack of access to the means for generating these resources by some groups relative to others.[13] Several studies have demonstrated the relationship between social inequality and developmental outcomes.[2, 34, 35] As specific groups experience the effects of social inequality—lack of resources and lack of access to services and diminished self-efficacy—there is potential for their stores of human, psychological and social capital to decrease, thereby concentrating the risks for particular groups and sub-populations.

In summary, this section has discussed the prompts, facilitators and constraints underlying the development of SEWB. While these mechanisms operate similarly among Aboriginal and non-Aboriginal people, the scale of the problems (constraints) are generally much larger for Aboriginal peoples. In addition, many of the factors that support development in early life are either missing in the lives of Aboriginal children or are too limited to produce sustainable benefits and opportunities in later life.[36] As a result, too many young Aboriginal people find themselves in a situation where they are overwhelmed by the stresses of everyday life and unable to cope effectively—and this typically leads to high levels of mental health problems,[13] including psychological distress.[37]

To this point we have considered the importance of social factors to the health of populations and outlined some of the key social determinants according to the international literature. We have also focussed on SEWB specifically and summarised the evidence from the child development literature to provide an understanding of how this aspect of wellbeing develops and is shaped over the lifecourse. We now consider some of these determinants and mechanisms as they pertain to Aboriginal peoples, as well as circumstances and characteristics that are unique to Aboriginal populations and critical to their health. In doing so, we provide a summary of the available evidence that describes the prevalence or incidence of these health determinants and their relationship to various SEWB outcomes.

RISKS TO ABORIGINAL SOCIAL AND EMOTIONAL WELLBEING

Many Aboriginal people face a set of interrelated risks to their social and emotional welfare.[38] While single risk factors—such as particular negative life events—might have a minimal effect on their own, when combined they can have a strong interactive effect, and exposure to multiple risk factors over time can have a cumulative effect.[39]

Many of the unique risks faced by Aboriginal peoples have persisted across generations. This reflects the fact that the health and wellbeing of Aboriginal peoples has been profoundly shaped by the circumstances of the past, and most particularly by the events and conditions in Australia since colonisation. The enduring legacy of colonisation on Aboriginal life has been pervasive and affected multiple generations and extends to all dimensions of the holistic notion of Aboriginal wellbeing, including psychological, social, spiritual and cultural aspects of life and connection to land. This has resulted in serious additional risks to wellbeing, including: unresolved grief and loss; trauma and abuse; violence; removal from family; substance misuse; family breakdown; cultural dislocation; racism and discrimination; exclusion and segregation; loss of control of life; and social disadvantage.[1]

Discrimination and Racism

Racism occurs at both interpersonal and systemic levels in Australian society and it impacts a disturbingly high proportion of Aboriginal people.[13, 31, 32, 40, 41] A recent national study indicated that 27 per cent of Aboriginal adults in Australia experienced discrimination, i.e. received unfair treatment as a result of being Aboriginal, in the 12 months to 2008.[42] It should be noted, however, that the reported prevalence of the experience of racism can differ depending on age and geographic location, and the aspect of racism being examined as well as the nature and number of questions asked.

The issues of violence, imprisonment, control, segregation and forced removal from family and traditional country (discussed below) have been in part fuelled by a persistent undercurrent of racism in Australian society which, in its various forms, is still a major problem in contemporary society. See Chapter 1 (Dudgeon and colleagues) for further discussion. For example, providing culturally inappropriate or insensitive public services can exclude Aboriginal people from accessing effective health care. This is one way in which racism in contemporary Australian society influences the state of Aboriginal health and reinforces existing socioeconomic disadvantage.[31] With less than one-in-seven Australians agreeing that Aboriginal and other people trust each other,[43] ongoing racism relates, in part, to a lack of trust which also represents a significant barrier to the process of healing and reconciliation in Australia.

An emerging body of evidence in Australia highlights that racism is a key source of stress (see section on S*tress*, below) and socioeconomic disadvantage faced by Aboriginal people and families, with negative impacts on SEWB and other health outcomes. This includes effects on conditions such as anxiety, depression, risk of suicide, mental and physical ill-health, emotional and behavioural difficulties, childhood illness, alcohol, smoking and substance use and poor oral health.[13, 31, 32, 41, 44-48]

Widespread Grief and Loss

Grief and loss have perhaps had the most profound impact on the wellbeing of Aboriginal people as discussed further in Chapter 17 (Atkinson and colleagues) and Chapter 28 (Wanganeen). National data illustrate that, in the 12 months to 2008, 40 per cent of Aboriginal adults had lost a family member or friend (compared with 19 per cent in the non-Aboriginal population),[42] and 39 per cent had attended a funeral.[49] These data reflect the substantially higher death rates among Aboriginal populations.[50] Too often, deaths involving infants, children, young adults, and men and women in their prime are sudden, unexpected and potentially preventable[51]—and therefore very traumatic. Extended family networks serve to extend grief across communities and regions and impact on community capability, and the funeral costs deplete the financial reserves and resources of family networks.

Child Removals and Unresolved Trauma

There are possibly no better examples of the deliberate and systematic disempowerment of Aboriginal people by white Australia than the suite of legislation enacted (mostly) in the beginning of the 20th Century that aimed to control Aboriginal peoples (see Chapter 1 for more details). These policies impacted the lives of virtually all Aboriginal people in Australia in some way. Their effects on the wellbeing of children were direct and unequivocal, as they gave rise to the widespread removal of children from their natural family and traditional lands.[52]

The effects of forcibly removing children from their natural families have been profound and enduring for Aboriginal people. This was made poignantly clear in the stories contained in the *Bringing Them Home* report, which linked forced removal to transgenerational trauma, feelings of helplessness, and loss of control in the lives of Aboriginal people and placed these realities into the public consciousness.[53] The first-hand accounts in this report are now supported by empirical evidence. Those who were forcibly removed as a child have poorer overall health and wellbeing[54] and higher rates of psychological distress.[55] Furthermore, the current generation of children are more likely to have emotional and behavioural difficulties if they have a family history of forced separation.[13] See Chapter 17 (Atkinson and colleagues) for further discussion of transgenerational trauma and Chapter 22 (Walker and colleagues) for further discussion of the emotional and behavioural issues experienced by young people.

Recent national survey data indicate that a substantial proportion of the current generation of Aboriginal adults had either a direct or indirect experience of forcible removal. Around 8 per cent of adults in 2004-05 had been taken away from their natural families by a mission, the government or welfare, while 43 per cent reported that a relative had been taken away.[49]

Life Stress

Research suggests that life stress may be the most important influence on the development of mental health problems among Western Australian Aboriginal children.[13] This research (in 2000–02) and subsequent studies have highlighted that Aboriginal children and adults are exposed to considerably greater life stress than other Australians.[36, 42, 56] Around three-quarters of Aboriginal adults across Australia experienced at least one major life stress in the 12 months to 2004–05, with over a quarter experiencing four or more stressors (2.6 stressors experienced, on average). Serious stress events, such as the death of a family member or close friend, trouble with police, and abuse or violent crime are experienced far more often by Aboriginal people when compared with other Australians.[42]

In addition, many Aboriginal people (particularly those in less remote areas) may experience the effects of acculturative stress. This can be faced by those who are striving to maintain their cultural heritage, negotiate a relationship with the dominant culture and deal with ongoing discrimination.[57] These are the stresses associated with living in 'two worlds' that have incompatible values and beliefs.[58]

Social Exclusion

Governments have a duty to minimise or prevent actions that result in the unjust exclusion of individuals or groups within the Australian population from participation in social, economic and civic life. This can be achieved through legislative and regulatory frameworks and/or providing support for mechanisms that promote access and equity in society.[13]

Relative to colonisation, it is only recently that governments have acted on that duty to provide Aboriginal Australians with a legal framework to address the fundamental aspects of social exclusion affecting them. Over the past 50 years a series of laws and judgments have played a central role in both recognising the existence of Aboriginal people before colonisation, and asserting their rights of participation and ownership (relevant policy milestones are discussed in Chapter 4). Key examples include:

- the 1967 Constitutional Referendum granting the Commonwealth concurrent power to make laws for Aboriginal people wherever they lived, as well as to allow Aboriginal people to be included in the national census

- the *Aboriginal Land Rights (Northern Territory) Act 1976* which recognised that Aboriginal people in the Northern Territory have rights to land based on their traditional occupation

- the 1992 Mabo judgment in which the High Court recognised that Aboriginal and Torres Strait Islander peoples' occupation of and 'native title' to their land survived the Crown's annexation of Australia in 1788

- the 1996 Wik Case which determined that the granting of a pastoral lease did not necessarily extinguish all native title rights and interests that might otherwise exist.[59]

Economic and Social Disadvantage

There is a plethora of government statistical and academic research reports that have highlighted the existence of deep-rooted social and economic disadvantage faced by Aboriginal peoples. This disadvantage is evident in measures of education, income, employment outcomes, occupational class, overcrowding and home ownership, and tends to be more pronounced in remote areas. For example, an alarmingly high proportion of Aboriginal people are under financial stress: almost half (47 per cent) of Aboriginal adults were unable to raise $2000 in a week if needed and 28 per cent ran out of money to pay for basic living expenses (such as food and rent) in the 12 months to 2008.[60] This underscores the fact that Aboriginal households have low income levels, in absolute and relative terms—13 per cent of Aboriginal people had an equivalised weekly household income of $1,000 or more, compared with 33 per cent of

non-Aboriginal people.[61] Poor outcomes in these areas give rise to other forms of disadvantage, leading to substantial proportions of the Aboriginal population experiencing multiple forms of socioeconomic disadvantage. For example, leaving school early can lead to difficulties in securing meaningful work and have consequences for long-term employment prospects and financial security.

The gaps in social and economic outcomes between Aboriginal and non-Aboriginal Australians have persisted over time, despite modest improvements in some indicators in recent decades. The trends over time signal that disadvantage is deeply entrenched in the lives of Aboriginal people, and, for many families, likely to have been passed down through generations. This has occurred despite considerable policy effort in recent decades aimed at improving Aboriginal education, employment and housing. The persistence of these trends in the face of long-term remedial efforts of governments makes it clear that Aboriginal disadvantage is complex and perhaps the long-term result of processes that began with the exclusion and marginalisation of Aboriginal peoples in Australia since colonisation.

It is generally agreed that better socioeconomic circumstances are associated with better mental health outcomes,[62, 63] although the links between these two elements are not fully understood.[64] Few studies have explored these links in Aboriginal populations, although a recent Western Australian study showed that higher socioeconomic status (particularly indicators of housing quality, home ownership and neighbourhood-level advantage) was associated with a reduced risk of mental health problems in Aboriginal children (see example of housing quality in Figure 6.3).[12] This suggests that improving the social and economic conditions of Aboriginal families may help to reduce the gaps in SEWB outcomes between Aboriginal and other Australians.

Figure 6.3: Relative odds of a mental health problem (a) in Aboriginal children aged 4–17 years in Western Australia, by number of indicators of poor housing quality (b)
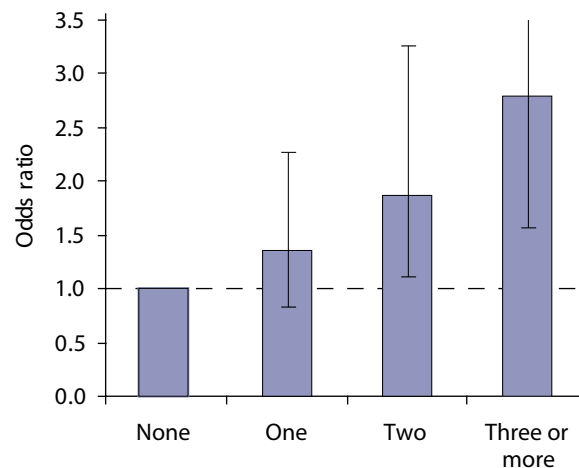
(a) High risk of clinically significant emotional or behavioural difficulties.
(b) Regression model also adjusts for a range of factors related to the physical health of the child, the
   physical and mental health of the carer, and the circumstances of the family and household.
Source: Shepherd et al. (2012),[12] used with permission.

Incarceration and Juvenile Justice Supervision

The high rates of imprisonment of Aboriginal people (especially men) today are among the most alarming statistics of the Aboriginal circumstance. Aboriginal persons across Australia are 15 times more likely to be imprisoned than non-Aboriginal persons,[65] with rates over 20 times higher in Western Australia. In addition, Aboriginal children and young people are substantially

over-represented in the juvenile justice system: Aboriginal people aged 10–17 years were 14 times more likely to be under community-based supervision, and 24 times more likely to be in detention, than non-Aboriginal people of the same age in 2010–11.[66]

The relationship between contacts with the justice system and SEWB is multi-layered. Research highlights unequivocally that juvenile and adult offenders are more likely to have mental health problems,[67-69] and that high-risk alcohol consumption and illicit drug use is a common link between crime and wellbeing (these issues are discussed more fully in Chapter 10, Heffernan and colleagues). These relationships are likely to be exacerbated by a range of 'upstream' influences—including low educational attainment, unemployment, financial stress, overcrowded living and, for Aboriginal people specifically, being a member of the 'Stolen Generations'.[70]

Child Removal by Care and Protection Orders

Aboriginal children are vastly over-represented in the child protection system in Australia. When compared with non-Aboriginal children, Aboriginal children were nine times more likely to be on a care and protection order, ten times more likely to be in out-of-home care, and eight times more likely to be the subject of a substantiation of a child protection notification.[71] The reasons for this over-representation are complex, although they are likely to include the social and economic legacies of past practices of removal from family and culture, e.g. ongoing cycles of poverty, violence and drug and alcohol misuse in Aboriginal families and communities.[53, 71]

Children may come into contact with the child protection system for various reasons, including serious incidences of abuse, neglect and harm. While this system is designed to intervene as early as possible, it may not prevent or substantially reduce the effects of trauma that some children have been exposed to. The effects of various forms of abuse (e.g. traumatic violence) in early life can have profound consequences for emotional, cognitive and social development and wellbeing into adulthood.[23]

Violence

Exposure to violence is a key risk factor for the development of mental health problems in all populations.[13] The empirical literature indicates that Aboriginal people are far more likely to experience violence than others in the population, although the level of the relative risk varies depending on the type of violence (for example, physical violence or sexual violence) and the source data (for example, surveys, hospital data or police data). The 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) identified that 15 per cent of Aboriginal adults witnessed violence in the 12 months prior to the survey; 10 per cent reported being subject to abuse or being a victim of violent crime and 20 per cent had been a victim of physical or threatened violence in this period.[56] Deaths and hospitalisations from assault were 10 and 14 times higher for Aboriginal than non-Aboriginal Australians, respectively, although these relative rates were considerably higher among females. Alcohol-related arguments (22 per cent) and mental disorders associated with psychoactive substance use (8 per cent) were commonly linked to assault deaths of Aboriginal people.[68]

The broad range of risk factors for violent victimisation reflects sociodemographic circumstances, family and community difficulties, historical factors, and access to resources.[72] Evidence suggests that Aboriginal people are more likely to be faced with multiple risks and this may have a cumulative impact on the likelihood of experiencing violence.[73] For example, a person who engages in high risk alcohol consumption and experiences social stress will be at greater risk of violent victimisation than an individual who only experiences social stress.

Family Violence

A substantial proportion of violence experienced by Aboriginal people is related to family violence. This type of violence can be perpetuated throughout the lifecourse[74] and increases the risk of hospitalisation, death and incarceration and of children being removed on protection

orders. It is of particular concern that there is a disproportionately high rate of family violence among Aboriginal women: half of Aboriginal women hospitalised for assault were victims of family violence compared with one in five for males.[75] Spouse or partner violence accounts for 82 per cent of female admissions for family violence.

The implications of domestic violence on Aboriginal wellbeing, and approaches to assisting people, are explored in detail in Chapter 23 (Cripps and Adams).

Substance Use

Alcohol and substance use are among the most prominent preventable causes of death and disease in modern society, and account for a substantial proportion of the overall burden of disease in both Aboriginal and non-Aboriginal populations.[42, 76] Alcohol, tobacco and illicit substance misuse are strongly linked with poor SEWB outcomes. Alcohol misuse, for example, is one of the leading causes of hospitalisations for mental and behavioural disorders among Aboriginal people.[77]

Survey data suggest that 24 per cent of Aboriginal adults were impacted by an alcohol or drug-related problem in the 12 months to 2008 (that is, they—or someone close to them—had a problem). In terms of alcohol specifically, 17 per cent of Aboriginal adults had a long-term pattern of risky consumption, while 37 per cent were considered binge drinkers.[42] While it is acknowledged that risky consumption is generally more prevalent in Aboriginal than non-Aboriginal populations,[78] Aboriginal people experience a disproportionately high rate of problems from alcohol use.[79] For example, Aboriginal people are far more likely to be incarcerated from public drunkenness, and be the victim of serious physical violence.[68, 72]

The links between alcohol and substance use and mental health are discussed in more detail in Chapter 8 (Wilkes and colleagues).

Physical Health Problems

We have acknowledged that aspects of both physical and mental health can be influenced by social factors. However, it should also be borne in mind that physical and mental health are interdependent, i.e. physical health can impact on mental health and broader notions of SEWB, and vice versa.[5] This is important given the poor physical health profile of Aboriginal populations. Recent survey data indicate that 76 per cent of Aboriginal people had a long-term health condition, with many experiencing multiple conditions (15 per cent had two conditions; 43 per cent had three or more).[56] Further, Aboriginal adults were hospitalised at 2.4 times the rate of other Australians—with substantially higher relative rates (7 times) for potentially preventable chronic conditions.[50]

FACTORS THAT PROTECT ABORIGINAL SOCIAL AND EMOTIONAL WELLBEING

There are unique aspects of Aboriginal culture that can have a significant influence on Aboriginal health and that enables Aboriginal people to maintain spirituality central to the Indigenous notion of health. Connection to land, spirituality and ancestry, kinship networks, and cultural continuity are commonly identified by Aboriginal people as important health-protecting factors. These are said to serve as sources of resilience and as a unique reservoir of strength and recovery when faced with adversity, and can compensate for, and mitigate against, the impact of stressful circumstances on the SEWB of individuals, families and communities.[37, 80]

Connection to Land, Culture, Spirituality and Ancestry

The importance of land and the 'country' one belongs to is central to most aspects of Aboriginal culture, and maintaining a spiritual, physical and emotional connection to the land is intrinsic to many Indigenous people's beliefs about mental, social and emotional wellbeing:

To understand our law, our culture and our relationship to the physical and spiritual world, you must begin with land. Everything about Aboriginal society is inextricably interwoven with, and connected to, the land. Culture is the land, the land and spirituality of Aboriginal people, our cultural beliefs or reason for existence is the land. You take that away and you take away our reason for existence. We have grown that land up. We are dancing, singing, and painting for the land. We are celebrating the land. Removed from our lands, we are literally removed from ourselves.[81(p.141)]

In addition to the importance of land and country, the wellbeing of individuals, families and communities are shaped by their connections to body, mind and emotions, spirituality, ancestry and broader, inter-related notions of culture and cultural heritage. These connections are complex and cannot be dealt with in detail here. However, some elaboration of the influences of these factors on SEWB is provided in Chapter 4 (Gee and colleagues). This includes a discussion on the importance of maintaining a secure sense of cultural identity and values, and participating in cultural practices.

Issues of cultural wellbeing are more readily being captured in household surveys, including level of attachment to language group and traditional lands. Data from the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) in 2008 highlight that:

- 11 per cent of Aboriginal adults spoke an Aboriginal or Torres Strait Islander language as their main language at home—the vast majority of whom lived in remote areas

- the majority of Aboriginal children aged 4–14 years (73 per cent) and adults (63 per cent) were involved in cultural events, ceremonies or organisations in the last 12 months

- 62 per cent of Aboriginal adults identified with a clan, tribal or language group[60]

- most Aboriginal people either lived on homelands (25 per cent) or recognised them (but did not live on them; 46 per cent).[42]

Biomedical research on the influence of the homelands on health in central Australia illustrates that there is an association between connection with land and lower prevalence of diabetes, hypertension and obesity, and lower mortality and hospitalisation rates.[82, 83] There is also evidence to support the view that connection to country and culture is beneficial to aspects of SEWB.[82, 84] Further, the literature consistently highlights that SEWB outcomes are more favourable among Aboriginal people in more remote settings,[13, 56] and these are typically the areas where Aboriginal communities maintain a greater connectedness with traditional culture, land and ways of life.

Kinship

Kinship and community relationships play a critical role in the lives and identity of Aboriginal people, and can be a source of strength and wellbeing. The unique status of every individual is defined by their connections with other people through their kinship, ritual and spiritual relationships. These are defined and understood from a very early age (with many Aboriginal people familiar with these relationships and responsibilities) and importantly, provide a sense of belonging. The centrality of kinship ties and relationships means that the bonds of reciprocal affection, responsibility and caring are inextricably linked to an individual's wellbeing. It is for this reason that any discussion of Aboriginal SEWB needs to recognise these cultural dimensions of wellbeing and the significance of support from the community to which they belong.

Self-determination, Community Governance and Cultural Continuity

The effective functioning of communities plays a critical role in supporting the economic and social wellbeing of families and children. Good community leadership and governance is well recognised as a primary driver of human development in Aboriginal communities. Failures in community governance, on the other hand, have been associated with catastrophic social dysfunction such as endemic alcohol misuse and family violence.[85, 86] The maintenance of

Aboriginal self-determination consistent with traditional cultural practices and values is another important driver of social functioning and human development, as evident in a number of studies of Indigenous communities in the USA and Canada.[87] For example, a study of variations in youth suicidal behaviour among First Nations communities across British Columbia's communities demonstrated that suicidal behaviour was dramatically lower in communities which had taken active steps to ensure good community governance structures, as well as preserve and rehabilitate their own cultures, languages and traditional practices.[88] One of the key findings from this research is the importance of fostering a secure sense of personal and cultural identity as a necessary protective factor against the threat of self-harm. This highlights the important role that maintaining cultural beliefs and traditional practices can play in assisting people to have a sense of personal continuity and cultural identity and enhanced sense of wellbeing.

In this section we have discussed some of the factors that are a source of potential strength and resilience for Aboriginal people. More research is required in this field to gain a greater appreciation of the complex set of interdependent factors that have helped Aboriginal cultures to survive several generations of trauma and extreme disadvantage.

CONCLUSION

This chapter has examined the complex array of factors in the social environment that influence and determine the SEWB of Aboriginal and Torres Strait Islander peoples. We have examined this topic from both a theoretical and empirical perspective, and highlighted that—despite improvements in the data and scientific literature in recent decades—the ways that social factors affect Aboriginal health are not fully understood. While the mechanisms that prompt, facilitate or constrain the development of SEWB are likely to be similar among Aboriginal and non-Aboriginal populations, the population context is very different. The current social and wellbeing circumstances of Aboriginal peoples reflect a history of profound dispossession, exclusion, discrimination, marginalisation and inequality, in various forms. The vicious cycle between these experiences and inequalities across the spectrum of health and social conditions has served to perpetuate the disadvantage faced by Aboriginal and Torres Strait Islander peoples. The ongoing effects of colonisation have been particularly harmful to people's SEWB and have created a burden that extends across generations of Aboriginal families.

History has provided a guide to understanding the set of factors that uniquely affect Aboriginal SEWB, and highlighted that there needs to be a multifaceted, holistic and long-term approach to improving people's SEWB. A social determinants approach is not a quick-fix to Aboriginal people's relatively poor wellbeing outcomes. Interventions need to target the reduction of risk factors (including pervasive systemic discrimination), increase protective factors across a number of domains and be based on the best available evidence. The challenge for mental health practitioners, policy makers and service providers is to identify and implement culturally secure, context specific strategies that are designed to recognise and reduce the impact of cumulative and overwhelming stress, developmental chaos, social exclusion and social inequality. This includes strategies that foster interagency cooperation and enhance cultural competence at the system, organisational and individual/practitioner levels as discussed further in Chapter 12 (Walker and colleagues).

The development and support of ongoing culturally appropriate SEWB programs and commitment to culturally competent organisations and practitioners will help to close the current gap in wellbeing between Aboriginal and non-Aboriginal Australians. However, for substantial and long-lasting changes to be made, a long-term commitment throughout the community and government sectors is also required.

REFLECTIVE EXERCISES

1. Consider and discuss the viewpoints below

Viewpoint One: One of the things about social determinants is that they are never really useful when working at an individual level. That is, for those incarcerated as a result of systemic discrimination, interventions for individuals are the same, regardless of how they got there. Also, telling someone that it is 'unfair' they are in jail (for example) will not help them in any way once they are there. So prevention is better than cure and population-level interventions are better than individual-level interventions when dealing with social determinants.

Viewpoint Two: It is important for all practitioners to be cognisant of the complex array of social determinants that may impact on their clients at an individual or community level. For instance, a practitioner may be dealing with a client in a particular setting for a range of reasons that they may not have previously understood or taken into account, and that might signal the need for strategies to support a person differently. For non-Aboriginal practitioners, understanding the social determinants at a system level may actually influence or transform the way they interact with people at an individual level: the degree of compassion they have, and the tacit values and prejudices that influence their practice.

In your discussion of the viewpoints above, do you agree or disagree? Consider the implications for your practice for clients.

2. Exercise

A study which analysed responses to the NATSIS Survey 2002 to determine the economic and social factors that underpinned Indigenous contact with the criminal justice system found that respondents were far more likely to have been charged with, or imprisoned for, an offence if they misused drugs or alcohol, failed to complete Year 12 or were unemployed. Other factors that increased the risk of being both charged and imprisoned included experiencing financial stress, living in a crowded household and being a member of the Stolen Generations. The two most important factors were high-risk alcohol consumption and illicit drug use. Respondents in remote areas were about as likely as Indigenous people in major cities to be charged, but those living in remote areas were more likely to be imprisoned.[70]

a. If you were a counsellor working in a prison, how could you use this information to design a program to prevent recidivism among Aboriginal and Torres Strait Islander prisoners? What factors would you try to influence during your program to make it less likely that your clients would end up back in prison?

b. If you were asked to implement a cultural awareness program for police, what information would you present to try to reduce the high rates of imprisonment of Aboriginal and Torres Strait Islander peoples?

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7

Mental Illness in Aboriginal and Torres Strait Islander Peoples

Robert Parker and Helen Milroy

OVERVIEW

This chapter specifically deals with mental illness, a concept associated with a 'clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and is associated with significant distress and disability'.[1(pxxi)] The common types of mental disorders that affect people are anxiety disorders, mood disorders, psychosis and personality disorders and these are discussed in this chapter in terms of what Aboriginal and Torres Strait Islander peoples may have experienced in both traditional and current contexts.

It is important to view the information in this chapter in the context of other material in this book, particularly the chapters on psychology, social determinants, and harmful substance use (see Chapter 3, Dudgeon and colleagues; Chapter 6, Zubrick and colleagues; and Chapter 8, Wilkes and colleagues). We also caution that any diagnosis of mental illness affecting an Aboriginal and Torres Strait Islander person should be conducted by expert clinicians, such as psychiatrists and psychologists within a culturally safe context, wherever possible. This allows for a more accurate assessment of the person being reviewed, with recognition of culturally relevant issues, in addition to the recognised availability of adjunctive therapeutic supports, such as social and emotional wellbeing counsellors, to assist the person, if appropriate. The chapter does not recommend any specific treatments for the conditions discussed per se, but mentions a number of standard resources that may be used by the Aboriginal and Torres Strait Islander person suffering from mental illness and their family membersto discuss available treatments with their clinician.

WHAT IS MENTAL ILLNESS?

An appropriate introduction to this chapter should focus on the question of 'What is mental illness?' in respect of Aboriginal and Torres Strait Islander peoples in Australia. Since it was first published in the early fifties the DSM has been recognised as a key diagnostic manual. It has been updated on a regular basis to reflect new understandings about mental illness. The newly released DSM-5 (replacing the DSM-IV) is the standard text for classification of psychiatric disorders and mental illness in a Western cultural context. It emphasises the need for explicit definitions as a way of promoting reliable clinical diagnoses.[1(pxxii)] However, there has been an increasing recognition of other factors that may affect the validity of such diagnoses in cultural groups, such as the Aboriginal and Torres Strait Islander population. These include, the standards of what constitutes scientific evidence, the meaning and uses of ethnic and racial categories, interpretations of differences of prevalence for mental disorders, and the tension between universal and group-specific approaches to mental health research and policy.[2]

An inherent concept in the reliability of the definition of such data is an atmosphere of, and commitment to, cultural safety as an essential component of any mental health intervention with Aboriginal and Torres Strait Islander peoples. See Chapter 12 (Walker and colleagues) for a detailed discussion of cultural safety.

Unsafe cultural practice is defined as:

> *any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual, whereas culturally safe practice is simply defined as 'effective clinical practice for a person from another culture'.*[3(p2)]

The emphasis on culturally safe practice with Aboriginal and Torres Strait Islander peoples is particularly important in the context of perceived deficiencies in medical practice in Aboriginal communities in remote Australia, where 'serious and unrecognised miscommunication is pervasive in non-Aboriginal doctor/Aboriginal patient interactions'.[4(p203)] This can also be true in the cities, as miscommunication can occur on a variety of levels and there can also be significant misinterpretation of symptoms and behaviour within the mental health context.[5] Chapter 15 (Dudgeon and Ugle) further explores the issues and strategies for communicating and engaging effectively with Aboriginal and Torres Strait Islander peoples in diverse contexts.

English may not be the first language of remote community-based Aboriginal people and might be the fifth or sixth language. Other compounding influences in the remote setting include differing belief systems regarding illness, a potential perceived inefficiency of health systems and the disempowerment of Aboriginal patients, compliance issues and an overwhelming high burden of disease.[4(p204)] In addition, mental illness issues are often compounded by issues of stigma where the term:

> *mentally ill … causes a variety of reactions when used with Aboriginal people, depending on their level of education, knowledge and the way that they use language … [P]eople gave warnings about how the term could be reinterpreted in ways that would reflect other meanings than [w]hat was intended. These meanings cluster around both what people have heard about their relatives' experiences with mental health services and what they would have heard or seen of peoples' behaviour when experiencing a mental illness.*[6(p95)]

Hunter also comments on the increasing complexity of defining mental illness in Aboriginal and Torres Strait Islander peoples.[7] He notes an increasing coincidence of mental disorders associated with harmful substance use and the problem that this leads to in diagnostic systems where the two entities are often separate. In addition, Hunter notes that:

> *Indigenous societies have undergone rapid social change and it should be no surprise that there have been changing patterns of mental health problems including mental health disorders.*[7(p129)]

He adds that:

> *a constant across most of the above considerations … is a change, both in the patterns of disorders for social and emotional wellbeing and in the social context in which these disorders arise.*[7(p130)]

A number of factors therefore contribute to the accuracy of diagnosis or definition of any mental illness in Aboriginal and Torres Strait Islander peoples. Sheldon notes the particular importance of an appropriate review of contextual data and the familiarity of an interview setting in engaging Aboriginal and Torres Strait Islander peoples in any therapeutic process for mental health issues.[8] The involvement of family, along with Aboriginal and Torres Strait Islander Mental Health Workers (AMHWs) in assessments of Aboriginal and Torres Strait Islander clients, is also an important component of culturally safe practice and the reliability

of information thus obtained.[9] Additional factors involve the use of translation services where appropriate, along with Social and Emotional Wellbeing (SEWB) workers, where the affected person may have specific needs in respect of grief or loss and the Stolen Generations. See Chapter 17 (Atkinson and colleagues) for further discussion of these factors.

Given the above cautionary factors, the remainder of this chapter attempts to review the past and current burden of mental illness as it affects the Aboriginal and Torres Strait Islander population.

Depression

Mood disorders are currently defined by the ICD-10 classification system with a graded transition from mild mood disturbance (commonly described as adjustment disorders) to the more severe types of depression such as major depression with melancholia, and major depression with psychosis. The category also covers bipolar disorder (previously known as manic depression). The new DSM-5 has removed the 'mood disorder' category and made changes to the major depression (also known as clinical depression) and depressive disorders area. There is a new condition known as 'persistent depressive disorder' which includes both chronic major depressive disorder (MDD) and the previous dysthymic disorder.

Major depression, as defined by DSM-5,[1] usually involves the affected person developing a low mood along with feelings of worthlessness and loss of interest in normal activities, which is out of character with their normal persona. The person may experience suicidal ideation. They often have altered vegetative features such as poor sleep, reduced appetite with weight loss and impaired concentration. The person may also have developed emotional restriction and anxiety in the context of the mood disturbance. The DSM-5 made no changes to any of the core criteria symptoms of major depression.

There is also a new condition introduced in the DSM-5 called 'Distruptive Mood Dysregulation' disorder. This new disorder can be diagnosed in children up to age 18 years who exhibit persistent irritability and frequent episodes of extreme, out of control behaviour.

Pink and Allbon, using the ICD-10 criteria, note that the admission to hospital of Aboriginal and Torres Strait Islander men with severe mood and neurotic disorders is 1.2 times the rate of the non-Aboriginal population, with the rate for Aboriginal and Torres Strait Islander women being the same as the non-Aboriginal population.[11] However, individual Aboriginal community surveys have found differing rates of mood disorder, with these being variously reported at 2.5 per cent for Mornington Island, 6 per cent at Bourke, but 1 per cent for a community in the Kimberley.[7] McKendrick conducted a survey of Aboriginal people attending a community-controlled health service in Victoria, reporting that 54 per cent of the people tested with standard psychiatric rating scales were suffering from psychiatric illness and that depression was the most common among this group.[12] Jorm reports that recent community surveys have shown similar high levels of psychological distress (anxiety and depression) amongst Aboriginal and Torres Strait Islander peoples, with a rate of 50 per cent of respondents to the survey being three times higher (overall rates 20.2%–26.6%) compared with other Australians.[13]

In terms of atypical features of mood disturbance that may be present in the Aboriginal and Torres Strait Islander population, Jones and de la Horne, in a survey of a Central Australian Aboriginal group, noted that people affected by mood disturbance in the group suffered vegetative disturbance and restriction of emotional response.[14] They also noted that the affected population often projected feelings of unworthiness and guilt onto others, were more aggressive and had more physical or somatic symptoms. Cawte also describes a number of features of atypical depression experienced by Aboriginal people.[15] He notes a 'suicide fit' in the context of alcohol withdrawal, where a person develops a significant degree of anxiety following an intense encounter with a relative. The affected person will often run away to seek a private

place and may then attempt to harm themselves. Cawte describes depression precipitated by a person being shamed or being fearful that they were subject to sorcery or payback.[15] Morice has reported that the Pintubi have a range of words to express a range of feelings of sadness and depression from mild to severe.[16] Brown, in a survey of Aboriginal men from Central Australia, found that symptom profiles for depression were comparable to other Australians.[17] However, what the Aboriginal men understood and related to depression was as a weakness or injury of the spirit. In addition, the Aboriginal participants felt that depression related to a loss of connection to social and cultural features of Aboriginal life, cumulative stress and marginalisation.[16] The participants identified a reluctance to talk about their emotional issues and described anger and impulsivity as prominent features of depression, particularly in the context of trying to suppress the anger they felt in respect to what had occurred in their lives.[16] The importance of strong spirit and strong mind is explored in Chapter 26 (Casey).

Ketchell, following a description of normal funeral rituals required by members of the Torres Strait Islander population, notes that people may become emotionally distressed if they are unable to fulfil these duties for some reason related to their present circumstances.[18]

Given the high rates of social disadvantage affecting Aboriginal and Torres Strait Islander mothers, along with additional factors such as being a member of the Stolen Generation and having much higher numbers of children in out-of-home care,[19] it would be considered that the potential for postpartum depression in Aboriginal and Torres Strait Islander women would be greater. A recent survey of 25,455 women in South Western Sydney did not reveal a greater prevalence of postpartum depression in the very small component number (481) of Aboriginal and Torres Strait Islander women sampled.[20] However, the survey did point to some significant health and social issues leading to an increased prevalence of postnatal depression (PND) that also commonly affect Aboriginal and Torres Strait Islander peoples. These included placement in public housing, difficult financial situation, single status, poor rating of own health and poor rating of their child's health.[20] A study of 210 Aboriginal and Torres Strait Islander mothers in Queensland using an adapted, more culturally appropriate form of the Edinburgh Postnatal Depression Rating Scale (EPDS) found higher rates of participants with 'at risk' issues (27.7 per cent) on the culturally adapted scale compared with 16.7 per cent identified with the normal scale. This disparity suggests that miscommunication and cultural safety issues may be leading to a poor recognition of postpartum depression within the Aboriginal and Torres Strait Islander population.[21] The issues and strategies around perinatal maternal and infant mental health are discussed in detail in Chapter 19 (Marriott and Ferguson-Hill).

Anxiety

Anxiety disorders encompass a range of mental illness conditions, where there is elevated psychological arousal accompanied by physical sensations of fear.[1] The psychological and physical features, along with avoidance behaviour to reduce these issues, are core features of anxiety disorders. There are seven categories of disorders listed in the 'anxiety disorder' section of the new DSM-5 criteria. Some of these disorders may be a fear of a particular object or situation (phobia); fear in response to certain social or performance situations (social anxiety disorder); chronic persistent fear with physical overactivity (generalised anxiety disorder); sudden unexpected episodes of fear (panic attack) and the fear of experiencing anxiety or having a panic attack (agoraphobia). The symptoms of anxiety disorders may sometimes be the consequence of medical conditions such as thyroid disease, and are frequently associated with substance misuse, both intoxication and withdrawal. It is therefore important to have these matters examined before a diagnosis of anxiety disorder can be definitively made.

Listed under a new heading in the DSM-5 called 'obsessive-compulsive and related disorders', is the intrusive thoughts and associated ritualistic avoidant behaviour known as obsessive compulsive disorder. Acute Stress Disorder (ASD) which is emotional numbing and recurrent

traumatic memories and dreams following exposure to a severe traumatic incident and post traumatic stress disorder (PTSD) are now listed under the new DSM-5 heading known as 'trauma and stressor-related disorders'.

Anxiety conditions rarely reach the severity required for admission to hospital. However, community surveys of mental illness point to varying prevalence rates of anxiety, from 1.5 per cent of community members in Mornington Island and 1.4 per cent of community members in the Kimberley, to 5 per cent of community members in Bourke.[7] More focused surveys, such as the Western Australian Aboriginal Child Health Survey, showed that up to one-quarter of surveyed children aged 4–17 years may have been at risk of developing emotional and behavioural disorders that may be associated with anxiety conditions.[22] This finding is not surprising against a background where Aboriginal and Torres Strait Islander peoples are exposed to high levels of multiple life stressors. Forty-four per cent of Aboriginal and Torres Strait Islander respondents surveyed by the Australian Bureau of Statistics reported at least three life stressors in the previous 12 months, and 12 per cent of respondents reported experiencing at least seven life stressors that included the death of a family member or close friend, serious illness or disability, inability to get work, overcrowding at home, and alcohol and drug-related problems. Multiple stresses were more prevalent for Aboriginal and Torres Strait Islander peoples living in remote and rural locations.[23] Walker and colleagues discuss the issues associated with anxiety, depression and behavioural issues for young Aboriginal and Torres Strait people in Chapter 22.

The high level of exposure to stress can be contrasted with Aboriginal and Torres Strait Islander cultural factors that appeared to reduce stress and anxiety in traditional cultures. Hunter and Eastwell have commented on the ability of Aboriginal and Torres Strait Islander peoples to express strong feelings within a defined cultural context such as a funeral.[24,25] Eastwell also comments that the Yolgnu tribe of Eastern Arnhem Land relieved stress by ascribing significant adverse personal events, such as the unexpected death of an individual, to sorcery, which was satisfying to individuals and the community and carried great local conviction.[25] However, there are also occasional reports of significant anxiety disorder in the traditional Aboriginal and Torres Strait Islander context. During his time with the Walpiri in the 1960s, Meggitt described what is most likely a case of dissociative fugue, secondary to intense anxiety resulting from a woman accidentally viewing sacred items.[26] Morice reports that Pintubi language describes extreme fear, in addition to other grades of anxiety, that could also account for such a phenomenon.[16]

Psychosis

Psychotic disorder usually refers to a complex of symptoms of mental illness. These include hallucinations (abnormal sensory perceptions), delusions (false beliefs), disorganised speech and behaviour, and cognitive issues such as emotional blunting, limited intellectual function and ability to motivate oneself.[1] The experience of psychosis is often very frightening for the individual concerned and is related to a range of conditions, such as schizophrenia (a long-term condition where the affected person has disability related to persistent psychosis), mania (elevated mood related to bipolar disorder or manic depression), severe depression and substance misuse. Occasionally, psychosis may be precipitated by a severe emotional stress.

The experience of psychosis in traditional Aboriginal and Torres Strait Islander culture was likely to have been rare. As an example, Kidson and Jones estimated that the rate of schizophrenia among tribal Aboriginal people in Central Australia was about 0.46 per cent.[27] This estimate stands in significant contrast to the high rate of psychosis currently affecting the Aboriginal and Torres Strait Islander population. Pink and Allbon report that Aboriginal and Torres Strait Islander men were admitted to hospital with mental disorders due to psychoactive substance misuse, at 4.5 times the expected rate for their proportion of the Australian population, and the same population had hospital admission for schizophrenia and related

disorders at 2.7 times the expected rate. Aboriginal and Torres Strait Islander women have 3.3 times the expected rate of mental disorders due to psychoactive substance misuse and 2.5 times the expected rate of hospital admission for schizophrenia and related disorders.[11]

It appears, therefore, that the experience of psychosis, particularly in the context of substance misuse, is a significant issue for the Aboriginal and Torres Strait Islander population at present. A recent study by McKetin and a review by Paparelli point to the contribution of substances such as cannabis and amphetamines in the current epidemic of psychosis, and how it is often difficult to differentiate psychosis related to substance misuse from psychosis associated with a more pervasive cause such as schizophrenia.[28,29]

The recognition of cultural factors and use of AMHWs is an important component of care and diagnosis for any Aboriginal and Torres Strait Islander person presenting with psychosis. As an example, it is common for Aboriginal people to experience the voices of their relatives, and this may be misinterpreted as a hallucination by clinicians who do not have an appropriate understanding of relevant cultural issues.[30]Notwithstanding the above cultural factors, psychotic disorders have been reported in a number of cases of the traditional Aboriginal and Torres Strait Islander context. Aboriginal people apparently suffering from positive symptoms (hallucinations) and negative symptoms (emotional and cognitive blunting) of schizophrenia were observed by Jones and de la Horne in Central Australia in the 1970s.[14,31] Morice notes that the Pintubi words to describe someone suffering from schizophrenia are having closed ears or living in a world of their own.[16] Meggitt described the case of a woman suffering from psychosis, most likely related to emotional stress, as well as a person suffering from mania in the Walpiri.[26] Eastwell commented on transient delusional states in certain Yolgnu family groups in East Arnhem Land.[32,33] Ketchell also reports on delusions that affect Torres Strait Islanders where they become abnormally jealous of their partner, incorrectly believing that they are having an affair, or believe that sorcery is being performed against them.[18]

Personality Disorder

Personality disorders are a class of social disorders characterised by enduring maladaptive patterns of behaviour, cognition and inner experience, exhibited across many contexts and deviating markedly from those accepted by the individual's culture. The DSM-5[1] now lists personality disorder in exactly the same way as other mental disorders, rather than on a separate 'axis' as previously. Personality, defined psychologically, is the set of enduring behavioural and mental traits that distinguish human traits. Hence, personality disorders are defined by experiences and behaviours that differ from societal norms and expectations.

Pink and Allbon note that Aboriginal and Torres Strait Islander men have a rate of admission to hospital for personality issues that is 1.8 times the rate expected for their proportion of the population.[11] The rate of admissions for Aboriginal and Torres Strait Islander women with similar issues is 0.8 times the rate. Community prevalence surveys have reported rates of personality disorder of 4 per cent in Mornington Island, 16 per cent in Bourke and 8.2 per cent in a Kimberley community.[7] However, one has to be careful diagnosing personality disorder in situations where an atmosphere of cultural security was not maintained or supported during the assessment, as outlined at the beginning of the chapter. Morice notes a number of qualifying issues in the diagnosis of personality disorder when the assessor is from a different culture to the person being assessed. He cautions that:

> there are many people who exhibit atypical (for themselves) behavioural responses to certain environmental stimuli. These behavioural reactions occur in direct response to the stimuli and usually disappear when the stimuli are removed … A diagnostic dilemma occurs when adverse environmental stimuli are prolonged and behavioural responses may appear to be relatively fixed.[34(p296)]

Given this caution, there is still a range of information about the vulnerability of Aboriginal and Torres Strait Islander peoples to personality issues. A number of authors[35-37] have commented on tribal sanctions that were applied to continually disruptive individuals (usually young men) that may be indicative of antisocial personality, as currently defined by DSM-5.[1] The significant amount of stressors affecting young Aboriginal and Torres Strait Islander peoples currently, seen against the historical background of the negative impacts on their health, culture and society generally, may be considered vulnerability factors for further continuing personality dysfunction.[23] This may be an issue in the case of members of the Stolen Generations in Western Australia, where surveys have shown that people are more likely to live in households where there is problematic gambling and drinking, more likely to have been in contact with mental health services, and almost twice as likely to have been charged by police.[22] The findings may also indicate that, although personality disorders are problematic categories of illness due to historical, cultural and political factors, they cannot be ignored due to the cumulative impact of trauma, grief and loss on a person's development and hence require strategies for management.

ISSUES FOR FAMILIES

The 2008 submission of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to the Australian Government House of Representatives Standing Committee on Family, Community, Housing and Youth Inquiry into Better Support for Carers, outlines a number of issues which affect the carers of people suffering from mental illness that are also quite applicable in the Aboriginal and Torres Strait Islander context. The College submission points out that those general attitudes to mental illness add to the existing social exclusion and pressures faced by carers. In addition, most people are largely uneducated in the effects of mental illness on the individual, let alone carers. The College submission adds:

> *The reality is that mental illness is difficult to understand and often generates fear and considerable stigmatisation for the consumer and their family. It is often seen as being in the 'too hard basket' by many in the service system and the greater community. Consequently, social support structures such as housing, rehabilitation, justice systems, income support arrangements, employment assistance etc., all face particular difficulties and are often less effective in providing well tailored services and outcomes to people with mental illness. For carers, these difficulties and complexities are at least as great, but the pressures they face in trying to deal with all of the issues and interactions can be extreme and unrelenting. As a result, carers' own health needs can suffer adversely and/or be overlooked .[38(p3)]*

These issues are further complicated for the families of Aboriginal and Torres Strait Islander peoples with mental illness in remote Australia. According to Dillon and Westbury, there may be a performance gap in terms of the provision of services, a legitimacy gap in that standards of governance are deficient, and a security gap in that levels of violence are high.[39] A similar situation may also face families of Aboriginal and Torres Strait Islander peoples with mental illness who reside in cities where they tend to be poorer and more marginalised than their non-Aboriginal counterparts, thus reducing their access to quality support services.[39]

Thus, an appropriate clinical response to the large majority of Aboriginal and Torres Strait Islander peoples suffering from mental illness would involve a comprehensive appreciation of the community that they live in.[8,40] Further, the essential interaction between the family of individuals suffering from mental illness and AMHWs within a primary health setting is considered an important component of the management of that individual.[41] The authors go on to suggest a range of ways that mental health clinicians, including AMHWs, can work with families. These include clarifying mutual goals; not forcing families to fit specific models

to encompass the diversity of Aboriginal and Torres Strait Islander culture and social issues; acknowledging your own limitations as a therapist when working with Aboriginal and Torres Strait Islander families; working with the families as a team; pointing out family strengths; learning to respond to the family's intense feelings; encouraging family enrichment to fulfil their own needs in the context of care for the affected individual; providing information about the illness and therapies (including medications) required; providing practical advice (including information on community resources); encouraging family involvement in support and advocacy groups; acknowledging a diversity of beliefs; and making a personal commitment to the issues at hand.[41]

Forensic Issues

Aboriginal and Torres Strait Islander peoples continue to make up a disproportionate amount of prison populations in Australia. In 2004, they were 11 times more likely to be imprisoned than non-Aboriginal Australians.[42] It is estimated that approximately 19 per cent of men and 30 per cent of women in full-time custody in Australia are Aboriginal and Torres Strait Islander. Butler[42] suggests that the high rates of mental illness recorded for Aboriginal and Torres Strait Islander women indicate that they are one of the most psychologically vulnerable groups in the community.[42] Forensic mental health issues are particularly pertinent for Aboriginal and Torres Strait adolescents. Over one-third of young people under juvenile justice supervision during 2005–06 were identified as being Aboriginal and Torres Strait Islander[43] (44.9 per 1,000 population compared with 2.9 per 1,000 population for non-Aboriginal young people Australia-wide).[42]

Another review notes that prison data give a more severe picture of mental illness and impairment for Aboriginal and Torres Strait Islander prisoners than general population data.[44] A local prisoner health study found that one-in-seven Aboriginal and Torres Strait Islander men and one-in-five Aboriginal and Torres Strait Islander women prisoners reported having been hospitalised at least once in the past for psychiatric reasons. Particularly high rates of substance misuse, post-traumatic stress disorder, acquired brain injury and comorbidity were evident or inferred for Aboriginal and Torres Strait Islander prisoners. A strong link between substance misuse and offending was evident, especially crimes involving assault. Contradictory findings for depression, upon closer analysis, revealed a pattern of under-diagnosis, wherein the symptoms needed to be more extreme before services were accessed or made available to Aboriginal and Torres Strait Islander prisoners. It was also considered likely that Aboriginal and Torres Strait Islander prisoners experienced higher rates of subjective distress, not adequately picked up by current systems of assessment and diagnosis, relating to loss of identity, acculturation stress and/or 'spiritual sickness'.[44]

Overall, the findings in the report by Jones and Day pointed to the need for more culturally attuned mental health assessments and responses for Aboriginal and Torres Strait Islander peoples involved in the criminal justice system, and a much higher standard of culturally appropriate data collection in the mental health field[44] (refer to Chapter 10, Heffernan and colleagues; and Chapter 30, Hovane and colleagues).

There has been a range of innovative programs devised for Aboriginal and Torres Strait Islander adolescents within the juvenile justice system that, may provide models generally for the improved care of Aboriginal and Torres Strait Islander peoples within prisons, who may be vulnerable to mental illness. Stathis and colleagues describe a program conducted in a prison for Aboriginal and Torres Strait Islander adolescents that was coordinated across a number of departments.[45] Education Queensland provided substance use information to all adolescents attending the prison school. The Queensland Department of Communities offered psycho-educational programs as part of regular life skills programs, and clinical treatment was offered to young people identified as suffering from significant substance misuse disorders. The recruitment of an AMHW to the team was a further incentive for Aboriginal and Torres Strait

Islander adolescents to engage in the program.[45, 46] In addition, the AMHW was able to assist the other clinicians with the definition of cultural issues affecting the adolescents, allowing them more accurately to define issues of mental illness and personality dysfunction. The AMHW also engaged the adolescents in concepts of emotional and spiritual wellbeing. Other strategies such as the use of a 'buddy system' have also been suggested to assist adolescents adjust to custody.[47]

Treatment

It is not within the scope of this chapter to critically review therapies currently available for the treatment of mental illness. Australian practice guidelines developed by the RANZCP are a good initial reference point for this issue, and clinicians should be able to discuss their proposed treatment with affected individuals and their families in the context of these guidelines.[48] People affected by severe mental illness such as psychosis, severe depression and mania, may be at risk of death or serious injury to themselves by accidents or suicide. They may also be a danger to others, through fear or aggression. Urgent medical attention should generally be sought to help the person affected by these disorders. It is not inevitable that the person who is affected by mental illness will be admitted to hospital—they may be able to be treated in their community with the help of family, AMHWs and Mental Health Services. People affected by mental illness and their families may be aware of National Standards in Mental Health, which emphasise treatment in the least restrictive environment for people affected by mental illness.[49] Other publications such as the CARPA manual also have protocols for treating Aboriginal people with mental illness in their community.[50] However, if the mental illness is severe and the person suffering from it may be a danger to themselves or others as a result of their illness, the person may need to be treated involuntarily under the *Mental Health Act 1996* for a period before returning to their community and family.

There have also been a number of innovative strategies to improve the outcome for people affected by mental illness. The Northern Territory AIMhi project has developed a *Story Telling Project* to improve compliance and reduce recurrence of mental illness for people living in remote communities, as well as attempting to reduce the stigma in the community for people affected by mental illness.[51] The developed stories are produced in collaboration with a range of clinicians, service providers and the communities concerned. These programs work on a concept of improving mental health through strength in spiritual, physical, family, work, social, mental and emotional components of the life of the person affected. The stories emphasise the importance of culture and of the Aboriginal and non-Aboriginal way of working together to improve the outcome for the person. The stories developed were then used to preface a further intervention strategy of motivational interviewing, problem-solving therapy and chronic disease self-management, to improve outcomes for a group of people suffering from severe mental illness.[52] Other resources include the DVD collection of personal stories of Aboriginal and Torres Strait Islander peoples, in addition to a guide for the care of Aboriginal and Torres Strait Islander peoples experiencing severe mental illness produced by ORYGEN.[53, 54] The use of these resources to inspire and educate Aboriginal and Torres Strait Islander peoples, their families and service providers is a welcome trend.

CONCLUSION

This chapter demonstrates that mental illness was present in Aboriginal and Torres Strait Islander culture prior to European colonisation of Australia but was, most likely, a fairly rare occurrence. The much greater prevalence of mental illness in the Aboriginal and Torres Strait Islander population currently is a reflection of the significant disruption to Aboriginal and Torres Strait Islander society and has a strong context of social and emotional deprivation. Management of the issues of mental illness requires a strong emphasis on cultural safety, along with the recognition of family, culture and community in any healing process.

REFLECTIVE EXERCISES

1. Discuss how the significant changes to Aboriginal and Torres Strait Islander culture and society since European colonisation have led to changes in patterns of mental illness.

2. Discuss how you may go about the assessment of an Aboriginal and Torres Strait Islander person who is referred to you by another clinician for assessment of 'depression'.

3. Discuss how the experience of an Aboriginal and Torres Strait Islander person suffering from mental illness may affect that person's family, and ways that you as a clinician may assist the family.

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8

Harmful Substance Use and Mental Health
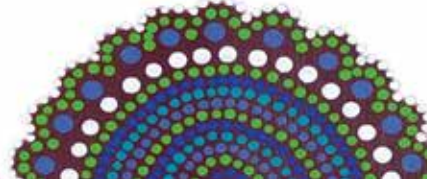
Edward Wilkes, Dennis Gray, Wendy Casey, Anna Stearne and Lawrence Dadd

OVERVIEW

In this chapter, we briefly examine harmful substance use and mental health among Aboriginal Australians. We explore a range of issues including current substance use and related harms, social and emotional wellbeing and comorbidity, and the social determinants of mental health and harmful substance use. We examine the range of services that have been developed to address these issues, through the National Drug Strategy's demand, supply and harm reduction framework. We argue that a multi-systemic strategy is required that addresses issues of cultural security, evidence-based practice to enhance treatment outcomes, better service coordination, and attention to the development of the Aboriginal substance use and mental health workforce. Some evidence-based treatments to help with mental illness and harmful substance use are adaptable to work with or along-side local, culturally appropriate, interventions. However, we reiterate that until the social and structural determinants of good mental health are addressed, the comorbidity of harmful substance use and mental health among Aboriginal Australians will linger.

This chapter will explore these issues in more detail and focus specifically on four important areas of concern. What are the problems? What are the underlying issues? What is, and can be done, to address harmful substance use among Aboriginal people? What else needs to be done?

THE BACKGROUND

For over 200 years, colonisation, racism and domination have left a legacy of marginalisation and mental anguish that is still with us today. Few Aboriginal Australians have been spared that anguish or the self-destructive behaviour associated with the harmful use of alcohol and other psychoactive substances. While harmful use of alcohol and other substances is represented as the problem of Aboriginal Australia, the source of all or most of its ills, especially poor physical and mental health, is influenced by many factors—including as an escape mechanism and a focus of socialising—and the causes and effects of alcohol and other drug use need to be better understood. Otherwise, there is a great risk that policy interventions will be simplistic and ineffective and the current opportunity for change will be lost.

The search for effective answers to today's problems with the harmful use of alcohol and other substances must start with the facts—each Aboriginal person has a lived experience and story that should be told by them. The experience of assimilating into Western ways or retaining Aboriginal ways creates anxieties that reverberate through the families that make up the Aboriginal Australian world. While Australia now has racial vilification laws, Aboriginal Australians are still made to feel uncomfortable or denied access to public places where others are welcomed.

The apology by the Prime Minister of Australia on 13 February 2008, recognising past wrongs against the Stolen Generations of Aboriginal Australians, cannot be a solution on its own until the demeaning stereotype of Aboriginal and Torres Strait Islander peoples is dismantled.

The prevalence of substance use in the wider population is thoroughly documented[1] and the *National Survey of Mental Health and Wellbeing*[2] has documented the high prevalence of comorbid harmful substance use and mental illness in that population. The authors of the latter report concluded that their is growing evidence for some direct causal relationships between harmful substance use and poor mental health, in particular cannabis use leading to psychosis in the vulnerable.[2] They also demonstrated that regardless of whether substance use complicates psychiatric disorder or vice versa, the prognosis is poorer for both conditions together than for either condition alone.

Comorbid Harmful Substance Use and Mental Health Problems

Several reports document high rates of substance use among Aboriginal people in general and young people in particular.[3-5] There is evidence that comorbidity is more common than in the wider population, although as Hunter[6] observes, identifying disorders of social and emotional wellbeing (SEWB) in Aboriginal and Torres Strait Islander populations is problematic. He notes that Aboriginal people's mental health disorders and substance use problems continue to be treated separately and this contributes to poor prognosis.[6] The three main approaches to managing comorbid harmful substance use and mental health problems are:

1. *serial treatment*—managing the psychiatric disorder and harmful substance use in separate settings and services, one after the other;

2. *parallel treatment*—managing both concurrently, but by different staff and in different settings; or,

3. *integrated treatment*—when the same staff treat both disorders in the same setting.[7]

Both serial and parallel treatment models have limitations with high rates of patient withdrawal or people not getting treatment at all. Increasingly, integrated treatment is regarded as the preferred model, and although the evidence is evolving, this model is most in accord with the approach of many Aboriginal community controlled health services.

SUBSTANCE USE AND RELATED HARMS

It is important to note that not all substance use is harmful.[8] Here we use the term 'harmful substance use' in the public health sense, meaning any use of a psychoactive substance that causes harm to users or to others. This is a broader definition than the psychiatric definitions of 'substance abuse' or 'substance dependence' used in the Diagnostic and Statistical Manual of Mental Disorders.[9] See also Gray et al.[8]

For methodological reasons it is far easier to ascertain the prevalence of use of various psychoactive substances than it is to document the frequency and levels of such use, and whether or not individuals are using those substances at harmful levels[10]. Nevertheless, the levels of each are related and estimates of the prevalence of substance use provide an indicator of likely levels of harm. The figures on current prevalence (that is, any used in the previous 12 months) presented in Table 8.1 and used for comparison with older data in Table 8.2 were compiled from AIHW publications (2005, 2006) for the year 2004[1]. Unfortunately, later published figures are either not directly comparable or are not reliable. However, there is little evidence to suggest that, since that time, there has been significant change.

Table 8.1(a): Current Substance Misuse (previous 12 months) — Persons Aged 14 Years or Older, by Aboriginal Status, 2004

Substance	Aboriginal/ Torres Strait Islander (%)	Non-Aboriginal/ Torres Strait Islander (%)
Tobacco	52.0	22.5
Alcohol		
Abstainer	21.3	16.1
Short term high risk	52.0	35.5
Long term high risk	22.7	9.7
Cannabis	23.0	11.3
Meth/amphetamines	7.0	3.2
Pain killers/analgesics (non-medical use)	6.0	3.1
Inhalants	approx. 1.0	0.4
Heroin	approx. 0.5	0.2
Injected drugs	approx. 3.0	0.4

(a) Note the limited Aboriginal sample size for the National Drug Strategy Household Survey (NDSHS) (AIHW, 2005).
- The NDSHS had a sample size of 29,445 Australians aged 12 years and older with a response rate of 46 per cent.
- The NDSHS does not have an enhanced Aboriginal sample—only 460 Aboriginal and Torres Strait Islander participants.

Source: AIHW (2005, 2006)

There have been dramatic reductions in tobacco use among the Australian population over the past two decades. In 2004, approximately 23 per cent were current smokers. Among Aboriginal people, however, the rate was more than double, at about 52 per cent. Smoking is a significant and preventable contributor to global death and burden of disease and this burden is placed even more upon Aboriginal people.[11]

Alcohol is the most widely used substance among Aboriginal and other Australians. Among those aged 14 years or older, more Aboriginal people abstain from alcohol use (about 21 per cent compared with about 16 per cent). However, the higher rate of current abstention reflects that more Aboriginal people are ex-drinkers (rather than lifetime abstainers); many have given up because of the serious health consequences of their drinking.[12,13] They consume alcohol in a manner that poses high risks to their health in both the short (52 per cent compared with 35.5 per cent) and long term (22.7 per cent compared with 9.7 per cent).

When we consider the use of illicit drugs, or the harmful use of licit pharmaceutical drugs, the prevalence of use among Aboriginal people is about twice other Australians (cannabis 23.0 per cent compared with 11.3 per cent; amphetamine-type stimulants 7 per cent compared with 3.2 per cent; non-medical use of painkillers and analgesics 6 per cent compared with 3.1 per cent; inhalants, including petrol, about 1 per cent compared with 0.4 per cent; and heroin about 0.5 per cent compared with 0.2 per cent). Furthermore, about 3 per cent compared with 0.4 per cent had injected drugs in the previous 12 months.

In Table 8.2, we have estimated changes in the prevalence of use of various substances by comparing the data in Table 8.1 with that for Aboriginal people in 1994 and 1993, and other Australians for 1993.[13] Apart from increases in the use of amphetamine-type stimulants (10 per cent) and the non-medical use of painkillers and analgesics (7 per cent), in the period 1993–2004, there were significant reductions for other Australians in the use of tobacco (down 22 per cent), alcohol (down 14 per cent) and cannabis (down 13 per cent). In 1994–2004, however, apart from a small reduction in the proportion of tobacco users, among Aboriginal people, there were increases in the percentage of users of alcohol (15 per cent) and cannabis

(5 per cent) and, in particular, amphetamine-type stimulants (204 per cent) and painkillers and analgesics (107 per cent). Similarly over the same periods, while there was a reduction of 20 per cent in the prevalence of injecting drug use within the Australian population, there was about a 50 per cent increase among Aboriginal Australians.

As highlighted in several studies, poly-drug use is common among Aboriginal Australians.[13-16] For many, this is confined to the use of alcohol and tobacco, but for others this is extended to include cannabis and the use of other substances. Other harmfully used substances that are less likely to be used by other Australians, such as kava (banned since 2007 in the Northern Territory (NT) by the Australian government) and petrol, are usually in specific areas.[17]

Table 8.2: Changes in Prevalence of Substance Use — 1993–94 to 2004, by Aboriginal Status

Substance	Aboriginal/ Torres Strait Islander (% change 1994–2004)	Non-Aboriginal/ Torres Strait Islander (% change 1994–2004)
Tobacco	– 4	– 22
Alcohol	15	– 14
Cannabis	5	– 13
Meth/amphetamines	204	10
Pain killers/analgesics (non-medical use)	107	7
Injected drugs	50	– 20

Source: Commonwealth Department of Human Services and Health (CDHSH) 1996; AIHW2005, 2006.

Although confined to Western Australia (WA), the results of the *Western Australian Aboriginal Child Health Survey*[5]—the most comprehensive study undertaken of Aboriginal children and young people—indicate levels of substance use among young Aboriginal people. Young people aged 12–17 years were asked about cigarette smoking, alcohol, and marijuana (cannabis). Of the 17 year-olds in the survey, 58 per cent smoked regularly, over 61 per cent of males and 43 per cent of females were drinking alcohol, and 45 per cent of males and 21 per cent of females were using marijuana at least weekly. These rates are a major concern, particularly the high level of cannabis use.

Social Problems Associated with Harmful Substance Use

Alcohol and other drugs are the cause of, or contribute to, a wide range of social problems among Aboriginal Australians. These include violence, social disorder, family breakdown, child neglect, loss of income or diversion of income to purchase alcohol and other substances, and high levels of imprisonment. In addition, these substances have a significantly deleterious impact on the health of Aboriginal Australians.[3]

Studies over the past two decades have shown that Aboriginal people are much more likely than their non-Aboriginal counterparts to suffer from conditions caused by harmful substance use, and tobacco smoking has been identified as the single most preventable cause of death among Aboriginal people.[3, 18-20] Harmful use of alcohol causes about 7 per cent of Aboriginal deaths and Aboriginal people die at much younger ages from these conditions than non-Aboriginal Australians.[3, 21] Alcohol contributes to the hospitalisation of Aboriginal people[3]. There is little published data on Aboriginal deaths and hospitalisation associated with illicit drug use. In WA, however, between 1994–2000, the crude rate of hospital admissions for conditions caused by psycho-stimulants and drug psychoses increased eight times from 2.8 to 22.4 per 10,000 persons among Aboriginal males, and 3.6 times from 4.3 to 15.5 among Aboriginal females. For the period July 2004 to June 2006, there were 4,214 hospitalisations of Aboriginal Australians for substance use in New South Wales, Victoria, Queensland, WA, South Australia (SA) and the NT—around twice the rate of other Australians[22].

Mental Health and Intellectual Disability due to Harmful Substance Use

There is growing acknowledgement that excessive harmful substance use can lead to permanent acquired brain injury. This is discussed in further detail in Chapter 18 (Parker and colleagues).

SOCIAL AND EMOTIONAL WELLBEING AND COMORBIDITY

There is a high prevalence of comorbid harmful substance use and mental health problems within the Australian population.[23, 24] For example, it is estimated that among those with an alcohol-dependence disorder, 20 per cent have an anxiety disorder, and 24 per cent an affective disorder.[23] The evidence shows that there are causal pathways in both directions between these problems. For example:

> there is a causal pathway from depression to substance use in males, and from daily cannabis use to depression and anxiety in females. There is also evidence that cannabis use precipitates psychosis in persons who are vulnerable because of a personal or family history of psychosis.[25(p43)]

These shared risk factors for mental health and harmful substance use have implications for prevention and treatment, with potential comorbidity issues needing to be addressed as soon as symptoms of one disorder appear.[25] While there has been no comprehensive study of rates or prevalence of comorbidity in the Aboriginal population, evidence of the relationship comes from a number of sources. In Table 8.3 the ratios of observed rates of hospitalisation (the rate of actual cases) to expected rates of hospitalisation (those to be expected if the rates were the same as in the non-Aboriginal population) for mental and behavioural disorders are presented.[3] Table 8.3 shows the ratio of observed to expected cases among Aboriginal males and females. In 2005–06, Aboriginal men are over four times, and Aboriginal women over three times as likely to be hospitalised for 'mental disorders attributable to harmful psychoactive substance use' than their non-Aboriginal counterparts.

Table 8.3: Hospitalisations for Mental and Behavioural Disorders, 2005–06

Disorder	Male			Female		
	Observed	Expected	Ratio	Observed	Expected	Ratio
Mental disorders due to psychoactive substance misuse	2,436	538	4.5	1,331	400	3.3
Schizophrenic, schizotypal and delusional disorders	1,517	558	2.7	1,035	412	2.5
Mood and neurotic disorders	1,111	906	1.2	1,816	1,790	1.0
Disorder of adult personality and behaviour	93	51	1.8	143	168	0.8
Organic mental disorders	81	34	2.4	71	30	2.3
Other mental disorders	266	186	1.4	183	264	0.7
Total	**5,504**	**2,273**	**2.4**	**4,579**	**3,064**	**1.5**

Source: Australian Bureau of Statistics (ABS) and AIHW 2008.

Aboriginal suicide is covered in detail in Chapter 9 (Silburn and colleagues), but we highlight it here because of its relationship to harmful substance use. In the period 2001–05, the suicide rate among Aboriginal males in Queensland, SA, WA and the NT was almost three times that among non-Aboriginal males, and among Aboriginal females aged less than 44 years was over twice that among non-Aboriginal females.[3] The relationship between harmful substance use—specifically alcohol—and suicide is evident in Table 8.4, which shows that suicide was the most common cause of alcohol-related deaths among Aboriginal males and the fourth most common cause among Aboriginal females.[21] Intentional injury is not the most common cause of alcohol related death in non-Aboriginal population.[26]

Table 8.4: Alcohol-attributable Death Among Males and Females, 1998–2004

Condition	n	%	Mean age at death
Males			
1. Suicide	222	19	29
2. Alcohol liver cirrhosis	210	18	56
3. Road traffic injury	87	7	30
4. Assault injury	70	6	34
5. Haemorrhagic stroke	60	5	27
Total	**649**	**56**	**35**
Females			
1. Alcohol liver cirrhosis	136	28	51
2. Haemorrhagic stroke	78	16	25
3. Assault injury	48	10	32
4. Suicide	33	7	27
5. Road traffic injury	18	4	36
Total	**313**	**65**	**34**

Source: Chikritzhs et al., 2007.

The hospitalisation and suicide data are the tip of the iceberg. A study of cannabis use in remote Aboriginal communities in the NT found that some mental health symptoms increased as cannabis use increased.[27] Specifically with regard to children, the *Western Australian Aboriginal Child Health Survey* states:

> *The ages of 12–17 years represent an important period in the social and emotional development of young people. The transition to adulthood brings with it a range of demands, pressures and temptations. Compared with earlier generations, today's young people are under great pressure, with a more competitive labour market requiring higher education standards and greater skills. Aboriginal young people, like other groups in society who are sometimes marginalised and subject to discrimination, are potentially more vulnerable to harmful health risk behaviours.[5(p207)]*

This study, and other research on the frequency of mental health problems, and high levels of harmful substance use[3, 5, 28] indicate that levels of comorbidity are likely to be significant.[29-32] In turn, this highlights the need for interventions which address both sets of morbidities to enhance the efficacy of interventions.

SOCIAL DETERMINANTS OF MENTAL HEALTH AND HARMFUL SUBSTANCE USE

Poor Aboriginal mental health and risky health behaviours are related to the social determinants of health.[33] The extensive international evidence for the role of social factors in determining health status and the harmful use of alcohol and other drugs has been summarised by Wilkinson and Marmot.[34] The social, cultural and historical contexts of Aboriginal and Torres Strait Islander Australians are discussed in detail in Chapter 1 (Dudgeon and colleagues).

Turrell and colleague have demonstrated that Australians in low socioeconomic positions suffer more ill health at all stages of life.[35] Social factors which cause or protect against ill health and harmful substance use occur at all levels, from the macro-social to the individual, and are at play at all stages of the life course, from before birth to old age.[36] These social determinants have important implications for interventions. With respect to harmful substance use, for instance, macro-level policies such as increasing the price of alcohol through taxation at the national

level, and state and territory laws pertaining to the minimum drinking age are proven strategies for limiting alcohol-related harm.

Like harmful substance use, many mental health problems are influenced by social factors outside the control of individuals and their immediate contexts.[29] It is not simply about 'individual problems with individual psyches'.[37] Many of the factors that can lead to mental health problems also affect the risk of harmful substance use. Some of the overlapping vulnerabilities for psychiatric disorder and substance use disorders include common genetic vulnerability, brain development, exposure to substance use and stress.[38]

Contemporary Social Indicators

The history of oppression and repression has contemporary consequences for the structural position and health status of Aboriginal Australians.[39,40] Despite improvements in recent years, Aboriginal Australians continue to lag behind the general population on virtually every social indicator. Education is a key social indicator for improving the health and wellbeing of Aboriginal Australians, assisting them to deal with psychologies and social hardship. In the 2011 National Assessment Program – Literacy and Numeracy (NAPLAN) results, the proportion of Aboriginal children meeting national minimum standards in literacy and numeracy were significantly lower than the wider population.[41] These disparities give reason for concern. In addition, Aboriginal adults are more than twice as likely as other adults to be unemployed, and Aboriginal household incomes are only 59 per cent of that of adults in the wider population. Overcrowding and poor housing quality are experienced by a greater proportion of the Aboriginal population. These factors are implicated in poorer general health, lower life expectancies, higher harmful substance use and higher reported mental health problems.[3]

Dispossession and the Stolen Generations

Government policy towards Aboriginal people has fluctuated between attempts to protect Aboriginal people from European violence and the consequences of settlement, to assimilation, which saw the forced removal of many Aboriginal children from their families. The *National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* reported that 'between one-in-three and one-in-ten Indigenous children were forcibly removed from their families and communities in the period from approximately 1910 until 1970'.[42(p37)] This history of separation is strongly implicated in the poor mental health and harmful substance use problems of many Aboriginal Australians.[28]

From the early 1970s to the mid-1990s, there was bipartisan support for policies of Aboriginal self-determination and self-management at the national level. Although implementation of these policies was under-resourced, they provided for the growth of Aboriginal community-controlled services, including health and substance use services. However, it is apparent that Australian governments are reticent to fully commit to Aboriginal self-determination. This came to a head in 2007 with the Australian Government's Northern Territory 'Intervention' (*Northern Territory National Emergency Response Act 2007*), which was one of several measures introduced in response to the *Little Children are Sacred* report on child abuse.[43] Many Aboriginal people have supported the need for the input of resources and action. But there was considerable disquiet about the fact that the Act facilitating the Intervention overrode provisions of the Commonwealth Government's *Racial Discrimination Act 1975*. Furthermore, many claim that consultation with, and involvement of, Aboriginal people was inadequate, and that the Intervention is a 'new paternalism' that risks contributing to existing abuse and neglect.[44-46]

WHAT IS BEING DONE?

It is important to note that while funding comes from the Australian and state and territory governments, most alcohol and other drug interventions among Aboriginal Australians have been initiated and conducted by Aboriginal people themselves,[47] such as that conducted by Benelong's Haven.[48] In 1985, the Australian and state and territory governments agreed to a coordinated effort to address alcohol and other drug use. This was initially known as the *National Campaign Against Drug Abuse*. This umbrella strategy, now known as the *National Drug Strategy* (NDS),[49] is based on the principle of harm minimisation:

> *Harm minimisation does not condone drug use, rather it refers to policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for both the community and the individual, and encompasses a wide range of approaches, including abstinence-oriented strategies.[50(p2)]*

The NDS focuses on minimising the harms of substance use by: demand, supply and harm reduction. In non-Aboriginal populations, there have been extensive reviews of these strategies and their effectiveness.[49, 51-53] To complement the NDS, a plan focusing specifically on substance use among Aboriginal Australians has also been developed; the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan (CAP)*.[54] The 'CAP', as it is commonly known, identifies six key result areas for the focus of intervention. It is not intended to be prescriptive in terms of specific interventions, but provides a framework for intervention with which each state and territory jurisdiction can implement strategies they deem appropriate to their own situation. Like the NDS itself, the CAP is based on demand, supply and harm reduction strategies, and this provides a useful framework for the review of current interventions. At the time of writing this, the Aboriginal and Torres Strait Islander sub-strategy was being developed in line with the CAP and the current NDS.

Demand Reduction

As the name implies, demand reduction strategies are designed to reduce or prevent substance-related harm by reducing demand for those substances.[54, 55] They include broad-based prevention projects and both community-based and residential treatment services.

Prevention and early intervention programs to address harmful substance use among Aboriginal people are mostly conducted by Aboriginal community-controlled organisations. They include health promotion projects, recreational activities and community development projects. Research conducted for the 2006–07 financial year on behalf of the National Indigenous Drug and Alcohol Council identified a total of 144 such projects nationally.[56] Even though this is an increase from 1999–2000,[47] only 48 per cent of all projects operating in 1999–2000 were still operating in 2006–07.

Over the past decade, various services have responded increasingly to calls for a more diverse range of treatment options or alternatives to an abstinence-only approach.[12] One example is the residential treatment service in WA, Milliya Rumurra, which employs a diverse approach to meet the needs of individual clients.[57] Although the number of evaluations of such interventions is relatively small, there are clear indications of their effectiveness.[8, 58]

Supply Reduction

Generally, the greater the availability of a particular substance, the higher the level of use and related harm. Supply reduction strategies are those that aim to reduce availability and thus the levels of harm, and target both illicit and licit substances. In the case of illicit drugs, such as amphetamine-type stimulants, these include outright prohibition. In the case of licit substances, such as tobacco and alcohol, they include taxation and other price control measures, and constraints on who may or may not purchase particular substances and under what circumstances.[54]

In the general population, a combination of taxation, purchase age restrictions, and health promotion campaigns (a demand reduction strategy) has significantly reduced tobacco consumption. In the Aboriginal population, however, such measures and the few Aboriginal-specific strategies have had limited success.[59, 60]

Under various pieces of state and territory legislation, over many years, Aboriginal people have undertaken a range of strategies to reduce the supply of alcohol. In discrete communities, these include declaring their communities 'dry' (prohibiting alcohol) and establishing wet canteens to regulate availability. In towns, supply reduction strategies include working with non-Aboriginal residents and liquor licensing authorities to impose additional restrictions on the availability of alcohol. Of these, the least successful has been the establishment of wet canteens[61] and the most successful has been licensing restrictions—particularly those related to price.[62, 63]

Supply reduction strategies have also been used to considerable effect in the reduction of volatile substance use, particularly petrol sniffing. Evaluations, first of the 'Comgas' Scheme under which non-sniffable aviation fuel (avgas) was substituted for regular petrol and more recently the substitution of non-sniffable Opal fuel for regular petrol, have demonstrated the effectiveness of these strategies.[64, 65] Law enforcement is an essential component of strategies to reduce the supply of both volatile substances and illicit drugs. Best practice strategies and their impact have been reviewed in studies commissioned by the National Drug Law Enforcement Fund.[66, 67] While supply reduction strategies can be useful in reducing harm from drugs, such strategies can contribute to increased harm to the individuals and a greater cost to society if not better managed.[68]

Harm Reduction

Harm reduction strategies are those designed to decrease immediate harms associated with harmful substance use. The most common of these strategies have been developed in response to the acute harm caused by alcohol intoxication.

Night patrols, or mobile assistance patrols, are aimed at removing intoxicated persons from public to safe places to minimise the likelihood of them causing harm to themselves or others. The first such patrol was established by Julalikari Council in Tennant Creek in the mid-1980s. The numbers of these patrols expanded rapidly following recommendations made by the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) that they be supported.[40] Although the current number of operating patrols is not known, in 2006–07 there were 47.[56] Sobering-up shelters provide safe surroundings for intoxicated people following the RCIADIC, by 2006–07 they were expanded to 36 nationally.[56] Like night patrols, sobering-up shelters are effective but must be properly resourced and have sustainable Aboriginal involvement.

Needle and syringe programs (NSPs) are designed to reduce the harm associated with injecting drug use, particularly the spread of blood-borne viruses such as hepatitis C and HIV. Although they are sometimes contentious, the evidence in the wider Australian population shows that they have been effective.[69]

In Aboriginal communities, NSPs are also an issue of contention. Nevertheless, there are several operating around the country and innovative and successful strategies have been established to also link Aboriginal people who inject drugs into NSPs.[70, 71]

Addressing Comorbidity

As discussed above, a mental illness concurrent with substance use tends to exacerbate both the mental illness and harmful substance use. Often mental health services do not adequately assess substance use well, as alcohol and other drug services do not assess mental illness. Despite the funding of the 'National Comorbidity Initiative' by the Australian Government Department of Health and Ageing from 2006 to 2011, as yet there are very few interventions that specifically

address comorbidity in Aboriginal contexts. An example of a program that does so is operated by the Warlpiri Youth Development Aboriginal Corporation. One of the objectives of this NT-based program is to prevent suicide and petrol sniffing among the young people in the community.[72]

Aboriginal community health services have also attempted to address this gap in services for those suffering from comorbidities. The Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) has developed a model for integrating treatment of substance use, mental health, and primary health care services.[73] One of AMSANT's member organisations, the Central Australian Aboriginal Congress, is trialling this model. Another service commissioned a study examining the service needs of Aboriginal women experiencing both mental health and substance use issues. The study identified, amongst other factors, the need for improved service coordination, education for families and carers, and access to local treatment options.[74]

Recent Initiatives

A report published by the Australian National Council on Drugs (ANCD) showed that, over the period from 1999–2000 to 2006–07, there was a significant increase in the number of alcohol and other drug intervention services specifically for Aboriginal people, and a doubling of funding for such projects.[56] In 2006–07 few of the substance use services were specifically addressing issues of comorbidity, and a study of services in Queensland found that the staff of many services felt they did not have the expertise to do so.[75] Since 2006–07, resourcing of both Aboriginal substance use treatment and mental health received a significant boost under agreements reached by Council of Australian Governments (COAG). Up to $98.6 million has been allocated to increase drug and alcohol treatment and rehabilitation services in regional and remote Indigenous communities under two new measures announced by COAG in July 2006 and December 2007.

WHAT NEEDS TO BE DONE?

As we have discussed, harmful alcohol and other drug use plays a significant role in the disruption of Aboriginal people's lives. Having also established that harmful substance use often co-occurs with mental health disorders and problems of emotional and social wellbeing, it is important to plan appropriate treatment and rehabilitation services to complement broader interventions. Generally, intervention requires a multi-systemic approach; however, this is not always utilised. While it appears that much is being done, epidemiological evidence indicates that, in many respects, things are getting worse, not better.

Cultural Security

Cultural competence is addressed in considerable detail in Chapter 12 (Walker and colleagues), but it is worth reiterating here that a fundamental principle when working with Aboriginal people is to ensure that engagement is maintained in a culturally secure manner.[76] The term 'culturally secure' describes a guiding principle that ensures respect for cultural difference. Cultural security is central in the development of programs, services, policies and strategies. Aboriginal leadership, community consultation and involvement form an essential part of this process. In our efforts to reduce alcohol and other drug-related harm, a culturally secure approach is imperative.

The development and delivery of culturally secure alcohol and other drug programs should be based on recognition of the following principles:

- a holistic concept of health and wellbeing grounded in an Aboriginal understanding of the historical factors that have influenced alcohol and other drug-related harm;

- culture as a central core component;
- reinforcement of Aboriginal family systems of care, support and responsibility; and
- Aboriginal ownership and control.

There also needs to be recognition of the diversity within and between Aboriginal Australian communities in remote, regional and urban areas.

Practical Approaches

As acknowledged, many people report not having the expertise to deal with both substance use issues and mental illness, and Aboriginal and Torres Strait Islander peoples often have limited access to culturally specific and secure services. Recognising the stage of change and using motivational interviewing concepts can be useful in addressing both mental illness and substance use issues.

Stages of Change Model

Working with clients with a mental illness and who are harmfully using substances can be challenging. A useful approach when intervening in such complex situations is to consider what the client is ready to do to help themselves. Prochaska and Diclemente developed a Stages of Change model.[77] It considers how people respond to different interventions, based on their readiness to change. These stages are known as: Precontemplation, Contemplation, Preparation, Action and Maintenance.

This approach acknowledges that relapse is 'normal', and that people often may go through the five stages several times before making lasting change. Different people will be at different stages of insight and readiness to change with respect to both substance use and management of their mental illness. Those with mental illness may go through similar stages with respect to recognising any mental health problem or need for medication or counselling. The stages of change are represented in this diagram below:

Figure 8.1: Stages of Change Model
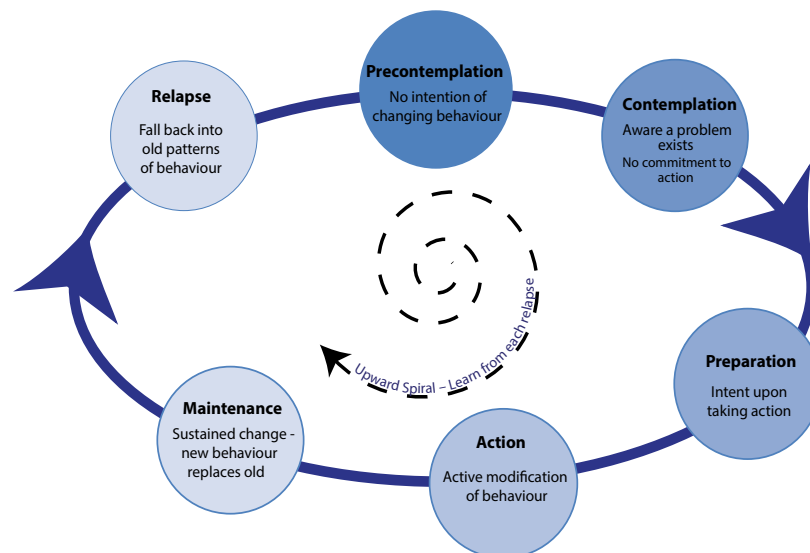
Source: Prochaska and Diclemente[77]

Precontemplation: Individuals do not feel that there are any problems with their use.

Contemplation: Individuals recognise that there may be some problems, but are not sure that they are ready or able to make the necessary changes. At this stage being too confrontational or directive will usually increase their resistance to any change. A brief intervention can be helpful.

Preparation: Individuals are preparing to make a change or are already taking action. They recognise a need to change.

Action: Individuals are doing something. They might need help with completing a plan and support to stick to their plan, perhaps with appropriate referrals to support groups etc.

Maintenance: Individuals are continuing the positive lifestyle changes needed to keep going.[77]

These stages, and recognition of them, allows for the use of different interventions. Table 8.5 lists different strategies for each of the stages. For example, running a support group that mixes people taking action with precontemplators may not help either group. The stages also acknowledge progress that may otherwise be difficult to recognise. An awareness of these stages and appropriate targeted interventions can: reduce conflict with patients, set realistic expectations, and reduce burnout for workers.[77]

Table 8.5: Stages and Differentiations

Stage	Instructional Strategies
Precontemplation No intention of taking action in the next 6 months	Engage the individual with information about need for change
	Provide personalised information about risks if no change and benefits of change
Contemplation Intends to take action in the next 6 months	Motivate and encourage the individual to set goals and make specific plans
Preparation Intends to take action in the next month and has taken some steps to change behaviour	Help the individual create and implement specific action plans and set realistic goals
Action Has changed behaviour for less than 6 months	Provide problem-based (action-oriented) learning experiences
	Provide social support, feedback
Maintenance Has changed behaviour for more than 6 months	Continue to provide social support, assist with problem solving, positively address slips and relapses if necessary
	Employ reminder systems/performance support tools

Motivational Interviewing

Motivational interviewing (MI) is a useful tool to help move people through different stages. It has been defined as 'a person-centred counselling style for addressing the common problem of ambivalence about change … by eliciting and exploring the person's own reasons for change'.[78 (p410)] MI can be difficult to master but an understanding of the key concepts can still be helpful. The aim is to get the person to express his or her thoughts about their issue (drug use and/or mental illness) and its effects, ultimately saying how their issue is a problem, expressing willingness to change. Techniques include: using open-ended questions, listening and reflecting their own responses, affirming the positive and negative points raised and summarising. This approach is characterised by the following five principles:

1. *Express empathy*: try to understand their point of view. A good start is to ask 'What are the good things about using?' and also 'What are the not so good things about using?' Very often health workers underestimate the 'benefits' of substance use. This approach can build some rapport and get a real understanding of what is motivating someone to continue using. These points are summarised in Table 8.6.

Table 8.6: Advantages and Disadvantages of Using Drugs and Not Using Drugs

	Using Drugs	*Not Using Drugs*
Advantages	Feels good	Better relationships
	Helps with socialising	Not depressed
Disadvantages	Problems at home	Loss of drug-using friends
	Legal problems	Nothing to do
		Cravings

2. ***Deploy Discrepancy:*** While summarising what has been said, helps to show where there might be areas that conflict. Help them to recognise that substance use is not all good. Clough[79] has reported some of the 'advantages' and 'disadvantages' of cannabis use in Aboriginal and Torres Strait Islander populations in Northern Australia, as well as reasons people want to give up, including health, family, work.[80]

3/4. ***Avoid Argumentation and Roll with Resistance:*** Arguing with people about what to do often does not improve engagement or assist clients in hearing what you are trying to say to them. An understanding of harm minimisation principles helps.

5. ***Support Self-Efficacy:*** Linked to eliciting self-motivational statements supporting self-efficacy, also includes recognising that only they are able to control their substance use. Even in gaol, substances are obtained and used. There is still a role for harm minimisation strategies and monitoring, counting pills, and minimising access to drug use.

The Stages of Change model and MI are useful for comorbid disorders; for example when assessing and motivating someone to take medication, they may perceive some advantage to not taking medication. These approaches are inclusive of an individual's beliefs and culture. For example MI-based resources developed by Menzies School of Health Research's Australian Integrated Mental Health Initiative (AIMhi) in the NT are useful for engaging Aboriginal and Torres Strait Islander peoples .[81] AIMhi uses tools specifically developed to apply MI principles in an Aboriginal Australian context.

Brief Interviews (BI)

Although there can be some difficulties in delivery, even brief interventions can be culturally appropriate[82] and have a significant impact.[83] To not attempt a BI may be seen as condoning behaviour.[84]

The 5A's strategy is used as a brief intervention guideline for smoking cessation that is broad enough to be applied in multiple contexts.

1. ***Ask*** – many patients who present to mental health services are not asked about their substance use, and conversely patients presenting to drug and alcohol services do not have their mental health assessed. If everyone is asked the same questions then it normalises the enquiry reducing clients' defensiveness.

2. ***Assess*** – any concerns need to be assessed. The potential harms need to be assessed carefully, as do the client's readiness for change.

3. ***Advice*** – should be given, tailored to their 'stage of change'. Motivational interviewing techniques can be used to guide the patient to 'advise themselves'.[85]

4. ***Assist*** – clients with the process, extra information and support.

5. ***Arrange*** – a follow up review or referral to appropriate services. Many people with mental health and substance use problems 'slip through the cracks', hence the No Wrong Door policy.[86, 87]

Practice to Enhance Treatment Outcomes

Social Learning Theory[88] also provides a culturally secure framework for understanding hazardous and harmful alcohol and other drug use. It acknowledges that people learn to use alcohol and other drugs within their social environments. Expansion of support programs that assist Aboriginal families to break the cycle of harm is essential for intergenerational change.

In the development of any intervention strategies, recognition of the historical, socioeconomic and political factors must be considered. Harmful alcohol and other drug use cannot be seen in isolation from other factors because there is always a multiplicity of causes.[89] In the RCIADIC report, Pat Dodson clearly articulated the principle that alcohol and other drug problems:

> *must be approached on a community basis and not with an individual disease ideology in mind … and … need[s] to be linked to a broader approach which deals with the structural determinants.*[39(p738)]

Australian governments do have programs in place to address underlying structural factors such as poor housing and educational outcomes and high unemployment, and over past decades some improvements have been made. Under the *Closing the Gap* initiative $4.6 billion is provided to address these gaps. The Australian government is working in partnership with Aboriginal and Torres Strait Peoples, state and territory governments, business, and community organisations to improve health and wellbeing outcomes. However, there is a need for significantly increased levels of investment in such programs otherwise, at present levels, the gaps between Aboriginal and non-Aboriginal Australians are likely to continue.[90]

The evidence indicates that individuals and families who seek treatment and support for substance use problems are more likely to succeed if change can be seen as worthwhile. Saunders and Allsop[91, 92] highlight the important role that factors such as improved housing and employment play in sustaining post-change lifestyles. They further state that changing behaviour in an environment of limited support and high temptation is challenging.

Improved Linkages Across Services and Local Partnerships

Although integrated treatment programs are ideal, given the often complex problems with which Aboriginal people regularly present, the need for streamlined clinical referral pathways to other specialist services is essential. Models of shared care and case management support a comprehensive and holistic approach to assist Aboriginal people and their families. Concurrent treatment programs need to be coordinated well so that people do not 'fall between the cracks.' Swan and Raphael[28] and Teesson and Proudfoot[24] clearly identify the need for programs to provide both improved identification and service delivery in the assessment, treatment and management of people with comorbid disorders within mental health services, alcohol and other drug services, and by general practitioners and other health care providers; and further program collaboration and inter-agency approach in the shared case management of clients with comorbid disorders.

An example of a working collaboration is that between Milliya Rumurra Aboriginal Corporation (residential alcohol and other drug treatment service) and Kimberley Mental Health Services. A formal agreement outlines each agency's roles and responsibilities in terms of clinical referral pathways, information exchange, and shared management of clients with comorbid presentations. This process was negotiated between the two services and is a demonstration of how working together can enhance treatment outcomes for clients. The development of formal inter-agency linkages is an extremely effective way to support clients and enhance service delivery.

Workforce Development Strategies and Partnerships

Workforce development for the Aboriginal alcohol and other drug sector and mental health continues to be an area that is under-resourced and there is a need to provide support and training for the existing workforce.[56] Gray et al state:

> *Several evaluations of substance misuse intervention programs have reported that program staff believe they have insufficient training and skills to adequately address substance misuse problems at either the individual or community level.*[93(p24)]

Some of the additional complexities relating to an Aboriginal Mental Health Workforce are noted on the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Position Statement on Aboriginal and Torres Strait Mental Health Workers.[94]

Workforce development was a key result area of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009*. The Complementary Action Plan clearly articulated the need for '[w]orkforce initiatives to enhance the capacity of Aboriginal and Torres Strait Islander community-controlled and mainstream organisations to provide quality services'.[54(p7)] In keeping with national strategic directions to address the issue of workforce development, the Indigenous National Alcohol and Other Drug Workforce Development Program was funded by the Australian Government from 2005 to 2012. Led by the Western Australian Drug and Alcohol Office, the program established partnerships with registered training organisations in each state and territory (with the exclusion of Tasmania) to deliver the Indigenous National Alcohol and Other Drug Worker Training Program, Certificate III in Community Services Work. The resources for this program were customised to reflect culturally secure evidence-based approaches for working with alcohol and other drug problems in the Aboriginal community. The program targeted existing Aboriginal workers within the alcohol and other drugs sector; 209 people were awarded a nationally recognised qualification. Consolidating partnerships across jurisdictions to develop and sustain a competent and skilled workforce enhances service delivery and improves treatment outcomes.

Workforce development measures must include a greater understanding of the comorbidity of substance use and mental health. A skilled workforce is the key to assisting Aboriginal community action and capacity-building processes that can facilitate addressing contemporary needs and sustaining intergenerational change.

CONCLUSION

The poor mental health of many Aboriginal Australians is associated with harmful use of alcohol and other drugs. Aboriginal people's use of alcohol, tobacco and other drugs is much higher than among the general population (within which some significant reductions in use have occurred, as in the case of smoking). The comorbidity of mental health and harmful substance use among Aboriginal people needs to be contextualised by the legacy of colonisation, racism and marginalisation from dominant social institutions. International and Australian research clearly demonstrates that health in general, mental health and harmful substance use are affected by social and structural factors such as housing, education, employment, income, transport and access to supportive social networks. Until Aboriginal people are generally equal in terms of social indicators such as adequate housing, literacy levels, employment and income, the prevalence of harmful substance use and mental health problems among them is unlikely to decline.

Despite the structural impediments, through community-controlled organisations, Aboriginal people are themselves doing much to address harmful substance use by Aboriginal people. The *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009*, provides a framework for reducing the demand for psychoactive substances, the

supply of them and the harms caused by them. It is clear from these endeavours that Aboriginal people themselves acknowledge the importance of tackling harmful substance use if health and wellbeing is to improve.

Despite current efforts, much still needs to be done both for the Aboriginal community-controlled sector and in mainstream service delivery to Aboriginal Australians. Services, wherever they are provided, need to be culturally secure, incorporating holistic concepts of health and wellbeing, with culture at the core, and respecting Aboriginal families and community notions of ownership and control. All services also need to be evidence-based to improve outcomes and to acknowledge the link between better outcomes and the structural determinants of health. Models of shared care and case management are integral to holistic and comprehensive service delivery and these, in turn, are dependent on a competent and effective workforce that is capable of working collaboratively with communities to address the challenges of Aboriginal mental health.

REFLECTIVE EXERCISES

1. Looking at the data presented in this chapter, what are the substance use rates of alcohol and drugs for the Aboriginal and Torres Strait Islander population compared to the wider population? Discuss what you think are the contributing factors of these outcomes.

2. What forms of approaches are in place to address harmful alcohol and drug use?

3. One of the key issues in addressing harmful alcohol and drug use is workforce development. How can this help?

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9

Preventing Suicide Among Aboriginal Australians

Sven Silburn, Gary Robinson, Bernard Leckning, Darrell Henry, Adele Cox and Darryl Kickett

OVERVIEW

This chapter begins with an overview of the recent epidemiological trends in suicide and attempted suicide for Aboriginal and Torres Strait Islander and non-Aboriginal Australians and how this compares with the situation in other post-colonial English speaking nations such as Canada and New Zealand. It then reviews studies exploring the historical and social aetiology of suicide and the nature of its occurrence and consequences within Aboriginal community contexts. These studies provide insights into the group, community, situational and inter-generational factors associated with the increased likelihood of suicide and suicidal behaviour in some communities. The life-course study of individuals who develop suicidal behaviour or complete suicide is another source of evidence which has helped explain why some individuals are more vulnerable to stresses which trigger or escalate suicidal behaviour. The phenomenon of suicide 'clustering' in which the idea of suicide, and suicidal behaviour appears to become socially 'contagious' with so-called 'copy-cat' behaviour is then discussed. The chapter concludes with a review of what works in prevention, early intervention and postvention, including proactive bereavement support and containment of suicide clusters, as well as longer-term strategies for community healing following 'outbreaks of suicide' and other collectively experienced trauma.

WHAT IS THE CURRENT SITUATION IN AUSTRALIA?

The June 2010 report of the Australian Senate Community Affairs Reference Committee, '*The Hidden Toll: Suicide in Australia*' recommended that '…the Commonwealth government develop a separate suicide prevention strategy for Indigenous communities within the National Suicide Prevention Strategy.' A separate Aboriginal strategy was needed to respond to the dramatic increase in suicide in some regions of Australia; to its different forms and expressions within some Aboriginal communities; and to the disproportionate impact suicide has on families and communities when compared with suicide in the general population.[1]

Suicide is a profoundly distressing event which has highly disruptive effects on the families, friends and communities who are bereaved. While it is well recognised that Aboriginal Australians experience high levels of bereavement stress due to the higher overall rates of premature death, it has been less well recognised that family and community recovery from bereavement through suicide is complicated by its traumatic nature, issues of stigma and the frequency of suicide as a cause of death for Aboriginal people.

While suicide is believed to have been a rare occurrence among the Aboriginal peoples of Australia in pre-colonial times, it has become increasingly prevalent over recent decades.[2-4] Reducing suicide and suicidal behaviour among Aboriginal Australians is now a public health

priority for all Australian governments.[5-6] In 2012, the Australian Government commissioned a nationwide consultation process to inform the development of a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy which is expected to be announced in mid-2013.

An average of around 100 Aboriginal Australians ended their lives through suicide each year over the decade 2001–2010. In 2010, suicide accounted for 4.2 per cent of all registered deaths of Aboriginal and Torres Strait Islander peoples compared with just 1.6 per cent for all Australians. In other words, suicide was 2.6 times more likely to be the cause of death for Aboriginal and Torres Strait Islander peoples than for all Australians.[7]

The actual rates of Aboriginal suicide are also believed to be significantly higher than the officially reported rates.[3] The reasons suggested for why this should be the case include the misclassification of Aboriginal status on death certificates and other data systems; differences between jurisdictions in their coronial processes; the procedures around reportable deaths (i.e. deaths which must be reported to a coroner); and the strictness with which the legal criteria are applied in arriving at the official determination of the death being suicide.[7-9] To reduce these uncertainties, there have been discussions between all Australian governments and the Australian Coroners' Society to establish a nationally uniform coronial data system, now known as the National Coronial Information System (NCIS), to better inform preventive action through more reliable monitoring of trends, and to improve understanding of the various factors associated with suicide deaths.

Rates of Aboriginal and Torres Strait Islander suicide and non-Aboriginal suicide vary considerably between Australian States and Territories. Figure 9.1 shows that the Northern Territory (NT) had the highest Aboriginal suicide rate of all jurisdictions followed by South Australia (SA), Western Australia (WA) and Queensland (Qld) which are all also substantially higher than the rate in New South Wales (NSW). The extent of this variation may be gauged from the fact that the rate of suicide among Aboriginal people in NSW was lower than that of non-Aboriginal people in the NT.

Figure 9.1: Age-standardised Suicide Rates by Aboriginal status—NSW, Qld, SA, WA and NT, 2001–2010[i]
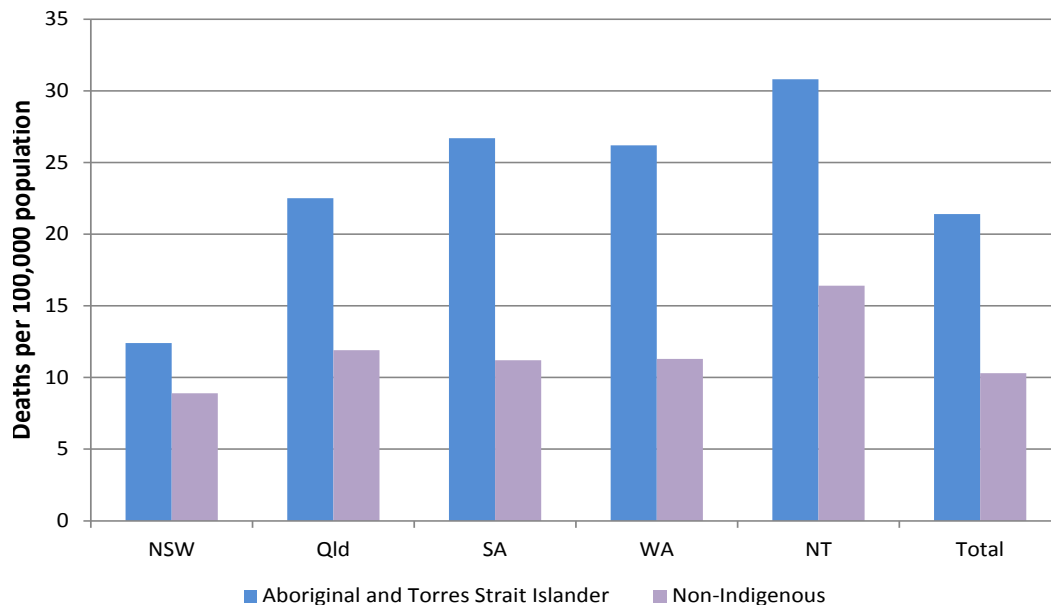

i   Age-standardised rates take into account differences in the size and structure of the population and are therefore more reliable for comparison purposes.

Source: Australian Bureau of Statistics (2012).[4]

Suicide generally occurs at much younger ages among Aboriginal persons than in the general Australian population, with most suicide deaths occurring before the age of 35 years. Figure 9.2 shows that, over the years 2001–2010, the greatest difference in rates of suicide between Aboriginal and Torres Strait Islander peoples and non-Aboriginal people was in the 15–19 years age group for both males and females.

Figure 9.2: Age-specific Suicide Rates by Aboriginal Status and Sex—
NSW, Qld, SA, WA and NT, 2001–2010
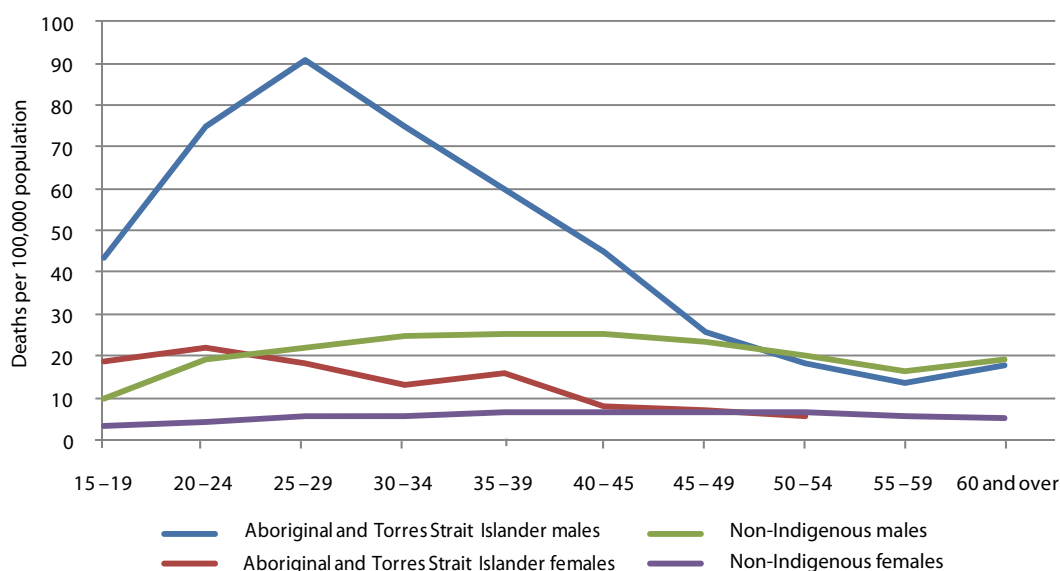
Source: Australian Bureau of Statistics (2012).[4]

The highest age-specific rate of Aboriginal and Torres Strait Islander suicide was among males aged 25–29 years (90.8 deaths per 100,000 population). For Aboriginal and Torres Strait Islander females, the highest rate of suicide was amongst 20–24 year-olds (21.8 deaths per 100,000 population). For the non-Aboriginal population, the highest rate of suicide occurred among males aged 35–39 years (25.4 deaths per 100,000) and among females (6.6 deaths per 100,000) across the age groups from 35 to 54 years of age.

A worrying increase in the occurrence of suicide at earlier ages has also recently been noted among NT Aboriginal and Torres Strait Islander children and young people between the first and second half of the 2001–2010 decade. Robinson et al (2012) reported that among NT Aboriginal and Torres Strait Islander children aged 10–17 years, the age-specific rates of suicide increased from 18.8 per 100,000 for the years 2001–2005 to 30.1 per 100,000 for the years 2006–2010.[10] Over the same period, the rate of suicide among NT Aboriginal and Torres Strait Islander youth aged 18–24 years decreased from 99.9 to 69.9 per 100,000. For NT Aboriginal and Torres Strait Islander females aged 15–19 years, the suicide rates were 5.9 times higher than those for non-Aboriginal females in this age group, while for males the corresponding rate ratio was 4.4 times higher. In older age groups, the rate ratios for suicide deaths of Aboriginal and Torres Strait Islander and non-Aboriginal peoples are lower, with similar rates of mortality observed from the age of 45 years and above.[4]

In terms of the actual number of suicide deaths, Table 9.1 shows that Qld had the highest overall number (311) of Aboriginal and Torres Strait Islander suicides over the period 2001–2010, followed by the NT (225), WA (176), NSW (157) and SA (77). The data in this table also show the occurrence of suicide among Aboriginal and Torres Strait Islander peoples in Capital City Statistical Divisions and other urban and rural areas was much less frequent than in more remote 'rest of state' areas.

Table 9.1: Number of Suicide Deaths and Age-standardised Suicide Rates by Geographic Region, Jurisdiction and Aboriginal Status, 2001–2010

	State or Territory of Usual Residence					
	NSW (No.)	*Qld (No.)*	*SA (No.)*	*WA (No.)*	*NT (No.)*	*Total (No.)*
Aboriginal						
Capital City Statistical Division	54	64	35	49	47	249
Other Urban (a)	41	84	n.a.	10	n.a.	135
Rest of state/territory	62	163	42	117	178	562
Total state/territory deaths	**157**	**311**	**77**	**176**	**225**	**946**
Rates per 100,000 population	***12.4***	***22.5***	***26.7***	***26.2***	***30.8***	***21.4***
Non-Aboriginal						
Capital City Statistical Division	3,576	1,883	1,282	1,643	167	8,551
Other Urban (a)	1,209	1,622	n.a.	192	n.a.	3,023
Rest of state/territory	1,176	1,151	468	401	52	3,248
Total state/territory deaths	**5,961**	**4,656**	**1,750**	**2,236**	**219**	**14,822**
Rates per 100,000 population	***8.9***	***11.9***	***11.2***	***11.3***	***16.4***	***10.3***

n.a. = not available for publication.
(a) 'Other Urban' is derived from the Statistical Districts of a state or territory. South Australia and the Northern Territory do not have Statistical Districts and therefore 'Other Urban' could not be calculated.

Source: Australian Bureau of Statistics (2012).[4]

By comparison, the rates of suicide over the past three decades among Canadian First Nations people (i.e. Indians with registered and non-registered status, Metis and Inuit) have also been consistently higher than in the general Canadian population.[11] In 2000, the overall First Nations suicide rate was 24 per 100,000 which was twice the general population rate of 12 per 100,000. However, the suicide rate within Inuit regions over the period 1998–2003 averaged 135 per 100,000—over 10 times the national rate. In the United States between 1998 and 1999, the rate of death by suicide for the American Indian population was 19.3 per 100,000 which is around 1.5 times the general population of 11.2 per 100,000. In New Zealand, similar overall rates of suicide were recorded for Maori and non-Maori up until 1987. However, significant increases in Maori suicide have occurred subsequently—particularly among the age group 15–29 years. In 2007, the age-standardised rate of suicide deaths was 16.1 per 100,000 population for Māori, compared with 9.9 per 100,000 for non-Māori. The suicide death rate for Māori youth (15–24 year-olds) in 2007 was 28.1 per 100,000 compared with the non-Māori rate of 12.3 per 100,000. While suicide death rates have declined for non-Māori since 1996, there has been no significant change in the higher rates for Māori.[12]

Suicide Attempts and Intentional Self-injury

Obtaining reliable data on suicide attempts is problematic due to the difficulties of establishing (and reliably recording) whether the motivation of a person's non-fatal intentional self-harm was suicide or some other reason. Data on non-fatal intentional self-harm hospital admissions from five Australian jurisdictions for the period 2008–2009 show higher rates for Aboriginal Australians (3.5 per 1,000) compared to other Australians (1.4 per 1,000). These data also show Aboriginal females make more non-fatal suicide attempts (3.9 per 1000) compared with Aboriginal males (3.0 per 1000).[13]

Figure 9.3: Age-standardised Non-fatal Hospitalisations for Intentional Self-harm—
NSW, Victoria, Qld, WA, SA and public hospitals in the NT
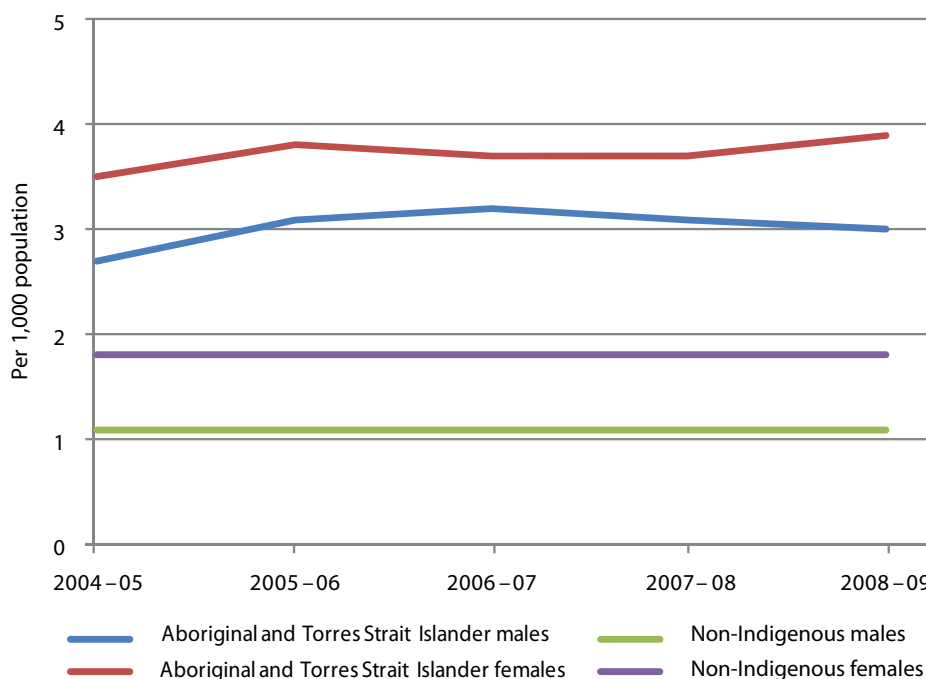
Source: Steering Committee for the Review of Government Service Provision (2011)[13]

A recent population-based Australian survey found that the lifetime prevalence of any form of self-injury for Aboriginal people was 17.2 per cent, which was 2.2 times (95 per cent Confidence Interval: 1.5–3.3) that reported by non-Aboriginal participants.[14] This showed a distinctly different age-specific pattern for Aboriginal and non-Aboriginal self-injury. Among the 15–24 year age group, Aboriginal females are about 30 per cent more likely to report having harmed themselves intentionally than Aboriginal males; and both male and female Aboriginal rates are around double those of their non-Aboriginal counterparts. For those aged 25–44 years, Aboriginal males and females had very similar rates (8.5 and 9.0 per 1,000 persons respectively). These rates are around 2 to 3 times higher than those of non-Aboriginal males and females (2 and 3 per 1,000 persons respectively). Finally, among the 45–64 years age group, the rate of Aboriginal self-harm was 3 per 1,000 which is still around three times higher than among non-Aboriginal males; while the Aboriginal female rate was 1 per 1,000 which is 30 per cent lower than the comparable rate for non-Aboriginal females (1.3 per 1,000).[14]

Regional Differences in Rates of Suicidal Behaviour

Given the differences in the geographic distribution between Australia's Aboriginal and non-Aboriginal populations, and the wide diversity of socio-economic and cultural living circumstances, it is not surprising that there are marked regional variations in the occurrence of Aboriginal suicide. Hunter has described how approximately one-half of the Aboriginal people living in Qld live in the far north of Qld but they accounted for almost two-thirds of all Qld Aboriginal suicides.[15] Furthermore, just three communities with less than 20 per cent of the far north Qld region's Aboriginal and Torres Strait Islander population accounted for 40 per cent of Qld's Aboriginal suicides.[16]

The mobility of Aboriginal people between remote communities and regional centres— particularly in the more remote areas of Northern and Central Australia—is another difference. The extensive kinship relationships between Aboriginal people across quite dispersed

communities can mean that they function as a larger regional system when considering the occurrence of suicide and its impact on communities. The average age of the Australian Aboriginal population is much lower than that of the non-Aboriginal population, due to higher adult-to-child ratios and shorter life expectancy. This has important implications for understanding the psychological impact of suicide on families and the available community response capacity in terms of supports and services for treatment, support and prevention.

APPROACHES TO UNDERSTANDING ABORIGINAL SUICIDE

The first systematic studies of Australian Aboriginal mental health and self-harming behaviour were based in medical anthropology, clinical epidemiology and sociological methods of enquiry.[17-18] However, the historical event which first focused national attention on the growing problem of suicide among Aboriginal Australians was the Royal Commission into Aboriginal Deaths in Custody (RCIADIC).[19] The Commission's final report drew particular attention to the links between substance misuse and mental health disorders in the years and months prior to most of the deaths which it investigated. It also highlighted the disproportionate number of these Aboriginal deaths in custody (over three-quarters) where there was a history of the person having been forcibly separated from their natural families as children. The inter-connected issues of cultural dislocation, personal trauma and the ongoing stresses of disadvantage, racism, alienation and exclusion were all acknowledged by the Commission as contributing to the heightened risk of mental health problems, substance misuse and suicide. The Commission made several specific recommendations for improving police and custodial practice and providing adequate treatment for those with diagnosable disorders whilst in custody and in the 12 months following release from prison.[19] Most of the Commission's practice recommendations were implemented systematically across all Australian jurisdictions over the following decade with a resulting decline in deaths in custody. However, the Commission's broader recommendations for Australian governments to address the underlying social, economic and political circumstances—including the over-representation of Aboriginal people in the justice system—has received considerably less attention.

Hunter's seminal studies of Aboriginal suicide in the Kimberley region of WA and far north Qld since the late 1980s charted the historical impact of colonisation on the role of men in Aboriginal society and the relatively recent emergence of suicidal behaviour as a socio-cultural phenomenon.[20-21] Hunter noted that willed or self-willed death associated with sorcery or physical debility in traditional Aboriginal societies could be considered 'suicide equivalent' phenomena. However these are very different to the increases in deaths by hanging of young men over recent decades. He argued that both phenomena are meaningful but in different ways. He suggested that the former was a socially understood and affirmed consequence of behaviour (transgression) or circumstance (debility); while the latter could be considered as a statement or communication that had meaning in the particular intercultural political context of the Australian society and Aboriginal communities of the 1990s. Understanding Aboriginal suicide therefore demands a consideration of the historical context in which these socio-cultural changes are located.[20-21]

One of the most significant socio-cultural changes in Aboriginal communities associated with increases in suicide has been the disruptive effects of alcohol. Hunter's 1991 discussion of the effects of the extension of drinking rights to Aboriginal people observed that this initially resulted in a rapid increase in Aboriginal deaths due to motor vehicle accidents and homicide. The social disruption of alcohol on Kimberley communities had its most damaging effects on young adults, particularly unemployed men, who were already leading culturally dislocated lives in town camps. His analysis found that it was almost 15 years after the free availability of alcohol that the dramatic increase in suicide and self-destructive behaviours among young (mostly male) Aboriginal adults emerged in the late 1980s. Hunter describes this as: '… the

first generation to have grown up in an environment of widespread drinking and its social consequences'.[20] In his analysis, alcohol was not seen as the immediately contributing factor for these suicides but rather it was the effects of alcohol on the conditions of childrearing which was the more fundamental cause. This hypothesis is supported by another finding of his study—that a history of heavy drinking in the family was more predictive of suicides among incarcerated young Aboriginal men than these men's own alcohol use. Thus, in addressing these problems, it is important to ensure culturally appropriate treatments are available to alleviate individual suffering while also supporting communities to take action in addressing the harm which alcohol causes in the social environments in which Aboriginal children are being raised.

As already noted, the variation of suicide by location and time in these remote regions of northern Australia suggests that socially mediated factors within communities may have a more powerful effect on the likelihood of suicide than the traditional 'medical model' concepts of individual risk inferred from psychological autopsy studies and clinically based investigations of suicidal behaviour. Hunter and his co-authors observe that, given different communities contribute to this excess (of suicide) at different times in '… overlapping 'waves' of suicides', this phenomenon is more indicative of a condition of *community* risk rather than *individual* risk'.[20] This view is consistent with Colin Tatz' critique of 'medicalisation' of Aboriginal suicide as a 'mental health problem' in much of the previous research and reports such as the RCIADIC. This, he argues, has prevented the problem being examined and understood in a proper historical, political and social context and the way in which the processes of 'decolonisation' have undermined the internal values of Aboriginal society and left many Aboriginal youth with a profound sense of frustration, alienation and distress. Tatz' use of the term 'decolonisation' refers particularly to the devastating effects which the removal of direct government controls over Aboriginal affairs in 1972 had in many Aboriginal communities— particularly the inadequate infrastructure and services within what were essentially artificially created settlements.[2]

Tatz further suggests that many of the mainstream social risk factors for suicide simply do not apply to Aboriginal people and their communities. His studies of a range of communities in NSW, the Australian Capital Territory (ACT) and New Zealand identified the following community factors as being most relevant to explaining increases in suicide:

Community Factors Relevant to Explaining Increases in Suicide

- Lack of a sense of a purpose in life;
- Lack of recognised role models and mentors outside of the context of sport;
- Disintegration of the family;
- Lack of meaningful support networks within the community;
- High community rates of sexual assault and drug and alcohol misuse;
- Animosity and jealousy manifested in factionalism;
- The persistent cycle of grief due to the high number of deaths within communities; and
- Poor literacy levels leading to social and economic exclusion and alienation.[2]

Hunter and Milroy have taken this a step further in seeking to explain the underlying psychological processes through which broader historical, socio-economic and community factors may become internalised and how this can lead to the impulse of self-annihilation in vulnerable individuals. They argue that Aboriginal self-harm reflects vulnerability stemming from internal states informed by individual experience and collective circumstance. Most particularly, they highlight the way in which historical forces have impacted on the environment

of family life and in shaping individual identity, health and wellbeing. Thus in considering the meaning of one's life as a narrative or story,

> …the desire to end one's personal story abruptly, prematurely and deliberately can [therefore] be seen to stem from the complex interplay of historical, political, social, circumstantial, psychological and biological factors that have already disrupted sacred and cultural continuity; disconnecting the individual from the earth, the universe and the spiritual realm—disconnecting the individual from the life affirming stories that are central to cultural resilience and continuity.[22(p150)]

CULTURAL CONTINUITY AS A KEY PROTECTIVE FACTOR

Chandler and Lalonde's study of five years of data on youth suicide rates in Canadian First Nations communities in British Columbia investigated reasons for the variation in suicide rates between communities which had similar historical backgrounds and levels of socio-economic disadvantage.[23] They identified a number of 'cultural continuity' factors which were significantly associated with lower rates of youth suicide:

> **'Cultural Continuity' Factors Associated with Lower Youth Suicide Rates**
>
> 1. Self-government
> 2. Actively pursuing land claims
> 3. Existence of education services
> 4. Tribal-controlled police and fire services
> 5. On-reserve health services, and
> 6. Existence of cultural facilities. [23]

Of particular note was the finding that communities with more of these 'cultural continuity' factors had lower rates of suicide among their young people. These ranged from 137.5 per 100,000 for communities where none of the factors were present, to no suicides at all for communities with all six factors. They concluded that 'cultural continuity' as defined in this way, was an important protective community characteristic and appeared to assist young people in maintaining their sense of personal continuity and cultural identity in the face of rapid social and cultural change.

Further studies of the same set of communities investigated whether Aboriginal language knowledge also had a similar protective effect to the original six identified 'cultural continuity' factors.[24] These demonstrated that Aboriginal language knowledge retention and revitalisation was strongly correlated with the six original cultural continuity factors but also had a significant and substantial independent preventative effect. The application of these insights in these communites has led to locally developed healing initiatives aimed at strengthening young people's positive identification with culture and enabling their social and economic participation in community life, and this has been found to be a key recovery feature of communities where high rates of suicide and other self-destructive behaviours have been reduced.[25]

UNDERSTANDING HOW SUICIDE CLUSTERS APPEAR TO DEVELOP

Hunter and Milroy's description of how the idea of suicide may become internalised is particularly relevant to the development of *suicide clusters* where suicidal behaviour and suicide deaths appear to become socially 'contagious' with so-called 'copy-cat' behaviour. A number

of such 'outbreaks' have been documented in Aboriginal and non-Aboriginal Australian communities over the recent decades.[10, 22] These typically involve an unusually rapid increase in the number suicides and occurrences of self-harming behaviour within a community or region over a limited period of time (i.e. several months or a few years). The specific method of self-harm and suicide is typically the same within each cluster. Kral's sociological analysis of suicide clusters in Canada suggested that:

> the only direct 'cause' of suicide is the idea of suicide and ways to do it, and in order to better understand suicide we need to know more about how ideas are spread throughout society and become part of an individual's repertoire. [26(p253)]

High levels of alcohol and drug misuse have been noted in almost all documented Australian Aboriginal suicide clusters, with many of the affected individuals being either intoxicated or in severe withdrawal when attempting or completing suicide. The other common underlying community factor is widespread unemployment and limited opportunities for young people developing the skills and self-esteem to take their place as productive adult members of the community. Hanssens has also noted that exposure to suicidal threats, attempts and suicide within the family or by close associates was a common factor in suicide clusters.[25] This was also observed in Robinson et al's study of child and adolescent suicide in the NT.[10] Geographic isolation and complex clan and family relationships are other factors which have been associated with documented clusters. Cultural and family obligations to participate in numerous funerals and grieving rituals may also magnify the cumulative impact of these distressing events and, in extreme cases, result in the family and community load of bereavement stress temporarily overwhelming their normal recovery processes.[26]

Nizen's ethnographic account of a suicide cluster in Canadian Inuit communities in northern Manitoba, sought to explain why suicide rates should vary so dramatically between communities which had common historical backgrounds of cultural dispossession and comparable levels of socio-economic disadvantage. His analysis recognised the protective and life affirming function which 'cultural continuity' plays in strengthening young people's self-identity and sense of connectedness with family and community. However, he also noted two other cultural features which appeared to have played a central role in young people arriving at a self-reinforcing cycle of emotional injury and self-harm. First was the family and cultural obligations to attend prolonged funerals where the collective expression of grief seemed to have become reminders of the collective trauma suffered by the Innu people. Second, and more critical, in his analysis, was the observation that the pattern of increasing self-destructive behaviour in young people appeared to be more prevalent in those communities where there was a disengagement of young people from older generations and the absence of almost any opportunities for productive and creative activity. Young people in communities where individual and community identities are fragile, and where they are cut off from the positive example and social persuasion of older generations, are likely to gravitate to a peer group of similarly disconnected youth. Their group affiliation is then shaped by their shared sense of social alienation which leads them to develop an identity based on the collective normalisation of suffering. This can then go on to their giving a 'positive' (sic) value to self-harm and other self-destructive, high-risk behaviours.[29] The cases studies in Chapter 20 (Hayes and colleagues) and Chapter 21 (Milroy) illustrate this potential pathway.

WHAT WORKS IN PREVENTION, EARLY INTERVENTION AND POSTVENTION?

Mainstream initiatives to reduce suicide and suicidal behaviour in Australia have largely been informed by the National Suicide Prevention Strategy (NSPS) which commenced in 1999 and extended the initiatives of the former National Youth Suicide Prevention Strategy (NYSPS) to include all age groups.[28] The strategic platform of the NSPS is described in the *Living is For Everyone* or *LIFE Framework* published in 2000 and updated in 2007.[29] While all state and

territory suicide prevention strategies are now aligned with the *LIFE Framework*, the state and territory strategies differ in how they address the prevention of Aboriginal suicide. Given the higher rates of suicide in the Aboriginal population in all jurisdictions, it is surprising that these state and territory strategies are mostly focused on targeted approaches with an emphasis on cultural appropriateness of mainstream services and for Aboriginal people and other cultural and language groups. Victoria is currently the only jurisdiction to have developed a separate whole-of-government approach to Aboriginal suicide prevention while there have been calls for similar developments in NSW, SA and WA.

The national *LIFE Framework* is informed by current international research in suicide prevention which highlights the importance of two sets of risk factors. The first are immediate (proximal) individual factors evident in the months, weeks and days before a suicide attempt or suicide. These include the individual's mental state, precipitating circumstances such as recent adverse life stress events and drug and alcohol use. The second set of factors are the longer term (distal) factors, which have a cumulative effect in increasing an individual's risk from early childhood and through the life course. These two categories of risks require quite different prevention strategies and interventions to reduce the occurrence of suicidal behaviour and suicide.[29]

Preventive Early Intervention for Individuals in Distress

Preventive early intervention for distressed individuals showing signs and symptoms of acute suicidal risk generally aim to interrupt the proximal risks for suicide and to stabilise and reduce an individual's level of emotional arousal through physical containment, social support and/or clinical intervention, depending on the assessed level of risk. In communities with limited access to mental health practitioners, community workers may need to make an initial assessment of the risk of suicide or serious self-harm based on their knowledge of the person and their circumstances. However, this should wherever possible be done in consultation with others rather than making potentially life-and-death decisions alone. Direct or telephone consultation with a mental health practitioner can help in reaching a considered decision about the level of monitoring or action needed to ensure safety. This should consider what action and supports need to be in place: immediately (i.e. over the next two hours); in the short-term (over the next two days) or in the longer term (e.g. over the next two weeks). Such assessments usually require speaking directly with the individual and inquiring about their thoughts about ending their life or harming themselves.

A number of culturally appropriate training programs are now available to assist community workers and natural community helpers in making risk assessments of this kind e.g. the *Gatekeeper Training Program*; the *Indigenous Psychological Services Whole of Community Suicide Prevention Forums*; the *Aboriginal Mental Health First Aid Training and Research Program*; and *Suicidal Thoughts, Behaviours and Deliberate Self-Injury: Guidelines for providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Person*.[30-32] Training programs such as these aim to develop skills of engaging with highly distressed individuals, increase knowledge of mental health issues such as depression and psychotic behaviour which often underlie suicidal behaviour, and build understanding of the social and clinical supports which can help in reducing suicide risk and prevent crisis situations escalating.

While some programs are designed for helping professionals, others are designed for community members with the aim of ensuring that communities have a number of key individuals who can be relied upon as 'gatekeepers' to link and refer suicidally distressed individuals with the clinical or other supportive interventions which they may need. They particularly stress the importance of 'gatekeepers' learning to recognise the feelings of hopeless, dread and escalating agitation which commonly precedes fatal and non-fatal impulsive suicidal behaviour.

Longer-term Prevention Promoting Resilience

The current national policy framework for suicide prevention also has an increased emphasis on 'whole-of-population' and strengths-based approaches to prevent individuals from becoming at risk in the first place. This is consistent with the evidence on Aboriginal suicide reviewed earlier which suggests the social and community determinants of Aboriginal suicide contributes as much as, if not more than, individually based risk factors. Such universal approaches to prevention have been shown to be particularly effective in addressing issues which arise through multiple risk exposures over time or which are highly prevalent at lower levels of risk. [33]

Improved scientific knowledge of the early-life factors which promote emotional resilience in children and young people is also informing 'strengths-based' policies and increased national investment in 'place-based' (i.e. community) initiatives to better support the development of all children and young people and equip them for managing the challenges of life in 21st century Australia.[34] Other community-based strategies seek to strengthen protective factors (e.g. help-seeking) at the community and family level and to reduce the 'upstream' risks (e.g. alcohol and other drug misuse) that increase the likelihood that an individual will respond to adverse life circumstances with impulsive suicidal behaviour. This is based on the evidence that stresses (such as social disadvantage, racism, family violence, mental health or behavioural problems, as well as traumatic events such as bereavements, relationship breakdown or trouble with the law) have a cumulative biological impact over time.[35]

For each developmental period there is a range of known environmental risks (and preventive opportunities) which should be a priority focus of the agencies responsible for the services most relevant to that stage of development. Developmental prevention approaches have long been advocated as the most cost effective means to reduce early onset conduct disorders, juvenile crime and population rates of incarceration.[36-37] It is now generally recognised that a much greater proportion of the prevention effort should be spent on 'up-stream' preventive policies and services. This will require both community action and resolve and more effective alignment of policy services to ensure that health, family and community services, education, mental health and justice service sectors work together to build community, family and individual wellbeing, capability and resilience.

Proactive Bereavement Support and Containment of Suicide Clusters

The high rates of bereavement suffered by Aboriginal families has become a growing concern in some parts of Australia. Where there is little time to recover from one loss before another has occurred, whole families and communities can be left in a constant state of mourning, grief and bereavement. For some individuals, this can be accompanied by extended grief reactions such as shock, numbness and disbelief. Bereaved family, friends and other community members often see their own distress reflected in the predicament and actions of the deceased person. For more vulnerable individuals, this can trigger their own suicidal thoughts and actions. Ripples of loss, grief and mourning after suicide can spread outwards through the community and to other communities—particularly where families are highly interconnected and there are strong cultural obligations with regard to funerals and observance of sorry business.

In one remote Australian region, a pattern of association of suicidal behaviour was observed between four families who together lost 15 members of their family to suicide from 1998 to 2007.[27] The heightened awareness of suicide associated with such levels of bereavement through suicide can be further complicated by unthinking media reporting—particularly when reports give graphic and sensational accounts of the methods and circumstances of the suicide or which fail to respect the rights of privacy of grieving family members. The highly distressing nature of such events highlights the need for developing and maintaining expertise

in bereavement support and counselling within communities and Aboriginal community organisations. At the same time, the trauma and additional stresses associated with suicide, may also require emergency additional mental health intervention, as well as consultative support and back-up for 'front-line' community workers and family members caring for suicidal individuals.

AUSTRALIAN ABORIGINAL COMMUNITY HEALING INITIATIVES

Over the past few years a number of Australian communities have initiated local community healing processes in response to the collective trauma of child abuse and multiple bereavements. A notable example is the model of community healing developed by Darrell Henry through his therapeutic support of communities recovering from suicide clusters in the Pilbara, Kimberley and WA Southwest.[38] This integrated community healing model involves a three-level strategic response to suicides and suicidal behaviour which aims to build the capacity of community people as the key 'first-response' service providers, has a primary focus on the implications of suicide for the community, and involves a 'whole community' response (See Figure 9.4).

This model recognises the central and significant role of cultural work in Aboriginal communities. It involves actively supporting culture and working with culture, e.g. using traditional practices such as being taken to country and 'held' through a formal community process with strong men and women for cultural, spiritual and personal learning. Other examples of the cultural use of this process of 'holding' have been described by McCoy within the context of the Kutjungka region in the southeast region of the Kimberley.[39] Henry suggested that such healing practices could be further enabled by funding support for 'going to country', using or re-creating traditional rituals of healing including the use of smoke, water, stones, leaves and plants to cleanse the spirit and clear aberrant and distorted spirits from the being. While the inclusion of these practices in this model of community healing depends on the availability of natural helpers and recognised traditional healers, this is considered as key to the effectiveness of the other levels of therapeutic work.

Figure 9.4: Henry's Three Level Model of Community Healing and Helping

©Darrell Henry
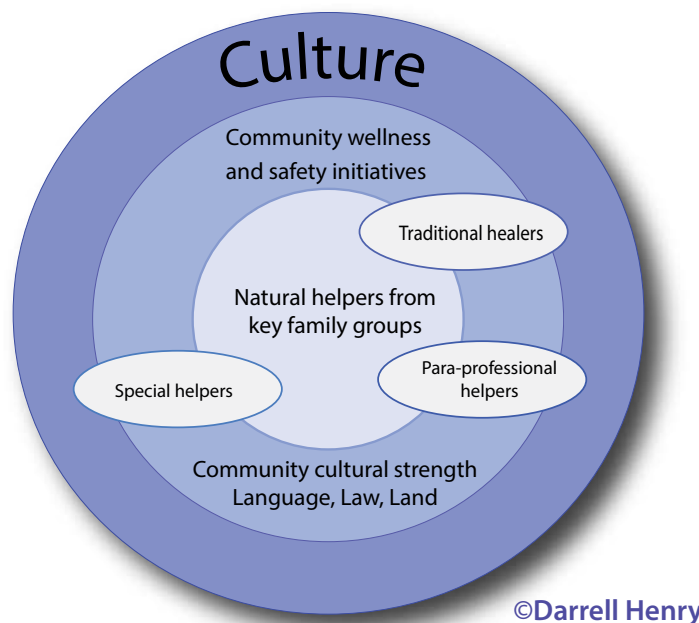
Henry's next layer of helping involves Aboriginal para-professional workers acting as a bridge between community natural helpers and counsellors trained in mainstream generic counselling methods. These may include Aboriginal health and mental health workers (MHWs) as well as dedicated community counsellors who can provide counselling for trauma; assist in managing critical responses to family violence and disclosures of abuse, etc. Counselling training is seen as advantageous but not absolutely essential for community based workers—particularly in small and remote communities where there are limited employment opportunities and career paths available to them. However, the workers access to various forms of advisory support is considered vital.

While some professional bodies (e.g. the Australian Psychological Society (APS)) have set guidelines for the assessment, diagnosis and treatment of Aboriginal people, including the use of cultural advisers in the interview process, Henry recommends the need for specialist training for adapting psychological and psychiatric methods for their more appropriate use with Aboriginal people and suggests that this level of service could be improved through scholarships and personal support for tertiary training of Aboriginal people in the helping professions; professional mentoring and co-working; and specialist practitioner training delivered in communities. The integration of all three of these layers of this healing model brings together Aboriginal cultural, spiritual and community processes in community healing from trauma. The process is helpful in building cultural respect, strengthening the local social infrastructure as well as creating work opportunities and avenues for professional development and mainstream support where required.[38]

COMMUNITY HEALING AND RECOVERY FROM INTERGENERATIONAL TRAUMA

There is strong empirical evidence documenting the extent and intergenerational effects of Australia's past policies of forced removal of WA Aboriginal children from their natural families on rates of family breakdown, mental health problems and suicidal behaviour among families impacted by these policies.[40-41] Similar increased rates of social and mental health problems have been documented among Canadian Indigenous families affected by abuse and historical trauma which occurred within that country's residential school system.[42]

The Canadian Government's national strategy to redress the individual and collective trauma suffered by Indigenous peoples through their past policies has included support of the establishment of 'Indigenous Healing Centres'. Over the past decade these Healing Centres have proven to be one of the most effective components of the overall strategy. The Healing Centres offer a range of cultural strengthening activities, including traditional and spiritual healing practices as well as complementary and/or mainstream approaches to trauma recovery, health maintenance, and rehabilitation services. The final report of the Canadian Indigenous Healing Foundation concluded that properly funded community administered 'Indigenous Healing Centres' have led to significant reductions in many of the most socially damaging problems (including suicide) in families and communities impacted by the residential schools system.[42]

Prime Minister Kevin Rudd's 2008 apology to the Aboriginal peoples of Australia for the harm and intergenerational suffering caused by the policies of forced removal and resettlement marked an important first step in the national reconciliation process. It also begged the question of what else was needed in terms of reparation and restorative justice. It was encouraging, therefore, that on the first anniversary of the National Apology, the Australian Government announced that $26.6 million over four years would be allocated for the establishment of a similar healing foundation in Australia. This recognised that healing has always been an important concept and practice for Aboriginal and Torres Strait Islander peoples , and is deeply rooted in culture and should be supported. A committee co-chaired by the Hon. May O'Brien

and Dr. Gregory Phillips consulted nationally about how the foundation should be created and operate. The recommendations from their '*Voices from the Campfires*' report were implemented with the National Aboriginal and Torres Strait Islander Healing Foundation being established as an independent organisation in 2010.[43]

***Suicide Story* – An Indigenous Community-led Suicide Prevention Program[46]**

Suicide Story is an Indigenous-specific suicide prevention learning program. It aims to work holistically with communities in a 2 to 3 day workshop made up of short films, visual aids and culturally appropriate activities with follow-up support. *Suicide Story* was developed for remote communities in the Northern Territory in partnership with local Aboriginal people. The program concentrates on strengthening the skills, knowledge and confidence of communities to prevent and intervene with suicide at a community level. It can complement other suicide prevention programs with a training/education focus. Short films feature the voices of Indigenous people gathered from a collection of interviews from across the Northern Territory including Alice Springs, Santa Teresa, Yuendumu, Tennant Creek, Katherine, Darwin and the Gove Peninsula.

"Suicide Story *is about getting the conversations happening, giving people permission to talk, and giving Aboriginal people more appropriate tools to know how to handle suicidal behaviour in their families and communities*".

Suicide Story engages local Aboriginal facilitators in the delivery of the program; acknowledges that suicide is a very recent problem among Aboriginal families in this region; explores issues such as impulsive suicide, suicide as a threat, blame and payback in their cultural and local context; recognises the importance of learning through sharing stories from other Aboriginal communities and shares learnings through recognisable symbols, images and language. *Suicide Story* explores the history of social injustice and the consequent losses that are relevant to the current problem of suicide, is respectful of different learning styles and preferred learning environments and accommodates varying levels of English literacy.

Valda Shannon and Laurencia Grant

The Mental Health Association of Central Australia

Since its establishment, the Healing Foundation has supported a range of community initiated healing initiatives around Australia involving cultural support, community education and skills training in the prevention and healing of trauma. It has also undertaken a nation-wide process of community consultation regarding different ways of working with Aboriginal communities to support the local development, capacity and sustainability of community healing initiatives and centres. This has added to the international evidence from Indigenous healing initiatives in Canada, the USA and New Zealand[42] and the accumulating evidence from the evaluation of promising practices in the culturally informed, locally run community healing programs which the Healing Foundation has supported around Australia.

Insights from the Healing Foundation's community consultations, literature reviews and evaluations have been recently summarised in a report on the establishment, support and evaluation of healing centres.[44,45] The report notes that conventional health and welfare approaches have not resulted in the outcomes that Aboriginal and Torres Strait Islander communities want and are entitled to. It confirms that healing is seen by Aboriginal and Torres Strait Islander peoples as a promising alternative that can be generated from within their own communities. It also stresses the importance of needing to go beyond a narrow focus on the personal symptoms of trauma (e.g. family violence) to the mobilisation of a whole

community response. Given the depth and collective levels of exposure to the trauma from which Aboriginal and Torres Strait Islander peoples are recovering, and the complexity of the challenges this presents, it is clear that a more holistic and collective healing response is needed. Finally the report recognises that acknowledging Aboriginal and Torres Strait Islander history, culture and knowledge, is in itself an important healing and transformative act:

> *Acknowledging colonisation, racism and harmful policies as the common factors underpinning the trauma in Aboriginal and Torres Strait Islander communities provides a more facilitating environment for healing to occur. Healing will often make use of both mainstream and traditional knowledge and practices, but valuing Aboriginal and Torres Strait Islander knowledge and leadership is a prerequisite for adaptive solutions to be developed.*[45(p9)]

AUSTRALIA'S POLICY RESPONSE

After nationwide consultations by the Menzies School of Health Research with the assistance of the National Aboriginal Community Controlled Health Organisation (NACCHO), the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was launched by the Commonwealth Government on 23 May 2013.[47] It emphasises early intervention and building the capacity of communities to respond to suicide.

CONCLUSION

This review of the emergence of suicide and suicidal behaviour as major concerns within the Australian Aboriginal population over the past several decades highlights the depth and complexity of the issues involved. There is clearly no quick or simple solution. What is required is acknowledgment of the level of distress that brings individuals to this point and the heavy toll that suicide takes on families, communities and society. Addressing the individual, community and sociopolitical and historical issues involved requires action on many fronts and on several levels. Linking and enabling these endeavours is vital to restoring the past and creating a future that includes opportunities for individual and communal healing.

RESOURCES

The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy is available from: http://iaha.com.au/wp-content/uploads/2013/05/MAY-2013-Final-National-Aboriginal-and-Torres-Strait-Islander-Suicide-Prevention-Strategy11.pdf.

The National Suicide Prevention Strategy's LIFE Framework is available from: http://www.livingisforeveryone.com.au/LIFE-Framework.html

REFLECTIVE EXERCISES

1. You are a counsellor in a local community health centre. A member of the local Aboriginal community has approached you because she is worried about her 17 year-old son who has been feeling winyarn (sad) for a long time. Over the past month she has noticed a marked change in her son's behaviour. She says he has been 'flying off the handle' over minor frustrations and become aggressive towards her when she has asked him what's wrong. She has contacted you now because he has begun talking about killing himself over the past few days.

    Taking into account the issues discussed in this chapter:

    a. How would you engage with this family?

    b. What would you need to consider when assessing his level of risk?

    c. Who would you consult when developing a plan of action?

2. Applying Henry's Community Healing Model (Figure 9.4) to work with communities where there has been a high rate of suicide and suicidal behaviour over several years, consider the following:

   a. How would you identify the natural helpers in your community (or the communities you work with)?

   b. What resources (or gaps) exist to support these natural helpers and to link them to the specialist, paraprofessional or traditional healers?

   c. What are the traditional healing practices in your community? Are you permitted to discuss them?

   d. How (if at all) are the traditional healers invited to participate in the mainstream programs and services designed to prevent suicide?

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10

Mental Disorder and Cognitive Disability in the Criminal Justice System

Ed Heffernan, Kimina Andersen, Elizabeth McEntyre and Stuart Kinner

OVERVIEW

This chapter examines what is known about the prevalence of mental disorder and cognitive disability amongst Aboriginal and Torres Strait Islander peoples in contact with the criminal justice system and how these issues impact on individuals, families and communities. The literature in this area is reviewed; there is now a considerable body of evidence supporting the premise that mental disorders are a significant health challenge for Aboriginal and Torres Strait Islander peoples in contact with all aspects of the criminal justice system. There is emerging evidence to suggest that this is also the case for cognitive disability, however further research is required to fully articulate the extent of this challenge. With this understanding, we consider the important and complex implications for mental health and disability services in meeting the needs of Aboriginal and Torres Strait Islander peoples in the criminal justice system.[1]

BACKGROUND

> *Commissioners could trace the familiar pattern of State intervention into, and control of, Aboriginal lives. The files start from birth; perhaps recording a child adopted out, perhaps its birth merely noted as a costly additional burden; through childhood, perhaps forcibly removed from parents after having been categorised as having mixed racial origins and therefore being denied a loving upbringing by parents and family; through encounters at school, probably to be described as truant, intractable and unteachable; to juvenile courts, magistrates courts, possibly Supreme Court; through the dismissive entries in medical records ('drunk again'), and in the standard entries in the note books of police investigating death in a cell ('no suspicious circumstances').*[1(1.2.12)]

The landmark report of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) published in 1991 highlighted for the general Australian community the significant problems associated with the over representation of Aboriginal and Torres Strait Islander peoples in custody.[1] It also clearly described the associated social and emotional wellbeing (SEWB). The RCIADIC[1] examined all 99 deaths of Aboriginal and Torres Strait Islander peoples in custody between 1 January 1980 and 31 May 1989, and in 1991 published a report containing 339 recommendations, of which 338 were accepted by the Australian Government. Among the many important issues highlighted in the extensive report were the extraordinary rates of incarceration of Aboriginal and Torres Strait Islanders compared with other Australians and the poor general and mental health of this group; 'The 99 cases have highlighted the issue of mental health as a significant underlying issue and a factor of concern for those who died in custody.'[1] Now, 22 years since the report was released, these issues are just as prominent for Aboriginal and Torres Strait Islander peoples incarcerated today, as is the ongoing trauma of deaths in custody.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES IN CUSTODY

Aboriginal people are 15 times more likely to be incarcerated than other Australians and represent 27 per cent of the adult custodial population[2] despite being around 3 per cent of the Australian population.[3] In the most recent National Aboriginal and Torres Strait Islander Social Survey (NATSISS), 15 per cent of people aged 15 years and over reported that they had been arrested at least once in the preceding five years[4] and it has been estimated that more than one-in-five Aboriginal and Torres Strait Islander children experience incarceration of a parent by the age of 16 years.[5]

The annual National Prisoner Census[6] indicates that, over the past decade, there has continued to be a dramatic rise in the proportion of Aboriginal people incarcerated.[6] In 2002, there were 4,494 Aboriginal people incarcerated in adult prisons, increasing to 7,982 in 2012.[2] Over the same time period, the proportion of prisoners identifying as Aboriginal increased from 20.0 per cent to 27.2 per cent and the age-adjusted ratio of Aboriginal to non-Aboriginal incarceration increased from 10.1 to 14.8. In 2012, the national age-standardised incarceration rate for Aboriginal people was 1,914 per 100,000 population compared with 129 per 100,000 population among other people. Aboriginal and Torres Strait Islander peoples are over-represented among prisoners in every state and territory of Australia, although the extent of this over-representation varies from a factor of 4 in Tasmania up to twenty fold in Western Australia (WA). New South Wales (NSW), Queensland and WA account for 73 per cent of the total Aboriginal and/or Torres Strait Islander prisoner population.[2] The number of Aboriginal women in prison is increasing at a much faster rate than that for Aboriginal men, with a 20 per cent increase in women compared with 3 per cent in men over the past 12 months.[7]

Across Australia, Aboriginal prisoners are mostly male (92 per cent) and relatively young, with 26 per cent less than 25 years old and 48 per cent less than 30 years old. Aboriginal and Torres Strait Islander peoples in prison are also more likely than other people to have been sentenced or charged with acts intended to cause injury and less likely to have been sentenced or charged with illicit drug offences. The average sentence length (two years) for Aboriginal prisoners is considerably shorter than for other prisoners (3.9 years). Three quarters (74 per cent) of Aboriginal prisoners have a history of prior adult imprisonment, compared with around half (48 per cent) of other prisoners. Many of these individuals have spent time in juvenile detention across Australia. Over half (53 per cent) of all juveniles in detention are Aboriginal or Torres Strait Islander or both Aboriginal and Torres Strait Islander.[8]

These statistics paint a stark picture, but in isolation do not capture the suffering and distress experienced by incarcerated Aboriginal and Torres Strait Islander peoples, their families and their communities. The experience of the criminal justice system is likely to be different for Aboriginal and non-Aboriginal people. The majority of the Australian prison population are non-Aboriginal males[2] and the majority of correctional officers, correctional health staff and non-custodial staff employed in the correctional system are non-Aboriginal. Programs and supports that relate to the SEWB of Aboriginal and Torres Strait Islander peoples in custody must be culturally informed,[9] however it is debatable whether this is the case.[10] Similarly, whereas the focus of rehabilitation for Aboriginal and Torres Strait Islander prisoners must be culturally informed, to the authors knowledge, there is no published evidence of the outcomes of preventive or post-release programs for Aboriginal Australians that were developed, implemented and evaluated in collaboration with Aboriginal families and their communities. It has been suggested, though, that using an approach based on desistance theory may not be useful for Aboriginal women caught in the criminal justice system; this approach is based on work with non-Indigenous males, focuses on offending behaviours, not necessarily individual and cultural needs, and does not take account of broader social and cultural drivers of criminalisation.[11]

In addition, for Aboriginal and Torres Strait Islander women, many of the challenges of incarceration are compounded by the fact that they usually have young children in their care prior to coming into custody.[12] Many also report experiences of trauma and social disadvantage related to family violence, sexual assault, alcohol and other drug use, racism, unemployment and poverty.[13, 14] However, it is apparent that there is a lack of appropriate services to meet these complex social, cultural and health needs.[15]

THE SOCIAL, HEALTH AND INCARCERATION NEXUS

When compared with the general community, prisoners experience higher levels of adversity with respect to the social determinants of health. They have:

- higher levels of unemployment;
- unstable accommodation;
- lower levels of education; and
- poorer access to health services.[16, 17]

This appears to be particularly the case for Aboriginal prisoners who, when compared with their non-Aboriginal counterparts, report earlier and more frequent contact with the criminal justice system,[18] a higher prevalence of unemployment and poorer education, defined as completing 10 years of schooling.[13] Aboriginal and Torres Strait Islander prisoners are more likely to have been placed in care as a child and to have experienced parental incarceration, with one-in-three reporting that they had a parent imprisoned when they were children.[13]

For Aboriginal and Torres Strait Islander peoples, being charged by police or imprisoned in the preceding five years is strongly correlated with misuse of alcohol or other drugs, failure to complete high school, unemployment, financial stress, crowded accommodation and being a member of the 'stolen generation.'[19] Experiences of trauma, discrimination, domestic violence, substance misuse, mental health problems and mental illness, are also strongly associated with incarceration.[18, 20, 21]

This nexus between social adversity, poor health and incarceration for Aboriginal people can at least in part be understood in terms of the impact of historical factors such as the colonisation of lands and the forced removal of children, discrimination, and associated experiences of unemployment, poverty, poor education and a lack of social capital.[13, 19, 22-25] Aboriginal and Torres Strait Islander peoples have been the target of various forms of social control including mass killings, dispossession of land, being forced onto missions, children being stolen and imprisoned in girls' and boys' homes and restrictions affecting mobility and personal liberty policed by mission and reserve authorities.[1] Knowledge of this history is critical to understanding the impact that interaction in the criminal justice system can have on Aboriginal and Torres Strait Islander individuals, family and communities. In Chapter 1, Dudgeon and colleagues discuss the social and historical context; in Chapter 6, Zubrick and colleagues examine the social determinants of SEWB; and in Chapter 30, Hovane and colleagues outline elements for culturally appropriate rehabilitation programs.

MENTAL DISORDER AND COGNITIVE DISABILITY AMONG PRISONERS

This section reviews the current evidence related to the prevalence of mental disorder, (mental illness and substance use problems) and cognitive disability among Aboriginal and Torres Strait Islander men and women involved in the criminal justice system. In doing so, it is acknowledged that these elements are only part of the more holistic concept of health for Aboriginal and Torres Strait Islander peoples' SEWB.[9] The evidence base for mental illness and substance use disorders in this population is relatively well characterised, the extent of cognitive

disability among Aboriginal and Torres Strait Islander peoples in contact with the criminal justice system is not as well understood, despite its importance as a component of broader SEWB.

In the largest and most recent survey of the mental health and wellbeing of the Australian community, mental disorders—defined in accordance with the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10)[26]—were considered to include affective (or mood) disorders, anxiety disorders, substance use disorders[27] and psychotic disorders.[28] It was estimated that almost half of the Australian population aged 16 to 65 years (45 per cent) had experienced a mental disorder at some stage in their lifetime, with 20 per cent experiencing a mental disorder in the preceding 12 months. This survey, like most population surveys in Australia, did not include people in custody.

At a population level, a comprehensive understanding of the distribution of mental illness requires a focus on incarcerated populations, given that when compared with the general community, the prevalence of mental disorders among prisoners is elevated by orders of magnitude.[29] However until recently, relatively little has been known about the mental health of Aboriginal people in custody.[30, 31] Recent studies have shed some light on the prevalence of mental illness among Australian prisoners, although few have focussed on Aboriginal and Torres Strait Islander peoples in prison. Research related to the rates of cognitive impairment in Aboriginal and Torres Strait Islander prisoners is even more limited; however the research that does exist suggests that Aboriginal and Torres Strait Islander prisoners who experience cognitive impairment are likely to also experience mental illness and alcohol or other drug use.[32, 33]

A study of individuals with intellectual and other cognitive impairment in the criminal justice system in NSW found that, compared with other Australians, Aboriginal and Torres Strait Islander peoples with an intellectual disability had earlier police contact and higher levels of police contact, and were less likely to receive a disability service.[32, 33] Given uncertainty about the prevalence and presentation of cognitive disability among Aboriginal and Torres Strait Islander peoples in the criminal justice system, there is a need for further research to better understand the nature and extent of this problem. Equally, there is a pressing need to improve our understanding of how Aboriginal and Torres Strait Islander peoples with co-occurring mental disorder and cognitive impairment interact with, and are dealt with by, the criminal justice system and by human service providers after release from custody.[2]

More is known about mental disorders among Indigenous people in custody, but much of the evidence has come from only two Australian jurisdictions. The 2009 NSW Inmate Health Survey: Aboriginal Health Report[13] was the first significant Australian report to focus on the general health of Aboriginal inmates. It was based on a cross-sectional survey that included screening items related to mental health, administered to 312 Aboriginal prisoners in NSW. The mostly self-report items covered psychiatric history (ever assessed or treated by a doctor or psychiatrist for an emotional or mental health problem), psychiatric admissions (ever admitted to a psychiatric unit or hospital), medication use (current use of psychiatric medications), history of suicide thoughts/attempts or self harm, and screened for depression using the Beck Depression Inventory. Consistent with previous studies in NSW, the findings indicated a high prevalence of mental health distress among Aboriginal prisoners and while not diagnostic, the findings suggested a high prevalence of mental disorder. On all measures related to mental health women had poorer outcomes than men. (Table 10.1)

Table 10.1: Mental Health Items, by Gender

	Male %	Female %
Psychiatric History	44.5	51.9
Psychiatric Admission	14.5	21.6
Current Psychiatric Medication	16.8	31.4
Moderate/ Severe Depression	34.1	51.0
Suicide Thoughts	33.6	39.2
Suicide Attempts	22.7	37.3

Source: 2009 NSW Inmate Health Survey[13]

The survey also identified that substance use was a significant problem for Aboriginal inmates. The vast majority of both men and women were current tobacco smokers and based on responses to the Alcohol Use Disorders Identification Test (AUDIT),[34] three-quarters of men and one-half of women were classified as having engaged in hazardous or harmful alcohol consumption before incarceration. The vast majority reported a history of illicit drug use and around one-in-two reported a history of injecting drug use (Table 10.2). Consistent with suggestions of a link between substance use and offending among Aboriginal and Torres Strait Islander peoples,[35] the majority also reported that they were intoxicated at the time of their offence .

Table 10.2: Substance Use Characteristics, by Gender

	Male %	Female %
Current Smoker	83.2	88.0
Hazardous Harmful Alcohol Use	74.2	51.0
Illicit Drug Use Ever	88.3	88.0
Injecting Drugs Ever	46.1	50.0
Intoxicated During Offence	73.0	67.3

Source: 2009 NSW Inmate Health Survey[13]

Two major diagnostic surveys of mental illness have been conducted with Aboriginal prison populations. The first was embedded within the 2001 NSW Inmate Health Survey[36] that included a sample of 277 Aboriginal prisoners (226 men, 51 women), the second was undertaken in Queensland. The NSW survey included a modified version of the Composite International Diagnostic Interview (CIDI) to diagnose mood, anxiety and substance use disorder and screen for the presence of possible psychotic disorder.[37] Among this sample, the prevalence of affective and anxiety disorder was extremely high, as was the estimate of psychotic disorder inferred by the psychosis screen and this was particularly evident among the female sample (Table 10.3).

Table 10.3: Mental Disorders (12-Month Prevalence), by Gender

	Male (n = 226) %	*Female (n = 51)* %
Affective Disorder	83.2	88.0
Anxiety Disorder	74.2	51.0
Psychosis Screen	73.0	67.3

Source: 2001 NSW Inmate Health Survey[36]

This study highlighted not only that mental disorder was extremely common among Aboriginal people in NSW prisons, but also that the prevalence of mental disorder was much higher than would be expected in a community sample of Aboriginal people. The research indicated that there was a significant demand for mental health services for Aboriginal people in custody, and also that women in custody were a particularly vulnerable group with respect to mental disorder.

The most recent and most comprehensive study of mental illness among Aboriginal people in custody was conducted in Queensland in 2008, with the findings reported in 2012.[14] This study, known as the *Inside Out* study, focused exclusively on the mental health of Aboriginal and Torres Strait Islander prisoners (331 men, 65 women). Depressive, anxiety and substance use disorders were assessed using the CIDI, while a novel and comprehensive method was developed to diagnose psychotic disorders. This involved psychiatrist assessments and the use of a diagnostic panel including a cultural advisor to ratify diagnosis. A particular strength of the study was the culturally competent method that included community consultation to inform the research design and implementation, Aboriginal leadership throughout the project, and data collection conducted by trained Aboriginal mental health practitioners.[38]

Consistent with the earlier NSW studies, the *Inside Out* study identified that mental disorder was extremely common among Aboriginal and Torres Strait Islander prisoners (Tables 10.4 and 10.5). Depressive disorders, which included major depression and the less severe but chronic dysthymic disorder, were common among both men and women. Major depression, the more severe form of depression, was the most common depressive disorder diagnosis in both groups.

Table 10.4: Twelve Month Prevalence of Mental Disorder, by Gender

	Male (n = 347) %	*Female (n = 72)* %
Depressive Disorder	11.4	29.2
Anxiety Disorder	20.2	50.7
Psychotic Disorder	8.1	25.0

Source: Inside Out[38]

Anxiety disorders were present in one-fifth of all men and in one-half of all women surveyed. For both groups, the main anxiety disorder was Post Traumatic Stress Disorder (PTSD).[26] This is a disorder characterised by exposure to a significantly traumatic event or events that result in mental health symptoms including re-experiencing the event (nightmares or flashbacks), hyper-arousal (difficulty sleeping, anger, poor concentration, hyper-vigilance) and avoidance phenomena. While the rates of PTSD were very high (12 per cent of men, 32 per cent of women), this finding was congruent with other studies of trauma experiences among Aboriginal and Torres Strait Islander inmates.[28-30] It is likely that these very high rates of trauma reflect the high prevalence of trauma experiences among Aboriginal and Torres Strait Islander peoples in the community.[5,31,32] Several chapters in this book address the issue of trauma, particularly Chapter 17 (Atkinson and colleagues). Other chapters outline healing programs to address the levels of trauma experienced.

A major strength of the *Inside Out* study was the ability to diagnose psychotic disorders in a way that was both rigorous and culturally competent. Using this approach, the prevalence of psychotic disorder among Aboriginal prisoners, when compared with prevalence estimates from the community, was found to be high for men and dramatically higher in women.[14] Psychotic disorders are brain disorders characterised by hallucinations, delusions, disorganised thoughts and behaviours and sometimes associated with changes in cognition, mood and motivation.[26] In the Australian community the 12 month prevalence of psychotic disorder is relatively low (0.47 per cent), however the impact of these disorders on an individual's social, occupational and general level of functioning is significant.[28] The *Inside Out* study found that psychotic disorder is much more common among Aboriginal and Torres Strait Islander peoples in prison than in the general community.[36, 39] Among Aboriginal and Torres Strait Islander people in custody, psychotic disorder is associated with significant morbidity,[40] higher rates of reoffending[41] and significant rates of hospital re-admission post-release.[42]

The *Inside Out* study into the mental health of Aboriginal people in custody also found that substance use disorders were extremely common (Table 10.5), with alcohol and cannabis being the most common substances misused. In the general Aboriginal community, substance dependence is relatively rare,[43, 44] however among Aboriginal prisoners substance dependence was normative.[14] Alcohol dependence was the most common dependence problem and is more common among Aboriginal and Torres Strait Islander prisoners than other prisoners.[45] There is a recognised association between offending, particularly violent offending, and alcohol dependence for Aboriginal and Torres Strait Islander peoples.[46] This underpins the critical importance of having culturally appropriate drug and alcohol services available to Aboriginal and Torres Strait Islander peoples in custody.[47]

Table 10.5: Twelve Month Prevalence of Substance Use Disorders, by Gender

	Male (n = 347) %	*Female (n = 72)* %
Alcohol	51.3	60.0
Amphetamine	10.8	6.1
Cannabis	21.1	26.1
Opioids	9.6	10.7
Sedatives	1.8	6.1
Others (a)	8.4	16.9
Any Substance	65.5	69.2

(a) Includes Hallucinogens, Volatile Solvents and Psychoactive Substances and other stimulants
Source: Inside Out[38]

Cognitive impairment among Aboriginal and Torres Strait Islander peoples in custody is associated with factors including brain injury from trauma and substance misuse.[48, 49] There are no reliable estimates of the prevalence of cognitive disability among Aboriginal and Torres Strait Islander peoples in the criminal justice system, partly due to significant uncertainty about the cultural appropriateness of assessment tools. Furthermore, stakeholders in the criminal justice system such as police, lawyers, correctional officers and other justice system personnel rarely have the skills and training necessary to recognise cognitive disability in an Aboriginal and Torres Strait Islander person.[50]

The evidence suggests that Aboriginal and Torres Strait Islander peoples in custody suffer from complex health problems, with a high prevalence of co-occurring disorders that may include chronic health conditions, mental health disorders, substance use disorders and intellectual disability.[10, 30, 33, 36] An understanding of these inter-related health issues, and their impact on the broader SEWB of Aboriginal and Torres Strait Islander peoples in custody, sheds light on some of the drivers of incarceration of Aboriginal and Torres Strait Islander men and women and some potential targets for intervention. However, these complex health problems must also be placed in the context of the social disadvantage that characterises the majority of Aboriginal and Torres Strait Islander peoples who come into contact with the criminal justice system and the challenges faced in returning to their communities.

MENTAL DISORDER AND COGNITIVE DISABILITY AND TRANSITION BACK TO THE COMMUNITY

There is limited Australian data available on the health outcomes of Aboriginal and Torres Strait Islander peoples with a mental disorder following release from custody, and even less is known about the outcomes for those with a cognitive disability. Most prisoners return to the community after a relatively short incarceration period and, due to the rapid turnover of those on remand or serving short sentences, the number cycling through prison each year is considerably greater than the number in prison on any one day; probably in excess of 55,000 per annum.[51]

Release from prison is associated with a range of poor health outcomes including homelessness, risky patterns of substance use, drug overdose and death.[39,44-46] Among the leading causes of death among recently released prisoners is suicide,[52,53] highlighting the pivotal role of mental health in shaping post-release outcomes for vulnerable ex-prisoners. Drug-related deaths are also common, particularly in the weeks immediately following release from custody.[54] For example, the rate of unnatural death among people released from Victorian prisons between 1990 and 1999 was found to be 10 times the rate of unnatural deaths in the general population,[55] with most deaths due to drug overdose and suicide.

Similarly, in a retrospective cohort study of over 85,000 people leaving NSW custody from 1988 to 2002, it was found that the risk of death due to mental and behavioural disorders was elevated by a factor of 13.2 for men and 62.8 for women.[53] Among the 9,353 Aboriginal and Torres Strait Islander ex-prisoners in the cohort, the risk of death from suicide was 2.9 times higher among men and 6.5 times higher among women, than among age and sex-matched members of the NSW community.[56] The mortality excess in the cohort was greater for Aboriginal and Torres Strait Islander peoples.

Similar findings emerged from a study by Hobbs (2006) of 13,667 ex-prisoners in WA, released from custody between 1995 and 2001 and followed for an average of 4.5 years.[57] The majority of the cohort was male (88.3 per cent) and 36.1 per cent identified as being Aboriginal. The rate of death was highest in Aboriginal men and higher among Aboriginal women than other women. The main causes of death were suicide (20 per cent of deaths) and drug related (29 per cent of deaths). Among Aboriginal men, the overall rate of death was 9.4 times higher than among age and sex-matched members of the community, while the rate of suicide death was 4.3 times higher; among Aboriginal women the rate of suicide death elevated by a factor of 15.

Given the unstable environments to which many ex-prisoners return, few studies have been able to examine mental health outcomes after release from prison. One study in WA linked correctional records with hospital records for prisoners released between 2000 and 2002 (N=7,414) and found that one-in-five (20.4 per cent) were admitted to hospital at least once in the first year after their release. Hospitalisation was 60 per cent more common among females and 20 per cent more common among Aboriginal people. Mental and behavioural disorders accounted for 37 per cent of the 12,074 bed days and this was mostly accounted for by schizophrenia and depression.[42]

RESPONDING TO THE MENTAL HEALTH NEEDS OF ABORIGINAL PEOPLES IN CUSTODY

The mental health of Aboriginal and Torres Strait Islander peoples in contact with the criminal justice system is a public health priority and a key social justice concern. Finding appropriate ways to assess and treat poor mental health and provide the necessary custodial and community services for those with mental disorders and cognitive disabilities will not only assist in closing the health gap, but may also reduce Aboriginal and Torres Strait Islander incarceration, ultimately improving SEWB for individuals, families, carers and communities.

One of the key challenges to achieving these public health and social justice outcomes is to ensure access to adequate and culturally appropriate health and disability services pre-custody, in custody, at the time of release and post-release.[58, 59] Aboriginal prisoners report difficulty accessing mental health services and alcohol and other drug services appropriate to their needs, and this is compounded by isolation from SEWB supports that are inherently part of community and cultural activities and Elder support.[10, 38, 47, 60-62] In order for these issues to be addressed decisively, health and social services in custody and in the community must be informed by the growing evidence base regarding the delivery of culturally capable health services, and the benefits of culturally appropriate programs for Aboriginal and Torres Strait Islander peoples in contact with the criminal justice system, as outlined in Chapter 30 (Hovane and colleagues).

Similarly, given the emerging evidence that cognitive disability among Aboriginal and Torres Strait Islander peoples in contact with the criminal justice system is a significant challenge, it is critical that reliable and valid methods for identifying cognitive disability among Aboriginal people in contact with the criminal justice system be developed. There is also a clear need to ensure the availability of specialised disability services that are culturally capable, both in the criminal justice system and in the community, to enable a smooth transition between service systems. These services should be responsive to challenges that can be faced by communities, carers and extended family networks when individuals with cognitive disabilities return to the community. A mechanism that enables diversion from the criminal justice system for individuals with cognitive disability, to appropriate health and community services, could help address the recruitment of adversity that may otherwise follow.[63]

Despite the recommendations of the RCIADIC, Aboriginal and Torres Strait Islander peoples continue to be overrepresented at all levels of the criminal justice system and there continues to be a struggle for mainstream services to provide culturally competent health care and ongoing support. This in part has necessitated that the National Aboriginal Community Controlled Health Organisation (NACCHO) absorb responsibility for the provision of health and disability support services to Aboriginal and Torres Strait Islander peoples coming into contact with the criminal justice system. Accessing these services is often the only opportunity for Aboriginal and Torres Strait Islander community members to receive appropriate and culturally-informed services that are responsive to their individual cultural needs and differences. See Chapter 12 (Walker and colleagues) regarding the principles and strategies for ensuring organisational and individual cultural competence.

The networks of Aboriginal community-based services for those coming into contact with the criminal justice system includes diversion programs, in-reach programs to custodial settings, and programs to assist individuals to transition back to life in the community.[55-57] These activities are provided in acknowledgement of the need for services that are meaningful for Aboriginal and Torres Strait Islander peoples and are strengths-based, building upon cultural knowledge and practices. However, in the busy custodial environment where resources are scarce, culturally-informed services are often required to compete with mainstream service models that are universal and directed at the needs of an individual, but not necessarily in a social or cultural context.[64]

The challenge is, therefore, for mental health and disability services to deliver care for Aboriginal and Torres Strait Islander peoples involved in the justice system in a manner that is culturally respectful and competent. Appropriate mental health and disability services would actively seek Aboriginal and Torres Strait Islander mental health practitioners to provide mental health and SEWB services to a large and culturally diverse population. They would need to be culturally aware and responsive to local individual, family, carer and community practices. Such services would also include meaningful transitional support systems that would commence at the system entry point and continue on post-release, to improve the prospects for successful integration into the community.[65] In parallel, training for police, justice, custodial and correctional health staff, with a goal of increasing their cultural competence—that is, their understanding of Aboriginal and Torres Strait Islander history, cultural distinctiveness and diversity—would empower professionals and paraprofessionals within the criminal justice system to contribute to the improvement of health and social outcomes for Aboriginal and Torres Strait Islander peoples.

There is some evidence that some existing initiatives have been of benefit to prisoners and their communities. These initiatives range from locally-based, community-driven initiatives to more structured programs, such as described in Chapter 30 (Hovane and colleagues) and in a range of healing programs in Part 6. There are existing formal partnerships between justice departments and Elder groups in most states and territories, which could be utilised as a mechanism for building formal partnerships that can positively impact at the service delivery level. Numerous informal, cross-sectoral collaborations exist, which are generally inspired by a common motivation to strengthen cultural identity and practices within Aboriginal and Torres Strait Islander families and communities. There is also the recognition that, within prison, isolation from their family, community, land and cultural activities can further contribute to adverse life experiences.[38, 62, 66]

Health practitioners, particularly mental health practitioners, working in custodial environments need to have a good understanding of the linkages between social inequalities, poor health and incarceration for Aboriginal and Torres Strait Islander peoples. They must have the ability to recognise the historical, cultural and sociopolitical context of SEWB, including the impact of colonisation; trauma, loss, separation of families and children, and dispossession of lands.[9, 67] If practitioners operate from an understanding of Aboriginal and Torres Strait Islander views of health, mental health and disability, and are aware of the interconnections between spiritual, social, emotional, cultural and physical domains,[9] the delivery of services would be more holistic by design and outcomes for Aboriginal and Torres Strait Islander peoples in contact with the criminal justice system would be more optimistic, positive and meaningful.

REFLECTIVE EXERCISES

1. What impact might the high rate of incarceration of Aboriginal and Torres Strait Islander peoples have on their communities?

2. How might having a mental illness increase the risk of having contact with the criminal justice system, and under what circumstances?

3. What barriers may exist for Aboriginal and Torres Strait Islander peoples accessing appropriate mental health services in custody and post-release?

4. Why might the rates of mortality and morbidity associated with mental health problems be so high for Aboriginal and Torres Strait Islander peoples when they leave custody?

5. What steps should be taken to prevent the cycle of adversity faced by many Aboriginal and Torres Strait Islander men and women with mental health and other disabilities when they come into contact with the criminal justice system?

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Part 3

Standards, Principles and Practice

Better health outcomes can be achieved by best work practice, which includes consideration of and working to the National Practice Standards and ensuring, where possible, support is offered within an interdisciplinary team in a culturally competent and culturally secure environment.
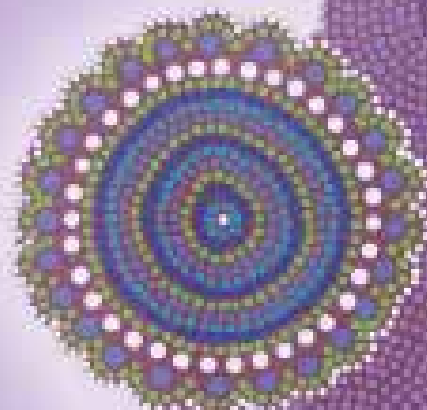
Chapters

11 National practice standards for professional practitioners working in Aboriginal and Torres Strait Islander mental health are described with an emphasis on principles, standards and practice that contribute to the capacity and empowerment of practitioners and Aboriginal and Torres Strait Islander clients, families and communities. Also discussed are national service standards and how their effective implementation and integration can ensure the provision of culturally competent mental health services.

12 Complex issues and contestations surrounding cultural competence and the critical need for practitioners to develop knowledge, skills, understandings and attributes to be able to work in diverse cultural settings and what is involved in being a professional practitioner is explored. Principles, standards and practice frameworks that contribute to the capacity and empowerment of mental health practitioners are outlined.

13 A focus on interdisciplinary care as a model of practice supporting equality and interconnectedness of responsibility amongst team members is examined. The professionals and practitioners that comprise interdisciplinary teams working in mental health and their roles are outlined. The context of how interdisciplinary care fits into social and emotional wellbeing values and mental health best practice and human rights is explored.

14 The experiences of caregiving for Aboriginal families living with a serious mental illness is expained. The disconnection with mental health providers and their lack of knowledge of Aboriginal concepts of caregiving are highlighted. There is limited knowledge of the complexity of caregiving across the mental health sector. Aboriginal caregiving is explored through multiple lenses. The stories of Aboriginal caregivers help to explain their experiences for those living with a serious mental illness.

15 Communicating and engaging effectively across diverse contexts and attending to concepts of community and culture, kinship affiliations, community obligations and values of people are addressed. Protocols for communicating and engaging with Torres Strait Islander people are highlighted. Various strategies which highlight the need for recognition and respect of cultural difference are explained.

11

Introduction to National Standards for the Mental Health Workforce

Roz Walker

OVERVIEW

This chapter describes what is required as a professional practitioner working in Aboriginal and Torres Strait Islander mental health, with regard to the principles, standards and practice frameworks that contribute to the capacity and empowerment of practitioners and Aboriginal and Torres Strait Islander clients, families and communities. *The National Practice Standards for the Mental Health Workforce 2013* (the *practice standards*)[1] are intended for the five professions that contribute significantly to the mental health workforce: mental health nursing, occupational therapy, psychiatry, psychology and social work. These standards are equally relevant for a range of other practitioners including Aboriginal health workers and mental health workers and social and emotional wellbeing workers. This chapter briefly describes how each of the chapters in **Part 3: Standards, Principles and Practice** embody the key practice standards that are of particular relevance to mental health and other practitioners working in Aboriginal and Torres Strait Islander mental health. In addition the chapter also discusses the *National Standards for Mental Health Services 2010* (*service standards*)[2] and how the effective implementation and integration of the national standards for services and practitioners can ensure the provision of culturally competent mental health services.

INTRODUCTION

The development of mental health practice and services standards is based on the belief that all people with mental health problems and their carers, families and communities have the right to expect culturally appropriate and clinically relevant professional expertise when they engage with the mental health services sector to achieve good mental health and wellbeing outcomes. The *practice standards* are applicable across the lifespan from infancy to old age and apply irrespective of cultural and linguistic background and geographic location. These *practice standards* uphold the rights of all sub-population groups in Australia to receive quality care.

The *practice standards* form the basis of the key competencies expected of graduates and practitioners to contribute to culturally responsive, client and recovery focused mental health services. The national standards recognise and support the strengths and expert knowledge of each of the different professions, as well as provide ideals to address any potential limitations. The contribution and collaboration of each of the five mental health workforce groups: mental health nursing, occupational therapy, psychiatry, psychology and social work are essential to quality mental health care. Several other professions who work with mental health clients, their families and/or carers also play an important role in supporting their social and emotional wellbeing (SEWB) and mental health recovery including: general practitioners, primary health care workers, Aboriginal and Torres Strait Islander health and mental health workers, rehabilitation counsellors and other therapists.

REVISED NATIONAL PRACTICE STANDARDS IN MENTAL HEALTH

In 2012 a review of the *National Practice Standards for the Mental Health Workforce 2002*[3] was carried out by the Mental Health Workforce Advisory Committee and Health Workforce Australia. Of relevance and importance here is the addition of a new standard around Aboriginal and Torres Strait Islander mental health and greater focus on diversity.

The 13 revised practice standards, which replace the 12 practice standards in *National Practice Standards for the Mental Health Workforce 2002*[3], bring some important and very relevant changes for Aboriginal mental health and SEWB. The revised *practice standards* place greater emphasis on a recovery approach, include a specific standard for Aboriginal and Torres Strait Islander peoples and greater value for all groups including carers and families and acknowledge and integrate the role of professional groups and mental health services.

Increasingly, the Australian government has acknowledged the importance of mental health services within the health system. The interaction between the practitioner and the client is pivotal to effective mental health service delivery—empathy, understanding and expert knowledge are critical to successful outcomes. These practice standards are designed to support practitioners to develop their skills, knowledge and attitudes as part of their individual development and to contribute to the continuous quality improvement of mental health services in order to improve health and SEWB outcomes for individuals, families and communities.

Overview of the Revised *Practice Standards*

Standard 1: **Rights, responsibilities, safety and privacy**	Privacy, dignity and confidentiality are maintained, and safety is actively promoted. Mental health practitioners implement legislation, regulations, standards, codes and policies relevant to their role in a way that supports people affected by mental health problems and/or mental illness, as well as their families and carers.
Standard 2: **Working with people, families and carers in recovery-focused ways**	In working with people and their families and support networks, mental health practitioners support people to become decision-makers in their own care, implementing the principles of recovery-oriented mental health practice.
Standard 3: **Meeting diverse needs**	The social, cultural, linguistic,spiritual and gender diversity of people, families and carers are actively and respectfully responded to by mental health practitioners, incorporating those differences into their practice.
Standard 4: **Working with Aboriginal and Torres Strait Islander peoples, families and communities**	By working with Aboriginal and Torres Strait Islander peoples, families and communities, mental health practitioners actively and respectfully reduce barriers to access, provide culturally secure systems of care, and improve social and emotional wellbeing.
Standard 5: **Access**	Mental health practitioners facilitate timely access to services and provide a high standard of evidence-based assessment that meets the needs of people and their families or carers.

Standard 6: **Individual planning**	To meet the needs, goals and aspirations of people and their families and carers, mental health practitioners facilitate access to and plan quality, evidence-based, values-based health and social care interventions.
Standard 7: **Treatment and support**	To meet the needs, goals and aspirations of people and their families and carers, mental health practitioners deliver quality, evidence-informed health and social interventions.
Standard 8: **Transitions in care**	On exit from a service or transfer of care, people are actively supported by mental health practitioners through a timely, relevant and structured handover, in order to maximise optimal outcomes and promote wellness.
Standard 9: **Integration and partnership**	People and their families and carers are recognised by mental health practitioners as being part of a wider community, and mental health services are viewed as one element in a wider service network. Practitioners support the provision of coordinated and integrated care across programs, sites and services.
Standard 10: **Quality improvement**	In collaboration with people with lived experience, families and team members, mental health practitioners take active steps to improve services and mental health practices using quality improvement frameworks.
Standard 11: **Communication and information management**	A connection and rapport with people with lived experience and colleagues is established by mental health practitioners to build and support effective therapeutic and professional relationships. Practitioners maintain a high standard of documentation and use information systems and evaluation to ensure data collection meets clinical, service delivery, monitoring and evaluation needs.
Standard 12: **Health promotion and prevention**	Mental health promotion is an integral part of all mental health work. Mental health practitioners use mental health promotion and primary prevention principles, and seek to build resilience in communities, groups and individuals, and prevent or reduce the impact of mental illness.
Standard 13: **Ethical practice and professional development responsibilities**	The provision of treatment and care is accountable to people, families and carers, within the boundaries prescribed by national, professional, legal and local codes of conduct and practice. Mental health practitioners recognise the rights of people, carers and families, acknowledging power differentials and minimising them whenever possible. Practitioners take responsibility for maintaining and extending their professional knowledge and skills, including contributing to the learning of others.[1(p19-20)]

Each of these practice standards detail a range of criteria that must be addressed in order for a practitioner to competently meet the requirements of the *National Mental Health Workforce Practice Standards 2013*.[1] Each of the chapters in Part 3 and many other chapters in this book discuss how these *practice standards* can be used to:

- promote clinical best practice

- identify appropriate skill levels

- guide workplace training and education needs

- guide clinical supervision, mentoring and continuing education

- influence the development of curricula for each of these professions.

The revised *practice standards* are expected to inform the curriculum guidelines and training in each of these professions to develop a quality Aboriginal mental health workforce in primary, secondary and tertiary health care sectors across local, state and commonwealth governments. Education providers will also find the *practice standards* useful in developing curricula to support practitioners working in Aboriginal mental health—for example, the Djirruwang Program, discussed in Chapter 31 (Brideson and colleagues), is developed in accordance with the *practice standards*.

Alignment with complementary standards

The *practice standards* address core elements of common mental health practice across the five disciplines. They are intended to complement the valuable discipline-specific contributions of each profession, and to address the shared knowledge, skills, values and attitudes required when working in an interdisciplinary mental health service.

The *practice standards* should be used in conjunction with the *service standards* and the discipline-specific standards, competencies or curricula that apply to the individual practitioner's profession. A list of specific guidelines for each of the five mental health professions can be downloaded from the website addresses listed in the Resources section at the end of this chapter.

PRACTICE STANDARD 4 – ABORIGINAL AND TORRES STRAIT ISLANDER MENTAL HEALTH

In 2012 a review of the *National Practice Standards for the Mental Health Workforce 2002*[3] was carried out by the Mental Health Workforce Advisory Committee and Health Workforce Australia. Of relevance and importance here is the addition of a new standard that focuses on Aboriginal and Torres Strait Islander mental health—**Standard 4: Working with Aboriginal and Torres Strait Islander peoples, families and communities.** It requires that mental health practitioners actively and respectfully reduce barriers to access, provide culturally secure systems of care, and improve the social and emotional wellbeing and mental health of Aboriginal individuals, families and communities.

Practice Standard 4 – Criteria and Objectives

Standard 4: Working with Aboriginal and Torres Strait Islander peoples, families and communities

By working with Aboriginal and Torres Strait Islander peoples, families and communities, mental health practitioners actively and respectfully reduce barriers to access, provide culturally secure systems of care, and improve social and emotional wellbeing. The mental health practitioner:

1. Develops an understanding of Aboriginal and Torres Strait Islander history, and particularly the impact of colonisation on present day grief, loss and trauma and its complexity.

2. Communicates in a culturally sensitive and respectful way, being aware of potential mistrust of government and other service providers as a result of past history.

3. Uses culturally sensitive language and preferred terminology in line with current policy directives.

4. Implements culturally specific practices as described in relevant national, state and local guidelines, policies and frameworks that pertain to working with Aboriginal and Torres Strait Islander peoples.

5. Respectfully collects and records information identifying Aboriginal and Torres Strait Islander status in line with current policy directives.

6. Works in collaboration with Aboriginal and Torres Strait Islander cultural advisors where appropriate regarding appropriate care and engages meaningfully to develop culturally appropriate care in collaboration with these support networks.

7. Seeks to understand and work within local cultural protocols and kinship structures of Aboriginal and Torres Strait Islander communities.

8. Respectfully follows Indigenous protocols in community contexts, such as the process of vouching in which one or some of the community members attest to the person wishing to enter the community.[1(p24)]

In an important sense, in addition to adhering to Standard 3: Meeting Diverse Needs and Standard 4: Working with Aboriginal and Torres Strait Islander peoples, all of the standards need to be enacted with regard to the nine Guiding Principles outlined in the Introduction of the book which underpins mental health practice, in Aboriginal contexts (page xxiv).

LINKING PRACTICE STANDARDS AND CHAPTERS

While all of the chapters in this book are relevant to, and support, the criteria described within each of the 13 *practice standards*, Table 11.1 identifies the *practice standards* which are specifically addressed within the four chapters in Part 3.

Table 11.1: Relationship between Chapters and *Practice Standards*

Standard	Part 3 Chapter	Title
Standard 3 and 4	Chapter 12	*Cultural Competence—Transforming Aboriginal Mental Health Practice and Policy*
Standard 9	Chapter 13	*Interdisciplinary Care to Enhance Mental Health and Social and Emotional Wellbeing*
Standard 3	Chapter 14	*Reframing Aboriginal Family Caregiving*
Standard 11	Chapter 15	*Communicating and Engaging Effectively with Diverse Groups*

The *practice standards* identify a need for awareness of diversity by individual professionals to provide care in a sensitive and appropriate manner to ensure that social, cultural, linguistic, spiritual and gender issues are respected. In particular, the care provided to Aboriginal and Torres Strait Islander peoples must seek to incorporate a holistic approach that encompasses spiritual, social and emotional wellbeing and issues related to land and way of life. Likewise, the importance of family and community identity networks to the mental wellbeing of people from cultural and linguistic backgrounds needs to be acknowledged. It is the responsibility of services to provide mental health professionals with opportunities for appropriate education and cultural awareness.

Part 3 covers a range of workforce and professional practice issues. Chapter 12 (Walker, Schultz and Sonn) considers some of the complex issues and contestations surrounding cultural competence—and the critical need for practitioners to develop knowledge, skills, understanding and attributes to be able to work in diverse cultural settings. Chapter 12 briefly discusses the rights, responsibilities, safety and privacy. Chapter 13 (Schultz, Walker and colleagues) considers the issues involved for practitioners working as part of multidisciplinary/interdisciplinary and social health teams—their ethical practice and professional responsibilities. Chapter 14 (Wright) discusses the personal experiences of caregivers and those people with a mental health illness receiving care (the consumer/client). Their stories reinforce the critical need for policymakers, service providers and practitioners to involve both caregivers and those receiving care in their practice. The final chapter in this part, Chapter 15 (Dudgeon and Ugle), describes the communication skills across diverse contexts.

MENTAL HEALTH PRACTITIONER CORE COMPETENCIES

There are a range of core competencies, knowledge, skills, understanding and attributes regarded as essential for all mental health practitioners, including Aboriginal and Torres Strait Islander health workers, to be competent health professionals in accordance with these *practice standards*. The book in its entirety addresses the core competencies, knowledge, skills, understanding and attributes identified as essential for mental health practitioners to work in diverse cultural contexts.

Knowledge

Competence is gained through education and training supervision and experience and demonstrated through the acquisition or existence of specified knowledge, understanding, skills, values and attitudes.

Mental health practitioners are required to demonstrate knowledge in:

- the assessment of people who may have mental illness; the treatment and management of people with a mental illness;

- issues to do with medication;

- the management of aggression, particularly in community settings;

- particular population groups vulnerable to self-harming behaviours;

- issues of cultural difference and ways to access assistance when dealing with people from a cultural or linguistically diverse background;

- referrals to and from other agencies which require a comprehensive knowledge of community resources.

Mental health practitioners are also required to have comprehensive knowledge of the *Mental Health Act* and *Mental Health Regulations*, including their intent, the use of forms, the referral process, the use of police and community treatment orders, and the ability to give advice under Section 63 of the Act. The Act focuses on the generic competencies that recognise that, although people bring specific knowledge and understandings to their disciplines, they need cross-cultural skills and understandings for working in Aboriginal and Torres Strait Islander peoples' contexts.

Understanding

Mental health practitioners are required to demonstrate an understanding of:

- international, national, state or territory legislation relating to the human rights of people with mental health problems and mental disorders and the improvement of mental health care;

- legislation applicable to mental health services, including the State or Territory *Mental Health Act* and legislation on child protection, privacy, confidentiality, guardianship, freedom of information and anti-discrimination;

- mechanisms for involuntary treatment and care according to State or Territory mental health legislation;

- appropriate use of evidence-based interventions and treatments;

- legislation related to the application of informed consent for treatment and the consumer's right to refuse treatment;

- guidelines for dealing with anger, self-harm, violence and aggression developed at national, state, territory or local level (*practice standards)[1]*;

- reporting requirements and record keeping of State or Territory legislation including child abuse, Elder abuse, domestic violence, critical incidents and complaint procedures and duty to protect;

- information to be provided to consumers, family members and/or carers regarding their rights to receive evidence-based treatment;

- particular historical and contemporary concerns regarding rights, safety, privacy and confidentiality that apply to Aboriginal and Torres Strait Islander communities;

- the Convention on the Rights of the Child (1989) and principles and guidelines for management of children of parents with mental health problems and mental disorders.

Skills

Mental health practitioners are required to demonstrate an ability to:

- apply the principles of international and national standards on human rights and responsibilities;

- comply with state or territory legislation related to treatment of mental health problems and mental disorders, safety, privacy, child protection and confidentiality;

- organise the provision of involuntary treatment and care only when indicated and in compliance with state/territory legislation and in the least restrictive environment;

- inform consumers of issues regarding experimental or controversial treatment or treatment with an under-developed evidence base;

- inform consumers of their right to informed consent for treatment and of their right to refuse treatment;

- conduct adequate risk assessments and manage aggression, self-harming and difficult behaviours using negotiation and other appropriate interventions;

- support managers in establishing and maintaining an environment to protect consumers from financial, sexual, psychological and physical abuse and exploitation while receiving mental health care, and report incidences of abuse or violence to appropriate authorities;

- provide information on the rights of consumers, family members and/or carers and on legislation, which may impact on their rights, and facilitating their understanding of them;

- where appropriate, involve and utilise the skills of local Aboriginal and Torres Strait Islander communities and/or Aboriginal and Torres Strait Islander health and/or mental health workers in developing health service policy;

- communicate effectively with consumers, family members and/or carers to support them through the mental health system;

- assess the care and mental health needs of the consumer's family and, when children are involved, ensure appropriate plans have been put in place for their care.

Attitudes

Mental health practitioners are required to exhibit behaviours that demonstrate preparedness to:

- acknowledge and encourage consumers, family members and/or carers as team members;

- encourage the cycle of empowerment, hope, independence and recovery;

- acknowledge consumer's, family member's, and/or carer's understanding of their mental health problems, mental disorders and life issues and how they cope with and manage symptoms;

- recognise the value of the healing potential in relationships between consumers, family members and/or carers and service providers;

- acknowledge the role of health consumer/carer advocates and consultants;

- acknowledge and encourage the abilities, strengths and contributions of consumers, family members and/or carers;

- accept the impact of social, cultural, linguistic, spiritual and/or gender issues on presentation and management of mental health problems and mental disorders;

- promote the involvement of people from diverse cultural and linguistic communities;

- acknowledge that children of parents with a mental health problem and/or mental disorder have specific needs, which vary depending upon their age and circumstances.

Mental health practitioners are required to monitor their performance in regard to the above attributes and reflect on how their own practice is informed by knowledge.

Mental health practitioners recognise limitations in their knowledge and expertise and seek expert advice and supervision, as appropriate.

LINKING PRACTICE AND SERVICE STANDARDS

The new mental health standards for the workforce and services provide an important platform and guiding direction for Aboriginal and Torres Strait Islander mental health reform. Table 11.2 shows the relationship between these two sets of standards.

Table 11.2: Relationship between the National Standards for the Workforce and Services

National Practice Standards for the Mental Health Workforce 2013	National Standards for Mental Health Services 2010
Standard 1: Rights, responsibilities, safety and privacy	1. Rights and responsibilities
	2. Safety
Standard 2: Working with people, families and carers in recovery-focused ways	3. Consumer and carer participation
	6. Consumers
	7. Carers
Standard 3: Meeting diverse needs	4. Diversity responsiveness
Standard 4: Working with Aboriginal and Torres Strait Islander peoples, families and communities	
Standard 5: Access	10. Delivery of care (supporting recovery, access, entry, assessment and review, treatment and support, exit and re-entry
Standard 6: Individual planning	
Standard 7: Treatment and support	
Standard 8: Transitions in care	
Standard 9: Integration and partnership	9. Integration
Standard 10: Quality improvement	8. Governance, leadership and management
Standard 11: Communication and information management	
Standard 12: Health promotion and prevention	5. Promotion and prevention
Standard 13: Ethical practice and professional development responsibilities	

Source: National Practice Standards for the Mental Health Workforce 2013[1]

There are several key focus areas in the revised *practice standards* that are fundamental to professional development, training and postgraduate courses for practitioners in mental health services. Of key importance is the premise that any health professional entering the mental health workforce, or completing undergraduate or postgraduate mental health courses, should have the opportunity to be educated by individual mental health clients, their family members and carers (with particular regard for their cultural background and social circumstance) about their:

- 'lived' experiences of mental illness;
- requirements for adequate services and support;
- ability to work in partnership with mental health professionals.

The *Working Together* book supports all practitioners, policymakers and service providers to gain culturally relevant competencies, knowledge, skills and understandings, as well as culturally appropriate tools, strategies and models to address the pervasive, transgenerational trauma, grief and loss experienced by Aboriginal people, their families and communities.

NATIONAL STANDARDS FOR MENTAL HEALTH SERVICES

The *National Standards for Mental Health Services 2010* (*service standards*)[2] and the *National Practice Standards for the Mental Health Workforce 2013* (the *practice standards*)[1] form the basis of the key competencies expected of graduates to contribute to the provision of quality mental health services. These standards are also adopted and applied by other mental health workforce groups including the Aboriginal mental health workforce. Other professions involved in providing services for people with a mental illness—general practitioners, home and community care service providers, hospital staff providing acute care, and family and other carers—may also find these national practice standards useful.

The *service standards* tend to differ in the application across states and territories, and within a jurisdiction depending on the stage of development and their relevance to different service types. A series of implementation guidelines that, with respect to providing culturally responsive services and the expectations for different professions, sectors and service settings in different states, have been developed which link with the *practice standards*.

Mental health services (MHS) are expected to apply these *service standards* with regard to their stage of development and model of service delivery. It is expected that services will include consumers and carers in their planning, especially with respect to establishing Reconciliation Action Plans and ensuring a culturally responsive service.

Continuous Quality Improvement

Demonstration of the delivery of services against these *service standards* ensures that consumers/clients, carers and the community will receive culturally appropriate and respectful care from mental health services in accordance with their human rights.

Increasingly, implementation guidelines and standards focus on the experience of clients and carers (rather than the mental health service) to measure the effectiveness of service delivery. This is where the implementation of organisational cultural competence assessment embedded into the continuous quality improvement is crucial to ensure the cultural security of Aboriginal and Torres Strait Islander clients and their families. Measurement of attainment of agreed criteria against the standards forms a means of accountability to consumers, carers, community, staff and funders.

However, this in turn requires culturally competent staff and adequate resources to ensure ongoing professional development, training and support to provide services that meet these consumer and carer standards. Implementation of the standards requires the involvement of staff, consumers and carers to ensure shared understanding and awareness of the standards to be adopted and met by a particular service.

The *service standards* recognise that mental health services provide services to individual consumers, carers and, where appropriate, families and communities. The assessment of the *service standards* will be undertaken in the context of a specific community as defined by the particular service and the national, state and territory mental health policies and legislation that apply to such services and communities.

Regardless of the type of mental health service, the community or clients it serves, there are a number of principles that apply to the delivery of mental health services, irrespective of the context in which they are delivered.[2]

Importantly, the *service standards* need to be incorporated into the delivery of Aboriginal health services; alcohol, tobacco and other drug (ATOD) services; and aged care services, where they are responsible for the delivery of mental health care within the service. The *service standards* apply to ATOD services that are part of a mental health service. For stand-alone ATOD services, mental health services should be able to demonstrate that they are developing or have collaborative/partnership arrangements in place to ensure integration and coordination of care for consumers.[2]

Key Principles

The key principles are consistent with national policy and requirements for the delivery of mental health services in Australia and are embedded in the *service standards*. Key principles that have informed the development of the *service standards* include:

- Mental health services should promote an optimal quality of life for people with mental health problems and/or mental illness.

- Services are delivered with the aim of facilitating sustained recovery.

- Consumers should be involved in all decisions regarding their treatment and care and, as far as possible, the opportunity to choose their treatment and setting.

- Consumers have the right to have their nominated carer(s) involved in all aspects of their care.

- The role played by carers, as well as their capacity, needs and requirements as separate from those of consumers is recognised.

- Participation by consumers and carers is integral to the development, planning, delivery and evaluation of mental health services.

- Mental health treatment, care and support should be tailored to meet the specific needs of the individual consumer.

- Mental health treatment and support should impose the least personal restriction on the rights and choices of consumers taking account of their living situation, level of support within the community and the needs of their carer(s).

These *standards* detail the delivery of care in accordance with each of the nine domains from the K*ey Performance Indicators for Australian Public Mental Health Services (2005)*.[4] Importantly, the Act recognises of the need for culturally competent services.

CULTURALLY COMPETENT SERVICES

Embedded in the *National Practice Standards for Mental Health Services 2010 (service standards)*[2] is the need for services to be culturally responsive and respectful and to ensure that the service supports the cultural security of clients and carers/families. In particular, **Standard 4: Diversity responsiveness** lists a range of criteria to achieve these aims.

Service Standard 4 – Criteria

Standard 4: Diversity Responsiveness

The MHS delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care:

4.1 The MHS identifies Aboriginal and Torres Strait Islander religious/spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socioeconomic status that access the service.

4.2 The MHS whenever possible utilises available and reliable data on identified diverse groups to document and regularly review the needs of its community and communicates this information to staff.

4.3 Planning and service implementation ensures differences and values of its community are recognised and incorporated as required.

4.4 The MHS has demonstrated knowledge of, and engagement with, other service providers or organisations with diversity expertise/programs relevant to the unique needs of its community.

4.5 Staff are trained to access information and resources to provide services that are appropriate to the diverse needs of its consumers.

4.6 The MHS addresses issues associated with prejudice, bias and discrimination in regards to its own staff to ensure nondiscriminatory practices and equitable access to services.

Standard 6: Consumers; Standard 10: Delivery of Care

These *service standards* reinforce the need for service delivery models and staff within those services to ensure Aboriginal and Torres Strait Islander individuals, families and communities are treated with respect. Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery.

Importantly, standards require that the MHS:

- incorporates recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery;

- supports and promotes opportunities to enhance consumers' positive social connections with family, children, friends and their valued community (10.1.7);

- demonstrates systems and processes for consumer and carer participation in the development, delivery and evaluation of the services (10.1.8).

CONCLUSION

These *practice standards* are an important blueprint to be taken into account by key policymakers in each of the states and territories, and universities and Vocational Education and Training sectors that offer undergraduate and postgraduate services in mental health.

It is expected that the integration of standards into the curriculum process will help to achieve the outcomes of the *Emotional and Social Wellbeing Action Plan* and the Social Wellbeing Key Result Area in the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*.[6]

RESOURCES

Recommendations from each of the representative groups for clients/consumers, carers and their families have been integrated within each of the three implementation guideline documents. These guideline documents can be downloaded from the Mental Health Standing Committee website at: http://www.health.gov.au/mhsc

The discipline-specific guidelines that may apply include, but are not limited to, the following:

For Psychologists

From the Australian Psychological Society:

- Code of Ethics.
  Available from: http://www.psychology.org.au/Assets/Files/NewCode160807WEB.pdf.
- Ethical and practice guidelines and procedures.
  Available from: http://www.psychology.org.au/about/ethics/ (members only)

For Social Workers

From the Australian Association of Social Workers:

- Australian Social Work Education and Accreditation Standards (2012)
  Available from: http://www.aasw.asn.au/document/item/100
- Code of Ethics (2010)
- AASW Practice Standards for Mental Health Social Workers (2008)
  Available from: http://www.aasw.asn.au/document/item/17

For Occupational Therapists

From the Australian Association of Occupational Therapists:

- Code of Ethics (revised 2001).
  Available from: http://otaus.com.au/sitebuilder/about/knowledge/asset/files/1/codeofethics.pdf
- Australian Minimum Competency Standards for New Graduate Occupational Therapists 2010.

From the Occupational Therapy Board of Australia:

- Code of conduct for registered health practitioners (2012).
  Available from: http://www.occupationaltherapyboard.gov.au/Codes-Guidelines.aspx

Psychiatrists

From the Royal Australian and New Zealand College of Psychiatrists:

- position statements
- clinical practice guidelines
- ethical guidelines
- Code of conduct
- Code of ethics

Available from: http://www.ranzcp.org/Resources/StatementsGuidelines/Practice-Guidelines.aspx

For Nurses

From the Australian College of Mental Health Nurses:

- Standards of Practice for Australian Mental Health Nurses: 2010.
  Available from: http://www.acmhn.org/images/stories/About-Us/standards_2010_web.pdf

From the Nursing and Midwifery Board of Australia:

- Code of Ethics for Nurses in Australia (2008)

- Code of Professional Conduct for Nurses in Australia (2008)

- National Nursing Competency Standards for the Registered and Enrolled Nurses

Available from: http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/
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12

Cultural Competence – Transforming Policy, Services, Programs and Practice

Roz Walker, Clinton Schultz and Christopher Sonn

OVERVIEW

This chapter discusses some of the complex issues surrounding the notion of cultural competence—and the critical need for practitioners to develop knowledge, skills, understandings and attributes to be responsive in diverse cultural settings. The argument for culturally competent mental health practitioners and services is situated within a human rights framework which underpins the principles, standards and practice frameworks intended to facilitate/contribute to the capacity and empowerment of mental health practitioners and clients, families and communities. The *National Practice Standards for the Mental Health Workforce 2013 (the practice standards)*[1] outline core competencies (including cultural competence) regarded as essential for the mental health workforce: mental health nursing, occupational therapy, psychiatry, psychology and social work. The documented impact of these disciplines/professions on Aboriginal people requires new ways of working that are empowering, respectful and ethical. A case is made for the importance of practitioners providing more culturally inclusive and appropriate care to increase the likelihood that clients and their carers will experience a sense of cultural safety (as well as culturally appropriate services) for Aboriginal clients, their families and communities. The *practice standards* are complemented by professional guidelines and the *National Standards for Mental Health Services 2010 (the service standards)*.[2] This chapter provides a range of tools and strategies and a Critical Reflection Framework for Analysis to assist students or practitioners to adopt a critical standpoint in order to develop key competencies (knowledge, skills, attitudes and values) to be culturally respectful and effective in their practice in Aboriginal and Torres Strait Islander mental health. Equally important is the need for strategies for self-care and support such as mentoring, journaling, peer support, counselling and engaging in self-reflective, transformative practice.

INTRODUCTION

There are consistent and complementary themes identified in the literature for working effectively as mental health practitioners with Aboriginal and Torres Strait Islander peoples, such as adopting a community development/empowerment approach and using culturally responsive primary and preventative care models, and the crucial role of cultural competence. Importantly, enhancing individual practice is essential to ensure our ways of working with and across cultures are respectful and promote cultural security and achieve improved mental health and social and emotional wellbeing (SEWB) outcomes. However, it is also essential to ensure that systems and organisations and professions are also culturally responsive or competent.

The Framework aims to enhance practitioners' professional competence through critical reflection upon themselves, others, their discipline and professional codes of conduct and practice standards, and the broader contemporary and historical contexts in which practitioners, their clients, and their families and communities are situated, and in which policies are made and programs and services are delivered. It also discusses some of the cultural competence audit tools that can assist organisations to enact policies and processes intended to bring about system level change to enhance cultural competence across these sectors.

THE MENTAL HEALTH PRACTITIONER

Under the COAG mental health reform to improve Aboriginal and Torres Strait Islander health and wellbeing, health workers, counsellors and clinical staff in culturally-specific health services require the capacity and competence to identify and address mental illnesses and associated substance use issues and to recognise the distinctive and pervasive trauma, grief and loss experienced by Aboriginal people. They also need to work in accordance with the guiding principles contained in the *Ways Forward National Aboriginal and Islander Mental Health Policy Report*[3(pp19-20)] reinforced in the Charge by Rob Riley (page xvi) which asked all mental health practitioners to 'take on board' the understanding that:

- The Aboriginal concept of health is holistic.

- Self-determination is central to the provision of Aboriginal health services.

- Culturally valid understanding must shape provision of Aboriginal health (and mental health) care.

- The experience of trauma and loss contribute to the impairment of Aboriginal culture and mental health well-being.

- **The human rights of Aboriginal people must be recognised and enforced** (emphasis added)**.**

- Racism, stigma, adversity and social disadvantage must be addressed in strategies aimed at improving Aboriginal mental health.

- The strength and centrality of Aboriginal family and kinship must be understood and accepted.

- Diversity of groups needs to be recognised.

ADOPTING A RIGHTS BASED APPROACH TO MENTAL HEALTH

A recent national consultation to review the SEWB framework has reaffirmed the nine guiding principles which emphasise the centrality of human rights and self-determination. Human rights are moral, legal, and political devices for protecting the dignity, wellbeing and survival of human beings.[4(p95)] Recognition of human rights in mental health is particularly relevant in culturally diverse societies that include cultural minorities and particularly where Indigenous cultures have been displaced, marginalised, disenfranchised and forcibly assimilated by colonisers and settlers.[4(p96)] These rights are intended to 'assist individuals and communities to achieve the highest attainable standard of physical and mental health, including autonomy, information, education, and participation'[5] and are further reinforced by the *2007 United Nations Declaration on the Rights of Indigenous Peoples.*[6]

Culturally Appropriate Mental Health Services

In 2009, the Australian government formally endorsed the *2007 United Nations Declaration on the Rights of Indigenous Peoples.*[6] The Declaration outlines a set of principles and a framework that requires all states to provide accessible, quality health care to Indigenous peoples and to respect and promote Indigenous health systems. Article 24.2 states that:

> *'individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realisation of this right'.*

Article 35 recognises the collective rights of Indigenous peoples to maintain, promote and develop their distinctive customs, spirituality, traditions, procedures and practices in pursuit of their right to health.[6] However, while the Declaration acknowledges Indigenous people's individual and collective rights to promote, develop and maintain their institutional structures and their distinctive customs, spirituality, traditions, procedures and practices (Article 34), it also acknowledges their right to access all social and health services without any discrimination (Article 24.1). These latter articles confirm the importance of both the role of Aboriginal Controlled Health Services and the need for culturally responsive mainstream services.

Culturally Responsive Health Systems

It is important to recognise that failure to instil culturally safe practices erodes fundamental cultural and human rights for all Indigenous peoples. There is a need to establish processes and protocols to ensure culturally safe practices that are culturally responsive for diverse Aboriginal community contexts in Australia. As Cunningham argues:

> *To improve the health situation of Indigenous peoples, there must thus be a fundamental shift in the concept of health so that it incorporates the cultures and world views of Indigenous peoples as central to the design and management of state health systems.[7(p156)]*

Enforcing human rights requires the relevant institutions having the mandate and the resources to 'respect, fulfil, protect, and promote such rights'. Many of the policies, principles and guidelines that can enforce these Indigenous rights already exist. However, as Crepeau and Gayet (2012) observe, such mechanisms *'will remain powerless unless sustained by cooperation between institutions, a mobilisation of civil society and the availability of human rights education for all.'*[8(p548)]

THE CONTEXTS OF WORKING

Traditionally, the roles of professionals in the mental health services, therapies and associated disciplines have been underpinned by implicit values and assumptions that reflect the norms of the dominant professions in Western culture. As discussed in Chapter 5 (Zubrick and colleagues), successive reviews confirm that Aboriginal and Torres Strait Islander mental health policy implementation has been largely ineffective. This is generally attributed to:

- silos within government agencies and services;
- inflexible role boundaries between different health professionals;
- a lack of culturally responsive and appropriate services and organisations to meet the needs of Aboriginal and Torres Strait Islander individuals, families and communities;
- the assumptions and attitudes of practitioners, particularly non-Aboriginal practitioners, that can affect their ability to understand and appreciate the pervasive, transgenerational impact of colonisation upon Aboriginal and Torres Strait Islander peoples' individual, family and community social and emotional wellbeing and mental health; as well as
- overt racism described in Chapter 1 (Dudgeon and colleagues).

Further, the impacts of monoculturalism have proved particularly challenging for policymakers and practitioners aiming to implement the reforms in successive National Mental Health Plans. This has highlighted the need to ensure that staff can acquire and maintain the competence and

skills to deliver service reform in new, culturally responsive ways. For instance, *The Roadmap for National Mental Health Reform 2012-2022* [9] identifies the need to:

> *Strengthen the cultural competency of frontline professionals, including police, education and early childhood providers and healthcare professionals, to detect and appropriately intervene early in mental health concerns for Aboriginal and Torres Strait Islander peoples. (Strategy 24)*

This is a far more extensive plan than highlighted in the previous strategy which identified 'the need for education and training initiatives to ensure an appropriately skilled workforce to work effectively with culturally diverse client groups, particularly Aboriginal and Torres Strait Islander peoples'.[10] Nevertheless the implementation phase remains limited. According to Cunningham (2005)[7], the dominant paradigms fail to recognise human rights and do not consider Indigenous conceptions of health, which extend beyond the physical and mental wellbeing of an individual to encompass spiritual balance and wellbeing of the community as a whole. For many Aboriginal and Torres Strait Islander peoples this is a concept of health and mental health that is holistic social and emotional wellbeing (see Chapter 4, Gee and colleagues).

A national study into incorporating cultural competence into psychology curriculum content identified some important issues which indicate why policy implementation continues to fail:

- lack of awareness among professionals about Indigenous clients, cultures and contexts;

- lack of specific skills and strategies for working in Indigenous contexts;

- lack of engagement in broader issues of justice and human rights; and

- the need for understanding of, and strategies for, challenging prejudice, ethnocentrism and racism.[11]

GUIDELINES, PROTOCOLS AND PRINCIPLES OF PRACTICE

In addition to the *practice standards*[1], each of the mental health professions—mental health nursing, occupational therapy, psychiatry, psychology and social work—is governed by codes of professional conduct, ethical guidelines and registration requirements to ensure workers provide culturally secure care. These are detailed in Chapter 11 (Walker). Each of these national and community-based ethical guidelines, protocols and principles of practice encourage practitioners to familiarise themselves with the local history, customs and ways of working, as well as the local mental health issues of their clients, their families/carers and communities.

The guidelines and codes of ethical conduct are invaluable resources for practitioners to engage in empowering safe and respectful intercultural relations. The values and principles underpinning these codes and guidelines also aim to guide the actions of mental health and other service systems to work in ways that encourage practitioners to consider their own values, attitudes and positionality—privilege and power. For example:

- The Australian Psychological Society has produced a code of ethical conduct and a set of guidelines for engaging in an empowering manner when researching within, or delivering health services to, Aboriginal and Torres Strait Islander peoples.[12]

- The Australian and New Zealand College of Psychiatrists' *Australian Indigenous Mental Health Ethics, Protocols and Guidelines*[13] outline strategies to address the physical, psychological, social, cultural and spiritual dimensions of Indigenous social and emotional wellbeing in the *'Dance of Life'* matrix. (See Chapter 16, p277)

However, despite these guidelines, Aboriginal people continue to experience unacceptable levels of racism; and policies and programs continue to fail people. As a consequence,

Aboriginal people are experiencing increased levels of stress, ongoing psychological distress, poor mental health outcomes and disturbed social and emotional wellbeing. While the various professional guidelines are designed to enhance professional practice, contemporary Aboriginal mental health requires that practitioners acknowledge the impacts of colonisation (past), the contemporary social circumstances (present) and effective strategies and practices to move forward. In effect this requires a genuine commitment for practitioners to take on a personal and professional responsibility to close the gap.

CULTURAL COMPETENCE IN THE AUSTRALIAN POLICY CONTEXT

The rationale for developing cultural competence in the health services is documented in a raft of policy guidelines and frameworks that aim to address the health inequities experienced by Aboriginal and Torres Strait Islander peoples. There is widespread recognition and evidence that existing services and approaches to improve the health and SEWB of Aboriginal Australians have not been successful.[14] There is increasing recognition that practitioners, service providers and policymakers in the health sector need to take account of the pervasive historical legacy of colonisation, diverse cultural and environmental experiences and contemporary social and economic circumstances of Aboriginal people.[15]

In 2005, the National Health and Medical Research Council (NHMRC) produced a document, *Cultural competency in health: A guide for policy, partnerships and participation in cross-cultural contexts.*[16] This policy guide puts forward a model with national application aimed at high-level policymakers to:

> *lead the way forward for the development of cultural competence in Australian healthcare—if it can galvanise action to make cultural issues 'core business at every level of the health system'.*[16(p1)]

In addition, the Australian Health Ministers' Advisory Council, national *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009,*[17] set out a number of principles and examples of practice to guide both services and practitioners working with Aboriginal and Torres Strait Islander peoples. The *Cultural Respect Framework* encourages both services providers and practitioners to improve knowledge and awareness, skilled practice and behaviour, to develop strong intercultural relationships and create genuine equity of health outcomes. It aims to provide a nationally consistent approach to building a culturally competent health system that will improve access to, and responsiveness of, mainstream services for Aboriginal peoples.[14] The *Cultural Respect Framework* outlines strategies across a number of dimensions (system, organisational, professional and individual) to systematically lift the cultural competency of mainstream health services.[14] It builds on the recommendations put forward in several milestone reports detailed in Chapter 6 (Zubrick and colleagues) designed to improve the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

Despite the imperative for government policymakers and planners to take account of the specific needs and expectations of Aboriginal and Torres Strait Islander peoples, the planning and delivery of culturally secure and appropriate health and mental health services remains an ongoing challenge. It requires the commitment and recognition that cultural respect needs to be embedded across all sectors of the system including the corporate, organisational and care delivery levels to uphold the rights of Aboriginal and Torres Strait Islander peoples to maintain, protect and develop their culture and achieve equitable health outcomes.[14]

Cultural Competence as a Contested Site

The concept of cultural competence has become an increasingly contested area. While it is widely accepted that cultural competence is a commitment to engage respectfully with people

from diverse cultures, there are concerns and criticisms that some approaches to cultural competence tend to essentialise culture.[18,19] Some writers go as far as to suggest that cultural competence is a form of new racism.[18] However, it is also widely acknowledged that existing health practices and policies and system-wide health delivery have failed to deliver fair and equitable health services to Aboriginal Australians and have actually contributed to the gap in health and mental health outcomes. Recent reports confirm that many health services remain inaccessible and unresponsive for Aboriginal people,[20] and that many are affected by systemic and individual racism.[21]

Working in ways that homogenise people by not acknowledging difference in culture, ethnicity or religious affiliation is discriminatory as it assumes that all peoples should respond to constructs, ideals, programs and interventions developed largely around euro or america-centric belief systems—philosophies, ideologies and ways of knowing and doing. These belief systems also assume that Western-based sciences can explain everything, which in itself leads to many discriminatory practices. It is well documented that people across the globe do not hold the same views, beliefs or attitudes about many issues, particularly health and wellbeing; and that culture and cultural difference play an important role in terms of the facilitation of health and wellbeing. It is therefore argued here that not undertaking education or professional training or development that improves understandings of cultural issues and that assist in the evolution of attitudes, beliefs and behaviours related to such issues is discriminatory.

Individual Cultural Competence

A commitment by both individuals and organisations to cultural competence is the beginning of an ongoing process that requires motivation and willingness to improve cross-cultural communication and practice. Cross, Bazron, Dennis and Isaacs (1989) proposed the most widely accepted definition of cultural competence as:

> *a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations.[22]*

Importantly, for individuals, cultural competence requires far more than becoming culturally aware or practising tolerance. Cultural competence is the ability to identify and challenge one's own cultural assumptions, values and beliefs. It is about developing empathy and connected knowledge, the ability to see the world through another's eyes, or at the very least to recognise that others may view the world through a different cultural lens.[23] Cultural competence encompasses and extends elements of cultural respect, cultural awareness, cultural security and cultural safety. Cultural competence encompasses the knowledge, awareness and skills aimed at providing a service that promotes and advances cultural diversity and recognises the uniqueness of self and others in communities.[24-27] The focus on cultural competence is a response to ongoing health inequalities and related disparities in access to health services and experiences in health for different communities. It recognises the importance of acknowledging the influences of culture, ethnicity, racism, histories of oppression and other contextual factors in the experiences of individuals and communities. To this end, considerable attention has been paid to the development of models and guidelines for delivering culturally competent and safe health services.

The aim of cultural competence is to foster constructive interactions between people of different cultures. Importantly, cultural competence may not translate easily or appropriately from one culture to another, rather it is a commitment to an ongoing process developed in a particular intercultural context.[28,29]

Cultural Awareness

Cultural awareness requires practitioners to take responsibility for their own biases, stereotypes, values and assumptions about human behaviour generally, and recognise that these may differ from those held by other cultural groups. Importantly, they need to develop appropriate practices and intervention strategies that take into account their client's historical, cultural and environmental context.[30]

Cultural Respect

Cultural respect is a fundamental element of cultural competence that involves the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal peoples. It requires the health system to be a safe environment for all people, where cultural differences are respected and where the health care system and services respect the legitimate cultural rights, practices, values and expectations of Aboriginal and Torres Strait Islander peoples. The goal of cultural respect is to uphold the rights of Aboriginal peoples to maintain, protect and develop their culture and achieve equitable health outcomes.[14]

Cultural Safety

Cultural safety extends beyond cultural awareness and cultural sensitivity. The notion of cultural safety has its roots in nursing research in Aotearoa, New Zealand, and is in part about Maori asserting their legitimacy and diversity and challenging Western-based models of nursing.[31] According to Ramsden (2002), '*cultural safety developed from the experience of colonisation and recognizes that the social, historical, political diversity of a culture impacts on their contemporary health experience*'.[32(p112)] The corresponding impacts of colonisation on Aboriginal social and emotional wellbeing and mental health are discussed in several chapters within this book together with the critical need for cultural safety. The concept of cultural safety has further been refined and extended to the concept of cultural appropriateness in health practices. Clear (2008) makes the crucial point that while culturally safe practice focuses on '*effective clinical practice for a person from another culture*', unsafe cultural practice '*diminishes, demeans or disempowers the cultural identity and wellbeing of an individual*'.[33(p2-4)] This is a critical area of practice where as Morgan (2006) states '*serious and unrecognised miscommunication is pervasive in non-Aboriginal doctor/Aboriginal patient interactions*', particularly in remote communities.[34(p203)]

Cultural safety is about practitioners and services working to enhance rather than diminish individual and collective cultural identities, and empower and promote individual, family and community wellbeing. Culturally safe service delivery is crucial in enhancing individual and collective empowerment and more effective and meaningful pathways to Aboriginal self-determination.

Creating a culturally safe space involves a high level of critical reflexivity (a concept that is explored later in this chapter), as practitioners may not be aware of how their behaviours and interactions could make people from different cultures feel unsafe, or how the way services are provided can have negative consequences for client access and continuity of care.

Importantly, cultural safety is not something that the practitioner, system, organisation or program can claim to provide but rather it is something that is experienced by the consumer/client. Cultural safety focuses on the effective clinical practice for a person from another culture as it is experienced and perceived by them. While cultural competence contributes to a service recipient's experiences, cultural safety is an outcome. Cultural safety requires us to ask the client or service recipient whether they felt they were treated with respect, and had their culture, values and preferences taken into account—whether they felt safe.

ELEMENTS OF CULTURAL COMPETENCE

Cultural competence should be considered an ideal that is strived for rather than an end point that can be reached, ticked off and forgotten about. Cultural competence involves the knowledge, skills, attitudes and values necessary for effective intercultural transactions within diverse social, cultural and organisational contexts.[35] Sue's model encompasses elements of knowledge, values and beliefs, and skills considered necessary to enhance the cultural competence of practitioners.[35] These elements have been further articulated by psychologists such as Ranzijn et al 2008[11] and McConnichie et al 2008[36] in the context of education and training in Australia. These different dimensions need to be understood within a nested system that operates simultaneously at both individual, professional, organisational and system levels, recognising that a culturally incompetent system can undermine culturally competent practitioners.

Elements that Enhance Cultural Competence in Practitioners

Knowledge	• Broad or generic understanding of the nature of worldviews and culture, and the implications of culture for understanding human behaviour. (For further discussions, see Chapter 4, Gee and colleagues; and Chapter 30, Hovane and colleagues.)
	• An understanding of the specific cultural and historical patterns that have structured Aboriginal and Torres Strait Islander lives in the past and the ways in which these patterns continue to be expressed in contemporary Australia (see Chapter 1, Dudgeon and colleagues).
Values	• An awareness by professionals of their personal values and beliefs
	• A capacity and willingness to move away from using their own cultural values as a benchmark for measuring and judging the behaviour of people from other cultural backgrounds
	• An awareness of the values, biases and beliefs built into the practitioner's profession and an understanding of how these characteristics impact on people from different cultures (see Chapter 3, Dudgeon and colleagues).
Skills	The mental health practitioner requires a mix of generic skills to carry out their role; they also need to develop a repertoire of skills that build on their knowledge and values to work effectively as a professional in intercultural contexts. These skills include the ability to:
	• carry out all aspects of triage/intake practice including mental status examination
	• work as a team member
	• work collaboratively with a broad range of health services and providers
	• incorporate the principles of culturally sensitive practice in mental health care
	• self-monitor and critically self-reflect.
Attributes	Reflecting on our individual values and attitudes involves the skill of critical reflexivity, which includes, among other things, developing an understanding of:
	• the nature and dynamics of power as it operates in many levels from practitioner–client interaction, to organisational and political systems and between various professions and disciplines
	• the nature and impacts (on both Aboriginal and non-Aboriginal people) of unearned or ascribed privilege
	• the nature and effects of racism at individual, institutional and ideological and discipline levels
	• the history of relationships between Aboriginal Australians and systems and professions and the effects of this history on Aboriginal perspectives about the professions
	• the extent to which each profession is constrained by the culturally constructed models and disciplinary knowledges/theories used by the profession
	• the effects of white privilege, racism and cultural blindedness.

In summary, Aboriginal and Torres Strait Islander mental health and SEWB is situated in social justice and human rights frameworks. Mental health practitioners need to show a commitment to natural justice and the fundamental rights of each individual. They need to be able to show respect and empathy and demonstrate discretion and the ability to uphold confidentiality. This requires balancing the rights of the individual with the rights and needs of the community. It requires sensitivity, tolerance, and importantly, the ability to request assistance if necessary. Finally, mental health practitioners are expected to demonstrate good practice standards by adhering to the ethical codes and policies of the Department of Health in their state, as well as National Codes of Practice.

Mental health practitioners are also expected to comply with language services policy; they have an obligation to determine the need for, and provide, a qualified interpreter where required. They are strongly encouraged wherever possible to use professional interpreter services rather than family members or unqualified personnel when conducting a mental health assessment.

WORKING IN PARTNERSHIP

There is broad agreement from both clients and practitioners that practitioners need to work in genuine partnership with Aboriginal people to be effective. This model of working has important implications for practice, including adopting protocols for working with Aboriginal people such as:

- Recognising that the individual 'client' (in the case of individually-oriented practice), their family and community, Aboriginal co-workers and other professionals are equally 'experts' in the process. Letting go of the 'expert' role and being willing to share resources can be very difficult and involves being critically self-reflective of the possible barriers due to the unequal power inherent in the therapist–client relationship.

- Developing an effective partnership takes time, trust and personal relationship. For most Aboriginal Australians, *who* you are is more important than *what* you are.

- Having regard for Aboriginal protocols in community contexts. Often a process of vouching is required, in which one or some of the community members will attest to the person wishing to enter the community.

- Working in collaboration with cultural consultants, who will advise about cultural matters, provide guidance in appropriate behaviour, and mediate between the practitioner and the family/carer and community.

CULTURAL COMPETENCE AS A CONTINUOUS PROCESS

There is widespread agreement within the literature that the development of cultural competence is a continuous process—cultural competence is an ideal to strive towards and an ongoing process which continually evolves.[38] Wells elaborates on the continuum provided by Cross et al., who offer a model that links the elements of cultural competence (knowledge, attitudes and skills) to a developmental framework.[22,39] They identify a sequence of stages along a continuum:

- *Cultural incompetence:* lack of knowledge of the cultural implications of health behaviour.
- *Cultural knowledge:* learning the elements of culture and their role in shaping and defining health behaviour.
- *Cultural awareness:* recognising and understanding the cultural implications of behaviour.
- *Cultural sensitivity:* the integration of cultural knowledge and awareness into individual and institutional behaviour.
- *Cultural competence:* the routine application of culturally appropriate health care interventions and practices.
- *Cultural proficiency:* the integration of cultural competence into one's repertoire for scholarship (e.g. practice, teaching and research).

At the organisational level, cultural proficiency is an extension of cultural competence into the organisational culture. For the individual and the institution, it is mastery of the [five preceding] phases of cultural competence development. Although, importantly, it needs to be emphasised that cultural proficiency is about being in a constant state of learning dependent on our willingness to remain forever vigilant and reflective.[22,39] We suggest that cultural competence is about adopting a particular standpoint—a state of mindfulness, humility, sensitivity, authenticity and a willingness to really listen and learn from others.

Cultural Competence – A Dynamic Process

Cultural competence is a dynamic and interdependent process constructed by, and within the context of, human relations and their environments. Cultural competence can be understood within the context of the individual, the family and peers, the school and social or sporting clubs, ethnicity, class, race, gender and the broader policy, social, cultural and historical context. Cultural competence needs to be considered within a broader system-wide social, historical, political and economic context as well as at the level of individual professional practice. This notion of situating SEWB within the broader social, cultural, historical context is a recurrent theme throughout this book (and is discussed in Chapter 4, Gee and colleagues; and Chapter 13, Schultz and Walker and colleagues.)

By connecting cultural competence with the notion of social ecology, we need to consider different levels of a system that must be considered in promoting culturally competent practice and service delivery. At a system level, all health sector and organisational personnel need to develop significant aspects of cultural competence; and organisations need to respect and cater for cultural diversity, through both the physical layout and presentation, and the implementation of policies, procedures and practices that promote culturally safe, responsive environments (see the *service standards[2]*).

EXTENDING COMPETENCE THROUGH CRITICAL PRAXIS

Within the current health, education and workforce systems, great emphasis and recognition is placed on achieving qualifications and gaining experience in a specialised area of health, mental health and/or social and emotional wellbeing. Ongoing professional development, peer review and incremental promotion are mechanisms that can reinforce and recognise our professional and clinical competence and expertise in respective roles. It requires practitioners to:

- make a commitment to critical self-reflection;
- adopt a stance of resource-sharing;
- recognise the unequal power inherent in the practitioner–client relationship;
- acknowledge what that means for the client's sense of wellbeing; and
- empower their clients to address their mental health and SEWB issues, and ongoing psychological issues including grief, loss and trauma.

Indigenous Knowledges and Whiteness Studies

Several authors have demonstrated how mainstream services and practices work in exclusionary ways to the detriment and disadvantage of Indigenous populations. Oxenham (2000) and Rigney (1997) highlight the importance of incorporating and applying Aboriginal terms of reference (i.e. values, aspirations and ways of being and doing) into policies, practices and processes that impact on Aboriginal people.[30,40] This work shows how health service systems can be made more responsive and sensitive to Indigenous Australians and their particular needs. The work of ethnic minorities, women's studies and whiteness studies also shows how

mainstream systems and practices produce normativity—that is, the standards, regulations and protocols intended to provide uniformity of service and best practice can also undermine cultural competence by dispelling the importance of difference. In combination, this interdisciplinary work offers resources, standpoints and frames of reference that can be used to ask pertinent questions about race relations, histories of oppression, and constructions of health and mental health and wellbeing, which ultimately are crucial understandings and activities that affect health and mental health service delivery.

Sonn and Green[41] examined the notions of subjectivity and reflexivity identified by Aboriginal and Maori scholars for working towards liberation and decolonisation. Central to engaging in transformative practice across intercultural spaces is the requirement that we understand histories of colonialism and the role racism has played in the oppression of Indigenous peoples. This work offers a way in which cultural competence can specifically engage with issues of power and privilege, and the power that we are afforded because of our different group memberships, including our professions.

For instance, Smith[29] in New Zealand and Gilbert[18], Martin[42], Moreton-Robinson[43] and Nakata[44] in Australia, reveal how different disciplines, including psychology, public health practice and policy and service provision, have participated in the construction of knowledge about Aboriginal and other ethnic groups, often as an inferior or exotic 'other'. These constructions have implications for how individuals and communities are treated in different social settings, including health and mental health contexts. A shared feature of anti-colonial writing is the focus on decolonisation which examines and deconstructs the various ways in which ethnic and racial minority communities are presented as problematic and often blamed for their own misfortunes. At one level, this deconstructive work is aimed at understanding the assumptions, ideologies, motives and values that inform research and practice.[29] At another level, it is about developing and promoting ways of knowing, being and doing that are anchored in the lived social and historical realties of indigenous peoples.[45] Among other things, this work demands that we ask critical questions about what we know of different groups of people:

- Whose standards have we accepted as the key standard for comparison?
- Whose ways of living are privileged?
- What are the implications of imposing understandings on people?
- Is the voice of 'the other' noticeable, acknowledged and respected?

A related area of work is concerned with understanding how dominance and privilege is constructed and maintained.[46] At a broad level, whiteness studies are concerned with examining the production of dominance and understanding the complex interplay of privilege and power afforded by whiteness in the context of race relations—and how to undo it.[47] Green, Sonn and Matsebula (2007) have identified three mechanisms by which whiteness is produced and maintained, including the production of privilege through:

- the construction of knowledge and history;
- national identity construction and belonging; and
- in racist practice.[46]

In terms of knowledge and history construction, Western views and ways of knowing and doing have been privileged at the expense of other ways of knowing and doing.[48] For example, Sarra[49] and Dudgeon, Mallard and Oxenham[50] have discussed the powerful and oppressive effects of externally imposed definitions of self and community on Aboriginal people—often negative representations serve to reproduce racism. McKinney (2005)[51] theorised that anti-racism practice for white people will require a shift in focus from prejudice reduction to an awareness of systemic and inherited privilege and a commitment to challenge racist behaviour.

This important area of work allows us to examine at a deeper level the basic assumptions that inform disciplinary research and practice, including those we hold about notions of personhood. As Riggs (2004) and others have noted, some of the assumptions about universality of human psychological processes may benefit those who share this view, but they exclude other cultural understandings of self (and collective conceptions of health) and can be detrimental and harming.[48] To this end, critical whiteness studies offer a set of resources that may enable researchers and practitioners to make visible their normative assumptions, thereby opening up spaces for negotiation and interrogation.[52,53] Green and Sonn, for example, identified several narratives that informed non-Aboriginal people's engagement in reconciliation.[54] Among them were those that viewed Australian Indigenous culture as deficient, those that viewed other white people as racist, and those that blamed the system and history for Indigenous people's disadvantage. These narratives are not mutually exclusive but have different implications for intervention, and they can also work to reproduce the privilege of non-Indigenous people.[53]

Therefore, engaging in critically reflective practice and crossing intercultural boundaries involves different challenges: it is generally acknowledged that people make sense of their social world by creating categories of in-groups and out-groups. There is a tendency for people to exaggerate differences between some groups and similarities with others and to unconsciously favour one's in-group over the out-group—contributing to privileging the in-group and marginalising or othering the out-group. This auto processing and categorisation is problematic where there is a dominant group with more power than the other group and where the resources are not distributed equitably to all groups. Within the professions, this can result in assumptions, values, and beliefs and expectations of the dominant discourse being imposed on other groups.

Being critically reflexive in this context often means letting go of certainties and being prepared to negotiate with clients and communities. Letting go of certainties and foreclosing recipes for action can be emotionally challenging and leave one feeling vulnerable, powerless and out of place—having the ability to work outside one's own comfort zone is crucial. In addition, being able to negotiate and bring together and work with different knowledges and expertise within specific contexts are also important skills.

Safety, Self-care and Support

Mental health practitioners wanting to work competently in diverse cultural contexts may find themselves confronted by the potentially challenging nature of engaging in decolonising practice at the individual level, at the same time as supporting the complex and traumatic circumstances that clients and communities may be experiencing. This can be fraught with uncertainty. It is therefore important to have strategies for self-care and support. These may include mentoring, journaling, peer support, counselling and engaging in self-reflective, transformative practice.

Ethical Engagement and Exiting Strategies

As practitioners it is pertinent that we remain mindful that we have the ability to leave the client/practitioner relationship when we see fit or when funding for the research or programs ends. Aboriginal and Torres Strait Islander individuals, families or communities that we are working with may not be able to leave. Therefore we as practitioners need to ensure that when we leave, the appropriate steps and processes are in place to be of benefit to the individuals, families and communities with whom we have been working. If we cannot leave a positive legacy we must consider our own personal agendas or reasons for involvement in the first instance.

CRITICALLY REFLECTIVE PRACTICE

There are a range of reflective activities and learning processes that can give mental health practitioners skills, techniques and understandings to enhance their work in cross cultural settings. These activities and processes assist them to develop a clearer understanding of their roles and the power relations operating within their work and to develop strategies to address the issues and concerns they are facing. The transformative potential of critical reflexivity resides in interrogating the political, social and cultural positioning of Aboriginal people in temporal terms (historical and contemporary) and geographic contexts (including community contexts) to affirm and validate Aboriginal identity and difference. The intersection of these different elements is reminiscent of Sue's multidimensional elements of cultural competence.[55] These are explicit competencies that will enable students or practitioners to navigate the cultural interface to understand how they can make a genuine difference to Aboriginal mental health and social and emotional wellbeing.

Viewing cultural competence as a dynamic-in-interaction requires us to consider critical reflection/reflexivity as central to culturally competent practice. It involves both interrogating and integrating Indigenous and Western knowledge systems and critically reflective practice at the cultural interface.[56] Critical reflection/reflexivity is an essential skill for all professional practitioners working at the highly politicised, complex and dynamic Indigenous/non-Indigenous interface.[45] This is in line with the idea of knowledge as 'knowing how to act'. As Greenwood and Levin (2005) note '*To act is to contextualize behaviour, and being able to act skilfully implies that actions are appropriate to a given context*'.[57(p51)] Here, new knowledge and ways of being are produced in the act of reflection-on-action in the real world. Critical reflection is a key principle for ethical practice, as Walker, McPhee and Osborne (2000) state:

> *All practitioners, both Indigenous and non-Indigenous, tend to operate according to a complex interaction of their own values, beliefs and experience and the values, assumptions and paradigms of their professional discipline or field. The way individual practitioners carry out their roles, and the way they act with clients and other professionals depends largely on their interpretation of that discipline which is largely influenced by their own beliefs and values, knowledge and experience.*[56(p322)]

As practitioners, we need to consider how our own social, cultural and professional positioning will influence the relations we have with people who seek our assistance in any context—but in this instance in the mental health setting. Thus, reflexivity in one sense is about recognising and critically engaging our own subjectivities in the context of relating across cultural boundaries. It means examining our own social and cultural identities and the power and privilege we have because of these identities. It also requires that we engage with the political and ideological nature of practice and knowledge production and consider the implications of these for those we aspire to work with. Therefore, as Parker suggests:

> *Reflexivity should not be a self-indulgent and reductive exercise that psychologizes phenomena and psychologizes your own part in producing them. Instead, the reflexive work is part of action, and in action research much of that reflexive work is undertaken alongside and in collaboration with [clients, and their families].*[58(p35)]

The process of critical reflection is a powerful tool for producing new knowledge and processes, and has the potential to improve fundamental social justice outcomes for Aboriginal people.[56] It encourages practitioners to embrace a human rights framework and the nine guiding principles which underpin Aboriginal social and emotional wellbeing (page xxiv). In reflecting on these elements, we become more conscious of the power that inheres in our own practice in order to democratise relationships, interactions and processes and to promote a culturally secure process and environment that will improve health and wellbeing outcomes for Aboriginal clients and communities. As Walker and colleagues[56] state, our desire and commitment to be ethical,

effective, culturally competent practitioners requires that we:

- analyse and understand the broader cultural, social, political and economic environment and how it impacts on, or influences, our professional and personal practice and the lives of the people with whom we are working;

- make our own disciplinary and professional practice the subject of our inquiry in order to analyse and, where necessary, change so that our actions are more culturally responsive, relevant and effective for the specific individuals and groups with whom we are working;

- draw information from a broader social and historical context as well as our professional context to better inform and interpret our own and our clients' actions and responses.

While the focus is about our professional practice in context, explanations need to extend beyond our taken-for-granted practice. We need to look at how relations of power in the broader social and political context impact on issues of race, culture, gender and class and, in turn, how they may influence our own and [others] beliefs, values and behaviour.[56]

Figure 12.1 below depicts the multidimensional and iterative nature of critical reflection and illustrates how our understandings of self, others and the particular profession interact with the broader cultural, social, historical, political and economic contexts; our understandings and how the formal and informal theories underpinning our professional practice are informed by a complex interaction of values, beliefs, assumptions, experiences and contextual factors.

Figure 12.1: Critical Reflection Framework of Analysis
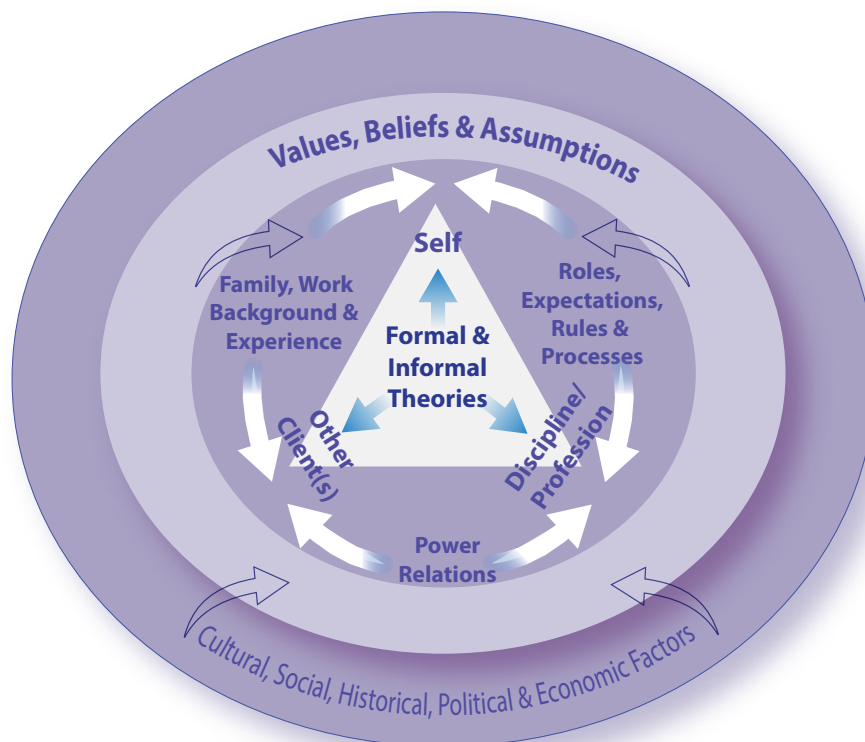
© R. Walker 1999

This figure also depicts the tensions and interacting elements that occur at an individual level and that are experienced by those people who recognise and acknowledge that they are working within the cultural interface and attempt to understand their own relationship with the various elements within it.

TOOLS AND TECHNIQUES FOR CRITICAL REFLECTION

The tools and techniques developed to facilitate the process of critical reflection enable practitioners to make more conscious decisions in their work to support the interests of the groups with whom they are working. Many of these tools and techniques of critical reflection have been developed, refined and applied over several years by staff and students or practitioners in the Indigenous Community Management and Development (ICMD) program as part of the transformative and decolonising project to improve the overall circumstances of Aboriginal Australians.[52] These same tools and techniques can help practitioners to identify and take account of Aboriginal terms of reference in their work in community management, policymaking and social services and community health and mental health areas.[30]

The main tools and techniques developed for the ICMD course materials were summarised in *Working with Indigenous Australians: A handbook for psychologists* (Dudgeon and colleagues) as follows:[56]

Questioning	Helps us to generate new knowledge about ourselves, others, the context and their interconnecting influences. Questions should uncover: reasons, factors, links, possibilities, intentions, consequences, feelings (*how* others feel and *why*).
Analysing	Requires looking behind what's happening for underlying issues, causes and effects, identifying own/others' assumptions, and deconstructing complex situations into specific issues. Analysis helps make meaning of situations, events, issues and practices, both at a personal and professional level, privately and publicly.
Defining the issue	Means identifying issues that cause concern or require further exploration and/or evaluation. The issues may be related to our own practice, someone else's response, or feelings of uneasiness or uncertainty with respect to an interaction or intervention.
Seeking other perspectives	Involves reading widely, talking with relevant people, and 'stepping into the shoes' of clients/others to see how situations and ideas appear for them.
Mapping	Helps to draw links between different perspectives and ideas to reveal how taken- for-granted things fit together. It can help to clarify the problem and situate it within the bigger picture.
Critical reflection through dialogue	Takes place formally or informally between the practitioner's personal experience and the shared understandings, discipline, knowledge and professional rules and practices that inform their experience. These different perspectives are underpinned by values and assumptions that may differ substantially from, and challenge, those of the practitioner. Approaching critical reflection as a kind of dialogue helps us to work through our own mental processes and to see other perspectives we might not come up with on our own. As such, critical dialogue can assist practitioners to use tools and discourses to challenge the accepted boundaries of traditional or dominant theories and practices. It helps practitioners to identify, critically assess and articulate how their own informal theories about working at the cultural interface contribute to, and have the potential to transform, their understandings about their own practice as well as assist in their self-care and support.[59]
Recording activities/ observations	Keeping a diary or journal or using tape-recordings can be a useful way to record activities or observations or pose questions relating to specific differences between cultural values, beliefs and those of discipline and self. These observations can form a basis for self-reflections, further discussions or assessment, although issues of confidentiality need to be acknowledged.

NEGOTIATING THE CULTURAL INTERFACE

In this section, adopting an anti-colonialist, decolonising standpoint, we consider the concepts of white privilege/colonial hegemony, Aboriginal knowledge, power and positionality and multi-disciplinarity. Walker (2000) encourages practitioners to employ the theoretical construct of the Indigenous/non-Indigenous interface as part of a practice framework that is both decolonising and transformative.[52] The chapters in this book exemplify how:

> the incorporation of Aboriginal and non-Aboriginal knowledges and practices can decolonise and transform disciplinary practices that have traditionally oppressed, marginalised and otherwise harmed Indigenous interests (and legitimised the process) in the name of Anthropology and Psychology.[52(p187)]

Working Together is an example of transdisciplinarity—drawing on and sharing understandings, methods and experiences across a range of disciplines to interrupt, inform and transform these disciplines and knowledges. It inserts Aboriginal ways of knowing, being and doing firmly into the disciplines of psychology as well as each of the disciplines that influence Aboriginal mental health and SEWB.

Multidisciplinarity: Working with Multiple Discourses

Practitioners need to interrogate and integrate reflective processes on Indigenous terms of reference. It is important to acknowledge and maintain the tensions between the different standpoints and discourses underpinning critical, ethical, socially just practice in Aboriginal mental health contexts. These include the various critical positions available to the mental health practitioner as a consequence of the interactivity between the different disciplines, standpoints (Indigenous, feminist and post-structuralist) as well as the multiple and competing discourses of community psychology, social psychology, psychiatry and primary health care 'which are critiqued through the discourse of Indigenous cultural values and protocols' for mental health practice in diverse contexts.[52(p188)]

These multiple critical positions embrace the diverse and complex politics operating across the intersections of race, class and gender within both Indigenous and non-Indigenous domains, enabling the mental health practitioner to identify the level of complexities at the intersection of ideas and practices and their own potentially ambiguous location within them.[52] In other words it is possible to interrogate the potential positive and negative effects of different disciplinary discourses from different subject positions. These dialectics avoid simple, uncomplicated notions of cultural difference, subsuming some of the broader and general imperatives of social transformations. Practitioners need to acknowledge the complexity of the cultural politics of difference, and incorporate processes to problematise, dialogue and negotiate around this difference within their professional practice in order to initiate a more inclusive and effective practice.[30,45,60]

All practitioners working in the mental health area need to be aware of, and take into account, the complex nuances of cultural politics operating at the cultural interface in order to address the relations of power and issues of social justice and fundamental human rights.[52] Negotiating the interface is underpinned by the idea that a decolonising and transformative potential resides in that space.[45,52,61] Incorporating human rights principles to inform our work at the cultural interface enables new ways of working that recognise and facilitate equal power relations and partnerships.[52]

Power, Knowledge, Culture and Politics

Part of the critique of the cultural competence discourse is around the unequal power relations that operate within and between the various service delivery and policy sectors as well as between the professions/disciplines and between dominant and minority populations. As

Kessaris (2006) argues:

> 'cultural awareness' and 'anti-racism' type training can no longer focus primarily on seeking to 'understand' the 'other'. Emphasis must be placed on understanding the self in the midst of unbalanced power relationships.[42(p358)]

Australia's colonial history, Aboriginal contemporary circumstance, lack of access to services and resources and lack of control over the most fundamental aspects of their lives are key determinants of Aboriginal health, mental health and SEWB (see Chapter 1, Dudgeon and colleagues; and Chapter 6, Zubrick and colleagues).

Applying Conceptual Frameworks

The conceptual frameworks of critical reflection and the cultural interface are frameworks of analysis which enable practitioners to identify, acknowledge and critique the historical and political factors and existing power relations operating in their interactions with clients, their families and communities. The enduring realities of colonial domination require practitioners to operate in an ethical, conscious and critically reflective manner and with regard to the power, responsibilities and expectations inscribed within their professional and personal (and community) roles.

The application of these analytical and reflective tools will enable students and practitioners to recognise the relations of power operating within the political structures and the way they influence policies, standards and resources and services in the sectors that affect how people's needs are attended to. The deconstruction of knowledge and power entails looking at:

- how the various discourses (including public policy discourses and paradigms around quality assurance and best practice) and the disciplines that support mental health and wellbeing can operate to serve both positive and negative ends; and

- how and why they operate in ways that do not always serve interests and achieve positive outcomes for Aboriginal clients, families and communities.

See, for example, Kowal and Paradies[62]—the results of workshops that apply similar concepts and tools confirm that the understanding and competence developed through critical reflection allows practitioners to identify their areas of ambivalence and reach a level of proficiency over time to identify strategies to change and/or reinterpret institutional and social policies, practices and processes that impact negatively on Indigenous people.

As Kirmayer (2012) notes:

> The self-reflexivity of practitioners and systems opens the door to reorganizing the delivery of services and the conduct of clinical work in ways that share power and control over health care but the details of how this is achieved must be worked out for specific contexts.[63(p158)]

CONCLUSION

This chapter has aimed to consolidate ideas regarding the professional responsibilities of working as part of a multidisciplinary team, engaging in ethical practice, facilitating cultural safety and acquiring cultural competence. It has demonstrated how practitioners must provide cultural safety and care (as well as culturally appropriate services) for Aboriginal clients, their families and communities. Practitioners are encouraged to adopt strategies for self-care and support as they question some of their own ways of thinking and doing while engaging in self-reflective, transformative practice.

Cultural competence has been explored within a human rights framework which situates the process within a decolonising paradigm to ensure Aboriginal people's right to culturally secure care rather than as a new form of colonisation and racism. Central to this chapter is the *Critical Reflection Framework of Analysis*, which offers a process to enhance professional competence through reflection upon self, others, the discipline and professional codes of conduct and the broader contemporary and historical contexts in which their work is situated. Such a process can help individuals and professions avoid the pitfalls of a newer colonial voyeurism through superficial cultural awareness training.

The changing relations of power between the disciplines/professions and Aboriginal people and the role they have played in critiquing the history of the disciplines of psychology, psychiatry and the social sciences are part of the context that has given rise to new ways of working that are empowering, respectful and ethical. This chapter has argued that cultural competency is a dynamic that is contingent and contextual—it is not an end state, but rather an iterative process to ensure sensitive, democratic, just and transformative practice. The policy terrain needs to be inclusive and respectful of Aboriginal cultural needs, priorities and aspirations. It needs more than to require practitioners and services to be culturally competent—it needs to address the various forms of racism that are still evident and pervasive in Australian society, its people, the structures, the system and practices.

REFLECTIVE EXERCISES

Throughout this chapter we have highlighted the importance of being critically self-reflective as well as engaging in more critical reflection on the disciplinary practice in which mental health practitioners are located. We have suggested that, among other things, this work demands that we ask a number of important questions. These exercises are designed to assist student/practitioners to do just that.

1. Reflect on your own position of privilege

Tannoch-Bland (1998) wrote that racism is dialectical: there are those who are disadvantaged by it and those who benefit from it. White race privilege is taken for granted and reproduced in everyday institutions.[64] Privilege refers to a variety of situations which disproportionately benefit white people; it ranges from being in control of the economic and political system to more simple forms such as being able to buy bandaids and cosmetics suitable for white skin, and watching television programs that are representative of white people.[64,65] Tannoch-Bland provides 40 examples of the kinds of invisible privilege and unearned benefits associated with whiteness. We have selected 10 examples for illustrative purposes.

- I can be reasonably confident that in most workplaces my race will be in the majority, and in any case that I will not feel as isolated as the only, often token, member of my race.

- When I am told about Australian history or about 'civilisation', I am shown that people of my colour made it what it is.

- I can send my children to school in unironed uniforms without it reflecting on their race.

- I can dress down, or get drunk in public without reinforcing negative stereotypes about my race.

- When I speak in public my race is not on trial.

- When I'm late, my lateness isn't seen as a reflection of my race.

- When I win a job or a scholarship, I am not suspected of doing so because of my race rather than my merit.

- When I need legal or medical help, my race doesn't work against me.

- I expect that neighbours will be neutral or friendly to me.

- From among the people of my race, I can choose from a wide range of professional role models.[64(pp34-36)]

Read the examples above and list three examples of benefits that you believe come from your race/ethnicity/gender/position/location.

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2a. Undertake an individual cultural competence audit

According to Campinha-Bacote (2002), 'As we begin, continue, or enhance our journey towards cultural competence, we must continuously address the following question, "Have I ASKED myself the right questions?"'[66] Campinha-Bacote has developed a mnemonic 'ASKED' which poses some critical reflective questions regarding one's awareness, skill, knowledge, encounters and desire.[66] These questions have been adapted with permission to encompass working with Aboriginal and Torres Strait Islander peoples.

Awareness	Am I aware of culturally appropriate and inappropriate actions and attitudes?
	Does my behaviour or attitudes reflect a prejudice, bias or stereotypical mindset?
Skill	Do I have the skill to develop and assess my level of cultural competence?
	What practical experience do I have?
Knowledge	Do I have knowledge of cultural practices, protocols, beliefs, etc?
	Have I undertaken any cultural development programs?
Encounters	Do I interact with Aboriginal and Torres Strait Islander persons?
	Do I interact with culturally and linguistically diverse persons?
	Have I worked alongside Aboriginal and Torres Strait Islander persons?
	Have I worked alongside culturally and linguistically diverse persons?
	Have I consulted with Aboriginal and Torres Strait Islander persons or culturally and linguistically diverse groups?
Desire	Do I really want to become culturally competent?
	What is my motivation?

Consider each of these questions honestly.

_____

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_____

2b. Consider these additional questions:

What do I know about the culture, values, beliefs, individual and collective history and social circumstance of the clients/families/communities with whom I work?

_____

_____

Whose standards have we accepted as the key standard for comparison?

_____

_____

Whose ways of living are privileged?

_____

_____

What are the implications of imposing my understandings on people?

_____

_____

3. Undertake organisational cultural competence audit

Westerman's research findings related to organisational cultural competence highlight the need for practitioners to reflect critically on the organisation in which they are working in terms of organisational competence.[67] Westerman makes the point that:

> *We've had organisations where 80 percent of their staff have had training in cultural knowledge or cultural awareness but that has had no relationship whatsoever to cultural competence and service delivery.[48]*

Westerman lists five key components of organisational competence:

1. local Indigenous-specific knowledge

2. skills and abilities for being able to adapt or utilise mainstream training in a way that will be effective with Indigenous clients

3. resources and linkages for the use of cultural consultants, cultural guides, having lots of links with the local community

4. organisational structures, ensuring that those are actually consistent with culturally appropriate practice

5. beliefs and attitudes—which is the most important?

Consider an organisation or service in the mental health service you work with or are familiar with. Conduct a cultural competence audit by identifying those issues that you believe contribute to, or diminish, the sense of cultural safety and responsiveness for Aboriginal clients and families and staff that the organisation or service may or may not be aware of.[48] Taking into account the five components identified by Westerman, consider the following elements of organisational cultural competence:

Context (organisational environment)

In relation to the organisation:

- Does it promote and foster a culturally friendly environment?

- Is it located in an area where Aboriginal and Torres Strait Islander persons and culturally and linguistically diverse persons may wish to access services?
- Do the staff display attitudes and behaviours that demonstrate respect for all cultural groups?

Practices (culturally inclusive)

Does the organisation:

- involve or collaborate with Aboriginal and Torres Strait Islander persons or groups or culturally and linguistically diverse persons/groups when planning events, programs, service delivery and organisational development activities?
- develop policies and procedures that take cultural matters into consideration?
- provide programs that encourage participation by Aboriginal and Torres Strait Islander persons and culturally and linguistically diverse persons?
- use appropriate communication methods and language, e.g. appropriate and relevant information communicated through user and culturally-friendly mediums?

Relationships (collaborative partnerships)

Does the organisation:

- have knowledge of local Aboriginal and Torres Strait Islander groups?
- have knowledge of culturally and linguistically diverse groups in the community?
- have knowledge of local Aboriginal and Torres Strait Islander protocols?
- have knowledge of the protocols for communicating with culturally and linguistically diverse groups in the community?
- actively involve Aboriginal and Torres Strait Islander persons or groups and culturally and linguistically diverse persons or groups in the community?
- have a strategy for community engagement?

Service delivery (outcomes)

Does the organisation:

- develop and/or implement a collaborative service delivery model with other organisations relevant to the specific cultural needs of the clients?
- provide culturally responsive services that meet the cultural needs of clients?

4. Key concepts

Provide a brief definition for each of the following key concepts:

Social ecology

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Subjectivity

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Reflexivity

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Power

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_____

Cultural interface

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_____

Whiteness

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_____

Privilege

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13

Interdisciplinary Care to Enhance Mental Health and Social and Emotional Wellbeing

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OVERVIEW

This chapter discusses and defines the difference between multidisciplinary and interdisciplinary/interprofessional care with a focus on interdisciplinary care as a model of practice which supports equality and interconnectedness of responsibility amongst team members when working in Aboriginal and Torres Strait Islander contexts. The chapter describes the various professional and para professional practitioners that comprise interdisciplinary teams working in mental health and wellbeing contexts and their roles. The focus is on an interdisciplinary team approach to providing health and wellbeing care as its ethos of equal relationships and interdependent collaboration is more encompassing of social and emotional wellbeing values. Identification of the issues and limitations of interdisciplinary practice and the means to addressing them are explored within the context of how interdisciplinary care fits into mental health best practice and human rights.

INTRODUCTION

There is mounting evidence to suggest that collaborative interdisciplinary, client-centred practice is the best approach to addressing the ever growing complex and varied health and social care needs of societies.[1] This argument has been echoed globally and is visible in many national government policies[2,3] and guidelines of regulatory bodies of health and mental sectors.[4,5] Given the disparities in health and mental health and the complexities of social and emotional wellbeing (SEWB) experienced by Aboriginal and Torres Strait Islander peoples the need for interdisciplinary/interprofessional collaborative approaches is evident.

MENTAL HEALTH PRACTICE STANDARDS AND INTERDISCIPLINARY CARE

The critical need for mental health professionals to work as part of multidisciplinary teams is outlined in the *National Practice Standards for the Mental Health Workforce* (NPSMHW)[3] herein referred to as the Standards. (See Chapter 11, Walker). The Standards were developed to promote high quality care and best practice in the delivery of mental health services in Australia and have underpinned models of multidisciplinary teamwork and best practice. First developed in 2002 and updated in 2013 (with input from Aboriginal health professionals) the standards acknowledge that health professionals come from a range of disciplines, and have a range of qualifications, skills and expertise to provide mental health services that meet the needs of culturally diverse populations. While many of these professionals work in private practice and consult with, or refer to other service providers, the importance of practitioners working as part of multidisciplinary teams is emphasised. Also embedded in the Standards is the critical need to recognise cultural diversity and family centred approaches to improve mental health care by working with family members and carers of people experiencing mental health issues.

Over the past 15 years there have been a number of reforms in mental health care as detailed in the National Mental Health Strategy (NMHS).[6] Key principles of the Strategy include an emphasis on positive consumer outcomes, priority for those with the most severe mental health problems, protection of the human rights of consumers, consumer participation in decision-making, multidisciplinary service delivery, and workforce education and training.[7] There is also an emphasis on mainstreaming of mental health services and the effective linking of these services with the broad range of other health and welfare services used, as well as a focus on prevention and promotion, partnerships among service providers and consumers, and on population health principles.[7]

A key aim of the Strategy is developing a competent workforce, capable of responding to the wide ranging service reform of the mental health sector, encompassing clinical, non-clinical, government and non-government services orientated towards rehabilitation and recovery. The Strategy covers the five major mental health disciplines (psychiatry, psychology, nursing, occupational therapy and social work) and requires each of these professions to be able to demonstrate the range of core knowledge and skills that underpin generic mental health competencies.

Importantly, these competencies emphasise the importance of clients and community partnerships for all professions to complement their disciplines' specific knowledge and skills. In addition to specific competencies for each of the disciplines the professions have identified two central principles as core for all mental health professionals, these are the need to:

- learn about and value the lived experience of consumers and carers

- recognise and value the healing potential in the relationships between consumers and service providers and carers and service providers.[8]

While there are obviously many challenges facing each of the professions in adopting a more collaborative approach and working in interdisciplinary teams, there are also many opportunities. For instance, Renouf and Bland[7] suggest that recent developments in mental health policy and services reform offer real opportunities for social work to contribute to the reform process as a vital relevant discipline and to 'assert a broader agenda in mental health, beyond narrow clinical concepts of illness and treatment'.[7(p429)] They point out that 'the core concerns of social work—human rights, self-determination, family relationships and welfare, employment, housing, community, life chance—are central to mental health'.[7(p430)]

What is an Interdisciplinary Approach?

Within health care, definitions around collaborative health care teams and collaboration are ambiguous, with the terms multidisciplinary, interdisciplinary and transdisciplinary used interchangeably. While there are differences in the meanings of each of these concepts, they reflect common goals or values essential to providing effective, holistic, culturally sensitive care. Furthermore, the context for care varies and may range from acute care service provision through to sustained care within a community setting. In line with an Aboriginal SEWB perspective and building on previous explanations of interdisciplinary care and care teams, we define effective interdisciplinary care as:

> *care offered by a group of health professionals, paraprofessionals, social and other community service providers including Aboriginal and Torres Strait Islander community members who work together to provide social and emotional wellbeing care at the individual, family and community level.*

Interest in an interdisciplinary approach and effective team processes has increased over the last two decades.[9] McCallin[10] suggests this growing interest in interdisciplinary models is due to political demands for economic rationalisation that drive changes in the health sector.

Cooper and colleagues[11] take a different position and claim that the delineated and hierarchical positions which are common in hospital settings are inappropriate for community based care, where teamwork is essential to addressing complex and diverse needs of clients, resulting in the need for new models of care partnerships.

Table 13.1, adapted from Crocker,[12] details the characteristics and limitations of each of the team models.

Table 13.1: Characteristics of Multidisciplinary, Interdisciplinary and Transdisciplinary Teams

Team model	Characteristics	Limitations
Multidisciplinary team	• Doctor controls team • Team meets to coordinate client care • Clients are not included in decision-making processes.	• Clients not involved • Services may be omitted, fragmented or duplicated • Team members expertise may not be used effectively.
Interdisciplinary team	• The team is not necessarily led by the doctor. They work within their areas of expertise and coordinate the work of others. Leadership is provided by the person with the most expertise in the given situation? • Reports of functional progress, decision making and care plans are informed by case conferences • The client is the centre of the team's focus and plays an important role in goal setting • Ideas are exchanged that lead to changes in clients' treatments.	• Team meetings require time • Team members may need to be trained in team processes • Individual team members need to cede some control to the team so that client care is driven by the team processes • The doctor needs to allow team decision making yet take medico-legal responsibility for outcomes.

Transdisciplinary team	• Communication and shared treatment among team members
	• All team members have the opportunity to work on all areas of function
	• Team meetings are more oriented to clients' function than to disciplines
	• In the case of discrepancies, leadership may be provided by the most relevant discipline.
		• Team meetings require time
		• Team members may need to:
		  – be trained in team processes
		  – cede some control to the team so that client care is driven by the team processes.

The Benefits of Interdisciplinary Teams

Within contemporary Australian health care it is common practice for teams of health professionals to collaborate in the provision of care to clients. Crocker[12] claims this approach provides benefits to the client, the team members, students, educators and the organisation/health care service delivery system. Kates et al[13] suggest that the experience from collaborative models of care in Canada indicates there are 'better clinical outcomes, a more efficient use of resources, and an enhanced experience of seeking and receiving care.'[13(p1)] Grant and Finocchio[14] also suggest that the benefits of interdisciplinary care can be seen across the four participants of interdisciplinary health care (clients, health care providers, educators and students). There are additional benefits from a SEWB perspective—for carers and families and the community as relationships are strengthened between community members and the various mental health

professionals and social service providers. The benefits of receiving interdisciplinary team care are significantly greater for those individuals with complex chronic health issues and needs. Clients with complex health care needs including chronic medical conditions, mental health conditions and social disadvantage are assisted through culturally appropriate interdisciplinary care. The advantages for each of the respective groups are listed in Table 13.2.

Table 13.2: Benefits of Interdisciplinary Team Care

For Clients	
Improves care by increasing coordination of services, especially for complex problems	Can serve clients of diverse cultural backgrounds
Integrates health care for a wide range of problems and needs	Uses time more efficiently
Empowers clients as active partners in care and enhances satisfaction and outcomes	
For Carers and Families	
Provides the best possible outcome for the physical and psychosocial carers (as well as clients with mental illness)	Involves carers with a range of professionals in the process of developing a mental health plan
Addresses the needs of carers, siblings and the children of those with mental health problems	Considers everyone's concerns and identifies resources for supporting someone with mental health issues
Assists with broader social, cultural and health issues experienced by families	
For Health Care Professionals	
Increases professional satisfaction	Encourages innovation
Facilitates shift in emphasis from acute, episodic care to long-term preventive care	Allows providers to focus on individual areas of expertise
Enables the practitioner to learn new skills and approaches	
For Educators and Students	
Offers multiple health care approaches to study	Promotes student participation
Fosters appreciation and understanding of other disciplines	Challenges norms and values of each discipline
Models strategies for future practice	Develops an understanding of the reality of working in a collaborative interdisciplinary team
For the Health Care Delivery System	
Holds potential for more efficient delivery of care	Facilitates continuous quality improvement efforts
Maximizes resources and facilities	Reduces health expenditure
Decreases burden on acute care facilities as a result of increased preventive care	Facilitates seamless transition between care sectors (such as acute and community care)

Information sharing between team members facilitates effective collaboration. Aboriginal and Torres Strait Islander peoples with a mental health condition and accompanying comorbidities are more likely to benefit from interdisciplinary care, which involves health professionals, para-professionals and community support workers.[15]

A CULTURALLY APPROPRIATE MODEL OF MENTAL HEALTH CARE AND SERVICE DELIVERY

Many Aboriginal and Torres Strait Islander communities, particularly in rural and remote areas rely on small health care teams, consisting of a limited number of health care providers, including Aboriginal health workers (AHWs), and paraprofessional health and mental health workers and counsellors. The AHW often plays a central role in the health team.[8] In addition to specific knowledge and health specialisations, these trained health workers have expertise in cultural and community knowledge systems. They are increasingly recognised as providing important assistance to professionals and enhancing interdisciplinary/interprofessional teams.[16]

Often, Aboriginal and Torres Strait Islander peoples are reluctant to utilise mainstream health services, acute care and community-based services, because of the reported lack of cultural competence and cultural security.[17] Mental health and SEWB care is accessed by Aboriginal and Torres Strait Islanders and non-Aboriginal clients through both acute care health agencies and community services depending on the client's need and mental health status. As acute care services are not offered in all regional locations, this care is more likely to be found in major cities. The geographical distance between services adds another dimension to a seamless transition for clients between the 'care sectors' and emphasises the need for effective interdisciplinary communication to ensure a 'seamless' continuity of care for the client.

The model of health care for Aboriginal and Torres Strait Islander peoples in rural and remote locations is the traditional doctor-centred model[18] but is provided by an interdisciplinary team, often led by the AHW in a client-centred manner and in accordance with the principles of culturally appropriate health care.[19] Importantly, people generally prefer to attend community controlled health services, as they use a similar model of care as discussed further in Chapter 5 (Zubrick and colleagues).

The care provided through community controlled health and mental health services moves beyond the traditional biomedical model of health care provided by doctors, to encompass a more culturally responsive, client-centred, holistic model of care.[18]

The Relevance of a Bio-Psycho-Socio-Cultural–Spiritual Model

A culturally responsive, client-centred, holistic model of care is in accordance with the psychosocial-cultural model, first proposed by Engel in 1961,[20] which includes the psychosocial–cultural dimensions (personal, emotional, family, community) in addition to biological aspects (diseases) of clients.[21] True to Engel's initial conception,[20] bio-psycho-social models have evolved to include cultural and spiritual aspects of health and mental health and encourage mental health practitioners to consider the social and emotional wellbeing of individuals within a broader fabric of their family and community[22] (for a comprehensive discussion of SEWB from an Aboriginal perspective, refer to Chapter 4, Gee and colleagues).

The bio-psycho-socio-cultural-spiritual model depicted in Figure 13.1 is a useful model for mental health practitioners, as it provides a context for the problems presented by the client to gain a better understanding of the issues faced by the client and their families. It enables practitioners to explore the five domains of a client's life. This model recognises that professional practitioners need to address a wide range of social, cultural, psychological and physical needs of individuals and their carers/families. Emphasis is also placed on a solution-focused approach to assessment and management, with consideration as to what has previously worked for a client and could work again.

Figure 13.1: Interdisciplinary Care using a Bio–Psycho–Socio–Cultural–Spiritual Framework
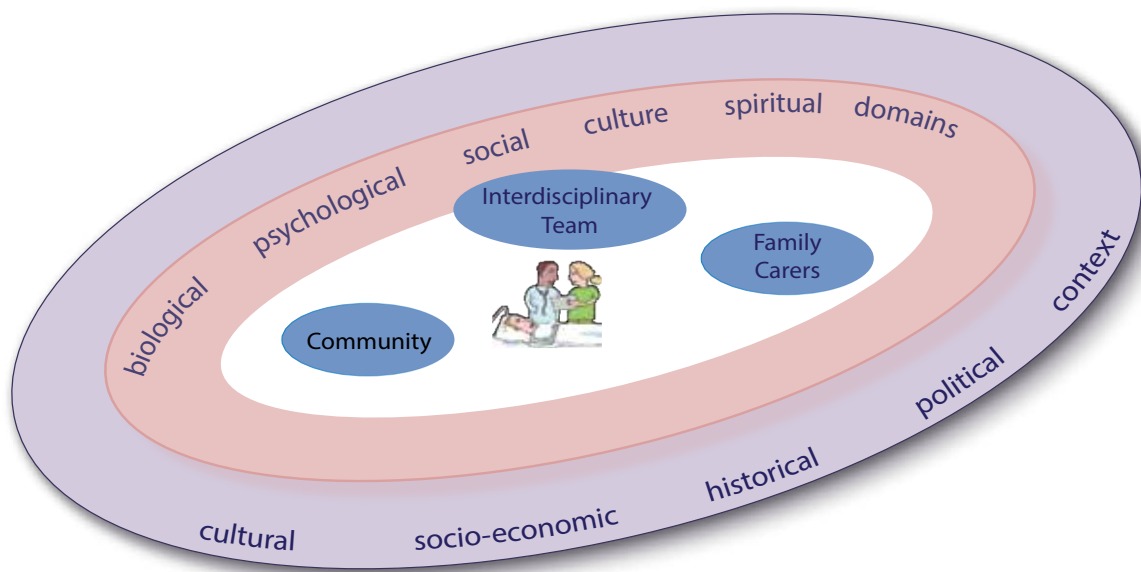
© Roz Walker
Design: Chrissie Easton

A bio-psycho-socio-cultural-spiritual framework integrates the multiple, interacting biological, psychological, social, cultural and spiritual domains within a broader historical socio-political and cultural context to more fully understand all of the factors impacting on what is happening for the client.

The social domain includes family background, social support, interpersonal relationships, cultural traditions, socioeconomic status, poverty, physical exercise.

The psychological domain includes cognition, intellect, learning, emotions, memory, thinking, attitudes, beliefs, values, coping strategies and perceptions.

The biological domain includes physical factors that may impact on a client's overall functioning wellbeing and involve health related effects of such things as harmful substance use, genetic predisposition, neurochemistry, effect of medications, immune response, hypothalamic pituitary axis, fight-flight response, physiological responses.

The cultural domain includes a person's sense of their culture, their response to and beliefs about mental illness/stress, as well as the impact of the majority culture on their cultural values and beliefs.

The spiritual domain includes practices and beliefs that support a sense of spiritual connection with country, ancestors, community, prayer, dance, meditation and music.

To provide effective inclusive health care to Aboriginal and Torres Strait Islander peoples, service providers need to incorporate the physical, social, cultural, spiritual and emotional wellbeing aspects of care; and consider the health beliefs of the client, their families and community.

Similarly, an effective interdisciplinary health team addresses the community need for client-centred and culturally appropriate health care. Suitable and effective care in health settings is dependent on the ability of the health team to work effectively together and to consider the needs and priorities of the client and their family and community.

AN EFFECTIVE INTERDISCIPLINARY TEAM APPROACH

The literature on multidisciplinary, transdisciplinary, interdisciplinary and interprofessional team work suggests that, in order for these teams of professionals, paraprofessionals and community members to work together effectively, there needs to be a clear understanding of each member's role, responsibility limitations, skills and flexibility to work in a setting with role overlap.[23-25]

> *Interdisciplinary collaboration requires teamwork. To function well … members need to share a common vision and goals (clear definitions related to interdisciplinary collaboration in primary health care will help), communicate clearly with the other members of their team, understand each other's roles, trust one another, and make decisions as a group.[24(piii)]*

To be effective, multidisciplinary, transdisciplinary and interdisciplinary teams need to:

- have shared goals and values;

- share a team culture;

- openly communicate;

- understand and respect the competencies of other team members (as well as understanding how and why they practise as they do);

- equally value and regard each member's contribution to current team practices;

- be willing to learn from other disciplines and respect their different views and perspectives;

- maintain clarity on individual professional and legal accountability within a context of shared responsibility towards the client.

Effective processes in interdisciplinary care require all mental health practitioners to accept, acknowledge and respect the different skills and valuable experiences that Aboriginal health and mental health workers bring to the team. The diversity of roles and disciplines can add to effective team work by enabling members to draw on different experiences, understandings and disciplines to problem solve.[26] The heterogeneous nature of interdisciplinary teams can also be problematic if members are not able to reconcile their differences and work together. Effective interdisciplinary teams require team members to listen and accept each other as meaningful and equal partners in contributing to the care process of clients. Interdisciplinary team meetings where these different perspectives are openly discussed strengthen the professional working relationships of the interdisciplinary team members.

Establishing Interdisciplinary Partnerships

Establishing interdisciplinary partnerships is most optimal when providing health services to Aboriginal and Torres Strait Islander clients with mental health issues and their families and carers. People often present to doctors or SEWB workers with a range of different issues that are not always directly health related. If health professionals understand the range of social and cultural determinants that can impact on a person's mental health and SEWB they are more likely to see the value of inviting other relevant service providers to assist the team, e.g. housing, Centrelink, child protection and justice. In some circumstances the team may include Aboriginal and Torres Strait Islander counsellors and mental health workers from *Link Up* or the *Bringing Them Home* SEWB programs to address issues such as loss of identity as experienced by the Stolen Generation. Spiritual and traditional healers from the community will be able to help inform a spiritual and or cultural intervention. Kates et al suggest a series of practical changes that can be made across mental health care to improve collaboration of health care provision.[13(p6-7)] An adaptation of these follows:

Practical Changes to Improve Collaboration in Providing Mental Health Care
• Include individuals and their families and (or) caregivers as partners in their own care.
• Develop strategies to reduce stigma and discrimination among all health care providers including those that will lead to a better understanding of cultural diversity.
• Promote mental health, wellness and recovery as goals of system changes.
• Focus on quality improvement, access and efficiency as drivers of system change.
• Define individual professional and interdisciplinary competencies for all health professionals working in collaborative mental health partnerships.
• Ensure that respective roles and responsibilities of all members of the interdisciplinary team are clearly defined and understood.
• Strengthen personal contacts of the team by organising events such as joint clinical and educational rounds, and formal continuing professional development events that bring team members together.
• Use new technologies for managing information which offer new ways to link providers, enhance collaboration and provide consultation to underserved communities.
• Foster the development of networks of providers, clinicians, researchers and consumers to exchange ideas, share experiences and work together to develop collaborative models of care for wider dissemination.

Although the discourse of interdisciplinary care is evident in the current Australian health space, there are challenges to applying an interdisciplinary approach when working with Aboriginal and Torres Strait Islander peoples. The enduring impact of institutional discrimination and racism and the lack of cultural competence among practitioners within Australia's health and mental health and wellbeing sector creates a challenging environment for interdisciplinary care.[17,27]

New modes and understandings of interdisciplinary care complement working from a SEWB framework that considers spirituality and connectedness to country, kin and community as vital parameters of health. They also ensure that all community members in Australia receive effective care in keeping with human rights standards.

A report conducted in the United Kingdom (UK) by Greasley and colleagues[28] suggested that including spiritual practitioners such as nuns, priests or other religious figures in the mental health care team was beneficial to both clients and other team members. Appelbaum and colleagues[29] point out the value of including correctional officers in the interdisciplinary team to inform them of treatment needs of people in prison and note that:

> *effective treatment of inmates who have mental disorders can alleviate the stress experienced by the mentally ill [clients] and by the correctional staff who supervise them.*[29(p1344)]

Opportunities of an Interdisciplinary Approach for the Aboriginal Health Workforce and Services

A collaborative, interdisciplinary approach to health care is best able to respond effectively to different and complex situations and environments. The benefits to be gained come through the valuing, by the wider health team, of the cultural knowledge and knowledge of the community that is held by the AHW staff employed in Aboriginal Health Services. This knowledge is often critical to the successful health care outcome/s from the interdisciplinary team when responding to client's mental health and SEWB issues.

In order to meet the Mental Health Practice Standards and the Standards of respective professions to provide equitable services for Aboriginal and Torres Strait Islander peoples, health services and health professionals have a professional and ethical responsibility to:

- increase the cultural competence of their staff and the organisation
- form partnerships with local Aboriginal Community Controlled Health Services (ACCHS) who have more cultural understanding and may be considered more appropriate by community members
- employ AHWs, Aboriginal mental health workers (AMHWs) or other Aboriginal and Torres Strait Islander health professionals within the organisations.

While this latter strategy may not appear practical for some smaller independent services, working together and towards exploring other options can help to address some of these issues. For example, in some instances a group of small services have arranged to co-employ Aboriginal and Torres Strait Islander staff such as AHWs on a shared employment basis.

An interdisciplinary approach has the potential to more equitably share the burden of care for Aboriginal and Torres Strait Islander peoples which is heavily placed on ACCHS and AHWs working in Aboriginal medical services and government services. An interdisciplinary approach values each of the members of the team and therefore it is more likely that AHWs will gain greater recognition and authority alongside other professional practitioners and have greater access to client information and consultation with respect to client medical advice and treatment. Being regarded as part of a team should result in more appropriate remuneration, professional or personal support, ongoing education, developmental or career pathways for AHWs and AMHWs than currently experienced.[30-32]

Many AHWs and AMHWs working with clients with complex issues related to harmful substance use report 'burn-out' related to work overload and under validation by their non-Aboriginal professional colleagues.[30, 32] An interdisciplinary team approach enables the burden of care to be more equitably shared and has the potential to address the experiences of disempowerment, burnout, and even self-harm and suicide anecdotally noted within the Aboriginal and Torres Strait Islander health/SEWB professional and paraprofessional workforce through more team and peer support strategies.

INTERDISCIPLINARY MENTAL HEALTH AND SEWB TEAMS

Adopting a SEWB perspective when working with Aboriginal and Torres Strait Islander individuals, families and communities involves many professional and paraprofessional practitioners in the interdisciplinary team. These may include practitioners from the five professions that comprise the mental health workforce - mental health nursing, occupational therapy, psychiatry, psychology and social work; general practitioners; other primary care staff; Aboriginal health and mental health workers; social service providers; community workers; and others who are recognised and respected in the community. Figure 13.2 indicates the range of potential service providers involved with SEWB teams.

Figure 13.2: Potential Members of an Interdisciplinary SEWB Team
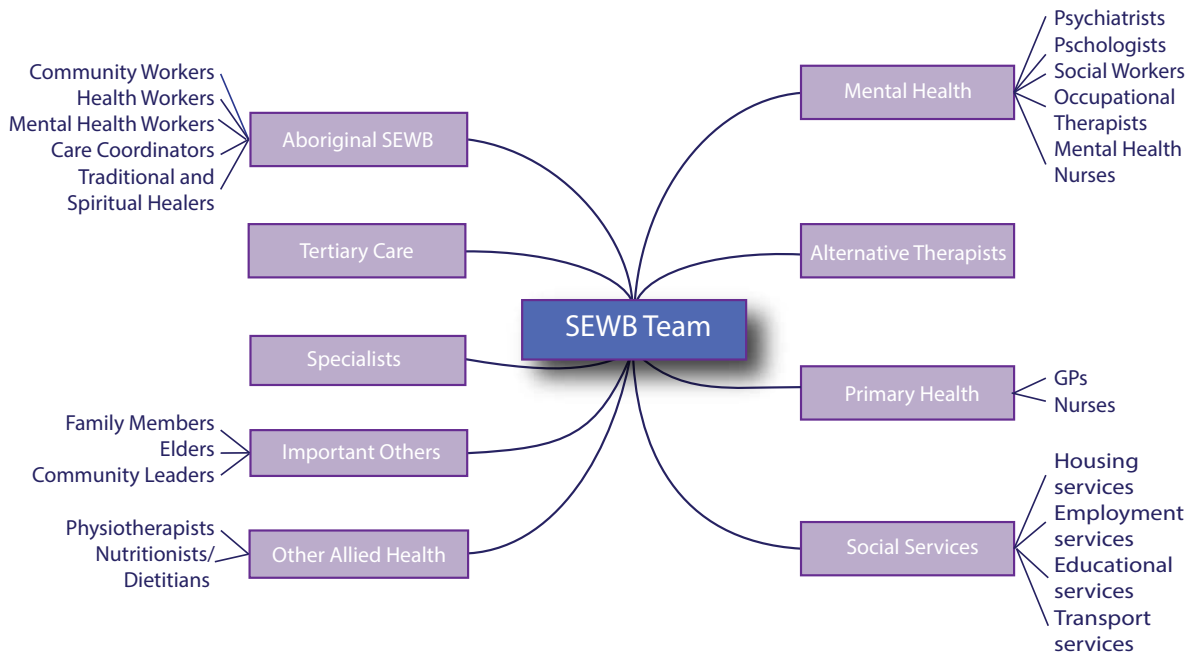
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Traditionally, multidisciplinary mental health teams were led by a doctor, psychiatrist or clinical psychologist who had the power to make the final decision regarding a client's care. A more collaborative approach in health teams requires these practitioners to relinquish their power to work in genuine partnership with other team members. In some cases, it may be the AHW who leads the team particularly when an Aboriginal and Torres Strait Islander client has cultural/spiritual concerns which require a cultural intervention.

Interdisciplinary team members have different areas of expertise. The combined skill sets are useful in providing effective care in complex and challenging cases. Renegotiating your power can be challenging, but satisfying for doctors and other mental health professionals, from the provision of effective interdisciplinary care as opposed to the illusion of authority:

> *It can be a very humbling, but rewarding experience for those doctors who work effectively in such teams to see themselves purely as a member of a team whose function is to provide effective health care for an Aboriginal or Torres Strait Islander person.*[33]

In order to provide the interdisciplinary care, the team meet regularly to discuss their work with individual clients so that each client has a care plan best suited to their individual needs. A description of the roles of different workers who comprise a typical interdisciplinary team is described in Table 13.3.

Table 13.3: Disciplines and Roles in a Multidisciplinary or Interdisciplinary Team

Discipline	Role/Experience/Capacity
Mental Health Nurse	Work with people with high and low prevalence mental health disorders, including mental illnesses or psychological distress. Services they provide are: • Identify client goals and interventions required to achieve them • Provide a comprehensive mental status assessment • Contribute to the development of a General Practice Mental Health Care Plan • Contribute to case conferences • Assist clients' families and carers to provide care and support • Provide psychological education • Provide counselling and psychological interventions. Clients may be referred for: • Education, management and compliance monitoring • Liaison point between General Practitioners (GPs) and psychiatrists • Support and interventions post discharge from a mental health service • Monitoring of mood, suicidality and self-harm tendencies • Counselling to manage and contain psychological distress • Home visiting.[34]
General Practitioner	GPs look after clients by promoting health and doing preventive health care. They: • Attend to clients who are physically or emotionally unwell • Provide 'person centred, continuing, comprehensive and coordinated whole person health care to individuals and families in their communities.'[35] GPs also: • Prescribe medication • Provide comprehensive care using a holistic framework and look after a client's acute illness (physical and/or emotional), and chronic disease, including mental illness • Provide continuity of care, looking after a client over time when he/she is well and unwell • Promote physical and emotional wellbeing and provide preventive health care • Coordinate care and refer to mental health services, specialists and allied health providers and work with these care providers to provide interdisciplinary care for mental health clients • Recognise and address the health and psychosocial needs of carers, families including children of those with mental health problems.
Psychiatrist	Psychiatrists are medical doctors who have specialist training in order to be able to coordinate and manage the treatment of clients' mental, emotional, and behavioural symptoms. Psychiatrists: • Have a complex understanding of biological, psychological, social and cultural factors that may impact on the experience and diagnosis of mental illness in a person • Understand the interaction between mental illness and other physical illnesses that may affect the person • Have an appreciation of the various therapies that may be applicable to treat the person's illness and the skill sets required from various professionals within a multi-disciplinary team to assist such treatments. Such therapies include understanding the role that a range of medications may benefit the treatment of the illness, including an appreciation of side effects and interactions of the medication.

Continued . . . .

Table 13.3: Disciplines and Roles in a Multidisciplinary or Interdisciplinary Team (continued)

Discipline	Role/Experience/Capacity
Occupational Therapist	Occupational therapy (OT) is a client-centred health profession concerned with promoting health and wellbeing through occupation. The primary goal of an OT is to enable people to participate in everyday life by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement. OT's assist with SEWB and can refer clients to a GP with: • Comorbidity (depression, other acute conditions) • Failure to progress • Wounds that do not heal • Poor compliance to medication regime • Life crises (sudden changes in life circumstances, such as death of partner, family member or pet).[36]
Mental Health Social Worker	Work with individuals with mental disorders to resolve associated psychosocial problems and with families in which mental health problems exist in connection with social problems, such as family distress, unemployment, disability, poverty and trauma. They work with issues such as depression, anxiety, mood and personality disorders, suicidal thoughts, relationship problems, adjustment issues, trauma and family conflicts. They provide a range of evidence-based interventions, which focus on achieving solutions, including: • Cognitive behavioural therapy • Relationship strategies • Skills training • Interpersonal therapy • Psycho-education • Family therapy • Narrative therapy. MHSWs interventions include: • Detailed psychosocial assessment identifying the connections between mental health problems and complex social contexts • Assessment of the mental illness and its impact on the life of individuals and their families • Working with individuals, families, groups and communities to find solutions to mental health problems.[37]
Psychologist	Provide services in a range of settings, including hospitals, clinics, schools and private practices. Psychologists specialise in understanding the effects of psychological factors related to health and illness using evidence-based interventions, such as cognitive behavioural therapy, to help people adjust to acute, chronic, or complex medical conditions; and assist people with mental illness. Their role includes working with: • Medical practitioners and other health care professionals to implement client programs to promote health, prevent illness and to facilitate chronic disease self-management • Individuals to make lifestyle changes to maximise health and functional outcomes • Client's emotional and behavioural issues related to adjustment to chronic conditions or injury *Continued . . . .*

Table 13.3: Disciplines and Roles in a Multidisciplinary or Interdisciplinary Team (continued)

Discipline	Role/Experience/Capacity
Psychologist (continued)	• Clients with life-threatening conditions to manage pain, cope with medical interventions and the side effects • Clients to adhere to treatment regimes • Client's families and carers to provide support.[38]
Pharmacist	Devise and revise a client's medication therapy to achieve the optimal regime that suits the individual's medical and therapeutic needs. They can: • Be an information resource for the client and medical team • Provide information on new drug treatments and the impact of different drugs when taken together.
Aboriginal Health Worker/ Mental Health Worker	AHWs liaise between health professionals, clients and visitors to hospitals and health clinics to assist with arranging, coordinating and providing a quality health care service. They work closely with both the client and the health care team. They can: • Act as interpreters to ensure that the health care practitioner is clear about the client's symptoms, medical and personal history and that the client has a good understanding of the diagnosis, treatment and health care advice • Work in specialty areas including drugs and alcohol services, mental health, diabetes and eye and ear health • Provide support, advocacy and counselling.
Aboriginal Healer/Elder	Aboriginal traditional healers assist in healing of the mind, body and the spirit through practices which use the natural environment, the spirit world (including totems and their dreaming) and plants in addition to advice about attitude, behaviour and faith in their spiritual connections. The traditional healer may: • Assist a client who is experiencing spiritual issues of a cultural nature • Support and strengthen a person's identity and understanding of culture • Conduct healing ceremonies such as smoking to make a person well. Aboriginal Elders can provide advice and direction on cultural issues and give feedback in relation to a client's attitude and behaviour. They can provide: • Mentoring, give comfort and support • Speak sternly if required to the client to encourage them to listen or respond to treatment or medical advice • Be an advocate or representative for a client if given permission.
Chaplain/Pastor/Priest	Provides: • Visits and ministry to clients and family • Spiritual advice and counselling.
Client	The consumer provides information necessary for assessment and planning of care. Communicates their needs and perspectives on illness, treatment and what they view as the major goals of care. **Note:** Any or all care goals must be endorsed by the client in order to achieve successful adherence to a therapeutic plan. *Continued . . . .*

Table 13.3: Disciplines and Roles in a Multidisciplinary or Interdisciplinary Team (continued)

Discipline	Role/Experience/Capacity
Family Caregiver/Spouse/Children	Consumer and family advocate for the client and are often the main provider of direct care. They can: • Provide a wealth of information regarding the client—pre-illness functioning, hobbies, interests, and concerns • Offers direct input about ability and willingness to assist in care • Provide a background and understanding of family history and/or dynamics that may interfere with knowledge of client and ability to participate. **Note:** May not have detailed knowledge of disease process or the roles and function of the professionals on the team. May or may not live with the client.
Caregiver outside family/Neighbour/Friend	Advocate for client. May provide: • Direct care for client • Information regarding the client—pre-illness functioning, hobbies, interests, and concerns • Offers direct input about ability and willingness to assist in care. **Note:** May not be identified or approved by the family.
Social and Emotional Wellbeing Counsellor	Can provide counselling in relation to identity issues. Can: • Help client to track and locate their family • Connect client to family records • Assist in re-connecting with family.

KEY FACTORS FOR EFFECTIVE INTERDISCIPLINARY TEAMS

Reeves et al[39] suggest the key factors to successful interdisciplinary teams are: organisational context, team processes, team structure and team outputs.

Organisational Context

Organisations control and co-ordinate human resources and activities to achieve specific aims and objectives. The development of effective interdisciplinary team work is dependent on the structure, function and performance of organisations and the behaviour of groups and individual professionals within them.

Health care teams face a range of challenges in their organisational context and team structures and their respective professions. Interdisciplinary teams create a challenge for health care organisations—there is a need to define relationships and priorities between the executive, teams and other staff members.

The concept of interdisciplinary teams comprises of professionals and paraprofessionals with different roles, levels of responsibility, disciplinary power and status. This can challenge traditional health care organisations, limiting the ability of teams to be culturally responsive. When providing interdisciplinary care, mental health care professionals caring for Aboriginal and Torres Strait Islander clients may find themselves in complex situations. They are generally employed by different organisations and required to work to different discipline and practice standards. Problems can occur within these organisational structures when there are uncertain boundaries and power relationships and individuals have to reconcile the differences. Team members can find themselves with dual or inconsistent accountability, which require them to acknowledge their professional differences and focus foremost on meeting client needs. Boundaries between teams, unclear tasks and inappropriate

leadership can impact on the effectiveness of teams. It is therefore important to develop a supportive organisational structure that encourages teamwork.

Team Processes

Effective interdisciplinary teamwork in mental health services involves both retaining differentiated disciplinary roles and developing shared core tasks. It requires sound leadership, effective team management, clinical supervision and explicit mechanisms for resolving role conflicts and ensuring safe practices. No one profession should hold a monopoly on leadership.[40]

As Reeves et al state, team processes are multidimensional.[39] The interplay of processes involved in maintaining an interdisciplinary team are highlighted in Table 13.4.

Table 13.4: Processes Involved in Interdisciplinary Team Management

Communication	• Communication within the team environment takes place in both verbal and non-verbal forms, communication which is open and free-flowing between team members provides the basis for effective care outcomes
	• Effective team communication is a shift beyond the traditional silo approach to care.[41]
Team Emotions	• Team emotions can play a significant role in the effectiveness of teams and the positive clinical outcomes
	• Team 'membership' carries a distinct set of emotions due to the attachment often felt with colleagues and the commitment felt to provide effective outcomes.
Trust and Respect	• Often developed via shared experiences and the ability for individuals to demonstrate clinical competence
	• New team members will often need to 'prove' competence
	• Development and maintenance of trust and respect within the team will promote a stable team
	• Absence of such important qualities will result in problematic behaviours amongst the team members.
Humour	• May support resilience by relieving the general stressors and strains of working closely with other professionals.
Conflict	• Different team members bring different ideas, goals, values, beliefs and expectations to the team
	• Can act as a barrier for team performance
	• Can strengthen team performance if it enhances innovation, quality and creativity[42]
	• Is likely to occur with multiple individuals working closely together from different disciplines
	• Important for the team to agree early on how they will resolve conflict.
Team Stability	Team stability produces positive outcomes due to the development of mutual respect, trust and goals. Tips for maintaining team stability:
	• Set standards for accomplishing tasks and for team behaviour
	• Encourage each team member to contribute by reinforcing the importance of equality and interdependence
	• Seek harmony when conflict occurs by acknowledging difference and listening carefully and respectfully to all opinions
	• Brainstorm collectively for possible solutions and focus on common interests amongst team members
	• Seek consensus amongst team members in arriving at the most appropriate decision
	Continued . . . .

Table 13.4: Processes Involved in Interdisciplinary Team Management (continued)

Team Stability *(continued)*	• Remain open to giving and receiving feedback about positive and/or negative behaviour, decisions, outcomes
	• Review and evaluate progress at the conclusion of interaction and be open to constructive criticism regarding the team's functionality.[14]
Team Building	• Can assist to enhance individual attitudes, skills, knowledge and behaviour both toward desired goals and each other
	• Can promote collaboration and improve performance of team members
	• Critical reflection activities allow teams to adopt and respond to change within the team environment.[42]

Team Structure

To be effective, multidisciplinary care requires a leadership style that moves away from control and power and facilitates trust and team work that values the combined expertise and knowledge of the group to effectively work together to provide comprehensive care for the client. Thus, working effectively as a member of a well-functioning interdisciplinary team requires an acknowledgement of the power differential that may occur in doctor or psychiatrist led teams.

When working with Aboriginal and Torres Strait Islander clients and health workers, the power differential can be twofold; particularly in relation to the assumed authority inherent in the medical discipline/profession and the implicit status of white privilege of medical personnel. In many instances, the doctor is not the appropriate person to lead an interdisciplinary team.

Role Boundaries

Determining clear professional roles within a team is an essential element to effective team performance and for maintaining professional integrity. Failure to do so can result in negative outcomes. A study in the UK found that, for some social workers, working in interdisciplinary teams resulted in role blurring and loss of professional identity, higher levels of role conflict and stress and marginalisation from the team.[43]

Team Outputs

The outputs for the team will be dependent on the extent and nature of the client's presenting situation. The GP may refer a client to an OT or counsellor or psychiatrist, or decide that they need to involve a social worker to link with various social services. The outputs will derive from the tasks assigned to each team member. What will be important is the ability of the team leader to synthesize the various viewpoints and specialisations and monitor and communicate the various elements of the bigger picture, to ensure everyone is aware of what is being proposed for the client, their carers and families. Specific outputs might involve the following—the identification and use of an agreed assessment tool and an accurate diagnosis and treatment plan (if appropriate) that requires disciplinary knowledge, but which is enhanced through the interdisciplinarity of approach in working with a client. The integration of these outputs into the overall patient plan must be discussed by the team so as to ensure that the work of each member is closely linked to the overall objectives.

Awareness of one's role and responsibilities within an interdisciplinary setting is crucial to the effective health and social and emotional wellbeing outcomes for the individuals, families and communities.

OVERCOMING BARRIERS IN WORKING WITHIN INTERDISCIPLINARY TEAMS

Interdisciplinary teams address multifaceted dimensions of health and wellbeing. There are a number of potential barriers to effective interdisciplinary teams. These include:

- lack of hierarchal support within, and external to, the team;

- inability of the team to share the same vision and goals with regards to outcomes;

- the trivialisation of others' opinions;

- resistance to change and reform;

- lack of access to appropriate resources (time, individuals and costs);

- poor communication within teams;

- lack of accountability of teams (working within teams means that you have someone else to blame);[44]

- competitiveness within the team;

- preconceived negative attitudes to outcomes and clients (based on lived experiences and taught behaviours);[45] and

- individual personalities may undermine the effectiveness of the team regardless of professional intentions.

Narisimhan states that a number of factors must be considered from the point of view of team members as well as the client to ensure good therapeutic outcomes.[46] By viewing the process in a holistic sense it is possible to take account of the complex and competing issues for all individuals involved in the process of interdisciplinary care, with direct recognition of the place and space of clients.

Freshman and colleagues observe that, unless potential issues and barriers are acknowledged and dealt with, interdisciplinary care can be negatively affected, resulting in poor health outcomes for services and individuals, their families and their communities.[45]

Human Rights Framework and Equity

Access to health is a basic human right irrespective of race, religion, culture, gender or sexual orientation and should be the founding principles of health service delivery. The principles of equality and non-discrimination are core principles in international human rights law, which all members of the United Nations have legal obligations to promote.[47]

The World Health Organisation (WHO) has suggested that the lack of concern for people of other cultures is a violation of the basic ethical principles of social justice, particularly in the area of adequate provision and maintenance of the social determinants of health.[48] Mental health professionals working in interdisciplinary teams that engage with clients, their carers and families, local community members and social service providers can help address a range of social determinant issues. The human rights framework helps to illustrate why Aboriginal and Torres Strait Islander peoples often lack access to mainstream services, including interdisciplinary teams.[49]

MacNaughton[47] and McMillan[49] acknowledge that the extent to which human rights principles have been adopted into law, interpretations of the rights to equality and non-discrimination, as well as their relationship to each other, vary considerably across countries and jurisdictions. The utilisation of the human rights framework and the underpinning of human rights principles in recognising positive equality as distinct from status-based non-discrimination has potential for ensuring that Aboriginal and Torres Strait Islander peoples have equal access to health and mental health services in Australia, (as well as services that address the social determinants).

Interdisciplinary Education

As pressure increases for more appropriate and effective means of health care, the need for interdisciplinary teamwork has been recognised, thus increasing the pressure to change the way health care professionals work and are educated.[11] Grymonpre[1] suggests that interprofessional education may assist health professionals to be more able to work as part of an interdisciplinary team; be reflective of, and able to make changes in their own practice; and, mentor their peer and students. By incorporating more constructivist, experiential and interdisciplinary approaches to learning—where all team members are actively involved in a process of meaning and knowledge construction—health professionals will gain a greater appreciation of the value each profession and paraprofessional brings to mental health and wellbeing care for clients from complex and culturally diverse contexts.

CONCLUSION

This chapter has outlined the critical importance of adopting an interdisciplinary approach to addressing the higher incidence of poor health, mental health and SEWB experienced by Aboriginal and Torres Strait Islander peoples. SEWB is a holistic concept of health and wellbeing held by many Aboriginal and Torres Strait Islander peoples. Interdisciplinary care to support SEWB is care offered by a group of health professionals, paraprofessionals, social and other community service providers and others of knowledgeable stature including Aboriginal and Torres Strait Islander community members who work together to provide social emotional wellbeing care at the individual, family and community level.

A key strength of mental health/SEWB multidisciplinary and interdisciplinary teams is that the combined expertise of a range of mental health professionals is integrated to deliver seamless, comprehensive care within a context that is culturally sound and secure for the client and family. An interdisciplinary approach has been shown to be beneficial to practitioners, clients, students and organisations. Successful management of interdisciplinary teams include effective communication, managing team emotions and stability, maintaining trust and respect, incorporating humour, addressing conflict constructively and facilitating team building.

Interdisciplinary education within the SEWB context is explained as the practice of professional disciplines working together and sharing their professional knowledge in arriving at solutions and approaches that can facilitate and help a mental health client achieve their potential and become well. Through interdisciplinary education multiple professional disciplines are encouraged and supported to come together as partners and equals to learn from each other and develop best practice. This newly constructed knowledge is then transferred to students to enable them to learn how to apply and facilitate improved quality of care in the field.

An interdisciplinary approach /interprofessional practice requires practitioners to acknowledge the traditional power differentiations that exist within their disciplines and positions and to relinquish some control to workers from other fields. Finally, it is argued that access to interdisciplinary care is a basic human right which all Australians, despite ethnic, cultural background or socioeconomic status should support, enable and maintain. To ensure health, mental health and other SEWB workers are confident and competent to participate in interdisciplinary teamwork, education and training in interdisciplinary models is essential.

CASE STUDY

The following case study about Jacinta is a real case presentation; all identifiable information has been removed to protect her identity.

Case Study   **Jacinta's story**

A 32 year-old Aboriginal woman (Jacinta) presents to her GP with the following symptoms:

- *low mood, low self-esteem, frequent fatigue and loss of energy, moodiness, rapid weight loss, periods of uncontrolled crying, shortness of breath, nervousness, re-occurring migraines, broken sleep*

- *recently started smoking again after having quit for five years*

- *hospitalisation 12 months previous after a serious episode of asthma; however Jacinta reports her asthma had not been problematic since this episode. She is not currently using Ventolin as she reports being unable to afford to get her script filled*

- *direct family medical history is not known as the client was raised by extended family members*

- *current medication: Ibuprofen, Valium (not prescribed)*

- *previous medication: Zoloft, Ventolin.*

Jacinta has six children under the age of seven in her care and is the biological mother of two. Jacinta's sister who is the mother of the other four children has had to leave town to care for a sick extended family member in a remote area. The children remained in town as travel costs were too high. It is undetermined how long the mother of the four children will be away.

Jacinta who had to resign from her employment in order to care for the children does not receive any extra money from Centrelink to assist in looking after the children. Her sister is unable to contribute as her money is being used to support the extended family member's medical treatment.

Jacinta is struggling to pay her rent and frequently misses meals in order to provide sufficient food for the children. She has lost considerable weight since her last presentation at the GP. She tells the GP that caring for the children is causing her to have memories of her own childhood. She reports feeling disconnected from community and not belonging, as she has only lived in the area for a few years. Jacinta reports experiencing great 'shame' in having to seek assistance from her GP and is concerned about further referrals.

REFLECTION EXERCISE

Taking into account the SEWB framework and the mental health best practice guidelines consider the following issues for Jacinta's situation:

- What needs to be done and who should be involved in developing a care plan for her?

- As a member of the interdisciplinary team, describe your role and what you can bring to the team?

- What challenges and opportunities do you think may exist for you in the team?

- What considerations need to be made to ensure the success of the team in providing best practice?

- How may diagnosis, treatment and referral impact on the following levels: Individual/Family/Community?

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14

Reframing Aboriginal Family Caregiving

Michael Wright

Michael Wright

OVERVIEW

This chapter describes the experiences of caregiving for Aboriginal families living with a serious mental illness. It highlights the disconnection with mental health providers and their lack of knowledge of Aboriginal concepts of caregiving. Indeed, there is limited knowledge of the complexity of caregiving across the mental health sector. This chapter explores Aboriginal caregiving through multiple lenses. Firstly, through the global context for mental health and Aboriginal families; secondly, through stories of Aboriginal people's experiences of mental health and caregiving; and, thirdly, through coalescing these experiences into considerations for an Aboriginal model of caregiving. It argues that Aboriginal mental health needs to be understood within the context of colonisation. Most importantly the chapter draws on the stories of Aboriginal people and their experiences of caregiving for those living with a serious mental illness to assist mental health practitioners and those working in the social services to gain a greater understanding in order to enhance their practice.

INTRODUCTION

This chapter is based on a research study that describes Aboriginal people's caregiving experiences. Many of the Aboriginal families found the attitudes of health professionals in hospitals to be patronising towards Aboriginal people, and generally lacking any commitment to collaborate with patients and their families.

A critical point in my own professional journey in the mental health services occurred when a keynote speaker living with a serious mental illness delivered an eloquent and powerful presentation at a conference in Sydney in 2005. This extraordinary young woman spoke not as someone living with a serious mental illness, but as a person with an authoritative message of caregiving and mental illness. Her address to the mental health professionals was inspiring and transformational; describing a vision of caregiving where Aboriginal families living with a serious mental illness can have greater control over their own futures.

MENTAL HEALTH AND CAREGIVING – THE CONTEXT

Mental Health Disorders – A Changing Scenario

It is estimated that world-wide there are currently 450 million people living with a psychiatric or behavioural illness, with a future prediction of at least one-in-four developing a psychiatric or behavioural illness in their lifetime. The morbidity and mortality impact on communities is considerable, with five of the ten significant listed disabilities resulting from a mental illness, and causes of premature deaths primarily due to a psychiatric condition.[1] There is increasing

evidence linking poor mental health outcomes to negative social and economic situations as discussed in Chapter 6 (Zubrick and colleagues). Most at risk are vulnerable groups, including people with disabilities (both mental and physical), and Indigenous populations and refugees, who are often marginalised socially and economically from society.[2]

In the 1950s throughout the Western world, there was a shift in the treatment of mental illness with the introduction of deinstitutionalisation, which involved releasing people with a mental illness from secure institutions and mental hospitals back into the community. The implementation of this policy in mental health has had a major impact on every aspect of community life.

Until the change to deinstitutionalisation in Australia, the state assumed the carer role when a family was unable to care for a family member.[3] Since the 1950s, there has been greater involvement by consumers and their caregivers in the processes of treatment and care for people living with a serious mental illness. In recent times the formalising of consumer and carer networks has improved the situation to some degree.[4] However, the emergence of the professional care approach has diffused the issue, with the result of hybrids or new forms of mixed care arrangements.[5] These continued shifts within mental health in the care paradigm have had varied results for all families.

Mental Health Services and Aboriginal People

In Australia, Aboriginal and Torres Strait Islander peoples have, over a long history of colonisation, experienced intergenerational racism and structural discrimination, which continues to have a negative impact upon individuals, families and communities.[6] (See the discussion by Dudgeon and colleagues in Chapter 1.) The Third National Conference on Human Rights and Mental Health held on 8 and 9 September 2005 in Canberra found that cultural prejudice still exists in Australia in the 21st century. The conference report stated as one of its four findings that:

> *Many Australians experience discrimination through the governmental, penal, legal and health systems because of their mental health, race, skin colour, sexuality, sexual formation and refugee status.[7]*

Past policies and practices directed at Aboriginal and Torres Strait Islander peoples have resulted in a form of cultural genocide, including dispossession and removal from traditional lands and the forced removal of children.[6,8] These acts have all constituted abuses of human rights and have left a legacy of contemporary trauma and unresolved loss and grief and the need for individual, family and community healing as outlined in Chapters 17, 24, 25, 27, 28 and 29.

Aboriginal and Torres Strait Islander peoples in Australia experience disproportionate poor health consequences in contemporary society.[9] A major contentious issue has been the inadequacy of mainstream mental health services to respond appropriately to the mental health needs of Aboriginal people.[10] Aboriginal people experience a double-bind situation whereby they live with both the stigma of a mental illness and racism because of their Aboriginality.[11-13]

Australian Government Policy Responses

There have been a number of high-level reports, strategies and policies on mental health in Australia highlighting the deficiencies in both access and response to the needs of Aboriginal and Torres Strait Islander peoples living with serious mental illness. These include the National Mental Health Commission (NMHC) 2012;[10] National Mental Health Consumer and Carer Forum 2011;[14] Mental Health Council of Australia 2012, 2009.[15,16] The Recognition and Respect-Mental Health Carers Report 2012[15] produced by the Mental Health Council of Australia, showed that there are still significant issues that need to be addressed, the most pressing being the appropriateness and adequacy of the provision of mental health services to the general

community.[15] This is even more so for Aboriginal people and their caregivers, where the Mental Health Council of Australia, Adversity to Advocacy 2009[16] report and the National Mental Health Commission 2012[10] report card describes the provision of mental health services as being both inadequate and inappropriate and recommend that changes be implemented immediately.[10,16] See Chapter 5 (Zubrick and colleagues) for a more detailed discussion of the key commissions, reports and initiatives that have impacted upon Aboriginal mental health and social and emotional wellbeing and ultimately influenced a broader appreciation of the role of carers, families and communities in addressing Aboriginal mental illness.

Caregiving: Being Present and Being Human

There is an urgent need to acknowledge and support the important role carers play within the mental health system. The renowned medical anthropologist and psychiatrist Professor Arthur Kleinman was, for seven years, the primary caregiver for his wife who was diagnosed with a debilitating form of Alzheimer's disease. Kleinman[17] provides a moving and eloquent, but also distressing, and at times harrowing, account of his experiences of being a primary caregiver for his wife:

> *Caregivers protect the vulnerable and dependent. To use the experience-distorting technical language; they offer cognitive, behavioural, and emotional support. And because caregiving is so tiring, and emotionally draining, effective caregiving requires that caregivers themselves receive practical and emotional support. But, to use the close experiential language of actually doing it, caregiving is also a defining moral practice. It is a practice of empathic imagination, responsibility, witnessing, and solidarity with those in great need. It is a moral practice that makes caregivers, and at times even the carereceivers, more present and thereby fully human.[17(p293)]*

In a society that benefits certain groups, particularly academics and medical professionals, with their attendant privileges of power, authority and control, it is easy to forget our humanness with all its frailty, fragility and vulnerability. Indeed, unless we directly experience either living with, or indirectly caring for, someone living with a debilitating chronic condition, we can forget our human condition or what it means to be fully human. As Kleinman states, the act of caregiving can often propel us into a virtual unknown:

> *Caregiving is not easy. It consumes time, energy and financial resources. It sucks out strength and determination. It turns simple ideas of efficacy and hope into big question marks. It can amplify anguish and desperation. It can divide the self. It can bring out family conflicts. It can separate out those who care from those who can't or won't handle it. It is very difficult. It is also far more complex, uncertain, and unbounded than professional medical and nursing models suggest. [17(p293)]*

Personal stories offer much for us to consider as people, practitioners, professionals or students in one of the caring professions. Hopefully, sharing Kleinman's experiences of caregiving, and those of the many Aboriginal families who shared their stories in my study, will enable mental health practitioners and students to come closer to their own unique experiences of being human, and of being both fragile and vulnerable. In our acceptance of our own humanness, we are more able to view others with greater compassion and understanding in our professional and everyday practice.

Drawing on those stories of Aboriginal people and their experiences of caregiving for those living with a serious mental illness, this next section discusses the findings from my study. Very little is understood about what constitutes caregiving for Aboriginal people living with a severe mental illness. The caregiver's stories are often a mixture of both joy and tragedy. Their stories are important because they provide a view into the lives of caregivers and of their discoveries in their journey of understanding of mental health from a deeply personal perspective.

MENTAL HEALTH AND CAREGIVING – AN ABORIGINAL EXPERIENCE

A Dark Place – Challenges of Living with a Serious Mental Illness

The stories of Aboriginal caregivers living with a serious mental illness highlight and confirm the multiplicity of effects of cultural racism, stigma and discrimination, as well as institutional and individual blocks to them providing care for their family members.[18] In general, the major focus and preoccupation of people living with a serious mental illness and their caregivers were issues surrounding mental illness itself. The chronic nature of mental illness makes the reality of day-to-day living difficult. For example, Andrea, an Aboriginal woman in the study, described living with a serious mental illness as living in a dark, scary place:

> ❝ *It is a dark place, and the main thing of coping with it is to know that you've got the support there, even though half the time when you're in a mental state you don't think there is. You know, and it takes a lot, takes a lot out of you because it's one scary place. That's all I can say; it's really scary.*[19] ❞

Most of the Aboriginal people in the study, either those living with a serious mental illness or those caring for them, talked about their sense of powerlessness when mental illness descended into their lives. Gail, a caregiver described her daughter's behaviour as bizarre and totally out of character, leaving her both confused and bewildered as to what to do:

> ❝ *It was at that point that I recognised that it was beyond the realms of my capacity to be able to deal with, or make sense of, what was happening. And I thought, 'This is really bizarre, this is beyond my control, this is something I don't have a grip on. What the hell is going on here!' I actually thought I was perhaps losing my mind.*[19] ❞

Ellen's grand-daughter, Andrea, acknowledged the importance of the support of her grandmother in her recovery:

> ❝ *It was really scary for everyone. It was like they all stood down from it and it was more like Nana just stood up and it's like, 'Well we're either going to be here to help, or otherwise we're just going to stand back and bicker amongst each other and nothing's going to get done'. They were scared because they didn't know what was going on. And it took for Nana to stand up and say, 'No, now is the time that we stand together, so who's going to stand with me'. It took a while but they all stood up in the end.*[19] ❞

The Important Role of Families

Mental illness can be a long-term, recurrent or persistent condition. Aboriginal families have shown that, even though they lack physical resources, they do not lack emotional resources when responding to chronic illness. They show remarkable resilience, compassion and insight when confronted with difficult life situations.

The Aboriginal kinship system can provide considerable support through the immediate and extended family networks. The extended family network and their involvement and support can be very important for those involved in caring for Aboriginal people living with a serious mental illness.[6] This support may go unnoticed and as a result be under-utilised by mainstream mental health providers. On the other hand, there is a risk that mental health practitioners may exploit these resources, so measures need to be in place to ensure that this does not occur. Meaningful partnerships between families and mental health providers are essential in the recovery process of someone living with a serious mental health illness.[8]

Cathy spoke of the difficulties she experienced with mental health services and drug and alcohol agencies, which resulted in a crisis for her son:

> 66 *That was a relief that he was diagnosed ... I know a lot about mental illness and I knew he had symptoms of schizophrenia and what I found unhelpful was when I called the Psychiatric Emergency Team, and I'm not criticising the Psychiatric Emergency Team, but being told it is not a mental illness. I understand the system, I work in the system, so I can see it from both perspectives. But when you're told that it's a drug issue and it's like, I know you can only assess someone's mental state if they're straight ... I found that frustrating, really frustrating. I think it's because of the stigma related to drug psychosis.[19]* 99

Cathy's experience also highlights the failure of the system to deal with comorbidities of drugs and mental illness and the associated issues of dual diagnosis discussed in Chapter 8 (Wilkes and colleagues).

Caregiving in a Family Context

Most Aboriginal people who were living with a serious mental illness shared similar experiences. They spoke of the importance of family as part of their healing, but were saddened and surprised at how mental illness can fracture and distance some family members. Sarah described her sometimes-strained relationship with her siblings:

> 66 *Sometimes I find it really difficult to explain it to my brothers, you know, that this is the situation. And they say 'Well snap out of it!' Well I wish I could 'snap out of it' [laughs]. You know, I wish I never 'snapped into it' [laughs] ... Mum's the primary carer, all my brothers and sisters, even though they care and they support me and we do social things together and all that sort of stuff, they're still there on the side saying, 'Well snap out of it. Get your life into gear.' And all that sort of stuff.[19]* 99

Gina talked about her family being in denial as they tried to come to terms with her daughter's diagnosis of a serious mental illness:

> 66 *I think it's different when you're a carer of a family member and in this case, my daughter. In her early thirties or late twenties she started having psychotic episodes. The first thing me and my family did, the ones close to her, was to try and deny that it was happening; we realised this later, what we were doing. But at the time it was like, 'Don't be silly', or 'Why don't you do this, or do that, or try this, or try that', and 'Please, can you take her to live with you', and all this sort of thing.[19]* 99

Families can be complex, as Cathy noted when talking about how her son's mental illness was made more complicated because of his insecurity and confusion about his Aboriginality. Being a sole parent and non-Aboriginal, Cathy felt that she was not able to assist her son with his identity issues. The lack of positive Aboriginal male role models in her son's life exacerbated his situation.

> 66 *My son was a beautiful child, his Aboriginal father though didn't have much to do with him. He left when he was about 18 months old; I was a single parent. My son had huge identity issues; he identified with his peer group who were sniffers and chronic solvent abusers.[19]* 99

The Impacts of Serious Mental Illness on Families

The children of parents or families where mental illness is present are often invisible, both to service providers and within families. When a serious mental illness impacts on a family there can be serious repercussions, including separation. Joan described the experience of her son's involuntary admission to hospital being witnessed by his children:

> ❝ *Yeah, you know how children are, they can take things or leave it, but some little things every now and again would come out where you think, 'Oh goodness me'! You know, 'Maybe the kids should have had some counselling', so you had a little talk to them and they would say, 'Nah that's fine, Dad's just this person, that's just Dad'. You know ... they sort of handled it really, really well. Maybe we had put more of our focus on my son and forgot about the children and what they shouldn't, maybe they should have had some counselling. Mainly how the police had to break the door down and their Dad had told them not to open the door, you know, that type of thing just gets to the kids a little bit. And maybe we forgotten about the kids and they should have more or less had some counselling, maybe.[19]* ❞

Any approach to mental health intervention needs to address the complexity of family life, underlying issues of comorbidity, drug and alcohol misuse, accommodation, poverty and underlying psychological issues. To just focus on clinical intervention and not the bio-social-psycho-physical aspects is a failure in duty of care.[20]

Being Aboriginal and Living with a Serious Mental Illness

The issue of being Aboriginal and living with a serious mental illness is a critical one. Participants spoke of racism, alienation and social inequalities. As Andrea highlights:

> ❝ *I mean it is bad enough living with a mental illness but they look at you because you're Aboriginal anyway you're getting the look and its ten times worse if you've got a mental illness. There have been times when I have been in at the mental health service with other Aboriginal young people especially in the adolescent unit and we have felt it.[19]* ❞

Many of the comments from participants revealed a deep sense of alienation from the wider community, as Sarah noted:

> ❝ *I think people think that we, Aboriginal people with a serious mental illness, are all criminals to some degree. The perception is that Aboriginal people with a mental illness commit crimes more than other people.[19]* ❞

Their concerns related to the lack of appropriate mental health information, particularly in the event of a mental health crisis.

Living with Mental Illness – But Not Being Heard

The issue of silencing about mental health issues was raised by several of the participants. Silence and shame surrounding mental illness are endemic and entrenched and as a result many of the participants believed that their voices were not being heard.

Aspects of inadequate and culturally unresponsive service provision and support were raised by numerous caregivers. Certain work practices by mental health professionals are used as

strategies to cope with burgeoning caseloads which can inadvertently silence the voices of carers and people with a mental illness. Jenny noted that when she tried to access someone to visit her son at home there were excuses given as to why they could not see her son, usually because they were 'too busy':

> 66 *I am having trouble with him leaving the house, I need someone to come to my home and do an assessment but the hospital will not visit you in your home. You have to go to; you can't get a psychologist to come and sit at your house to do an interview. You have got to go to them. In my son's position his major problem is leaving the house, getting out of the door. Because all these places say that you need to go to them it makes it impossible.[19]* 99

Lack of Support for Carers

The experiences of alienation and blaming highlight the need for greater awareness raising within the wider community to gain their support and recognition of the difficulties being experienced by caregivers.

Cathy spoke of what she believed were the inconsistent social expectations for someone who was a caregiver for a person living with a serious mental illness:

> 66 *I think we live in a society where parents are very much seen as focus of blame or whatever and it's very hard as a carer to not unconsciously take that on, but it's also part of the grieving process as well. So it has been a real struggle for me and probably still is on and off. Because your emotions often are different to what your rational mind is because you know one thing but your emotions can be quite different to that.[19]* 99

The person receiving care is very dependent upon the continued health and wellbeing of the caregiver and this is reflected in Andrea's comments about the lack of support for caregivers:

> 66 *There should be more supports for people to be caregivers for people living with a serious mental illness. To help people who are helping those living with a serious mental illness makes sense. For if you are working as a nurse in a ward it can be difficult because being around people with a mental illness is hard, as I tend to go a bit 'loopy' at times. Some people don't even know how to take me… That can be really draining and that's where they [caregivers] need the support. People need to be aware and have an understanding for as I said people are frightened, because they don't know anything about it, and they can get very frightened when they are around people with a mental illness.[19]* 99

The Importance of Aboriginal Workers in Mental Health Services

The issue of alienation was raised by some of the participants. Cheryl noted how she, as a patient, related to the care provided by mental health services:

> 66 *Not very good, not very good at all; by not seeing Aboriginal people working in the hospital when I was going through my illness was hard as I needed to see a black face, an Aboriginal face. I needed to be able to sit down with this person and talk to this person about my issues, but they were putting people from other nationalities in front of me instead of an Aboriginal person, a black face.[19]* 99

Cheryl also recalls how she and other local Aboriginal people had previously lobbied successfully for the hospital to employ Aboriginal workers:

> 66 *Through our local Aboriginal women's group, there were 15 women, there were grannies, some men, mums and cousins we argued for and now have black faces at the hospital. We now have two Aboriginal workers working at the hospital which is a major improvement particularly from when I was first admitted, that was really frightening.[19]* 99

Hospitals were generally viewed by participants as places of importance, but also as places of last resort. Given the integral part they played in people's lives, it is disconcerting that for most of the participants their interactions with hospitals were not pleasant experiences. Psychiatric hospitals in general were perceived as unfriendly and scary places. As Andrea notes of her first experience in hospital:

> 66 *It was very scary; I think I cried for the whole two weeks I was there for the first time.[19]* 99

The use of authority is contentious. If authority is abused, particularly in a hospital context, it can have quite negative consequences. Advocates for the person with a serious mental illness often felt that when they tried to mediate on behalf of the person with a mental illness they were discouraged from doing so by mental health staff. It is important that staff acknowledge and respect the rights of people to advocate on behalf of a family member. Aboriginal mental health workers and liaison staff are needed to effectively play that brokerage role to link families with senior clinicians.

Personal Impact of Caregiving

Due to the physical and emotional costs of being a caregiver, a number of the participants felt a sense of hopelessness for the future, as noted by Cathy:

> 66 *It's exhausting, absolutely exhausting, particularly when you have to get up to go to work and having to deal with a pretty tough job. Not knowing what you're coming home to, thinking I've got to get up in the morning so I've got to be refreshed and I could get a phone call at one in the morning or two in the morning and have to deal with it. And where to from here then?[19]* 99

Despite the difficulties, there were also examples of hope in Cathy's story:

> 66 *I think I've been pushed and pushed. I just think that the only thing that I can really draw on as my strength now is just this sense of letting go. Because it's all out of my control it's that I can only give so much and then I've got to a point now where I have to give him boundaries. I think that mental illness when you're a carer it pushes you beyond yourself ... You can have times where you can actually see that it's made you a richer and stronger person. Which it does but it's not something generally out there in society that most people would say could be the case.[19]* 99

As Ellen noted of her experience of being a caregiver of her grand-daughter living with a serious mental illness, while the issues confronting caregivers can be complex and demanding, certain qualities of strength often emerged during times of crisis:

> 66 *You have to have strength otherwise you know. It doesn't matter like every day of our life, every hour, you've got to believe that it doesn't matter whatever you do you've got to believe you're going to come through, and that it will be okay. Every little hurdle regardless, it doesn't matter how big or small you can still go over it.*[19]
>
> *I suppose we have to have a lot of understanding and lots of love because you got to really care about what you're doing I think. I was very emotional but I had to put that aside cause I knew that, like, getting emotional wouldn't help. I mean you do have your moments that are emotional, but I draw strength when you see how much they're trying. It doesn't matter, like, every day of our life, every hour, I suppose it will be how you've got to believe that it doesn't matter whatever you do you've got to believe that you're going to come through, that it will be good.*[19] 99

For some of the participants, their Aboriginality and culture were a source of strength, as Cheryl noted:

> 66 *Our culture we love to bring our culture in especially when our minds start racing and our hearts starts racing. We will go and get our wool and make our headbands and our armbands and our belts. We are concentrating on our colour we're concentrating on our culture and we know that at the end of the day the things that we make will be handed out, to share as part of our cultural experiences.*[19] 99

As Gina noted, it was the influence of her parents and being Aboriginal that was her source of strength:

> 66 *I think learning we were brought up as Aboriginal people; that we were Aboriginal. We were also taught the white man's way as well, as we were taught to cope with the white man's way because my parents knew that you couldn't survive by just being Aboriginal it wasn't going to help us fully. We had to cope with both sides. And that's what they taught us really.*[19] 99

A BROADER PERSPECTIVE ON CAREGIVING

Defining and Contextualising Caregiving

When care and caregiving have been discussed in the health literature, they have often been influenced by the bio-medical model with a strong focus on the physical rather than the emotional and spiritual needs of an individual.[20] More recently however, with increasing attention to carers and those cared for, and as carers are given more voice, the role and definition of carers has also come under scrutiny.

An example of the more recent scrutiny of the term 'carer' is that of Molyneaux et al,[21] based on considerations of the historical and political context of the term 'carer', as well as research in various carer-related settings in the United Kingdom. The authors are critical of the term 'carer' in that it invariably fails to account for the relationship between carers and those for whom they care. They are also critical of the use of the term in such a way that it may imply burden and polarise two individuals who would otherwise work together. They argue for a relationship-based description of caring and an approach where services focus on the fundamental care

needs of the person requiring care. The expectation is that, in this approach, the associated needs of 'carers' may be similarly met. However, the authors do acknowledge the danger of a return to the previous status quo in which care work was invisible and unvalued.

Within the Australian context, the last decade has witnessed an escalation of carer recognition and legislation. The Association of Relatives and Friends of the Mentally Ill (Arafmi) website dedicated to mental health carers, gives testimony to the recent proliferation of formal documents recognising carers. As well as the Commonwealth Carer Recognition Act of 2010,[22] the following Acts and Charters are in place in individual States and Territories:

- Western Australia: *Carers Recognition Act 2004*
- South Australia: *Carers Recognition Act 2005*
- Queensland: *Carers Recognition Act 2008*
- Northern Territory: *Carers Recognition Act 2009*
- New South Wales: *Carers Recognition Act 2010*
- Victoria: *Carers Recognition Act 2012*
- Australian Capital Territory: *ACT Carers Charter*

With some minor variation in wording, the 'carer' in the above is generally 'a person' who provides unpaid care for another who requires help with everyday tasks because of disability, frailty, and/or chronic illness, including mental health. A carer can encompass a diversity of individuals performing a caring role and, though not necessarily elaborated in legislative documents, carer support agencies recognize, encourage and in fact often rely upon, wider family engagement in the caregiving situation.

Edwards et al,[23] in an Australian Institute of Family Studies report on the impact on families of people with a disability, drew attention to the need to contextualise caring:

> To understand the experiences of carers of people with disability, the broader context of the family and social environment in which the care takes place needs to be considered. These contextual factors include family relationships, marital relationships and support networks.[23(p30)]

Although mental health carers share commonalities with other carer groups around having to deal with daily life issues of family, finances and maintaining their own wellbeing, they are recognised as unique because of the additional stressors they have to face in their caring role. The nature of mental illness itself—with predominantly behavioural symptoms as opposed to clear physical ones, societal perception of the illness and the structure and delivery of mental health services—make mental health carer positions different and unique to other carer groups.[24]

In the context of Aboriginal mental health caregiving, I propose a more realistic and comprehensive definition:

> Aboriginal caregiving should be viewed as a whole-of-life experience and seen in the context of an individual nested within their family, and their community. Caregiving includes all of the social, emotional and cultural support that enhances the wellbeing of the individual, family and the community where a member has a disability.[18(p204)]

The stories described in the current study strongly affirm the need to broaden the context within which caring is considered. They show that the experience of caregiving within an Aboriginal context is often a seamless activity involving individuals, families and communities.[18] As such, the Aboriginal experience of caregiving has much to inform the broader discussion around the term 'carer'.

An Aboriginal Framework of Caregiving

This section explores an Aboriginal framework of caregiving, developed from the findings of my study, to reflect, acknowledge, and take account of the lived experiences of Aboriginal people as caregivers for those living with a mental illness. The Framework ensures that these are framed in the context of their historical, social, cultural and political realities. The historical context in Australia includes the impacts of dispossession and forced removal of Aboriginal and Torres Strait Islander peoples from their land and the state-sanctioned programs of separation of children from their families as described in Chapter 1 (Dudgeon and colleagues) and Chapter 17 (Atkinson and colleagues).

In line with the recent focus on the caregiving context, its dimensions and how it shapes the process and outcomes of family care, this Aboriginal framework firmly locates care within the family rather than a single individual and, in turn, the family is embedded within a larger cultural, community and social context. Aboriginal people understand the importance of care in providing stability and as such have prioritised caregiving in their families and communities. The practice of caregiving from an Aboriginal perspective can best be understood as an activity applied in the everyday setting and including *caring about, taking care of, providing care* and *receiving care*.

Caring about

Caring about is the recognition that there is a need to provide a person with care which has both communal and individual qualities. Within an Aboriginal context, 'caring about' applies to the person, and to the person in the context of their family, their community and the wider environment. In order to be effective, mental health providers and others social services need to understand and take account of the complexities that exist within Aboriginal families and communities as well as the unique issues confronting care givers in families living with a serious mental illness.

Taking care of

Taking care of involves the commitment and responsibility in responding to the person receiving care needs. The concept of 'taking care of' is more than just recognising that there is a need; it involves the commitment to being active in responding to and resolving those needs. Being responsible is central to the activity of taking care of. This has wider implications, because responsibility is integral to the continual health and welfare of Aboriginal society.[25] The recognition and practice of culture are central to the health and wellbeing of Aboriginal communities, and inherent in these cultural practices is the action of responsibility fortaking care of family, community and country.[25,26]

Providing care

Providing care involves the responsibility of acting on behalf of those in need of care. It requires the total commitment to the task of caregiving. It is common for Aboriginal families to have three or more generations within a household, and providing care across these generations is accepted as the norm, despite the difficulties it may create due to the lack of resources.[6] Recognition of these circumstances may assist practitioners in asking the right questions and assisting families to plan how to support someone with a mental illness and at the same time recognise the potential impacts for the children and other family members and carers.

Receiving care

Receiving care assumes that the person receiving care will be responsive to the caregiving that is being provided. Care recipients in the study acknowledged the difficulties involved in the caregiving activity; they expressed their concern at the lack of services and support for Aboriginal caregivers. Given that the person receiving care is very dependent upon the continued health and wellbeing of the caregiver, it is really important that mental health

practitioners (and other service providers) attend to the health and wellbeing needs of the caregiver and encourage them to link in with appropriate networks and carers services that are available in the community.

CONCLUSION

This chapter has shared stories of the experiences of Aboriginal families as care givers and care receivers and outlined an Aboriginal approach to caregiving to assist mental health service providers and practitioners to develop more culturally responsive services, policies, practices and principles. It has argued the need for mental health practitioners to adopt a culturally responsive and respectful process when working with Aboriginal families who are living with a serious mental health illness. The basic qualities for all mental health service workers are a commitment to relationships and continuity of care, both of which derive from cultural life tools.

The stories of Aboriginal families recounted here affirm that caregiving is culturally a highly valued activity. Importantly, they highlight the need for service providers and mental health practitioners to recognise the unique contributions these caregivers make to supporting people living with mental illness, and to engage with Aboriginal individuals, families and community in a more respectful manner.

> **Recognising the high value and unique contribution of carers requires that service providers:**
> - incorporate partnership, collaboration and transparency in their practices;
> - engage in a more meaningful way; and
> - acknowledge and recognise that carers are not separate from but an integral part of the community.

In essence the stories in this chapter are a reminder to all of us about the importance of being there and being human in our everyday lives and in our work.

REFLECTIVE EXERCISES

1. Review the current protocols and practices in your agency for working with Aboriginal families. How do these protocols and practices fit with Aboriginal and Torres Strait Islander principles and values? If they don't, how can you change the protocols so that they do reflect Indigenous principles and values?

2. How can you and your agency adopt a more proactive position when working with Aboriginal people and communities in your local area?

3. How can your agency's policies and practices be adapted so that they remove the structures that privilege and support colonialist practices that exclude and disenfranchise Aboriginal and Torres Strait Islander peoples?

4. Review and identify current policies and practices that 'pathologise' Aboriginal people, in particular, through the negative representations in reports and publications. If present, how can you change policy and practices in your agency so that they do not misrepresent and reinforce negativity?

5. Review the current protocols and practices in your agency that might encourage discrimination and racism in the lives of Aboriginal people. If present, how can you change your agency's protocols and practices so that it adopts and models an anti-racism stance within and outside the agency?

6. Examine how your agency's policies and practices exclude and marginalise Aboriginal people. If present, how will you change your agency's policies and practices so that they are more inclusive, open and empowering?

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15

Communicating and Engaging with Diverse Communities

Pat Dudgeon and Karen Ugle

OVERVIEW

This chapter focuses on the skills and understanding required for communicating and engaging effectively with Aboriginal people in diverse contexts, with particular attention to the urban setting. We briefly discuss concepts of community and culture, such as kinship affiliations, community obligations and values of Aboriginal people.

The work of the late psychiatrist, Mark Sheldon, has been influential in establishing communication and engagement strategies for mental health practitioners working in remote communities, is briefly covered. In addition, protocols for communicating and engaging with Torres Strait Islander people are included. Importantly, the various strategies discussed here are in accord with the *National Practice Standards for the Mental Health Workforce 2013*[1] and highlight the need for recognition and respect of cultural difference for all Aboriginal people.

INTRODUCTION

Aboriginal people come from a variety of different cultural and personal backgrounds and histories. Aboriginal people living in urban contexts may not display stereotypical images of what people look like or live like; however, urban identity is very strong and there is greater diversity than is often realised. Similarly, the diversity among people living in remote communities is often disguised by stereotypical and simplistic images and ideas which do not reflect the nuances and complexities of people's lives and identities in these communities. Practitioners need to have an awareness of the diversity of backgrounds, experiences and histories of different communities in order to work effectively with clients and their families.

Although more than half of the Aboriginal population live in urban and regional centres, most guidelines and assessment commentaries tend to focus on the health, mental health and social issues of remote communities. The highest proportion of Aboriginal (34 per cent) and non-Aboriginal (71 per cent) people live in the major cities of Australia, although Aboriginal people are to live in remote areas than other Australians. More than one-in-five Aboriginal persons were living in regions classified as either remote or very remote in 2011; the same was true of only 1.7 per cent of non-Aboriginal people. This remoteness profile varies markedly by State and Territory—in the Northern Territory, for example, 80 per cent of Aboriginal people live in a remote or very remote setting, whereas practically the entire population of Aboriginal people in Victoria, Tasmania and the Australian Capital Territory were in either regional areas or a major city.[2]

While the largest numbers of Aboriginal people are living in major cities, they account for a relatively small proportion of the total population in these areas—1.3 per cent of the total population in major cities in 2011. Further, Aboriginal people make up 9.1 per cent of regional Australia and 13 per cent of the population of remote areas, but constitute over 40 per cent of very remote Australia.

CONTEMPORARY COMMUNITIES

The term 'community' was initially an imposed idea for the purpose of control over and management of the Aboriginal populations. As part of the history of colonisation, people were dislocated into reserves and missions. As discussed in Chapter 1 (Dudgeon and colleagues), this included disruption to people's social, political and religious life; and the relocation of distinct groups from different areas. Early constructions of 'community' did not recognise language and social and spiritual differences between groups.

Today, Aboriginal community groups vary considerably in their economic, social and geographic circumstances. The National Aboriginal Education Committee (NAEC)[3] developed a model of Aboriginal societies that included four broad categories of the community: traditionally oriented, rural non-traditional, urban and urban-dispersed communities. The following definition remains relevant today:

> *In the main, Aboriginal society is structured around the community. There exist very strong kinship ties within each of the communities and within each of the categories. These kinship ties overlap the various categories thus forming very strong relationships among all Aboriginal people of this country.*[3(p10)]

Aboriginal Perceptions of Community

The defining characteristics of Aboriginal perceptions of community are primarily based on family relationships, involving a sense of belonging along family lines and country or area of origin. Aboriginal perceptions of belonging to a community can be both physical and psychological, based on shared interest or shared location. For some groups, the concept may also hold a political and abstract dimension—an understanding of the entire cultural group of Aboriginal people working against oppression and towards self-determination. This concept of community is often used by those who are in leadership positions and representing Aboriginal interests. Community can also be a broad and fluid concept, uniquely shared by people and by those that work in the area.[4]

WORKING IN URBAN CONTEXTS

Contemporary communities are dynamic and flexible, including many family and political networks and affiliations. Members of these communities will have various responsibilities and obligations that confirm and reinforce their membership. These responsibilities may include:

- being seen to be involved and active within the community;

- supporting community activities;

- obligations to family;

- a sense of responsibility or commitment to use one's skills for the benefit of the community;

- affiliations to family, and broader kin relations (families become connected through marriage);

- affiliations to factions/sectors within the community (family, work, language group, country of origin, politics); and

- affiliations to particular organisations. Often, members of the community associate the employee with a particular organisation and this may become part of the individual's identity and even carry over to social situations.

There are also many layers of politics that practitioners may need to be aware of especially when drawing in other workers. Examples of this are representation, that is, who should speak and on what matters, and recognising that at times Aboriginal and Torres Strait Islander peoples themselves can be both 'insiders' and 'outsiders', depending on the issue at hand.

Cultural Diversity

Urban diversity is an important consideration when working with Aboriginal and Torres Strait Islander peoples who come from a variety of different cultural and personal backgrounds and histories. The term 'urban' refers to people living in cities or large towns where they are distinctly a minority group and more invisible than Aboriginal people living in country towns and remote communities. They may also move in and out of urban situations (unless it is their country), and may have experienced a longer and more intense history of colonisation.

Aboriginal people living in urban settings within their different forms of groupings may not be highly visible in the urban situation. It is not as easy to 'see' parts of the community as it is in more remote areas, and it is sometimes more difficult to locate or find people. Yet urban Aboriginal people's identity, including their cultural connections and ties to country and family, can be very strong. People living in urban contexts may also be more politically aware and resistant to a dominant society because of a longer and more intense history of oppression.

For many practitioners, assumptions about Aboriginal people are likely to be grounded in stereotypes and images that are probably based on romantic 'traditional' notions learned in the practitioners' early years. These images continue to be perpetuated by the media, which has considerable influence on public attitudes and observations and are not the result of personal contact and association with Aboriginal people.

The lifestyle of urban Aboriginal people may appear similar to the lifestyles of others. However, the reality is that many urban Aboriginal people experience racism on a day-to-day basis. Mainstream society often challenges the authenticity of people's identity, requiring them to constantly negotiate and affirm their identity. When people are confronted on a continual basis about their identity, they become accustomed to having to defend their rights as members of a marginalised and discriminated group.

In urban centres, there are often differences among the local groups in relation to their country of origin, which refers to the geographic area where they were born. For instance, in Perth there are Nyoongar people who are the traditional owners of the immediate and surrounding country, and there are other people from areas such as the Kimberley, Goldfields or Gascoyne regions. People come to live in urban areas for various reasons such as education, employment, health or domestic reasons. Similar patterns of mobility and urban migration occur in all major cities around Australia.[5]

From this diversity there have emerged different forms of affiliation:

- *Local family groups:* families who originate from the area or have lived here for some generations, reflecting different language groups;
- *Country of origin groups:* groups who are affiliated; people who have migrated recently but recognise a different home country; and
- *Transient groups:* outsiders who are in the area for only a short time.

In addition to these dynamics, there are also social groups that form from shared interests such as sports, social or work groups.

Family and Community Obligations

Kinship is very strong in urban situations with people identifying through family names, rather than 'skin' names, with great significance attributed to family and personal relationships. As such, urban people have many family obligations and responsibilities. This includes providing family with advice, helping with money, sharing housing, and assisting with transport and food supplies. This practice, however, can be abused, with some family members utilising the family's resources without reciprocation. Some people may not control their own resources and value things in the same way that others might, and they may rely on others to help them out. Often, because of limited incomes and resources, people are forced to make decisions based on family priorities, and resources are utilised in a biased manner.

There is also an expectation for family members to attend funerals, family gatherings for specific issues and events and other cultural obligations and activities. Funerals are very important in all Aboriginal groups. They tend to be very emotional and it is not uncommon for many relatives to attend. This is a time for reconnecting with kin, connecting with friends and acquaintances not seen for a long time, as well as showing respect for the deceased and the deceased's family. Funerals demonstrate a connectedness with the wider community and can often be a time of re-establishing where one fits into the family/community hierarchy and where new and extended family members are introduced into the family/community.

Specific Cultural Considerations

The specific cultural issues that a practitioner should be aware of when working with Aboriginal groups in urban settings have been addressed in other publications.[6] Many practitioners need to be mindful that negative and unrealistic images and stereotypes of urban Aboriginal people continue to be perpetuated by the media, which has considerable influence on public attitudes and observations, and are not the result of personal contact and association with Aboriginal people. Practitioners should also be careful not to impose judgments on urban people from the literature and/or from their experience of working with traditionally-oriented people. Some traditional cultural ways are not practised in urban situations. For instance, the mother-in-law taboo, where a son-in-law cannot have any contact with his mother-in-law, does not persist in urban situations.

Practitioners should consider developing a proforma to assist in finding out about urban clients. Good practice requires professionals to build a picture of all family members and others who might be significant in a particular situation. It is not always obvious who has the final authority about a member's health and wellbeing. For example, for a child it may not be the parents but the grandparents.

If a practitioner is aware of the historical and cultural context of Aboriginal people and has engaged in the processes of cultural competence, they need also to be aware that some issues may be just what they are. For instance, a practitioner may come into contact with aggressive or defensive Aboriginal people. People who present as either aggressive or defensive may do so for a variety of reasons. It is important not to take the behaviour personally and, instead, assert oneself appropriately depending on the contextual background and situation.

The practitioner should not always look for 'cultural' reasons for behaviours. Sometimes things are simply as they appear. If in doubt, ask. Allow for individuality to be expressed—different Aboriginal people will act differently in similar situations.

WORKING IN REMOTE COMMUNITIES

In the following section we draw on some of the work of Mark Sheldon, a psychiatrist who worked in remote Aboriginal communities. He was highly regarded as a 'pioneer psychiatrist' who realised that a western model of psychiatric assessment and examination

was not culturally appropriate to meet the needs of Aboriginal people with mental health issues living in remote communities. After working with the Ngangkaris (local healers), he was convinced that the best outcomes were often obtained when both traditional healing approaches and western clinical methods were used together.[7] Sheldon developed a flexible method of investigation which he documented, including how to engage with people in remote communities from the initial point of entry into a community, to the issues that practitioners need to be aware of when meeting with an individual. Further information on Sheldon's work with Aboriginal people is available in Chapter 15 in the first edition of *Working Together*,[8] or readers can view the full dissertation online.[7]

Working with Traditional Healers

Prominent Aboriginal psychiatrist, Helen Milroy, has also written extensively on the most appropriate ways of working with the diversity of Aboriginal people's experiences and understanding Aboriginal culture so as to be effective within the mental health context. She has also written about the value of working with traditional healers or Ngangkaris within remote communities. Milroy states:

> *As our understanding of traditional methods increases, it is easy to see some overlaps with more recent developments in mental health care. Family-centred care—recognising the vital importance of attachment systems, holistic approaches and long term support—are all well recognised in Aboriginal systems.[9(p12)]*

Many of the strategies for working with Aboriginal people in remote communities are equally important in urban and rural contexts. There are a number of ways for practitioners to appropriately and respectfully work with Aboriginal clients, including: storytelling; understanding the cultural significance of an event, both, currently and historically; and to listen to the persons understanding of their illness. See also Chapter 16 (Adams and colleagues) on assessment and Appendix III of DSM-5[10] for the core Cultural Formulation Interview (CFI). The CFI guides practitioners to consider many of the specific social, historical and cultural issues for the client and their family within the interview process.

WORKING WITH TORRES STRAIT ISLANDER PEOPLE

Practitioners working with Torres Strait Islander clients will find the following sets of protocols useful:

- the Torres Strait Regional Authority (TSRA) Cultural Protocols Guide for TSRA Staff (2011);[11] and,
- the Proper Communication with Torres Strait Islander People.[12]

The Torres Strait Islands are a unique part of Australia, and Torres Strait Islanders have a distinctive history and culture as described by Garvey in Chapter 1 (Dudgeon and colleagues). The Torres Strait has a number of governance arrangements in place that need to be considered when engaging with communities.[11(p7)] These comprehensive protocols cover important information about cultural issues that practitioners need to be aware of to work effectively with clients with mental health issues.[11] Some key ideas include:

Communication

> *Communicating with those unfamiliar to us does not come easily. The more distant and unacquainted the cultures, the greater the challenge. Therefore, good communication requires the parties to truly understand each other's social systems. It is important outsiders understand the behavioural ground rules of the Torres Strait, because if the latter are broken, people become offended and communication breaks down.*

> *Islanders' views and meaning systems vary from that of other cultures, although in some aspects there will be similarities. In cross-cultural communication there is always a risk that ideas will be misinterpreted and this can lead to considerable confusion, misunderstanding, disappointment and even resentment.*[11(p17)]

There is also the problem of dissimilar concepts of social process. In traditional Islander society, both the spiritual and the secular were interwoven, and this is still evident today. However, in European society the two are usually separated. Compounding these differences are past policies of segregation, paternalism, neglect and isolation which have not been erased from Islanders' minds. Similarly, contemporary policies, considered to be progressive and enlightened by some, do not necessarily enjoy widespread support among the Islander communities. For instance, land rights legislation introduced by the Queensland Government in the early 1990s was rejected by many Islanders. In addition, bureaucratic procedures often do not sit comfortably with the Island way of doing things.[11(p17)]

Interpersonal Skills

In order for practitioners to engage successfully with a Torres Strait Islander client, they need to have good interpersonal skills. You must demonstrate that you are sincere, trustworthy, open and honest. It does help to have a reasonable knowledge and appreciation of Torres Strait Islander custom and history. If you have this knowledge you will be better able to empathise with people and issues.

Taking a genuine interest in people - without being intrusive - helps foster ongoing relationships. Being helpful and friendly is particularly appreciated. Torres Strait Islanders place a good deal of emphasis on courtesy and kindness. This is commonly known as 'Good Pasin', meaning good fashion or behaving with a degree of sophistication and charm.

It is absolutely essential to tell the truth at all times, no matter how unpopular this can be. Failure to do so destroys credibility which is unlikely to be regained. Above all treat people the way they want to be treated, instead of the way you think they should be.[11(p17)]

Other Communication Protocols

- Familiarise yourself with behavioural protocols in Island communities. This will develop over time with patience and good observation skills;
- Accept guidance from a competent person familiar with local protocols;
- Respect religious protocols;[11(p19)]
- Respect 'Ailan Kastom' (Island Custom) such as Island adoptions. These have legitimacy in the Torres Strait;
- Do not cause anyone to suffer the loss of personal dignity;
- Avoid direct criticisms of particular individuals;
- Be careful with the use of humour; it may be misunderstood;
- Be patient, tactful and discreet;
- Avoid talking excessively, particularly in the company of Elders;
- Stick to formal addresses when talking to chairpersons and councillors until given permission to do otherwise;
- Do not be submissive; be organised, professional, confident and helpful;
- Never underestimate the breadth and depth of knowledge in the community and the technical skills available;

- Dress appropriately because poor dress standards may offend; and

- Be aware that there are distinct boundaries between males and females, and practice appropriate behaviour at all times. If in doubt about protocols, ask and find out.[11(p20)]

Consultation and Negotiation

Consultation and negotiation is not a time-specific process. It needs to be recognised as an ongoing and essential component of the policy-making process in Islander affairs. It also needs to be seen as a process founded on networks of relationships that require continual development and nurturing. It is important to remember that discussions in informal settings 'after hours' may be of as much, if not more, assistance than formal meetings.[11(p20)]

COMMON PRINCIPLES FOR PRACTITIONERS

Despite these differences and the diversity of communities, there are some common elements that should be understood and incorporated by practitioners when working and supporting Aboriginal and Torres Strait Islander individuals, families and communities. These include:

- A strong connection to land, country, ancestors and spirits;

- Respect for the important role of Elders in decision making and in passing on knowledge and culture;

- The importance of family—including the extended family structure;

- The importance of community and the obligations to one's community;

- The important role of AHWs in linking the health professional, the individual, the family and the community; and

- The importance of humour as a bond and source of strength.

Working with Clients and the Families

Several chapters emphasise the importance of involving family and carers when working with someone with a mental illness (see Chapter 13, Schultz and Walker and colleagues; Chapter 14, Wright; and Chapter 16, Adams and colleagues). Involving others equally applies for Aboriginal people in urban and remote areas. Often the boundaries between individuals within an Aboriginal family are less defined, and thus the 'illness' may, in a sense, be shared by the whole family. In general, there is a belief that mental experiences are not private but shared by close relatives and may also affect other family members.

There may be a 'sympathetic' or 'associated' aspect to the illness within the family or community. In effect, the illness becomes a family illness in terms of the perceived origins and the expected goals of management. The patient's subjective experience is modified greatly by the family and, in turn, they are affected by the experiences of the patient. Any discrepancies between a MHW's observations (through mental state examination) and the family's version of the psychopathology can be pointed out, raised for discussion, and can lead to fruitful additional information.

Often one or two family members have a special role as carer or of 'looking out for' the individual who has been referred. These carers usually give the most valuable history and will often act as spokesperson for the patient.

Involving an AHW or AMHW in the interview or management is always important to consider. (However, at the same time, there may be a reluctance to disclose, due to their presence. Ask the client privately.)

Interview Techniques

Practitioners working across a range of contexts need to have the skills and ability to work within situations with a high degree of ambiguity and with limited information. It is important to resist imposing one's own understanding and perception of the situation. It is essential to seek advice and help from Aboriginal people.

Sensitive Topics

Sheldon describes the importance of being aware of potentially sensitive topics, including bereavement, the breaking of taboos, ceremonial business, sexuality and fertility, and domestic habit. The key for the clinician/AMHWs is being aware of these sensitivities, reassuring the client that they are aware and seeking permission to discuss these issues. These issues are equally sensitive in urban settings.

Learning from Others

Ideally, practitioners should consider engaging with a mentor. There is a small number of psychologists, for example, who have formal arrangements with Aboriginal Elders as mentors. Mentoring helps to develop their cultural competence generally and, more specifically, in the areas of social and emotional wellbeing, and helps the mentee understand in a more sensitive manner the impacts of forcible removal of the Stolen Generations. In Chapter 29, Peeters and colleagues provide an excellent example of mentoring and two-way learning.

In all cases, when working with Aboriginal clients, practitioners need to be completely cognizant of the different communication skills required and be able to utilise these skills in an effective manner. Sheldon provides a good example of this in his reflection:

> *The interview skills which I had gained from my training in non-Aboriginal culture remained useful in my work. But they clearly needed to be added to and modified in this very different setting where the language and cultural differences between myself and the patients are immense. These new skills were developed largely through experiential learning, observing other clinicians and discussions with AHWs. One of the challenges is to be able to pick up how Westernised or how traditional the Aboriginal patient is, and be flexible enough to adjust my interview style accordingly.*[7(p26)]

It is important to gain rapport early in the interview. To do this, practitioners need to discuss their role, where their work is based and other places that they work. It is also good to highlight any connections with people they may know, and acknowledge if they know other family members or other workers including the clinic nurse, AHW or Senior Medical Officer. While this process takes time, it helps to put the client at ease, takes the pressure off them to start talking, and thus reduces their anxiety. In some cases, AHWs or AMHWs may vouch for practitioners if they have worked with them before. This can also help put the client at ease. Importantly, most Aboriginal people want to know your relationships with others before they can decide on their relationship with you.

Being Yourself

To engage successfully with Aboriginal people in both urban and remote settings, the practitioner should also consider and practice the following interpersonal skills as stated:

- demonstrate sincerity, honesty and trustworthiness;
- be helpful, kind and courteous;
- have a genuine interest in people and in establishing relationships;
- be responsive;
- be truthful; and
- ***be yourself***.

Throughout this book, there are pertinent chapters that provide information on the knowledge and skills a practitioner will require to work effectively with Aboriginal clients, whether as individual clients, families or communities. As a mental health practitioner, it is important to be yourself. Aboriginal people are more interested in you as a person than in your qualifications. When meeting an Aboriginal person for the first time it is important that they know who you are, where you are from and whether you can talk to them on a personal level. It is useful to engage in conversation and find common ground with the client before exploring the more complex issues that require addressing. This is an appropriate approach across all groups and settings—including urban, rural and remote areas.

Although people will assess whether you are able to engage with them on a personal level, it is still important that they have confidence in your qualifications and professional knowledge and experience as a practitioner. People like to know that they are receiving a quality service with a trained professional who is also able to engage well and authentically—to be him or herself.

The ideal of respectful and principled practice is asked of all mental health practitioners in the Mental Health Practice Standards in recognition that Australia is a diverse society—culturally, linguistically, geographically and historically. As highlighted at the beginning, mental health professionals are required to:

> *actively demonstrate sensitivity to the social, cultural and spiritual values of consumers, carers and their families and practice in a culturally appropriate manner.*[1(p14)]

Importantly, in the context of this chapter, we have also highlighted that there are complex layers of cultural diversity among Australia's First Peoples. Aboriginal and Torres Strait Islander peoples have unique and diverse cultures spanning urban, rural and remote contexts, influenced by desert and sea and the stories and song lines passed down from their ancestors.

Aboriginal people living in urban contexts, while often invisible to the wider society, bring rich, distinctive, culturally adaptive and diverse experiences and ways of being into this space whilst retaining their distinctive identity as urban Aboriginal people. Reflecting on cultural diversity among Aboriginal students, Ross Humphries, a prior staff member at the Centre for Aboriginal Studies, Curtin University (WA), made the following observations which are still relevant:

> *Despite all this diversity, the sense of shared identity of many Aboriginal people you will encounter is strong and is oriented by complex family and community networks, as well as a spiritual affinity with the regional area they call home. Consequently, there are few aspects of Aboriginal life that can be assumed or generalised about, although all Aboriginal families have experienced some form of oppression in the areas of health, education, housing, employment, social acceptance and basic human rights (racism). The oppression may have been directly or indirectly experienced, but an individual approach needs to be adopted for all clients as they may have different experiences and different intensity of these same oppressions…*
>
> *These differences vary between different groups, families, ages, and gender, but probably not to the extent that differences between these groups would vary in the non-Aboriginal community. There are greater commonalities and far more tolerance and understanding across the generations in Aboriginal society.*[6(p265-67)]

There is considerable material now available to assist practitioners when working with Aboriginal people in remote areas. Currently there is still very little written about 'what practitioners need to know and understand in urban contexts' other than Working with Indigenous Australians: A Handbook for Psychologists (2000)[6] and Dudgeon and Ugle.[13]

It is important for non-Aboriginal mental health practitioners to acknowledge the potential invisibility experienced by Aboriginal people, especially when living in urban contexts, and the potential to treat urban Aboriginal people 'as fully assimilated' into their own non-Aboriginal value base and experience of 'whiteness'. It is also important to ensure that Aboriginal people are provided with culturally appropriate care and that they have equal access to culturally safe services on the basis of clinically determined need, wherever they live. It is incumbent upon practitioners to learn what those differences are and to be culturally respectful at all times. Other themes already covered elsewhere include the need to work in accordance with the Nine Principles underpinning the Social and Emotional Wellbeing and Mental Health Framework. See page xxiv and Chapter 4 (Gee and colleagues) for further discussion.

CONCLUSION

This chapter has examined the diversity of people's communities and experiences and how this presents different expectations and requirements for practitioners working with Aboriginal people in urban, rural, and remote areas and Torres Strait Islander settings. In summary, there are many considerations for practitioners to undertake in order to work respectfully, appropriately and effectively with Aboriginal people. However, Dudgeon and colleagues in *Contemporary Aboriginal Perceptions of Community*[4] make the following salutary observation from which mental health practitioners, policy makers and service providers can draw encouragement and determination to be effective within this complex, diverse cultural context:

> *Despite our cultural differences and our diversity, the fundamental truth is that our commonalities (as humans) are greater than our differences. This is our great common humanity. This is not the notion of universality implicit in the discipline of psychology where cultural difference is treated as merely another variable, but is a shared spiritual humanity. We all laugh and cry; feel pain and have a need to belong; love our children and our families; and take joy in the environment around us. This is what enables understanding and communication across cultures.*[6(p5)]

REFLECTIVE EXERCISES

1. List the cultural considerations that might be important when working with Aboriginal and Torres Strait Islander peoples in an urban or remote context, or in the Torres Strait. Do you think this would differ from area to area?

2. What is the composition of the Aboriginal and Torres Strait Islander community where you work and/or live? What would be some of the considerations for working with people from this community?

3. Create a map of the biggest local families and also the other Aboriginal and Torres Strait Islander peoples living in the community who have come from other areas.

4. What are some of the key relevant Aboriginal organisations that may provide culturally secure and appropriate support services for mental health clients?

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Part 4

Assessment and Management

Assessing and managing an individual and ensuring cultural competency and a culturally secure environment are highlighted. Acknowledging and understanding the diversity of attributes impacting on an individual's assessment, such as trauma and transgenerational trauma and unrecognised or undiagnosed disability are considerations. A range of tools appropriate for assessment are provided.
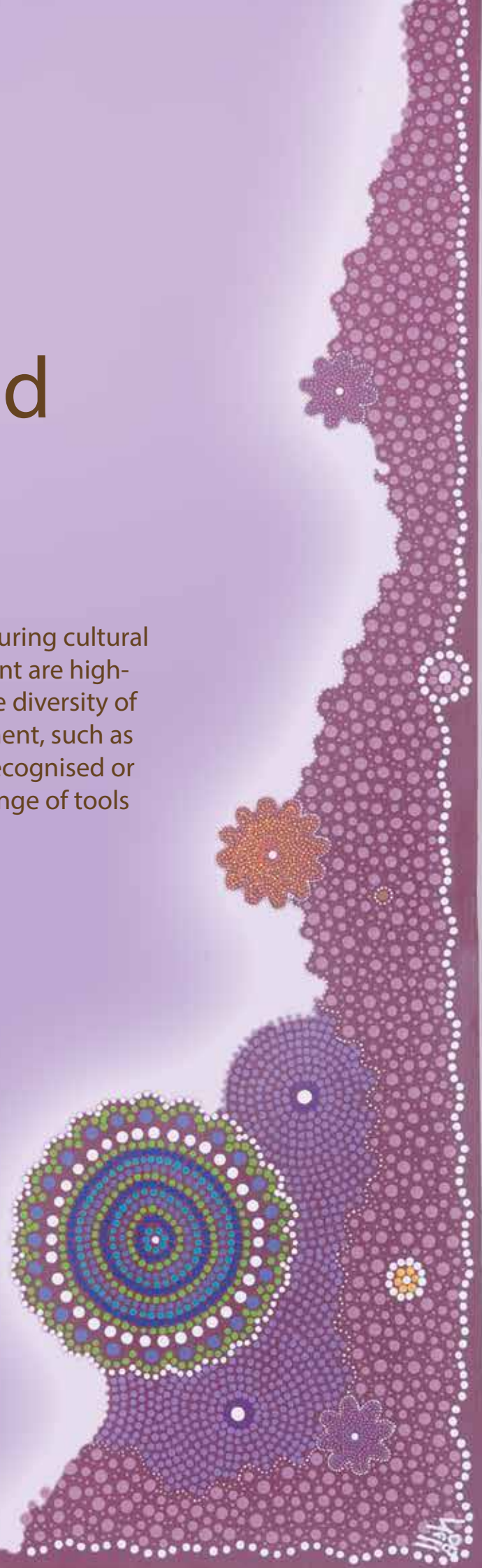
Chapters

16   Assessing and testing culturally diverse groups and a range of emergent principles and guidelines to improve assessment practices are explored. Practitioners conducting assessment are encouraged to reposition themselves when developing procedures and practices in the provision of mental health care to ensure a culturally competent and culturally secure environment.

17   The impact of transgenerational trauma, particularly the links between unresolved childhood trauma and violence, substance misuse, incarceration and the challenges associated with working in communities are identified. Untreated trauma within and across generations results in physical, mental, emotional, spiritual and social distress for individuals and broader social groups. The combined effects of colonisation, government policies and practices have significantly contributed to the circumstances experienced by people today. Programs that provide education and empowerment and trauma recovery are examined.

18   Current and emerging themes in intellectual disability are explored. Various factors that impact on people with an intellectual disability, on their families and carers, including diagnosis, Aboriginal perspectives on intellectual disability, the importance of an interdisciplinary approach in management and assessments that may be of use are outlined. The alarming rate of intellectual disability in Aboriginal communities when compared to other population groups is highlighted.

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Principles of Practice in Mental Health Assessment with Aboriginal Australians

Yolonda Adams, Neil Drew and Roz Walker

OVERVIEW

In this chapter, concepts and history of assessment and testing in the context of Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health are discussed. Importantly, recently revised diagnostic guidelines and the *National Practice Standards for the Mental Health Workforce 2013*[1] and their appropriateness for meeting the distinctive needs of Aboriginal people are reviewed. Various assessment tools and measures that have been validated or proved appropriate for use with particular Aboriginal populations, i.e. youth, women and older people, are described. We conclude that practitioners need to be critically reflective in their role in assessment, and position themselves to play an important transformative role in conducting assessment. This extends to acknowledging and enacting culturally responsive principles, procedures and practices to ensure that Aboriginal people have access to effective, culturally secure mental health care.

INTRODUCTION

Mental health and psychological assessment of Aboriginal Australians has a complex and contested history. Several chapters in this book confirm that Aboriginal people's experiences, such as the forcible removal of children, have led to psychological distress and ongoing despair and trauma (see, for example, Chapters 17, 28 and 29). This situation reinforces the need for more culturally sensitive and appropriate assessment and testing of Aboriginal people who are experiencing extreme levels of trauma and grief and SEWB issues. While assessment procedures and processes are important tools for mental health professionals, it is widely recognised that the misuse of assessment has perpetuated stereotypes based on race, culture and ethnicity (see Drew, Adams and Walker, 2010 for further discussion).[2] Much of the suspicion that Aboriginal people have regarding assessment derives from its political nature as a process of social and cultural control. As Chapter 3 (Dudgeon and colleagues) describes historically, assessment was deeply rooted in the power differential (of coloniser and colonised) between Aboriginal people and other Australians. Notwithstanding the criticisms, assessment tools and procedures, when understood, developed and implemented appropriately and sensitively, can significantly enhance our capacity to make accurate diagnostic and standardised measurements to provide quality care.

Over the past decade there have been significant improvements in our understanding of the issues of assessment with diverse cultural groups within Australia.[3-7] The work of Aboriginal psychologist Dr Tracy Westerman on assessment regimes for depression and anxiety in Aboriginal communities is an outstanding example, and there are several other assessment tools listed later in the chapter. Even so, a recent review of various psychological, mental health, social

and emotional wellbeing (SEWB) and cognitive assessment tools developed or adapted for use with Aboriginal individuals and communities confirms the need for further work in this area.[4]

WHAT IS ASSESSMENT?

It is important to understand the concept of assessment and how this is variously perceived within Aboriginal contexts. Current Australian perspectives on mental health assessment are derived from a clinical perspective embedded in a Western medical model. As the Social Health Reference group notes 'the concept of mental health comes from an illness or clinical perspective, and its focus is more on the individual and their level of functioning in their environment'.[8(p9)] The need for an immediate solution has many implications when assessing Aboriginal people, highlighting some fundamental differences in expectations between the practitioner, the client and their family, carer and community.

Given the cumulative, transgenerational SEWB and mental health issues experienced in Aboriginal communities, there is a need for assessment tools that are culturally appropriate and validated for Aboriginal populations. Without culturally appropriate assessments, 'the process relies heavily on the abilities and skills of the clinician which may lead to poor diagnosis'.[4(p21)] Inappropriate assessments resulting in poor 'test' outcomes not only perpetuate the marginalisation of Aboriginal people, but can result in inadequate treatment and access to appropriate services. Testing is only one part of the assessment process, one source of (potentially limited) information. Testing tends to produce normative quantitative information, while assessment is more holistic and includes the qualitative dimension[9], which more appropriately supports the SEWB model of working with Aboriginal people.

The Need for Culturally Appropriate Assessment

There is increasing acknowledgement that assessment tools must be developed, used and understood within the complex collection of information obtained from the assessment process. As cited in Brown 2001, the *National Mental Health Strategy 1995* states:

> *A thorough assessment, effective treatment, protection, care and rehabilitation of people who have mental health problems or mental disorders should be available at the highest standards of practice.*[10(p34)]

More specifically, the Social Health Reference Group (SHRG) explains that:

> *Culturally valid understandings must shape the provision of services and guide assessment, care and management of Aboriginal and Torres Strait Islander peoples' health problems generally and mental health problems in particular.*[8(p6)]

For Aboriginal people mental health is holistic, bound up in the social, emotional, spiritual and cultural life of people and communities. See Chapter 4 (Gee, Dudgeon and colleagues). Aboriginal SEWB is also holistic in nature, incorporating mental health. The concept of *Strong Spirit Strong Mind,* for example, reflects Aboriginal cultural practices where wellbeing 'encompasses the body, mind and spirit'. See Chapter 26 (Casey). A full appreciation of this holistic notion of health and mental health is absolutely vital as part of the contextual matrix within which assessment takes place (see Dance of Life, Table 16.1).

It is anticipated that the revised *practice standards* will require mental health practitioners to use culturally appropriate assessment instruments and techniques where available and appropriate, and to take into account cultural issues that may impact upon the appropriateness of assessment, care and treatment, including the need to involve family/carers. Practitioners are also required to comply with culturally-specific principles and practices included in relevant national, state and local guidelines, policies and frameworks.

ASSESSMENT GUIDELINES AND STANDARDS

There have been a number of approaches to assessment suggested in the literature.[11, 12] All grew out of the imperative to provide culturally appropriate assessment to minority groups. Australian frameworks emphasise the importance of relationship-building and engagement as crucial to success. Some of the more appropriate guidelines and approaches are briefly discussed here.

Increasingly, diagnostic guidelines and practice standards (including the DSM-5)[13] acknowledge that assessment needs to be systemic, taking into consideration individual, family and community factors to avoid inadequate or incorrect diagnosis. For example, the DSM-5 Appendix 111 includes questions which acknowledge that the intersection of conceptions of race and mental illness can be detrimental to the overall SEWB and mental health of an individual or group. This is important as a recent report by the Aboriginal Disability Network of New South Wales found that Aboriginal people with disability (including mental ill health) often face multiple layers of discrimination at the intersection of their Aboriginality and disability, resulting in their underrepresentation in receiving positive diagnosis, treatment and care.[14]

International Assessment Guidelines

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV-TR)[12] has been one of two internationally recognised manuals of mental health disorders—the other is the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10)[15]. The DSM IV-TR has been revised and was recently released as DSM-5.

Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, was released in May 2013 as the most comprehensive, current, and critical resource for clinical practice available for mental health clinicians and researchers.[13] These manuals are designed for use by mental health professionals with clinical training. All categories of mental health disorders and the diagnostic criteria required to meet them are based on a comprehensive literature review of available research to establish a firm empirical basis for all classifications. The revised manual has involved hundreds of international experts (including mental health experts from Australia) in all aspects of mental health to improve diagnoses, treatment, recovery and research. It aims to:

- create a common language for clinicians involved in the diagnosis of mental disorders using a range of agreed upon, clear and specific criteria;
- facilitate an objective assessment of symptom presentations in a variety of clinical settings— inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care; and
- take into account the biological, psychological, social, cultural and spiritual factors as well as the broader historical and socioeconomic context .

The DSM-5 includes guidelines for cultural assessment of people from diverse cultural backgrounds. These guidelines separate the cultural elements from the context of psychiatric diagnosis and labelling to identify some key dimensions to be explored in any assessment process:

- cultural identity;
- cultural explanations of the illness;
- cultural factors associated with psychosocial and environmental functioning;
- cultural elements of the relationship between the client and the practitioner; and
- overall cultural assessment.

The information is intended to be used by general practitioners and health professionals,

including psychologists, counsellors, nurses, and occupational and rehabilitation therapists, social workers and forensic and legal specialists. It has the potential to improve interdisciplinary care by providing clear information and a common language to help mental health practitioners and caregivers improve both diagnosis and clinical care.

Despite these intended aims, the DSM-5 manual has received some criticism regarding its tendency to pathologise the ordinary, as well as criticism regarding the cultural appropriateness of the revised diagnostic categories.[16] For example, the Australian Psychological Society (APS) submission on the DSM-5 to the American Psychiatric Association (APA) notes that:

> *Any classification that primarily focuses on problems or deficits at the expense of personal achievements, resources and preserved aspects of functioning or wellbeing runs the risk of over diagnosis, discrimination and stigma, and an undermining of self-efficacy and motivation.*[16(p7)]

Whereas the authors claim 'an increased focus on the classification of strengths as well as deficits' is in line with current conceptions of recovery in mental disorder (including the preservation and development of hope and fulfilment, regardless of symptom status).[16(p7)]

It is important that mental health practitioners guard against the potential to further pathologise Aboriginal people in the assessment and diagnostic process. This can be avoided by adopting a culturally aware and safe approach to assessment practices in which the DSM-5 and other diagnostic tools are applied as part of a holistic assessment process.

Incorporating Culture in Assessment

Importantly, the newly revised DSM-5 diagnostic classification system provides opportunities to take into account transgenerational trauma from genocide and ongoing discrimination, as well as culturally related symptoms. The APA offers the core *Cultural Formulation Interview* (CFI) and *Informant Version* (IV) and eight supplementary modules to the core CFI for further research and clinical evaluation.[13] They should be used in clinical settings as potentially useful tools to enhance clinical understanding and decision-making and not as the sole basis for making a clinical diagnosis. Additional information can be found in DSM-5 in the Section III chapter 'Cultural Formulation.'[13]

Establishing a Cultural Definition of the Problem

The DSM-5 outlines a number of questions for practitioners to take into account the cultural perceptions of the cause, context and support, as well as possible stressors for someone experiencing mental health issues. Practitioners are asked to consider issues around cultural identity, including psychosocial stressors, religion and spirituality, as well as issues for the specific ages and gender—older adults, children and adolescents, women—when undertaking an assessment. Importantly, practitioners are asked to take account of whether their client believes their condition is worsening as a result of discrimination due to race/ethnicity or sexual orientation.

Cultural Factors Affecting Self-coping and Help Seeking Behaviours

The CFI questions recognise that clients may seek help from a range of sources, including medical care, mental health treatment, support groups, work-based counselling, folk healing, religious or spiritual counselling, and traditional or alternative healing. Practitioners are encouraged to clarify the client's experience and regard for previous help through religion and spirituality, older adults, caregivers; and any barriers, including psychosocial stressors, to current coping and help seeking. This is particularly important and reaffirming given the recognised value that traditional healers and Ngangakaris still play for many Aboriginal people.

Practitioner–Client Relationship

Practitioners are encouraged to elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers or cultural differences that may

undermine goodwill, communication or care delivery. The DSM-5 recognises the potential for intercultural miscommunication—the possibility for clinicians and clients to misunderstand each other because they come from different cultural backgrounds, or have different expectations. It is important for practitioners to ask clients if they have any concerns about this and if there is anything that can be done to address this issue.

These questions or prompts acknowledge the importance of the client's perspective of their condition, which may be relevant for clinical care. The client may identify multiple causes, depending on the issue or problem they are considering. The DSM-5 CFI recommends that practitioners also take into account the view of the client's social or family network, which may be diverse and vary from the views of the client, by asking questions such as:

- Are there any aspects of your background or identity that are causing other concerns or difficulties for you?
- Why do you think this is happening to you?
- What do you think are the causes of your [PROBLEM]?
- Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.

Guidelines for Implementing the CFI Supplementary Modules

There are also guidelines for implementing the Core CFI which are designed to help clinicians conduct a more comprehensive cultural assessment. The first eight supplementary modules explore the domains of the core CFI in greater depth. The modules are intended to guide cultural assessment and should be used flexibly to maintain a natural flow of the interview and rapport with the individual. In situations where the individual cannot answer these questions (e.g. due to cognitive impairment or severe psychosis), questions can be administered to the identified caregiver. The caregiver's own perspective can also be ascertained using the module for caregivers. The DSM-5 Section III, chapter 'Cultural Formulation,' section 'Outline for Cultural Formulation,' provides additional suggestions regarding this type of interview.[13] These measures are only to be used to enhance clinical decision-making and not as the sole basis for making a clinical diagnosis. They also need to be interpreted with regard to the additional guidelines and principles outlined in this chapter specific to diverse Aboriginal and Torres Strait Islander contexts.

National Guidelines for Assessment

There are several national guidelines for assessment and for standards of practice in assessment.

National Practice Standards for the Mental Health Workforce 2013

In accord with the *practice standards* to achieve culturally secure practice, all mental health practitioners need to undertake recognised cultural competence, awareness or sensitivity training in the context of Aboriginal mental health and SEWB.[17, 18] Both the *practice standards* and respective individual discipline guidelines acknowledge the need for practitioners to ensure the cultural safety of clients through the assessment process. Providing a culturally safe environment is fundamental to the practice of cultural competence and involving Aboriginal Mental Health Workers (AMHWs) in assessments of Aboriginal clients is an example of cultural safety.[19]

The Australian Psychological Society Guidelines

The APS has developed a set of guidelines which outline a series of principles to inform ethical practice in the assessment and treatment of culturally diverse groups: *Guidelines for the Provision of Psychological Services for, and the Conduct of, Psychological Research with Australian and Torres Strait Islander People of Australia, 2003*.[17] Psychologists working with Aboriginal people have a professional responsibility to obtain knowledge of Aboriginal peoples, their psychological functioning and personal needs, and the cultural and other social factors that underlie those needs. Alternatively, they need to refer Aboriginal clients to psychologists considered to be culturally competent to provide the services required.

The Aboriginal Indigenous Psychology Association Framework for Assessment

The Aboriginal Indigenous Psychology Association (AIPA) offers another useful framework for assessment.[18] They also emphasise the need for practitioners to understand:

- the potential impact of adverse life events on serious psychological distress and SEWB;
- the factors that protect against the development of serious psychological distress following adverse life events;
- the consequences of high and prolonged levels of psychological distress on Aboriginal health and mental health; and
- detection of individuals and groups who are at high risk of mental ill health due to high and prolonged levels of psychological distress.

As Kelly et al. (2009) notes, assessment tools:

> *... aiming to provide a universal measure of psychological characteristics will require close examination for cultural bias, particularly with the diversity of cultures, peoples and regional variations found among Aboriginal and Torres Strait Islander communities.*[20(p7)]

The Royal Australian and New Zealand College of Psychiatrists' Guidelines

The Royal Australian and New Zealand College of Psychiatrists' (RANZCP) Indigenous Mental Health Group identifies some of the issues, gaps in knowledge and solutions to be considered across the physical, psychological, social, cultural and spiritual dimensions in the *'Dance of Life'* matrix (Table 16.1).[21] All these elements must be explored and understood as part of the assessment process. The matrix was devised as a way of exploring Aboriginal values, experiences and understandings in a systematic and culturally appropriate way, consistent with the Aboriginal terms of reference (ATR). As the assessment unfolds, the practitioner moves backwards and forwards through these dimensions in pursuit of a detailed and comprehensive understanding of the client's context. This may also involve extensive consultation with family and other respected community members.

A crucial aspect of the assessment focuses on the most appropriate ways of doing things. This includes discussion of alternative or traditional healing practices; intervention such as medication; and therapeutic interventions such as counselling. The framework provides an opportunity to integrate and understand the complex interplay of cultural imperatives and practices that may impact on the understanding of the mental health issues being assessed.

Table 16.1: Understanding the Dance of Life

Traditional	Historical	Contemporary	Gaps in Knowledge	Solutions
Physical Dimensions				
• Earth as 'Mother', Nature as family • Connection to country, source of renewal • Traditional medicine • Traditional diet and activity, 'healthy specimens'	• Physical genocide • Dispossession, 'uprooted' • Environmental degradation • Rapid change in diet • Incarceration, institutionalisation • Forced labour • Ill-health, exposure to disease	• Population changes • Present morbidity, burden of chronic illness • Burden of care on children • Land-rights and treaty • Holistic view • Urban, rural and remote differences • Exclusion from health	• Stress, immunity and chronic disease • Grief and mortality • Transgenerational trauma and physical health • Chronic illness and mental health • Complimentary healing practices	• Sovereignty and Native Title • Equity and access • Accountability • Traditional diet, medicines and healers • Connection to country • Holistic medicine • Best start to life • Basic requirements
Psychological Dimensions				
• Different concepts, beliefs and meaning • Sense of self; external attributions; site of distress • Shared learning, cognitive development • Identity and role • Autonomy and relatedness • Life continuum, belonging • Birth and bereavement	• Psychological genocide • Profound trauma • Abuse • Loss and grief • Extreme powerlessness • Misdiagnosis, mislabelling, re-traumatisation	• Place in society • Present trauma, loss, grief • Future uncertainty • Psychological morbidity, illness • Identity issues • Psychological strengths • Apology • International perspective • Exclusion from humanity	• Appropriate diagnostic systems • Treatment options • Culturally valid tools • Appropriate outcomes • Accountability measures • Impact of racism and discrimination • Cultural and spiritual phenomenology • Culture bound syndromes	• Truth in history • National 'Sorry Day' • Human rights, safe development, future assurance • Inclusiveness • Pride, positive images • Professional development • Indigenous therapies, grief and trauma • Addressing 'stress' • Identifying and tackling racism
Social Dimensions				
• Community centred • Kinship system • Attachment and child rearing • Early autonomy • Country as home, kin • Collective vs Individual • Obligation and reciprocity • Two-way sharing	• Social genocide • Stolen Generations • Racism and apartheid • Slave labour	• Changing role of family especially men • Role models • Family disruption, isolation • Loss of buffering • Removal of children, adults • Paternity • Present disadvantage, impoverishment • Reconciliation • Exclusion from society	• Family therapies • Children's needs vs Family • Community outcomes • Systemic barriers	• Social justice • Social determinants • Generational view, long term commitment • Whole of life concept • Tracing family, restoring kinship • Recording oral histories • Narrative therapies • Empowerment • Representative body
Spiritual Dimensions				
• Origins of life • Dreaming • Belonging, connectivity • Philosophical views • Beliefs, experiences, healing	• Spiritual genocide • Impact of mission life • Imposition of Christianity	• Value of wisdom • Intolerance, understanding difference • Exclusion from existence	• Spirituality and health • Existential despair	• Central to health of Australia • Healing • Understanding, tolerance, respect • Purpose and future hope

Continued . . . .

Table 16.1: Understanding the Dance of Life (continued)

Traditional	Historical	Contemporary	Gaps in Knowledge	Solutions
Cultural Dimensions				
• Lore/Law • Language • Ceremony • Healing beliefs, expression, experiences	• Cultural genocide • Misinterpretation • Tokenism • Sacrilege	• Cultural clash, two worlds • Cultural mix • Cultural practices, age, gender • Endurance and resilience, strengths • Cultural knowledge • Cultural grief • Exclusion from custom and consciousness	• Continuum of cultural identity • Diversity of practice and experience • Models of care	• Acceptance • National identity • Compensation • Cultural renaissance • Self determination (Indigenous rights) • Indigenous governance • Cultural security • Cultural Respect Framework • Education, training • Shared learning, collaboration

Source: Royal Australian and New Zealand College of Psychiatrists, Indigenous Mental Health.

RATIONALE FOR CULTURALLY COMPETENT ASSESSMENT

Cultural competence is fundamental to good assessment practice. Along with the processes outlined above, culturally competent assessment involves a commitment by the practitioner to self-exploration, critical self-reflection and recognition of the implications of the power differentials inherent in the role of clinicians and clients. Chapter 12 (Walker, Schultz and Sonn) outlines the tools and techniques for critical reflection and competence as well as the elements for engaging with Aboriginal clients and communities as culturally competent practitioners. These techniques involve both a commitment to ATR and a critical examination of 'whiteness'. Both promote decolonising practice. The incorporation of ATR provides a sound and coherent framework for assessment practice—a complete picture of the experiences and circumstances of the person being assessed. It serves as a guide to culturally competent practice, an analytic and reflective frame for understanding Aboriginal experiences of mental illness. It is consistent with culturally appropriate models for assessment recommended by the DSM-5's standards for incorporating cultural concepts in the DSM-5 and the mental health-related cultural competencies described by Westerman[6] and Garvey.[5]

This 'dual lens' is an essential component of the processes of deconstructing colonising practices that underpins cultural competence. Both strive to move the practitioner towards cultural competence as a necessary foundation to working with Aboriginal people—see Chapter 12 for a more comprehensive discussion of these issues.

Culturally Appropriate Assessment

The DSM-5 CFI schedule is consistent with the approach to assessment in cross-cultural contexts proposed by Ponterotto et al. (2001) outlining a framework which involves:

- an exploration of the client's worldview and understanding of his or her problems;

- an understanding of the client's family background;

- cultural explanations of illness for the individual;

- cultural elements of the client–practitioner relationship that reflect a clear understanding of the practitioner's insight into their own positioning.[9]

Professional Practice – Four Stages of Culturally Appropriate Assessment

Acevido-Polakovich et al. (2007) also outline four stages of professional practice in the assessment process.

Four Stages of Culturally Appropriate Assessment

Stage 1:	***Proactive steps before the assessment*** require that practitioners receive and maintain formal training in culturally appropriate assessment.
Stage 2:	***The outset of assessment*** requires that practitioners undertake a comprehensive interview with their client before deciding on the assessment processes and use of any formal testing (if that seems appropriate). They recommend an exploration of cultural history, contact with other cultural groups, acculturation status and stress, some assessment of language and language skill. This may include using an interpreter and/or the translation of material. A crucial element of this stage is to explain fully and document the limitations of any testing protocol that may be used.
Stage 3:	***The assessment process*** requires that practitioners recognise and document the impact of language and non-verbal communication. Proactive training should alert the assessor to the potential impact of culturally relevant international variables.
Stage 4:	***The interpretation and reporting of results*** requires that practitioners incorporate cultural explanations and avoid labelling in the final stage when interpreting the results.[22(p376)]

Stage 1: Pre-assessment

The pre-assessment phase requires practitioners to consider aspects of initial engagement and access. Westerman[6] and Garvey[5] identify a number of elements of good practice which are consistent with the DSM-5 CFI including:

Appropriateness of Referral

Practitioners need to consider whether they are the most appropriate person (or agency) to conduct the assessment. The gender, age and cultural identity of the practitioner could all be relevant in the decision to accept or not accept a referral.

Introductions and Community Access

This may include:

- using cultural consultants. They are a valuable resource in facilitating access and building good relationships in the community;

- taking the time to become both known and familiar with the community. This is especially important in regional and remote communities;

- adhering to community protocols such as notifying and seeking permission from community councils, reporting to the community office on arrival, and seeking permission to move around the community. These are all signs of respect, courtesy and cultural competence;[5]

- contacting the community. Other valuable information will often arise such as finding out about issues relating to the health service program and local issues of service delivery and in reference to the regional health services.[19]

The Site for Assessment

With respect to the site where the assessment takes place, it is important to:

- recognise the risk of misunderstanding that may arise when assessment is conducted away from country, family or community, such as prison and hospitals or other sites that may cause distress.[6]

- assess a client in their natural environment where they feel most comfortable—it is always preferable as the information gathered is much more informative and accurate.

Stage 2: Negotiating the Process of Assessment

Assessment in Perspective: 'Bringing it all Together'

The fundamental aspects of assessment of Aboriginal mental health have been discussed throughout this chapter. For accuracy, appropriateness and effectiveness of assessment there are a number of issues to consider:

- Be patient and take the time to engage with the client. Remember, this is the most important part of the process;

- Identify your own attitudes, values and beliefs;

- Respect community protocols;

- Find out who is the right person to speak with in the community;

- Involve an AMHW;

- Traditional and non-traditional healing practices should be considered when deciding on appropriate intervention, i.e. Elders, community healers;

- Are the assessment tools appropriate and what factors do you need to consider when inter-preting the data?

- Have you considered engaging a cultural consultant? If so, is this consultant appropriate to engage, i.e. relationship to client, gender?

- Is this person's behaviour within cultural context?

- Is it appropriate for you to see this client?

In summary, the key elements of culturally competent practice and assessment are:

- cultural respect;

- acknowledgment;

- empathy;

- understanding; and

- continuous consultation with family, Elders and community.

These principles of assessment serve as a guide for clinicians to employ best practice methods which have been documented by Aboriginal clinicians such as Westerman, Milroy and Hunter and others such as Mark Sheldon. Importantly, at the time of writing, the revised *practice standards* are expected to incorporate principles consistent with those outlined in this chapter signalling real reform in this sector.

The most important elements of assessment include:

- being flexible throughout the process to have time to establish rapport with clients;
- taking the time to understand the community and family, to enhance engagement and build trust;
- negotiating the process of assessment such as the number of sessions required; and
- providing a clear explanation of any tests or assessment including the purpose, uses, limitations and benefits .

Once initial pre-assessment activities have been undertaken the actual assessment may commence.

Stage 3: The Assessment Process

Almost all forms of mental health assessment will include some form of mental state examination (MSE).

Mental State Examination

The MSE is a crucial tool for understanding the mental state of the client or patient at the time of assessment. There are numerous approaches to MSEs but most include an assessment of the cognitive, emotional and physical state of the client. Clearly, these parameters are subject to interpretation that may be culturally biased if not undertaken by culturally competent practitioners.[23]

Does the person have the knowledge required? For example, asking the person day, dates and times may be inappropriate. Sheldon identifies considerations for assessing Aboriginal people when conducting MSEs as detailed in Table 16.2.[19]

Table 16.2: Implications and Considerations in Mental State Examinations

Appearance	Understand the person's 'usual' standard of self-care and appearance. Identify any changes that may indicate a mental health issue. Consider cultural influences and manifestations such as grief.
Behaviour	Have a good understanding of Aboriginal culture as it relates to a person's behaviour. Behaviours can be culture-specific.
Affect	Affect can take on cultural forms as not all human emotions are universal. Anxiety and depression for example, may be difficult to diagnose as the manifestation of these conditions could be vastly different to that of other people.
Mood	An Aboriginal person's mood may not be expressed in the same way as a non-Aboriginal person. Language may not have meaning for Aboriginal people and may need to be translated into meaningful terms.
Speech and thought form	Thought disorders may be difficult to detect if the client does not have good English. The clinician would then need to rely on the services of an AMHW.
Thought Content	Aboriginal spirituality may display as delusional or otherwise cultural. The clinician needs to ascertain whether the primary symptoms pre-date the culturally based retrospective attributions.
Perception	These may be pathologically or culturally based. It is advisable to seek advice from the AMHW. Auditory hallucinations are less commonly sited and may be indicative of a mental disorder.
Cognition	Assessing cognition is difficult due to the lack of culturally appropriate assessment tools— assessments of function and activities of daily living are not appropriate in remote communities where living in collective in nature. It is not uncommon for families to seek help as a last resort.

In particular, practitioners should avoid over-interpretation and culturally bound inferences. For example, in terms of behavioural presentation, posture, gesture, touch and eye contact, all have cultural interpretations that may differ from one setting to the next. Affective responses too, may be a function of cultural imperatives. Anger and resentment in Aboriginal people may be more historical than circumstantial, or indeed some combination of the two (an expression of suppressed grief—see Chapter 28, Wanganeen). Non-Aboriginal psychologists or psychiatrists conducting assessment are representatives of the dominant culture and may invoke anger and resentment that are substantially exacerbated in the context, particularly of involuntary review.

Language and speech may vary for reasons other than being solely a function of a person's mental state. Assessment of cognitive functioning and orientation in space and time should be carefully interpreted.

The common thread in all of these frameworks is that they are predicated to a greater or lesser extent on the dual lens discussed earlier—understanding and taking into account Aboriginal terms of reference and acknowledging and unmasking white privilege.

Stage 4: Post-assessment

Interpretation and Presentation of the Assessment

This should include a discussion of the cultural formulations developed during the assessment stage. The identification and implications of culture-bound syndromes will be crucial to this process.[5] Once again, the practitioner should consider the wider political implications of the assessment.

Intervention Strategies

This stage includes a contemplation of traditional healing practices as well as a thorough analysis of the appropriateness of traditional western approaches to intervention. Chapter 13 (Schultz and Walker and colleagues) outlines a range of relevant people including immediate family, extended family, Elders, community healers and relevant interdisciplinary care stakeholders who may need to be involved in the intervention. Sheldon suggests that intervention should be guided by the family's wishes.[19] There are some exceptions to this rule, where the client's situation presents risk factors, i.e. suicide—the clinician's involvement would significantly increase. Generally, family involvement is organised by a meeting and talking about the problems, then asking the family for some possible solutions. The AMHW is a key facilitator in this process.

Negotiating treatment intervention strategies is as equally important as the assessment process. Existing traditional healing methods practiced within communities should be offered in conjunction with clinical treatment, and even as the primary source of treatment. Community healing methods should be guided by an appropriate, identified person within the community. Failure to acknowledge and recognise this fundamental aspect promotes ongoing barriers for Aboriginal people to effectively access mental health services.[24, 25]

Follow-up, Disengagement and Closure

Most assessment processes are short term. However, the mental health practitioner has a responsibility to ensure that the outcomes of the assessment process are implemented and managed, and to evaluate the impact of their assessment on the client, their family and the community. This may take a variety of forms, including direct contact or liaison through a cultural consultant if one has been engaged. This form of empathetic engagement is welcomed by Aboriginal people and supports their cultural security.

The RANZCP Guidelines on diagnosis and management require practitioners to make sure an adequate explanation is given and treatment negotiated and planned appropriately with the patient and/or family. They stress the importance of follow-up as 'Aboriginal or Torres Strait Islander clients are often lost in the system due to geographical isolation, demarcation between service providers and failed communication'.[26]

Practitioner Reflection Post Assessment

The RANZCP Guidelines[26] suggest the following reflective questions:

- Has the team you are working with, or other providers working with your client, received cross-cultural education and do they understand the meaning of mental health for Aboriginal and Torres Strait Islander Australians? (See also Chapter 13)

- Has the presentation of illness been understood in the context of the patient's own culture and history?

- Has there been consideration of the impact of trauma, grief and loss?

- Is the treatment appropriate to the person's cultural belief system and does it include a broad based assessment of all needs?

- Have alternative treatments been considered or used in conjunction with mainstream practices?

- Has a second opinion been sought from an AMHW or cultural consultant?

COMMUNICATION SKILLS FOR ASSESSMENT

An understanding of micro skills is increasingly required as part of acquiring cultural competence. See Chapter 12 (Walker, Schultz and Sonn). Guidelines for assessment include the following micro skills:

- Self-disclosure is one of the most important processes in establishing rapport with Aboriginal people. It is important for Aboriginal people to know who you are, and for you to know who they are, where they are from and who their family is. Take time to allow for this engagement process to occur. See Chapter 15 (Dudgeon and Ugle);

- Communication style includes verbal skills such as awareness of the client's use of language and language proficiency, using plain language without jargon, finding out the preferred and culturally appropriate forms of address.[27] The use of technical language can lead to misinterpretation—make use of visual aids such as pictures;

- Non-verbal skills are also very important and include the appropriate use of eye contact, posture and gesture.[27] A nod may not be an answer to the question you're asking but an acknowledgment of what you have asked. The clinician or practitioner needs to check if the client has understood what has been said;

- Use a conversational or yarning approach.[5] It is important to let the person tell their story—asking direct questions to obtain information for assessment tends to create inaccuracies;

- Knowing what questions can and can't be asked and the right person to talk to to ask is important. See Chapter 15 (Dudgeon and Ugle). Take time to get to know the client and their community to determine the right way of going about your assessment;

- Be aware of sensitive topics and obtain a client's permission when discussing issues such as bereavement, ceremonial business, sexuality and marital problems;

- Explore treatment options, including traditional healing methods, westernised models of treatment, or a combination of both. This is particularly important if a 'client has a strong connection with their Aboriginal belief system'. However this needs to be a facilitated process by an appropriate cultural consultant.[24(p223)]

Consideration of these factors takes time, yet it is by far the most effective way of obtaining information to make an accurate assessment, which is critical in determining the most appropriate treatment and level of service.

EFFECTIVE MODELS FOR ASSESSMENT

One effective model for assessment with Aboriginal people is the *Mental Health Stay Strong Care Plan*.[23] This comprehensive package of support materials provides a series of culturally appropriate stages of assessment and care planning options for supporting mental health in Aboriginal communities. The package incorporates an understanding of the holistic nature of Aboriginal health and mental health.[23] Their 'grow strong mental health tree' is an excellent example of combining the visual with the written word to explain mental health issues and provide a framework for exploring them in a cultural context. The power of visual representations is also evident in other effective programs and models, for example, as developed by Casey (Chapter 26) and Powell and colleagues (Chapter 27).

While there are shortcomings in many of the assessment tools for Aboriginal people, several of the chapters in this book highlight the need for practitioners to access valid tools and to be able to effectively measure specific areas. These include assessment for:

- Young people at risk of suicide – Chapter 9;

- Cognitive disabilities and ABI, ND through trauma – Chapter 18;

- Dementia – Chapter 18;

- Perinatal mental health and wellbeing – Chapter 19;

- Fetal Alcohol Syndrome Disorders – Chapter 20;

- Behavioural and emotional problems in young people – Chapter 22;

- Youth social and emotional wellbeing – Chapter 22; and

- Early development – DSM-5, Appendix 111 module.

The following table lists a number of culturally validated assessment tools and where further information can be found from the references or websites.

Table 16.3: A List of Culturally Validated Assessment Tools

Assessment Tool	Description	Further Sources of Information
WASC-Y, WASC-A	Youth 13-17 years, Adults aged 18 years and over. Identifies risk of anxiety, depression and suicidal behaviour whilst factoring in cultural resilience.	(1)
Kimberley Indigenous Cognitive Assessment tool (KICA)	Cognitive screening tool that assesses dementia in older Aboriginal Australians living in rural and remote areas.	(2)
Strong Souls	Assesses SEWB of Aboriginal youth. Measure for depression, anxiety, suicide risk, and resilience.	(3)
Negative Life Event Scale	Assessment of psychological wellbeing in Aboriginal Australians. Measures exposure to stress.	(4)
Kearins' Visual Spatial Memory test	Assessment based around research with Aboriginal children aged 6-17 years that focused on task behaviour.	(5)
Australian Aboriginal Version of the Harvard Trauma Question- naire (AAVHTQ)	Culturally competent measure of specific traumatic stressors and trauma symptoms criteria for PTSD. This questionnaire includes specific cultural idioms of distress reactions that are relevant to Aboriginal people.	(6)
The K-5 measure of psychological distress	A subset of five questions adapted from the Kessler Psycho- logical Distress Scale-10 (K-10) developed in 1992 by Kessler and Mroczek (ABS 2003).	(7)
The K-10	A non-specific psychological distress scale of 10 questions to measure levels of negative emotional states experienced in the 4 weeks prior to interview.	(8)
Kimberley Mum's Mood Scale	Currently in development as an adapted version of the EPDS and is currently being validated across the Kimberley in Western Australia. This tool screens for depression and anxiety.	(9)
Q Test	Cultural-fair, language-free assessment measure of cognitive functioning screening and trainability.	(10)

Sources of Information:

(1)   http://www.indigenouspsychservices.com.au/staticpage.php?static_id=13
(2)   http://www.wacha.org.au/kica.html
(3)   http://www.ncbi.nlm.nih.gov/pubmed/20073566
(4)   http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2203968/
(5)   http://online.santarosa.edu/homepage/jkremer/kearinsvisualspatialmemory.pdf
(6)   http://www.wealli.com.au
(7)   http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/84330C2EDC3DB940CA2579D50015D74E?opendocument
(8)   http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/84330C2EDC3DB940CA2579D50015D74E?opendocument
(9)   Kimberley Mum's Mood Scale is an adaptation of the Edinburgh Postnatal Depression Scale (EPDS)
(10) VEQ Pty Ltd and G E Kearney.   http://www.VEQ.com.au

CONCLUSION

Assessment remains an important, yet problematic area to help address the magnitude and nature of issues being faced by Aboriginal individuals, families and communities. The low levels of confidence among practitioners in using many existing assessment tools for Aboriginal clients means that fewer assessments are undertaken than within the wider population. There are concerns regarding under-diagnosis of Post Traumatic Stress Disorder (PTSD) and other mental health issues. The potential cultural bias and monoculturalism, lack of understanding of Aboriginal culture, pervasive transgenerational impacts of colonisation upon Aboriginal children, and more holistic conceptions of mental health and SEWB among Aboriginal families and communities, creates real challenges for both mental health practitioners and services.

A number of tools have been developed/adapted to assess a range of mental illnesses. We discussed a range of principles and models of assessment and care to ensure cultural security in assessment. Mental health assessment is the gatekeeping process to mental health service provision, including alternative healing programs and services. Thus, the challenge remains to develop processes and tools to assist in appropriate and accurate diagnosis of mental illnesses, as well as processes for appropriate culturally secure engagement of individuals and communities to promote mental health and wellbeing.

In summary, culturally competent assessment is a decolonising practice that requires practitioners to simultaneously acknowledge the importance of Aboriginal terms of reference and the impacts of white privilege to overcome marginalisation and alienation. Culturally competent assessment promises to be transformative in its intention and practice for both individuals and the wider Aboriginal community. Practitioners require increased knowledge and abilities and culturally appropriate assessment tools to assess and treat Aboriginal people. Culturally competent assessment offers the promise of a shift from 'discourses of distress' to 'discourses of hope'.[28]

REFLECTIVE EXERCISES

1. Review the assessment protocols in your agency or agencies you are familiar with. Does the protocol systematically address all the elements for culturally appropriate assessment outlined in this chapter? If not, how could you revise the protocols?

2. If you employ psychological or other tests, review each of them using the issues raised in this chapter as a critical lens. Are the tests culture-fair? culture-free? Aboriginalised? In each case reflect on how you have used, interpreted and reported the results in your practice. Have you honoured the principles of culturally competent assessment practice? How could you do things differently in the future?

3. What are some of the processes that need to be considered when consulting Aboriginal communities and key stakeholders to undertake an assessment?

4. How do you determine your level of cultural competency before undertaking an Aboriginal mental health assessment?

5. Reflect on the limitations of mental health assessment, both past and present, and discuss how we move forward to improve mental health assessment for Aboriginal and Torres Strait Islander peoples.

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17

Addressing Individual and Community Transgenerational Trauma

Judy Atkinson, Jeff Nelson, Robert Brooks, Caroline Atkinson and Kelleigh Ryan

OVERVIEW

This chapter provides a focus on trauma as cause and effect which, when untreated, can compound within and across generations. The result is physical, mental, emotional, spiritual, and social distress for individuals and broader social groups. While the experiences and transfer of trauma are not limited to members of specific racial or cultural groups, religions, or socio-economic levels, there is substantial evidence that trauma-related behaviours and attitudes are most prevalent in Australia's disadvantaged and disengaged communities. The chapter acknowledges that the combined effects of colonisation (and the actions it legitimised), and more recent government policies and practices (e.g. child removal), have contributed substantially to the dire circumstances of many Aboriginal and Torres Strait Islanders' lives today. We argue that the provision of adequately resourced and credentialed trauma-specific services is vital if the current levels of mental health and social and emotional wellbeing are to be sustainably improved.

INTRODUCTION

The first section discusses conceptions of trauma; theories of its transgenerational transfer; its impact on the lives of Aboriginal families and communities, particularly the links between unresolved childhood trauma and participation in violence, sexually inappropriate behaviour, harmful substance use, and incarceration, as adolescents and adults. The second section explores the challenges associated with working in Aboriginal communities and highlights some community programs that are achieving positive results. These programs provide education and empowerment, and embed trauma-recovery in all facets of their curriculum and engagement.

IDENTIFYING TRAUMA

Identifying trauma in a given population must start with behavioural observations. Through observation we can begin to consider the likelihood of trauma in an individual, family, community, or other grouping. Our capacity to listen to, and witness the human story without judgment is vital, linking what we hear and see to empirical evidence.[1] However, we *must* act in a manner that does not re-traumatise those with whom we are working. The following case study highlights the need for further investigation, but not to label without understanding the full story.

A young man just entering early adolescence: 'expresses suicidal ideation, stating he wants to hang himself; has periods of antisocial behaviour, throwing stones at the house and climbing on the roof at home or school. During a recent episode at school he substantially damaged the school buildings. There is now court pending regarding this damage'.

A psychological assessment provided a diagnosis:

> 'Emerging psychosis with mood congruent depressive content, suicidal ideation with paranoid tendencies [a belief that the world is unsafe] and chronic unresolved grief, with chronic complex post-traumatic stress disorder'.

The label 'paranoid tendencies' may in fact be based in evidence. He may have good reason to believe the world is unsafe. At three years of age, he saw his mother killed. At 11 years-old he was present when his aunt was killed. To our knowledge he has received no loss and grief counselling support.

Clearly, the observable behaviour of this young man would be regarded as offensive to many and would likely attract a period of incarceration or community supervision. His behaviour also suggests the likelihood that he has experienced prior distress and that the affect is trauma-related affliction. In this instance, court action without consideration of the trauma-specific services he needs is not appropriate and arguably a contravention of his human rights.

The increasing incarceration of Aboriginal juveniles, while a reflection on the capacity and appropriateness of the justice system, is a product of young people, described in part in the above case study, transitioning from childhood trauma experiences as victims, to perpetrators of behaviours labelled as 'bad' or 'mad'. This behaviour usually results in engagement with the juvenile justice and/or the mental health system.

This case study highlights the need for practitioners working in the mental health sector and in the justice system (a place where many young people with inappropriate or offensive behaviours inevitably end up) to be able to identify when someone may have significant unresolved and undiagnosed behavioural issues.

Symptom as History

Richard Mollica, author of *Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World* suggests that our response in such situations is far more likely to be authentic and appropriate if we are able to understand 'symptom as history' (personal communication: Richard Mollica, 17th January, 2013).[1]

The incarceration rate of Aboriginal women continues to rise.[2] An Aboriginal prison worker writes:

> ❝ *I would like to share the situation here in (my state). I work with Aboriginal women in prison. Some women are in there as they have killed their husbands/ partners. This happened after years of domestic violence and abuse. Sometimes they are so damaged from years of violence, they are never the same. They have been beaten, broken, raped. They know no other life.*
>
> *And now they lose their husband (who they loved), children, community and homelands. They are put into a massive western system (prison) in another Aboriginal group's land. They are isolated, and often very alone. By the time I see them they are completely shattered and in shock. They never receive visits, as all their family are a long way away.[3]* ❞

The above passage illustrates 'symptom as history' and lists the co-contributing factors as:

- being removed as children;
- having their own children removed;
- experiencing violence on themselves and within their family and community surrounds;
- having alcohol and other drug issues;
- being homeless;
- having diagnoses of depression and other mental ill-health;
- *All* of the women have trauma histories.

For further discussion of these issues surrounding men, women and young people in incarceration, see Chapter 10 (Heffernan and colleagues), and for rehabilitation and preventative programs see Chapter 27 (Powell and colleagues) and Chapter 30 (Hovane and colleagues).

DEFINING TRAUMA: EVENT, ENVIRONMENT OR REACTION?

It remains contentious among mental health professionals as to whether 'trauma' relates to a single event or series of events, an environment, to the process of experiencing the event or environment, or to the psychological, emotional, and somatic effects of that experience. Briere and Scott[4] argued that trauma only refers to 'major events that are psychologically overwhelming for an individual'[4(p3)] and refer readers to the DSM-IV-TR definition of 'extreme traumatic stressor'[5(p463)] for clarification. A stressor, in this definition, must be assessed as extreme to qualify an individual for a diagnosis of Post-Traumatic Stress Disorder (PTSD) or Acute Stress Disorder (ASD), but can be of lesser severity for a diagnosis of Adjustment Disorder (AD). The DSM-IV-TR's reliance on the extreme/not-extreme dichotomy assumes homogeneity in how people process events and the perceived severity of the experience across individuals. The criteria do not take into account individual differences, the effects of previous histories, or current living conditions.

The DSM-5

The recently released DSM-5 does place a far higher importance on trauma and its effects. As well as providing a more clearly defined diagnostic procedure, it lists pre-traumatic, peri-traumatic and post-traumatic factors (temperamental, environmental and genetic/physiological) that must be taken into account when considering a diagnosis. It also clarifies what constitutes trauma, what qualifies as a trauma-related effect, the minimum duration of effect and the breadth of its effects.[6(p265-290)]

Figley[7] breaks his definition of trauma into two clear but related areas— psychological and behavioural. He defines *psychological trauma* as 'an emotional state of discomfort and stress resulting from memories of an extraordinary catastrophic experience which shattered the survivor's sense of invulnerability to harm'.[7(pxviii)] He also defines *behavioural trauma* as 'a set of conscious and unconscious actions and behaviours associated with dealing with the stresses of catastrophe and the period immediately afterwards'.[7(pxix)] Figley's requirement that events be necessarily catastrophic, extraordinary and memorable to trigger a traumatic stress reaction is consistent with the DSM- IV-TR's references to substantial severity.

Scaer[8] and Van der Kolk[9] concur with Figley by arguing that the inability to cope with highly traumatic events results in psychological and physiological effects that limit the ability to act or respond appropriately at the time of the event. It is more important to understand that overcoming the effects of trauma-related distress requires addressing not only the suffering (of the individual) but also the prevalence of events (within the community) that lead to re-experiencing and poor mental health.

DIAGNOSING TRAUMA IN ABORIGINAL CONTEXTS

A sociological and historical perspective is needed to understand trauma within colonised populations, which requires new policies and programs that move from individual treatment to whole-of-community healing. Distressing experiences result from a complex interaction between biological, social and psychological factors.

Several writers have argued that mental illness diagnoses such as PTSD do not conceptually capture the levels of chronic, ongoing stress that Aboriginal peoples experience in their everyday lives.[10,11] The sources of this stress are multiple, repeated and of great severity. The levels of this stress are argued to be unacceptably high and compounded by:

- the inability to identify and overcome a single source of stress;
- the presence of cumulative stressors; and
- the realisation that many of these stressors are inflicted by people in authority over, or well known to the victims.

Atkinson[10] developed the Australian Aboriginal Version of the Harvard Trauma Questionnaire (AAVHTQ) as a more culturally competent measure of specific traumatic stressors and trauma symptoms (DSM-III-R criteria for PTSD). This questionnaire included specific cultural idioms of distress reactions that are relevant to Aboriginal people.

As well as the problem of inadequacy at diagnosis, there are more substantial problems regarding treatment and control. Trauma-related illnesses, such as PTSD, ASD and AD, are conventionally managed by psychiatrists and psychologists, usually through medication, individual or group therapy and behaviour modification techniques.

IMPACTS OF TRANSGENERATIONAL TRAUMA

Atkinson's research[10] has identified a substantial lack of services that could effectively support victims of abuse and interrupt its intergenerational progression.

Her research also demonstrated a link between government policies and interventions, including the removal of Aboriginal children and behaviours associated with trauma experiences in Aboriginal people. These policies and interventions did so much damage, although they were often presented as bureaucratic generosity to people who were frequently living in clear distress. Atkinson's work exposes the role of intentional racism in the lives of Aboriginal Australians, including traumatic interventions which compounded the trauma of already distressed lives.[12] These findings highlight the need to invest in a skilled, culturally competent workforce who can respond in a healing way to the needs of children and their families.

Individual and Community Costs of Unresolved Childhood Trauma

Van der Kolk argues that childhood trauma is probably today's single most important public health challenge which could be overcome by appropriate prevention and intervention.[9] His work with trauma in childhood shows links with ongoing physical health problems, with intra and intergenerational transference of negative attitudes and troubled behaviour, and with the transmission of historical trauma across family and communal systems. He argues that childhood trauma violates a child's sense of safety and trust in the world in which they live, reducing their sense of worth. It establishes and/or increases their levels of emotional distress, shame and grief, and increases the proportion of destructive behaviours in the child's normal repertoire.

'Destructive' behaviours include unchecked 'aggression, adolescent suicide, alcohol and other substance misuse, sexual promiscuity, physical inactivity, smoking and obesity.'[9(p226-227)]

Survivors of childhood trauma are more likely to have difficulty developing and maintaining relationships with caregivers, peers and marital partners. Adults with a childhood history of unresolved trauma are more likely to develop lifestyle diseases (heart disease, cancer, stroke, diabetes, skeletal fractures and liver disease) and be likely to enter and remain in the criminal justice system. Van der Kolk's findings highlight the need for the early identification of children who are being offended against, to support these children and to help heal the behaviours that are compounding their already distressed conduct.[9]

Atkinson[10] recently investigated the link between being a victim of childhood trauma (direct or indirect) and being a perpetrator of higher-level violence in adulthood. Her study showed that a statistically significant proportion of Aboriginal men incarcerated for violent offending reported frequently experiencing traumatic and violent events in their childhood and youth. There was also a strong link between trauma and transgenerational transfer, the number of traumatic stressors or cumulative degree of traumatic exposure, and the likelihood of displaying PTSD symptomology.

The normalisation of family violence and the high prevalence of grief, loss and substance misuse were as much symptoms as causes of traumatic stress. One of the most alarming aspects of this study was this abuse, which often began in early childhood (victim) and continued until maturity, triggered the later acting out (perpetrator) on members of extended family and others. Atkinson concluded that the link between childhood suffering and adult offending was mediated by the presence of unresolved trauma and undiagnosed PTSD.

Such research findings have implications in our understanding of the serious situation of Aboriginal children who display distressed behaviour. In the case study above, Mitch, the 13 year-old, was unable to get assessment until he threatened suicide. Once a report was made by the school, Child and Adolescent Mental Health (CAMH) had him assessed. It would be hard to distinguish between his mental health diagnosis and co-contributing factors related to his childhood trauma. Developmental trauma[9] has now metamorphosed into complex trauma.[13] The more pressing issue is, however, the lack of trauma-informed therapeutic services delivered by a skilled workforce to meet the needs of our most vulnerable and disadvantaged children. This would go a long way toward interrupting the passage from childhood trauma into incarceration (juvenile detention and adult prison), involuntary detention in mental health wards, or serious self-harm and/or suicide. The potentially harmful impacts across the life course related to child mental health and social and emotional wellbeing (SEWB) are further illustrated in Chapter 21 (Milroy)and Chapter 22 (Walker and colleagues).

Child Sexual Abuse

While between 40 per cent to 73 per cent of all psychiatric inpatients have histories of sexual abuse in childhood,[14,15] there are generally other stressors and trauma present. As many as one-third of child victims of physical (including sexual) and psychological abuse grow up to demonstrate parental difficulties or become abusive of their own children; one-third of previously abused parents do not have this experience; but the remaining one-third remain vulnerable and, under stress, have an increased likelihood of becoming abusive.[16] According to Green:

> *There is considerable evidence that the abused child is at risk for re-enacting the original violent interaction with his parents in subsequent relationships with peers and offspring, supporting a theory of intergenerational transmission of violence.[17(p582)]*

The NSW Aboriginal Child Sexual Assault Taskforce[18] argued that the normalisation of violence that comes with generations of abuse was a determining factor in current rates of physical and sexual violence. One participant in the inquiry stated:

> *The trauma of child sexual assault makes it very difficult for people to develop healthy relationships...because you've got, you know, children being raised like three generations in a row where sexual and family violence has been part of their life.[18(p61)]*

According to Atkinson and Atkinson,[19] the endemic nature of family violence over a number of generations has resulted in a situation where:

> *violent behaviours become the norm in families where there have been cumulative intergenerational impacts of trauma on trauma on trauma, expressing themselves in present generations as violence on self and others.*[19(p7)]

The full implications of family violence and strategies that address these issues are discussed in Chapter 23 (Cripps and Adams).

The Intergenerational Transmission of Trauma

Atkinson[12] has mapped a progression of the transmission of trauma in a 6th-generation traumagram which links the historical events of colonisation to increases in family violence, child sexual abuse, and family breakdown in Aboriginal Australian societies. Tracing one family line across six generations, Atkinson listed the known memories of being victims of physical and/or sexual violence, being perpetrators of violence, suffering from mental health illness, attempting suicide and having substance misuse problems. The study provides evidence that unacknowledged or unresolved trauma in previous generations was linked to dysfunction within an extended family in later generations.

Historical Trauma and the Breakdown of Family and Community

Historical trauma is defined as the subjective experiencing and remembering of events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes as 'collective emotional and psychological injury ... over the life span and across generations'.[20(p36)] Helen Milroy in Zubrick et al.,[21] gave a comprehensive explanation of how trauma is transmitted across generations and the role of community networks in this transmission:

> *The trans-generational effects of trauma occur via a variety of mechanisms including the impact on the attachment relationship with caregivers; the impact on parenting and family functioning; the association with parental physical and mental illness; disconnection and alienation from extended family, culture and society. These effects are exacerbated by exposure to continuing high levels of stress and trauma including multiple bereavements and other losses, the process of vicarious traumatisation where children witness the on-going effect of the original trauma, which a parent or other family member has experienced. Even where children are protected from the traumatic stories of their ancestors, the effects of past traumas still impact on children in the form of ill health, family dysfunction, community violence, psychological morbidity and early mortality.*[21(pxxi)]

A study by the Aboriginal and Torres Strait Islander Healing Foundation,[22] analysing the stories of 90 people who had contributed to the Stolen Generation Australian National Library Oral History Project, identifies the long term impacts on the SEWB of children removed from family, listing the risk and resilience factors.[22] Figure 17.1 reports on the analysis of 89 Stolen Generations oral histories. It shows that 53 per cent, 28 per cent and 29 per cent of people screened positive for loss and grief, PTSD and depression respectively, while 35 per cent of people did not experience any of the outcomes. It is considered that these are likely to be underestimates as the oral histories were not aimed at identifying mental health outcomes. The four PTSD items are from a standard screening tool, where the criteria is the avoidance item or two of the others; the nine items for depression scale were validated in Alice Springs, the criteria used was suicidal ideation or two of the other eight items. For loss and grief, the criteria was experiencing two of five items from a scale of traumatic grief adapted to the cultural context.
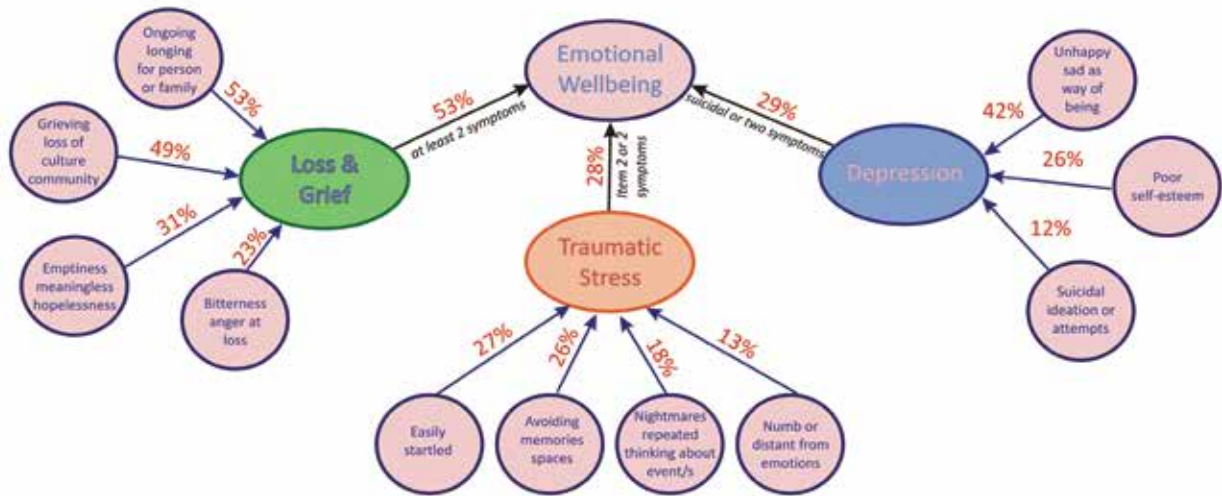
Source: Aboriginal and Torres Strait Islander Healing Foundation[22]

It is clear that these rates of depression, PTSD and loss and grief are substantially higher than the Australian population, where PTSD and depression are a few per cent. Thus the Stolen Generations members are likely to be experiencing significant disability associated with mental health issues resulting from their traumatic histories.

The risk and resilience factors are described in Table 17.1.

Table 17.1: Risk and Resilience Factors

Risk Factors	*Resilience Factors*
- victimisation because of Aboriginality - traumatic removal - incomplete education and missed opportunities to learn - fractured identity - sense of powerlessness - multiple care experiences - lack of attachment - domestic violence - significant losses - hidden punishments and/or victimisation in institutions - multiple generation removal.[22(p3)]	- a sense of control – autonomy - positive memories before removal - family tried to stay together - siblings stayed together - family visits with positive memories - developing a new loving family - having a mentor - having peer support - western education - learning to adopt responsibility - access to bush food, bush-land - cultural education - transferring cultural knowledge and identity maintained.[22(p2)]

Links Between Trauma and Suicide Ideation

Suicide is a traumatic and highly distressing event in the lives of family, friends and communities. It is also an indicator of problems occurring within communities and families. There is evidence to suggest that the more suicide experienced, the greater the levels of distress and dysfunction. In Chapter 9, Silburn and colleagues examine the individual and community level factors that contribute to a sense of cultural identity for Aboriginal young people.

Ralph et al.,[23] investigating proposed links between depression and the high youth suicide rates of the Kimberley region of Western Australia, concluded:

> *Aboriginal youth in the Kimberley region may experience several layers of trauma, through their own direct and secondary exposure as set against a backdrop of historical unresolved trauma and grief. These layers of trauma are thought to be cumulative in the manner in which they inform the adolescents' experience, and continue to adversely reinforce the basic assumptions that are violated by chronic trauma exposure; that the world is meaningful and safe, that the self is worthy, and that others can be trusted. It was thought that the current rate of suicide amongst Aboriginal adolescents in the Kimberley region may be the youths' contemporary expression of distress in response to chronic trauma exposure, as underpinned by the legacy of historical unresolved trauma and grief.[23(p123)]*

Importantly, Ralph et al.[23] demonstrated a clear link between being exposed to trauma and developing PTSD symptoms with suicidal ideation, particularly in Aboriginal children, both girls and boys, who identified as being victims of childhood abuse. Understanding this link between chronic and unresolved trauma throughout childhood and suicide ideation, and developing strategies early to provide young people with pathways to healing and recovery, is a critical step in suicide prevention.

The next section explores the challenges of working in communities to support positive change using community resources to their greatest potential, supported by a trauma-informed policy and educational service delivery.

COMMUNITY AND INDIVIDUAL HEALING MODELS

Healing from the social, emotional and psychological outcomes of traumatic experiences that has impacted whole communities requires interventions at both individual and the community levels. This section outlines recent examples of interventions for communities recovering from conflict, disaster and colonisation. They are the **Ad**aption **A**fter **P**ersecution and **T**rauma (ADAPT) model;[24] the Five Essential Elements of immediate and mid-term mass trauma intervention as outlined by Hobfall;[25] and evidence from the research work of Chandler and Lalonde supporting Cultural Continuity as a Moderator of Suicide Risk with First Nations from British Columbia.[26]

Silove[24] and Hobfoll[25] emphasise the link between community and individual healing. Silove stresses that healing the community contributes substantially to healing the individual, consequently requiring less 'clinicians' to heal individuals. The Chandler and Lalonde[26] study results show that communities with a strong sense of cultural continuity have significantly lower rates of youth suicide. Their work reinforces the connection between community wellbeing and individual wellbeing, with stronger communities having stronger individuals.

Silove[24] argues that there are five pillars of both the society and the individual which trauma and mass violence undermines:

- **Safety and Felt Security**—when threatened results in traumatic stress and depression

- **Attachment and Bonds**—when threatened results in loss and grief and damaged relationships

- **Justice**—when threatened results in anger and violence, often turned in on family and community

- **Identity and Roles**—when threatened results in isolation

- **Meaning and Coherence**—when threatened results in alienation.

Table 17.2 highlights the threats to each of the five pillars, the adaptive responses to each of the threats, and the consequence of not adapting.

Table 17.2: The ADAPT Model and the Impact of Threats to each Pillar

Pillar	Threat: Past Present and Future	Normative Psychological Response	Normative Adaptive Response	Negative Outcomes (if Adaptive Responses Fail)
Security	Ongoing violence, poverty, lack of food, absence of medical care	Fear, anxiety, hyper-vigilance, insecurity	Security seeking, protectiveness, vigilance	Anxiety, post-traumatic stress
Attachment and Bonds	Forced separation, losses, disappearances	Grief, separation anxiety	Parental protective-ness, attention to restoring families and networks	Complicated grief, pathological separation anxiety, depression
Justice and Human Rights	Discrimination, racism, humiliation, degrada-tion, rejection, incarceration, dehumanization	Suspicion, lack of trust in authorities, anger	Sensitisation to justice, universalism, human rights promotion and demanding of justice	Pathological anger and violence, loss of trust
Roles and Identity	Dispossession and dep-rivation, genocide, de-nial/inadequate rights to: work, residency, and self-support	Aimlessness, reduced awareness, loss of sense of belonging, reduced efficacy	Role confusion, recrea-tion of new or hybrid roles and identities	Loss of direction, giving up, persisting aimless-ness or persistent inactivity
Meaning and Coherence	Destruction of places of worship, banning of religious/spiritual activities, suppression of spiritual, political and cultural aspira-tions and practices	Loss of coherence, a feeling of disorientation and alienation from society Cultural disintegration	Rediscovery or regeneration of cultural, and religion/spirit, pursuit of social and political causes	Isolation, discontinuity, fragmentation, loss of coherence

Adapted from Silove[29]

A recent report examining the protective capacity of resilience in children shows clearly that once there is substantial trauma, resilience is not protective[27] and that substantial sustained threats will damage individuals and communities as their capacity to adapt is diminished. The establishment of security, maintenance and repair of family and social bonds, creation of effective systems of justice, re-establishment of social roles and identities and the building of institutions that create communal coherence and meaning (religious, spiritual, existential, political or cultural) may be necessary components of healing a community and consequently the individuals and families within it. 'Repairing these damaged systems and the institutions that support them forms the basis for building a framework of recovery for both individual survivors and their collectives.'[28]

The ADAPT model developed from clinical practice with torture and trauma survivors, and the Essential Elements model developed through a systematic literature review of post-

conflict and post-disaster communities shows that community level interventions may be an essential precursor to the provision of individual care, and at least reduce the size of the population requiring individual care following significant traumatic experience.[24,25,28] The cultural continuity work with First Nations people of British Columbia provides evidence that strong communities are very protective in the wellbeing of their members.[26,30] In fact this model supports community control of community services. Thus, the importance of the work by Chandler and others is less about the specific factors and more that strong communities, however they are defined, are protective of the wellbeing of their members. Thus, there is a need to identify Aboriginal and Torres Strait Islander specific factors. The work of Silburn et al.,[31] *Strengthening the Capacity of Aboriginal Children, Families and Communities* offers some important insights in this regard.

PROGRAMS TO SUPPORT COMMUNITY RECOVERY IN ACTION

Achieving sustained positive in-community change requires a substantial investment of resources, personnel and time which is beyond the reach of many organisations. It is partly because of this demand that successful programs such as the Family Wellbeing Program;[32-35] the *Yarning up on Trauma* of the Bouverie Centre, Latrobe University;[36] and the We Al-li Program[37-41] use the 'train the trainer' model to achieve and support community change over the longer term. The *Yarning up on Trauma* training had three layers in terms of understanding trauma and its impact, namely: within the community; with the work with children and families; and with the impact on self.[36(p71)]

These programs focus as much on the development of worker and community strength, confidence and skills as they do on overcoming the behaviours and attitudes that lead to dysfunctional communities. By establishing and equipping a core group of community members with the skills necessary to direct vulnerable individuals away from disruptive and damaging behaviour, substance and alcohol misuse and family violence and neglect, these programs are contributing to the development of safe, structured and stable Aboriginal communities.

The 'theory to practice' approaches outlined by Silove[24] and Hobfall[25] supports the work of Atkinson's whole of community model of education as healing (educaring), developed in the mid-1990s, and outlined as a response to the Northern Territory intervention, designed to provide trauma-informed health, mental health, and community therapeutic worker training.

We Al-li Program (Educaring Model)

The Ways Forward report names the We Al-li Program as a model for healing from trauma.[43] Developed at an Aboriginal community level over the period 1993 to 1997 by Aboriginal people, this program was documented in an applied research project into violence, relational trauma and healing in Aboriginal families and communities in Central Queensland.[12]

In the beginning, people wanted personal healing. In later years they wanted to enhance professional skills. In 1997 the principles and practice of We Al-li as a trauma-informed educational healing program was accredited at the tertiary level, with a balance of both personal and professional development. The teaching-learning approach was called an *Indigenous critical pedagogy*[42] at the university level, and *educaring* for all other purposes.

> In Indigenous education, the process of identifying 'who am I' and 'how I relate to the world' is of paramount importance and is considered the starting point for learning. The emphasis in the first instance is on what is happening for me 'in here' rather than an objective analysis of what is happening in the world 'out there'.[44(p5)]

Educaring is a trauma-specific blend of Aboriginal traditional healing activities and western therapeutic processes. It uses experiential learning to enable participants to explore their

understanding of the long-term consequences of trauma across generations and cultural tools for healing. It promotes and ensures relationships of mutual respect within the learning environment. Learning is through dialogue. Trauma-informed practice works to build cultural safety and spiritual integrity through individuals working together in the group. This requires the worker-educator to be culturally competent. It focuses on enhancing deep listening skills, self and other awareness, self and group reflective discussion and practice. Educaring is designed to heal the person while building on professional skills by focusing on transformational learning and social justice as fundamental to healing practice. It enhances levels of empowerment and self-confidence to support leadership potential.[12]

Educaring provides skills for working with individuals and groups using the healing power of story, cultural and personal narratives, emotional release and emotional regulation, in family history reconstruction, story maps, loss history graphs, trauma healing grams, using art, music, dance, theatre, in ceremonial processes, with children, young people, adults and Elders.

It is place-based. The stories of *place* can be both stories of trauma and stories of strength and resilience-healing. Place-based learning is community focused as it works to build sustainability while it skills local people to deliver local services. Aboriginal approaches to *education* place a strong emphasis on enhancing self and community learning. It is the *process* of becoming aware of self and others which underpins purposeful personal development and healing as a cornerstone to education, training and skill enhancement and professional practice:

> *At the basis of Indigenous philosophies and educational strategies are the underlying principles of relationships and balance…the individual is required to develop to the full those personal attributes that can enhance the life of the group. Learning is very much a process of experiencing, of watching patiently and quietly, and of absorbing. Learning is a life-long process, which takes place formally and informally. As people become increasingly knowledgeable, and assert their knowledge, they also become increasingly responsible for teaching the new generation who will take over from them. In an Indigenous educational environment this 'sharing of knowing' is made possible through the literature of Orality, Iconography and Ritual: of narrative, song, symbol, dance and drama.[44(p4)]*

A community of practice evolved, comprising a group of people who have completed the educaring model of personal and professional development, share a concern and passion for what they do, and how they do it at the community level. Graduates applied their theory and practice in diverse locations and situations across Australia and supported each other in the context of essential worker support for possible vicarious trauma—burnout.

The Educaring model is aimed at healing personal trauma while building a professional Aboriginal workforce skilled to address trauma issues in communities. The ADAPT model indicates the need for community-based interventions to reduce the amount of work required at the individual level and maximise the effectiveness of individual work.

Trauma-informed and trauma-specific programs and treatments are ones in which attention to traumatic experience is a key therapeutic strategy.[45] This is in contrast to therapeutic models which concentrate on psychosocial functioning and focus on a range of psychosocial stressors or issues (e.g. alcohol use). Hence, an educational approach that is trauma-informed encourages community conversations and has greater possibility of sustainable change and healing.

Ethical Community Engagement

The coverage of Aboriginal issues in the Australian print and digital media, in government reports and discussion papers, and in academic institutions is high. The number of other Australians who are now 'informed' and 'understand' Aboriginal issues has increased. There are positive and negative aspects of this.

Life in Aboriginal communities is fluid and has the same fluctuations as many other regions. People experience the full spectrum of emotions, children play in the streets and parks, but generally, life is restricted because of inadequate employment opportunities and widespread poverty. With inadequate employment and poverty come disengagement and resentment, increasing the probability of trauma-affected people not receiving the services they critically need. Being marginalised within an already marginalised population is a compound jeopardy.

In spite of history, there is considerable functionality, creativity and productivity in Aboriginal lives. There is, however, a small but significant group of people and families who, for many reasons, have fallen through the gap, and who have been made increasingly marginalised and disadvantaged within their own communities, as well as within broader service delivery functions. Often they have been misdiagnosed and, in many cases, maltreated by a system which is not trauma-informed and sometimes is trauma-inducing.

Being effective in these environments is stressful and requires specific trauma-recovery skills, skills that this chapter argues need to be more fully developed. Service providers need to acknowledge their ethical responsibility, to conduct trauma assessments as part of their service delivery before making assumptions about mental health/trauma problems. We therefore endorse a trauma-informed approach, which promotes ethical community engagement at all levels of policy development and service delivery. Table 17.3 has been adapted from the Australian Institute of Health and Welfare (AIHW) Resource Sheet: *Trauma-informed services and trauma-specific care for Indigenous Australian children.*[46]

Table 17.3: The Core Values for Trauma-informed Services

Understand trauma and its impact on individuals, families and communal groups.	People can be re-traumatised by inappropriate programs or service delivery, and hence may disengage from a service that could be critical to recovery. Two strategies that promote understanding of trauma and its impact, are trauma-informed policies, and trauma-specific training. Trauma-informed policies and service development and delivery formally acknowledge that some people have experienced trauma, demonstrate commitment to understanding trauma and its impacts, and detail trauma-sensitive practices. Training responds to the need for a skilled and qualified workforce at all levels of service provider responsibility. Ongoing trauma-related workforce training and support is therefore essential. For example, staff members need to learn about how trauma impacts across the lifespan.
Create environments in families and in social groups, where people feel physically, emotionally and spiritually safe.	Individuals and families who have experienced trauma require spaces in which they feel physically and emotionally safe. People themselves should be allowed to advise what measures make them feel safe. Creating safe physical and emotional environments involves allowing people to feel welcome and valued in the service, providing full information about service processes (in their preferred language), being responsive and respectful of all their needs and ensuring their physical safety in residential services is ensured. The identified measures must be consistently, predictably and respectfully provided. Workers report that creating a safe physical space for Aboriginal Australians in mental health/SEWB services, is both a basic human right, as well as critical for healing and recovery. *Continued . . . .*

Table 17.3: The Core Values for Trauma-informed Services (continued)

Employ culturally competent staff and adopt practices that acknowledge and demonstrate respect for specific cultural backgrounds.	Culture plays an important role in how victim/survivors of trauma manage and express their traumatic life experience(s). Culturally competent services are respectful of, and specific to, cultural backgrounds. Such services may offer opportunities for clients to engage in cultural rituals, speak in their first language, offer specific foods and have access to traditional healers if appropriate. Culturally competent staff are aware of their own cultural attitudes and beliefs, as well as those of the individuals, families and communities they work to support. They are alert to the legitimacy of inter-cultural difference and able to interact effectively with different cultural groups. Their first responsibility is to refer back to the client. Do they feel safe in how they experience the delivery of the service? Not, 'I am now culturally competent, and therefore you will be safe in the service I provide'. See Chapter 12 (Walker, Schultz and Sonn) for further discussion of cultural competence.
Support people who have experienced trauma to regain a sense of control over their daily lives and to be actively involved in all aspects of their lives, including their mental health–social and emotional wellbeing care.	Trauma denies a person or group a sense of being in control. Regaining a sense of control consists of two important aspects. First, victims/survivors of trauma must be supported to regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy and capability to respond to their own needs. Second, service systems are set up to keep individuals (and their caregivers) well informed about all aspects of their treatment, with individuals and groups having ample opportunities to make daily decisions and actively participate in the healing–recovery process.
Share power and governance, including involving individuals, families and community members in the development, design, delivery and evaluation of programs.	Power and decision-making is shared across all levels of the organisation, whether related to day-to-day decisions or the review and creation of new policies and procedures. Hence sharing power and governance reflects the same principles in community engagement. Practical means of sharing power and governance include recruiting Aboriginal and Torres Strait Islander peoples to boards, ensuring they are involved in the development, design and delivery of services, and involving them in the design and evaluation of programs and practices. Sharing power and governance involves supporting people in designing and managing their lives including their social health care plans and services.
Integrate and coordinate care to holistically meet the needs of individuals, families and communities, wherever the broad range of mental health, social and emotional wellbeing support services are required.	Integrating care involves bringing together all the services and supports needed to assist individuals, families and communities to enhance their physical, emotional, social, cultural and spiritual wellbeing. Documented practice experience suggests that approaches informed by Aboriginal culture and western health and healing practice, including neuroscience, show promise for supporting healing and recovery. There is also evidence that support of an ecological approach, which considers and acts on all systems that are negatively affecting an individual and community situation, are more effective than a separation of services.
Support relationship building as a means of promoting healing and recovery from trauma, both for clients as individuals or in groups, and within workforce teams.	Safe, authentic and positive relationships assist healing and recovery. Trauma-informed services facilitate relationship building and relationship healing. Trauma-informed services empower individuals, families and communities to take control for their own healing and recovery. Such services adopt a strengths-based approach, focusing on the capabilities that individuals, families or communities bring to a problem or issue. Facilitating peer-to-peer support across families and social groups is important. Appropriate support activities for staff within organisations might include regular supervision, team meetings and opportunities for self-care.

Source: Australian Institute of Health and Welfare (AIHW)[46]

CONCLUSION

This chapter has discussed definitions of trauma and how the different forms of trauma, particularly transgenerational trauma, impact on Aboriginal peoples. The consequences of colonisation expressed in trauma have been examined along with the links between unresolved childhood trauma and participation in violence, inappropriate sexual behaviours and incarceration. Importantly, the challenges of engaging with Aboriginal communities are discussed and examples of successful programs for community empowerment are outlined. While this chapter focused on a perspective of life in Aboriginal communities that is disadvantaged and fraught with dysfunction, it is mitigated by the fact that empowering solutions are available.

However, these solutions require full and long-term commitment by communities themselves, government agencies and service providers, whether community controlled or the non-government service sector. The impacts of trauma on individuals and communities can be changed if appropriate preventions and interventions are identified and implemented in culturally appropriate and safe ways. We promote trauma-informed policy development and service practice in response to particular and pressing mental health and SEWB needs for individuals, families and social groups.

REFLECTIVE EXERCISES

1. There are many factors that contribute to the traumatisation of individuals and communities. List what these factors are, how they are associated and how you would develop a service plan.

2. It is common to hear service providers arguing that improving the education and quality of life of children is the only way of overcoming chaos and dysfunction in Aboriginal communities. Discuss this statement focusing on the child–family and child–community relationships.

3. If the evidence that links being exposed to violence in childhood to perpetrating violence in adulthood is accepted, and we acknowledge the prevalence of violence, how do we intervene to break the cycle?

4. Discuss the trans-generational nature of trauma and outline a trauma informed service delivery to a community in crisis of multiple symptom factors.

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18

Intellectual Disability in Aboriginal and Torres Strait Islander People

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OVERVIEW

The aim of this chapter is to examine current and emerging themes in respect to intellectual disability to assist clinicians and their patients. Recent literature points to an increased rate of intellectual disability across the lifespan, from childhood, adulthood and old age, in Aboriginal and Torres Strait Islander peoples with a number of factors that appear to accelerate the prevalence from roughly two times the rate in childhood to five times the rate for people over 65 years of age. The chapter examines the various factors that impact on this issue including diagnosis, contributing factors, Aboriginal perspectives on intellectual disability, the impacts on family, the importance of an interdisciplinary approach in management and assessments that may be of use.

INTRODUCTION

Current estimates state that approximately eight per cent of Aboriginal and Torres Strait Islander peoples aged between 12 and 24 years are considered to have 'problems of psychological development'—this is approximately double the remaining population.[1(p4-5)] About 35 per cent of Aboriginal and Torres Strait Islander peoples who are affected by 'severe or profound core activity disability' have an intellectual impairment associated with this disability. Glasson et al.[2] (2005) in their study in Western Australia (WA) found that, although comprising 3.5 per cent of the population, Aboriginal and Torres Strait Islander peoples represented 7.4 per cent of all people registered with intellectual disability. The level of intellectual disability was assessed as borderline or mild in 40.7 per cent of cases, moderate in 19.9 per cent, severe or profound in 12.1 per cent, but had not been specified in 27.2 per cent of cases. Analyses of rates of childhood intellectual disability in WA by Leonard et al.[3, 4] have indicated a significantly greater prevalence rate of 2.3 for mild to moderate intellectual disability in children of Aboriginal mothers. The analysis by Leonard et al.[4] further suggested that the occurences of Autism Spectrum Disorders (ASDs) was less for the Aboriginal population. However, the issues raised by Roy and Balaratnasingam (2010)[5] in respect to the proper identification of Aboriginal and Torres Strait Islander peoples affected by ASDs suggests that the prevalence of intellectual disability may be greater than reported. In addition to this initial risk factor for intellectual disability in childhood and early adult life, Aboriginal and Torres Strait Islander peoples appear more at risk for other factors related to intellectual disability across the lifespan. A survey by Smith et al.[6] conducted in the Kimberley region of WA of Aboriginal people over 45 years of age found a prevalence rate of 8 per cent of cognitive impairment 'not related to dementia' and those over 65 appear to be suffering dementia at five times the rate of other Australians.[7]

DEFINITION OF INTELLECTUAL DISABILITY

Leonard and Wen[8] describe a range of factors that can determine whether an individual is diagnosed as having an intellectual disability. This includes 'medical', 'individual' and 'statistical' (population and group) approaches to the definition, and the diversity in the key criteria for definition.

Brown and Percy[9] note that the evaluation of the term 'intellectual disability' relates to the 'literal, definitional and social' contexts in which it occurs. Depending on the definitions used, the prevalence can vary enormously and it is important to be consistent. For a detailed discussion see Leonard & Wen.[8]

- *Literal* definitions relate to the specific meanings of the words 'intellect' and 'disability' that compose the term. As an example of this, the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10)* defines intellectual disability as 'arrested or incomplete development of the mind which is specifically characterised by impairment during the developing period of skills that contribute to the overall level of intelligence'.[10]

- *Definitional* meanings relate to what the terms mean for particular groups, organisations or purposes involved with individuals affected by the condition. As an example, intellectual disability is defined in a legal context as 'a significantly below average intellectual functioning existing concurrently with two or more deficits in adaptive behaviour'[11] whilst in the context of a helping organisation as:

  > … *an impaired ability to learn. It sometimes causes difficulty in coping with the demands of daily life. It is a condition which is usually present from birth and it is not the same as mental or psychiatric illness* [12(p2)]

- *Social* definitions are dependent on how various societies evaluate 'ability' in respect to the skills that people should have and thus 'what they should be able to perform'.[13] This has particular importance in the context of Aboriginal and Torres Strait Islander communities. Sotiri et al.[14] note that:

  > *Indigenous people often do not use, or recognise, the term 'disability.' Within communities, there is frequently recognition that someone is 'different', but this difference tends to be accommodated. Various impairments are viewed as simply one part of the person, but are often not considered central or core to one's identity.*[14(p9)]

All these issues including disability are intertwined. The authors add:

> *It was also noted by Indigenous stakeholders in our conversations, that in some communities, the presence of disability is viewed as simply one more disadvantage in a whole raft of disadvantages, and it is for this reason that it tends not to warrant any particular attention. When compared with suicide rates, imprisonment rates, levels of violence experienced in communities and institutions, drug and alcohol misuse, and other issues reflecting the challenges faced by severely fractured communities, disabilities were often considered to be fairly low on the scale of priorities. As with disability in the wider community, the support and management of cognitive and mental impairment is often left to the family to manage. And again, as is the case with the wider community, this only changes when the person with the impairment begins to impact on the wider community through their behaviours.*[14(p9)]

In addition, Stopher and D'Antoine[15] point out that Aboriginal families consider themselves to be accepting and supportive of family members with a disability and, while their specific impairment prevented them from doing certain tasks, they were still involved in the kinship system with roles and responsibilities.

Hollingsworth[16] also comments that:

> *A long history of poverty, marginalisation and racism (for Australia's Aboriginal and Torres Strait Islander population following European colonisation) can mean that many Indigenous Australians do not see impairment as a disability but as an aspect of more general challenges and disadvantages.*[16(p9)]

ASSESSMENT OF INTELLECTUAL DISABILITY

Principles of Culturally Relevant Assessment

Brown and Percy outline five basic principles of assessment integral to the management of any person (including those of Aboriginal or Torres Strait Islander descent) believed to be affected by an intellectual disability and who is behaving in a way that brings them to the attention of others.[9(p.1)]

Principles for Assessing Intellectual Disability

1. Attend to a situation or problem that may have come to one's attention for a specific reason or simply because it is occurring in a person's life.

2. Gather as much information as possible about the situation or problem. In the Aboriginal and Torres Strait Islander context, significant information in respect to the family, cultural and spiritual context of the problem would also be of major importance.

3. Analyse which aspects of the situation are working well (strengths) and which are not working well (needs).

4. Understand the factors that help improve the situation as well as the factors that limit the improvement.

5. Decide on plans to maintain or enhance factors that help improve the situation and to decrease or eliminate factors that hinder improvement. Plans that are put into place in this regard are referred to as interventions.

A multidisciplinary team, in a context of cultural safety, best conducts such assessments. A broad based approach to the issue is also useful given the large number of potential genetic issues and other factors affecting Aboriginal and Torres Strait Islander peoples in Australia both prior to, and following, European colonisation. A good example of this is Machado-Joseph Disease, a severe neurodegenerative disorder (without intellectual disability) that profoundly affects some Aboriginal families living on Groote Eylandt. The disease was initially thought to be due to exposure to manganese which was mined on the island but it was then discovered that it had a genetic basis, probably related to contact between the Groote Eylandt population and Asian seafarers up to 7,000 years previously.[17]

A multidisciplinary/interdisciplinary team may involve medical experts (pediatricians, rehabilitation physicians, geriatricians, psychiatrists, general practitioners) appropriate to the age of the person being assessed along with other allied health professionals—see Chapter 13 (Shultz, Walker and colleagues). Psychologists, specialist nurses, speech pathologists, physiotherapists, occupational therapists, dieticians and social workers may also be members of the multidisciplinary team. Members of government and non-government organisations appropriate to the person's age and level of impairment may also be needed in such assessment.

The involvement of Aboriginal Health Workers (AHWs), Aboriginal Mental Health Workers (AMHWs), and appropriate family members and translators, are essential to address cultural safety issues within the multidisciplinary team process. Educational experts could be involved in the case of children being assessed in relation to their potential for school. Table 18.1 outlines the roles that different health professionals may play in the management of Aboriginal and Torres Strait Islander peoples affected by intellectual disability. For further discussion of interdisciplinary teams, see Chapter 13 (Schultz and Walker and colleagues).

Table 18.1: The Role of Health Professionals in Managing Intellectual Disability

Health Professional	Roles
Nursing	Monitoring of epilepsy, mental illness, medications, setting up of behavioural interventions, educating families on the impact of ID and comorbid conditions
Psychiatrists	Assessment and management of mental illness, epilepsy, developmental disorders e.g. autism, Attention Deficit Hyperactivity Disorder (ADHD)
Psychologists	Management of behavioural problems, provision of specialist interventions available to those without ID e.g. bereavement counselling, anger and anxiety management, social skills training
Occupational Therapists	Advice on activities, aids and adaptations, sensory integration for people with autism
Speech and Language Therapists	Communication, assessment of dysphagia
Physiotherapists	Management of contractures, mobility problems, aids and adaptations, seating assessments
Dieticians	Help with special diets for people with dysphagia, eating problems associated with autism, management of obesity
Social Workers	Accessing appropriate day activities, respite care, residential care, benefits

Source: Balaratnasingam and Roy (2013)

The Physical Health Needs of People Affected by Intellectual Disability

The physical health of the person being assessed also needs to be considered. The median survival for Aboriginal people affected by intellectual disability was 55.1 years for men and 64.0 years for women, with a mean age at death (n = 102) of 19.6 years.[2] The leading causes of death were diseases of the respiratory and circulatory system, and accidents. Cheetham et al.[18] also review other medical conditions currently experienced by individuals affected by intellectual disability. For example, Aboriginal and Torres Strait Islander peoples have much greater impairments in hearing and vision than the general Australian population and this may influence the assessment process if not recognised[1].

The contextual health problems of Aboriginal people affected by intellectual disability living in the community, and who have a high prevalence of physical health requirements, need to be understood in the context of the causes of intellectual disability, be they specific syndromes or what we might call 'functional'—that is, mainly a cognitive deficit without other features. For instance, these physical needs may be just part of having intellectual disability, while others are associated with any underlying syndrome. Some may be associated with specific syndromes (e.g. cardiac abnormalities and thyroid dysfunction in Down syndrome); a side effect of drug therapy (e.g. obesity and metabolic syndrome due to antipsychotic medication); consequence of lack of opportunities (e.g. lack of exercise leading to obesity and inability to care for themselves and self-monitor leading to poor oral health); and poor hearing and vision. Other physical conditions include poor oral hygiene, exacerbated in rheumatic heart disease; gastrointestinal diseases; respiratory infections; musculoskeletal deficiency, including reduced bone and muscle strength from poor diet; genitourinary infections; central nervous system impairment; and neurological disorders such as epilepsy and skin infections.[19]

> *Emily is a 37 year-old Aboriginal woman with profound intellectual disability who lives in a group home and is normally very settled in the context of a stable community of care staff who work at the home and a good relationship with the other residents of the home. She has a comprehensive behavioural plan that has been developed in co-operation with her care organization, her adult guardian and her family. She normally receives medical care from her General Practitioner. Emily is bought to the local hospital Emergency Department late one afternoon by her care staff because she has become acutely disturbed. She is unable to sit still or focus on her normal daily activities within her care and behaviour plans. In addition to her agitation, she has started repeatedly striking herself in the head. One of her care staff wants her placed on sedating psychotropic medication to "settle her down". However, a careful physical examination of Emily by the Emergency Department physician reveals that she has a hard abdomen and an X-Ray of her abdomen confirms that she is severely constipated. Emily is treated for her bowel problems with the approval of her family and guardian and her agitation settles almost immediately once the constipation is resolved and she is subsequently able to return to her group home with recommendations for ongoing bowel care. At discharge from hospital, it is thought that Emily's intense agitation may have related to the discomfort that she experienced from the constipation and her inability to verbalise her distress.*

Approach to Assessment and Management

Given the above factors, the ideal approach for the assessment and management of Aboriginal people with an intellectual disability should focus on:

- Gathering as much information as possible about the person's original function, the presumed disease process impacting on them, and what has changed for them and is impacting on their lives and the lives of their families, carers and community;

- Including allied health professionals to contribute to the identification of an individual's impairments and solutions for their rehabilitation;

- Identifying and implementing strategies (including medication, behavioural, environmental and social) developed in conjunction with the client, their families, communities and available services. This will lead to the best interim solution that will need to be evaluated and modified over time according to the needs of the client and their carer and support network. See the new guidelines relating the *Cultural Formulation Interview* in the DSM-5 in Chapter 16 (Adams, Drew and Walker).

CHILDHOOD CONDITIONS ASSOCIATED WITH INTELLECTUAL DISABILITY

Percy makes the comment that intellectual disability is the end product of genetic and environmental factors.[20] There are usually a number of medical and psychiatric conditions alone or in combination that commonly underlie intellectual disability in children. These are briefly discussed in the context of this chapter. A more thorough discussion of each condition can be found in textbooks such as Brown and Percy[9] or other authoritative sources. Some of the genetic risk factors are referred to below and, given the 'cultural mix' in respect to the broader lineage of many Aboriginal and Torres Strait Islander peoples today, a range of genetic disorders may affect children and adults.

The environmental factors that Percy refers to include malnutrition,[21] toxic threats to a child's environment such as mercury and lead, prenatal maternal smoking and maternal alcohol misuse,[22] maternal effects such as diabetes and high blood pressure in pregnancy, low birth weight in infants,[23] intrauterine infections such as syphilis, rubella, cytomegalovirus and herpes simplex and post natal brain injury. Aboriginal and Torres Strait Islander peoples generally

appear to have a greater risk for most of these factors.[24] Glasson et al.[2] found in their prevalence study that non-genetic prenatal or perinatal factors were common, representing 36 per cent of cases.

These factors included maternal drug or alcohol use during pregnancy, physical trauma, multiple births, birth complications, infections and low birth weight. Women in rural and remote areas may also find it difficult to access optimal prenatal care and neonatal screening.

Fetal Alcohol Spectrum Disorder

Fetal Alcohol Spectrum Disorder (FASD) is technically one of a number of conditions contributing to intellectual disability in children. However, there is significant concern about the apparent increasing prevalence of the disorder in the Aboriginal and Torres Strait Islander population. For a detailed discussion of FASD, see Chapter 20 (Hayes and colleagues).

Down Syndrome

The condition is caused by an abnormality of Chromosome 21 that is associated with a number of physical abnormalities as well as intellectual disability.[25] Its prevalence in the developed world is 1 per 800 to 1,000 live births.[25] It is usually diagnosed initially by abnormalities in the foetal ultrasound and then by chromosome studies obtained through obstetric procedures such as amniocentesis.

Fragile X Syndrome

The condition is the most common form of inherited intellectual disability in the world and tends to affect men more severely than women. It has a range of characteristic physical features as well as intellectual disability.[26]

Autism Spectrum Disorder (ASD)

Autism is a behaviourally defined syndrome with a range of abnormal restrictions in the ability to form social relationships, language and symbolic or imaginative play in addition to stereotyped or repetitive behaviours.[27] The current prevalence of ASDs in the population is thought to be around 62.5 per 10,000.[5] Genetics, epilepsy and birth complications may have some relationship to autism although the appreciation of these issues is still at an early stage. A diagnosis of autism may be missed in the Aboriginal and Torres Strait Islander population owing to cultural and language barriers and the difficulty in obtaining an accurate developmental history, and individuals suffering from autism may be mistakenly diagnosed as suffering from schizophrenia as a consequence.[5, 28]

Asperger Syndrome

Asperger syndrome is another behaviourally defined syndrome characterised by impairments in emotional and social developments along with stereotyped or repetitive behaviours, inflexible adherence to routines, and abnormal preoccupations with objects or parts of objects.[29] The prevalence in the developed world is estimated to be 3.6 per 1,000 with a male to female ratio of 4 to 1. Genetic causes are thought to be a substantial contribution to the syndrome.[29]

Cerebral Palsy

Cerebral palsy is an umbrella term covering a group of disorders of movement and posture due to a non-progressive defect or injury to the developing brain occurring at any stage from conception to early childhood. These motor disorders can range in severity from barely noticeable to totally disabling and are often accompanied by other disabilities such as visual, hearing or cognitive impairments, epilepsy and/or disturbances of perception and behaviour.[30] The prevalence of cerebral palsy in developed countries is around 2–2.5 per 1,000 live births[31, 32] with a greater preponderance in more deprived socioeconomic groups.[33, 34]

Epilepsy

Epilepsy is defined as a group of neurological disorders characterised by spontaneous recurring seizures.[35] It is estimated that 4 per cent of the population may suffer from epilepsy during their lifetime.[35] Intractable epilepsy that starts in childhood may be associated with intellectual disability. Epilepsy can also occur in association with other conditions such as Down syndrome, cerebral palsy, Alzheimer's disease, stroke and acquired brain injury.[31, 36]

Attention Deficit Hyperactivity Disorder (ADHD)

Individuals affected by this condition have traditionally been regarded as possessing the ability to learn but having significant interruption to this ability though inattention and hyperactivity.[37] The prevalence of this condition in developed countries is thought to be 3 per cent to 7 per cent of school age children.[37] Neece et al. found that ADHD was three times more prevalent in children with an intellectual disability compared with those with a typical development and they experience a more prolonged course of the disorder.[38]

Rare Conditions contributing to Intellectual and Developmental Disability

Table 18.2 lists a number of other rare conditions that may result in intellectual and developmental disability.[20] Clinicians or families are advised to consult authoritative experts or information sources if they have concerns or are seeking further information in respect to these conditions.

Table 18.2: Rare Conditions of Childhood that may result in Intellectual and Developmental Disability[20]

Angelman Syndrome	Noonan Syndrome
Batten Disease	Paediatric Stroke
CATCH 22/22q11.2 Deletion Syndrome	Phenylketonuria
Congenital Hypothyroidism	Prader-Willi Syndrome
Congenital Rubella Syndrome	Progressive Myoclonic Epilepsy
Cornelia De Lange Syndrome	Rett Syndrome
Cri-du-Chat Syndrome	Sanfillipo Syndrome/ Mucopolysaccharidosis Type II
Developmental Coordination Disorder	Shaken Baby Syndrome
Hunter Syndrome/Mucopolysaccharidosis Type II	Smith-Lemli-Opitz Syndrome
Hypoxic-Ischemic Encephalopathy/Neonatal Encephalopathy	Smith Magenis Syndrome
Intraventricular Haemorrhage	Sturge-Weber Syndrome
Klinefelter Syndrome	Tourette Syndrome
Lafora Disease	Traumatic Brain Injury in infancy and childhood
Lesch-Nyhan Syndrome	Tuberous Sclerosis
Meningitis	Turner Syndrome
Neurofibromatosis	Williams Syndrome
Neuronal Migration Disorders	

Roger, a five year-old boy, is referred to a local child and adolescent mental health service by his paediatrician for further assessment. Roger is the third of four children for his mother and father. His mother is an Aboriginal person with an Irish grandfather and his father is Torres Strait islander with a French grandmother. Roger's mother reports that his pregnancy was complicated by poor weight gain and that he was very small when he was born at 34 weeks and required 6 more weeks of support in hospital before he was allowed to go home. Roger generally has had delayed developmental milestones, including language delay and delay in spontaneous play. His parents are now concerned about his lack of emotional response and temper tantrums. They are not aware of any history of mental illness on either side of their families.

The paediatrician says that Roger's hearing and vision appear to be normal and he does not appear to have any other serious medical problems. The paediatrician has also referred Roger to a speech pathologist to assess his communication development. Roger is assessed by a multidisciplinary team who work with Roger and his family to establish a context for his condition. This involved interventions that had been tried previously and assessing which of these had worked and which had not. Information about what is a typical day for Roger is also obtained. The process of family functioning is also explored in how they generally normally function and respond to crises and what supports they have. After gathering the data and an assessment of Roger that includes a mental state examination, the multidisciplinary team work together to develop a formulation about Roger's issues. The formulation includes a provisional identification of his problem and how the problem affects him, his family, their support systems. A 'philosophy of care' may focus on whether a chronological, developmental or age appropriate approach is best. The team also may decide that further investigations are needed such as psychological investigations.

The team then discuss their formulation and proposed interventions with Roger's family. In this case, it was decided to perform a further formal evaluation of Roger with an Autism scale. Behavioural programs to encourage emotional response and the temper tantrums were discussed with the family. The family were given information about support groups such as Autism Australia and educational resources available to Roger as he is approaching school age. Ongoing review by a mental health team clinician along with communication strategies for the team, Roger's family, paediatrician and general practitioner are discussed and implemented.

ACQUIRED BRAIN INJURY

The risk of Aboriginal and Torres Strait Islander peoples suffering a brain injury appears to be substantially higher than among the wider population. Aboriginal and Torres Strait Islander peoples of both sexes and aged below 64 years are much more likely to die from 'injury and poisoning' causes and a significant number of these deaths relate to intentional self-harm, traffic accidents and assaults.[1] Outcomes of head injury and subsequent intellectual disability are closely aligned with this higher risk. Acquired Brain Injury (ABI) is any kind of damage to the brain that occurs after birth. Traumatic brain injury is the term that tends to be used for brain injuries that occur through accidents, falls, or assaults. Other kinds of acquired brain injury occur such as strokes, loss of oxygen to the brain, degenerative neurological diseases, and drug and alcohol misuse.[14]

Acquired Brain Injury as a Result of Trauma

Males are about three times more likely to suffer severe brain trauma compared with females, and the most common causes of fatal head trauma are motor vehicle accidents, falls and assaults.[39] In Australia, death rates from external causes that closely align to traumatic head

injury, such as intentional self-injury, transport accidents and assaults in Aboriginal and Torres Strait Islander peoples, is over double that for the wider population.[1] Smith et al.[40] in their Kimberley survey found that the most common cause of head injuries in the survey population was fighting/violence (46.5 per cent) followed by horse riding accidents (14.6 per cent), motor vehicle accidents (10.3 per cent), falls (7 per cent), sorry time (hit head with hard object when family member died) (5.9 per cent), a sporting accident and lightning strike (both 0.5 per cent).

It is important to recognise that people do not have to experience loss of consciousness to suffer a potentially devastating brain injury. Impact to the head through activities such as sporting events, falls and fights may daze an individual without him or her being knocked out. The period of confusion and disorientation following impact to the head is called Post Traumatic Amnesia (PTA) and is another measure of the severity of brain trauma.[41]

PTA is measured from the moment a person suffers impact, to the time he or she is able to recall events and retain orientation consistently. If there is prolonged concussion, a person is deemed to have recovered from PTA on the first of three consecutive days, as assessed by a hospital clinician. It is a widely regarded indicator of the prognosis of recovery from brain injury, with longer duration of PTA correlating to poorer outcomes. PTA ranges from mild (1 minute to 1 hour) to moderate (1 hour to 1 day) to severe (1 day to 1 week) to very severe (1 week to 1 month) to extremely severe (more than 1 month) to chronic (more than six months).[42]

Invariably, after any length of PTA, a person will experience some level, even very subtle levels, of cognitive and/or behavioural change. Such changes range from difficulty organising multi-step or complex tasks and being stuck on one line of thinking, to problems remembering, lowered frustration tolerance and increased irritability. Fatigue is extremely common after brain injury, and the above changes tend to be accentuated when fatigued. There is often confusion and agitation when a person has not been admitted to hospital, but discharged after a few hours of neurological observation in the emergency department. It is common for the individual, family and friends to thinks 'he's fine'. However, people very often complain of the types of changes mentioned above, without realising that it relates to the impact of brain injury. Returning to pre-injury work or leisure activities is often inordinately difficult, with many even questioning whether it might be psychological in origin.

Moreover, the effects of brain injuries are cumulative, with a second brain injury having potentially much greater impact than the initial injury. That is, after initial injury, even a minor knock to the head can have potentially much more severe effect than that of the first injury. Further injuries after that tend to only compound problems in cognition and behaviour.[43] Two of the most poignant reasons for this are reduced awareness of risk and thereby increased problematic behaviour, and behavioural disinhibition leading to assault by others who take offence. Whatever the factors underlying it, there is little doubt that people with a brain injury are some of the most vulnerable in our society.[44]

The initial severity of acute brain injury is evaluated with radiological means such as CT and MRI brain scans, along with clinical evaluation through instruments such as the Glasgow Coma Scale that measures alertness and response to stimuli.[45] Gottesman et al.[45] describe the classification of traumatic brain injury:

- Epidural haematoma (blood between the skull and outer layer of the brain meninges or *dura mater*)
- Sub-dural haematoma (blood deeper in the brain between the arachnoid and pia layers)
- Subarachnoid haematoma
- Intraparenchymal haematoma (blood in the brain matter)
- Intraventricular haemorrhage (blood in the brain ventricles)

- Duret haemorrhage (brainstem haemorrhage)
- Diffuse axonal injury (involving trauma and cell death of brain matter)
- Anoxic (Oxygen deprivation) brain injury with cell damage in certain brain areas such as the hippocampus, thalamus and cerebellum.

All the various types of injury have different prognoses depending on the area of the brain affected and the Glasgow Coma Score and are evaluated through the Glasgow Outcome Scale:

Glasgow Outcome Scale

5	4	3	2	1
Independent	Moderate disability	Severe disability	Persistent vegetative state	Death

There are a number of complications that can occur after acute brain injury:[45]

- Elevated intracranial pressure
- Post traumatic epilepsy
- Stroke
- Hydrocephalus (build-up of cerebrospinal fluid within the brain)
- Dysautonomia (Sympathetic nervous storm within the brain matter that results in severe paroxysmal increases in temperature, heart rate and blood pressure, often with increased respiratory rate and diaphoresis (excessive sweating))
- Headache

Acquired Brain Injury resulting from Harmful Substance Use

A number of substances currently misused by Aboriginal and Torres Strait Islander peoples may contribute to brain injury. This may occur from:

- the direct toxic effect of the substances on brain matter along with
- the increased vulnerability of people affected by substance intoxication and withdrawal to damage themselves and others by intent or accident and suffer traumatic brain damage as a consequence.

For further discussion of the impacts of harmful substance use, see Chapter 8 (Wilkes and colleagues).

Alcohol

High risk alcohol consumption for all age groups of Aboriginal and Torres Strait Islander peoples is much greater than for the wider population.[1, 46] It is well recognised that harmful alcohol consumption has a direct effect on the brain. Oscar-Berman and Marinkovik[47] estimate that about one-half of people who had a problem with chronic alcohol dependence in the United States at the start of the new millennium may have been experiencing neuropsychological difficulties as a result of their alcohol misuse, and that these difficulties ranged from mild to severe. Harper[48] notes that long term excessive use of alcohol tended to damage brain areas in affected individuals such as the superior frontal association cortex, hypothalamus and cerebellum, and these areas are important for executive brain function. Alcohol-related damage to the diencephalic-hippocampal circuitry of the brain along with

thiamine deficiency due to poor diet may lead to severe and permanent memory loss in the context of Wernicke-Korsakoff Syndrome.[48] Oscar-Berman and Marinkovik[47] comment that the areas of the brain that are particularly vulnerable to alcohol are the limbic system (important for processing and feeling emotion), thalamus (important for communication within the brain), the hypothalamus (which releases hormones in response to stress and other stimuli and is involved in behavioural and physiological function) and the basal forebrain (the lower area of the front part of the brain involved in learning and memory). Deficits in these areas can contribute to, or exacerbate, pre-existing acquired brain injury.

Volatile Substance Misuse

Volatile Substance Misuse (VSM) has been termed 'the hidden epidemic' because it remains among the least researched and publicly recognised form of substance misuse. It is a significant but under-researched global health problem despite the significant criticism and consequences that often exceed those of other drug misuse.[49]

According to the 2001 National Inhalants Information Service,[50] young people aged 12–15 years appear to be the largest population of users. However, it is suggested that this group is expanding to include much younger and older users. In the 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), up to 4.2 per cent of respondents reported that they had inhaled volatile substances such as petrol and aerosols.[51]

Inhalant use is popular in some areas in Australia. This phenomenon is not restricted to any particular region as it occurs in urban, regional and remote settings. Some Aboriginal communities appear particularly at risk for this issue and it was estimated that the financial cost of volatile substance misuse (petrol sniffing) in Central Australia prior to the introduction of Opal fuel was $78.9 million per year.[50]

Patterns of VSM differ across race, age, gender and time; albeit in the Northern Territory (NT) Aboriginal young people are overrepresented at approximately 80 per cent of all VSM admissions. In the NT, VSM use is effectively 'self-medication' to alleviate the meaninglessness and depression felt by many community members, and this is the key issue that must be addressed for an intervention to be effective and demand to be reduced.[52] Few options are available for long-term care of people who have become severely disabled as a result of VSM, and their care generally falls to family members.[53]

Marginalised young people, both Aboriginal and other Australians, indicate they use volatile substances as a way of relieving boredom, to block hunger pains, and to cope with emotional distress.[54, 55] Victims of child abuse tend to be at greater risk for inhalant misuse, as are young persons whose friends or relatives misuse other substances.[56]

VSM is a difficult problem for any community to tackle, as it tends to occur cyclically, becoming highly visible and then dying down, often peaking at 14 years of age.[51] Many large national surveys have failed to identify significant gender difference in prevalence of VSM. This raises concerns about the specific risks that VSM may pose to adolescent and young women, and their children, and the consequences, such as spontaneous abortion and foetal solvent syndrome (FSS). FSS includes a range of physical/cognitive behavioural and/or learning disabilities with possible life-long consequences that are caused by perinatal exposure to inhalants. They include low birth weight, small head size, facial dymorphology, and muscle tone abnormality similar to FASD presentations.[57]

Research shows that most inhalants are extremely toxic. Perhaps the most significant toxic effect of chronic exposure to inhalants is widespread and long-lasting damage to the brain and other parts of the nervous system. For example, chronic misuse of volatile solvents, such as toluene or naphthalene (the volatile ingredient in mothballs), damages the protective sheath around certain nerve fibres in the brain and peripheral nervous system. This extensive destruction of

nerve fibres is clinically similar to that seen with neurological diseases such as multiple sclerosis. Neurologic toxicity is the most recognised and reported chronic side effect of inhaled solvent misuse. Common findings on brain imaging include enlarged ventricles, widened cortical sulci and cerebral, cerebellar or brain stem atrophy.[58] Magnetic resonance imaging suggests that these white-matter changes in chronic abusers are irreversible.[59] Dementia, chronic encephalopathy, and peripheral neuropathy also occur. Peripheral neuropathy may present as proximal or distal muscle weakness, muscle wasting, absent or decreased tendon reflexes, or parenthesis.

Cognitive testing of Aboriginal and Torres Strait Islander peoples who misuse volatile substances on a regular basis has indicated that they experience poorer performance on complex tasks of psychomotor, visual attention, memory, learning, spatial awareness and executive function compared with Aboriginal people who did not misuse volatile substances. Follow-up studies by the same group indicated that, whilst there may be an improvement in some psychological testing after abstinence from harmful volatile substance misuse, other psychological deficits in respect to visual motor speed, learning, memory and executive function persisted. [60]

Amphetamines and Cannabis

High rates of cannabis and amphetamine misuse may also place Aboriginal and Torres Strait Islander peoples at risk for brain injury.[1, 61] Research has demonstrated that chronic misuse of amphetamines may lead to substantive changes in brain chemistry, particularly dopamine and glutamate, that may make the abuser vulnerable to psychosis.[62] In addition, brain damage related to amphetamine misuse was demonstrated in a recent pilot study that appeared to show that one-in-five young people who presented to a hospital emergency department in the context of amphetamine use had an occult brain lesion, as a result of their amphetamine misuse, on MRI scans.[63]

Research also appears to indicate that cannabis misuse in adolescents can lead to changes in the brain (particularly in the hippocampus) and alterations of brain transmitters.[62] A recent brain imaging study in the United Kingdom shows an association between regular cannabis misuse and reduced brain grey matter in the cingulate and left insula regions of the brain, in a population of individuals who were at high risk for psychosis.[64]

Scenario 3 ▶ **David's story**

David, a 24 year-old Aboriginal male, is found unconscious in a laneway and bought to the local hospital emergency department. He appears to have to have been the victim of a serious assault. The medical team reviewing his condition become aware of the following information. David was born in rural community. His mother misused alcohol during pregnancy and he had a low birth weight when delivered. David had a number of admissions to hospital from the ages of two to five with malnutrition and diarrhoea. David left primary school at his community early because of poor learning performance and behavioural problems. He started sniffing petrol when he was about 11 years-old and had a number of apparent deliriums (where he appeared to be responding to auditory and visual hallucinations) related to volatile substance intoxication. David was noted to use cannabis from the age of 14 and had a couple of short admissions to the mental health unit with psychosis that was thought to be due to his cannabis intoxication. He moved to town at the age of 19 and had been consuming alcohol since then. David had a number of previous attendances to the Emergency Department following assaults whilst he was inebriated. He had a further presentation where he appeared to have an epileptic seizure whilst inebriated and an another attendance at the Emergency Department after he was discovered hanging from a clothesline following an argument with his girlfriend when both were inebriated. David was reported to be unconscious and had a seizure but was resuscitated and appeared to recover.

A mental health assessment at the time of this episode reported that David appeared to have low intelligence and poor impulse control, particularly in the context of alcohol intoxication. He did not appear to be depressed or psychotic. Alcohol counselling and assessment for entry into an alcohol rehabilitation program was offered but David declined.

In the current circumstances, David has a Glasgow Coma Score of 6, indicative of severe head trauma when he arrives in the emergency department. A CT Brain scan reveals an intraparechymal haematoma with blood present in his brain frontal lobes. David initially requires artificial ventilation and is admitted to Intensive Care. After a week, he is discharged from Intensive Care to a rehabilitation ward. David appears to be suffering from Post Traumatic Amnesia and this is assessed daily through the Westmead Post Traumatic Amnesia Scale. David's family is consulted and an auntie travels to the hospital to assist the team with rehabilitation. The hospital Aboriginal Liaison Officer is also involved in working with the rehabilitation team and with David's family. David is noted to become obsessed with certain issues such as the location of an item of clothing and can easily become aggressive if this is not attended to. He is also noted to be tearful at times. At other times David appears to be responding to voices. The rehabilitation team and David's family work with the hospital Consultation Liaison Psychiatry team to assess these issues. It is decided that David does not appear to be depressed and that his obsessional behaviour is consistent with the severe frontal lobe brain injury he has suffered. It is also likely that he is suffering from a delirium related to his brain injury rather than a long standing psychotic condition.

The rehabilitation and psychiatry teams work together with David's family and the Aboriginal Liaison Officer to work on behavioural and other solutions that may involve appropriate psychotropic medication. After 6 weeks, David still has a score on the Westmead Post Traumatic Amnesia Scale that may be indicative of permanent brain damage. David is also unable to perform issues that he would normally be confident with, such as using his bank key card at the hospital ATM (an activity that he was reportedly familiar with prior to his current head injury).

The Kimberley Indigenous Cognitive Assessment is administered to David and he scores 28/39 with deficits in executive function, recall and verbal fluency. As a result of this, it is decided that David is likely to have a have permanent brain impairment as a result of his brain injury. The rehabilitation team, in consultation with David's family, decide to apply for Adult Guardianship for David and such application involves further exploration of his psychological and other disabilities related to his brain injury by the multidisciplinary rehabilitation team. David is considered eligible for Adult Guardianship and is eventually placed in a group home in the community in coordination with his family, government and non-government agencies. His community are building an aged care facility and it is hoped that he will eventually be able to return to his community to be closer to his family.

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DEMENTIA IN ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

Dementia is an umbrella term used to describe a syndrome that can have many different causes. The syndrome is characterised by a gradual decline in cognitive abilities and neuropsychiatric symptoms. The causes are most commonly brain disease including Alzheimer's disease, Lewy body disease, cerebrovascular disease and 'frontotemporal lobar degeneration'.[65(p1)]

Sheldon noted an emerging high incidence of cognitive decline in Aboriginal communities in Central Australia in the 1990's and commented that:

> *Several cases of undiagnosed moderate to severe dementia were referred to me because of extreme disruptive behaviour while their declining abilities had been quietly managed by the family for the preceding several years.*[66(p35)]

The issue of dementia has become more widely recognised since that time with a much higher proportion of Aboriginal and Torres Strait Islander peoples having Aged Care Funding Instrument (ACFI) assessments compared with the wider population in 2008–09.[1] A much higher proportion of Aboriginal and Torres Strait Islander peoples with dementia (39 per cent) were aged less than 75 years compared with the remaining population (9 per cent).[1] A survey of Aboriginal people over 45 years of age in the Kimberley using the Kimberley Indigenous Cognitive Assessment (KICA) tool found a prevalence rate of 27 per cent.[6, 67] The study's finding of a prevalence of 27 per cent of participants over 65 years of age being affected by dementia was five times higher than the overall Australian population after standardisation.[7]

A further review of risk factors for their survey population found that older age, male gender, no formal education, currently smoking, previous stroke, epilepsy, head injury, poor mobility, incontinence and falls led to an increased risk of dementia.[40] This concords with generally higher risk factors recognised for dementia that are present in the Aboriginal and Torres Strait Islander population, such as higher rates of tobacco smoking, physical inactivity and alcohol misuse, as well as poor diet and diseases such as coronary heart disease, stroke[1, 68] and Type II Diabetes.[69]

Diabetes as a cause for dementia is of particular concern, with the rate of diabetes within the Aboriginal community being three times the rate of the general Australian population.[1] These risks appear to have a particular cumulative quality (see Figure 18.1) that may in part explain the significant excess in dementia in Aboriginal populations.[7]

Figure 18.1: The Prevalence of Dementia and some Associated Risk Factors for Aboriginal and Torres Strait Islanders and Other Australians
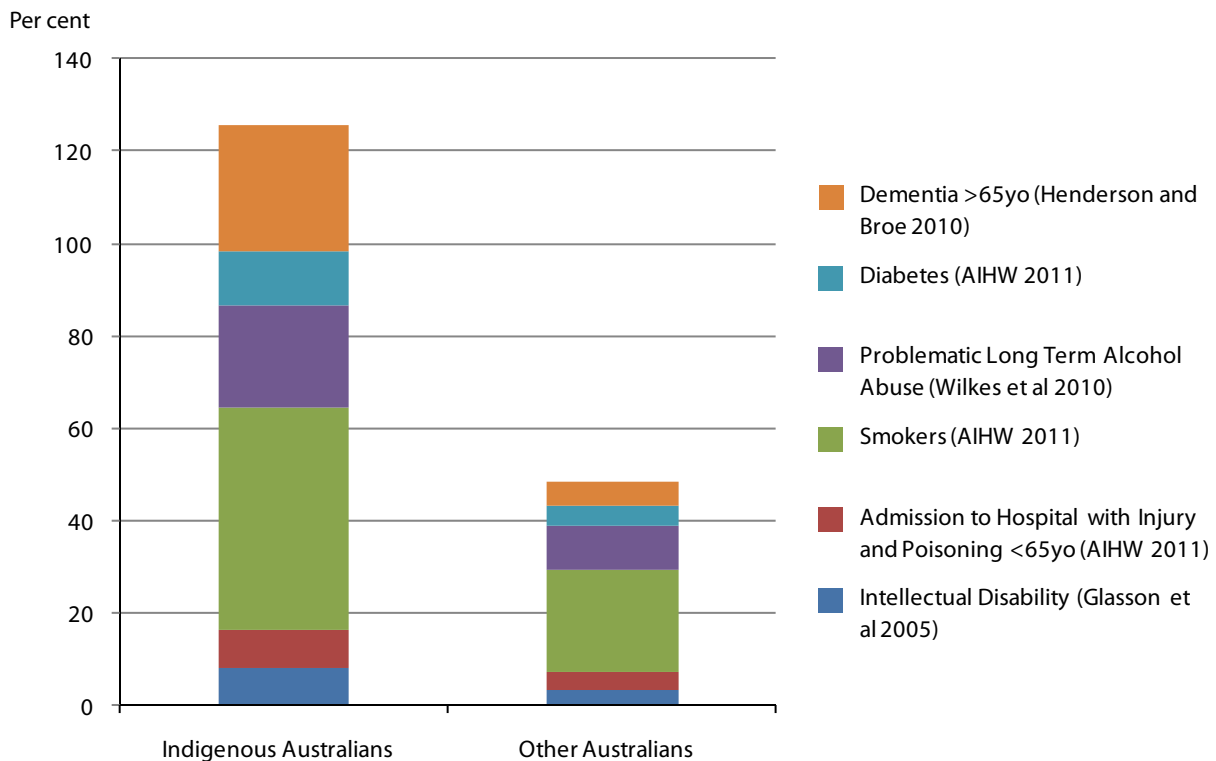
For people with existing intellectual disability, there appears to be a higher risk of developing dementia. Alzheimer's disease is an established complication for people affected by Down syndrome who often develop the disease 20 to 30 years earlier than the general adult population.[70] There also appears to be emerging clinical and post mortem evidence for higher rates of Alzheimer's disease in individuals affected by other forms of intellectual disability.[70]

Gladys is 70 year-old Aboriginal woman who lives with her daughter in a remote community. She has suffered from high blood pressure and diabetes for many years and had a stroke three years previously that has left her with left sided weakness to the extent that she requires the use of a walking frame to get around. Her daughter brings her to the local health clinic because she is "not making much sense when she talks any more". Gladys has also become increasingly forgetful and almost caused a fire at the house the other day when she forgot she was cooking some soup and left a saucepan on the stove top too long. Her daughter says that Gladys is more difficult to live with and argues more. She also used to enjoy caring for her grandchildren but her other children are less likely to ask her to do this currently because she does not appear to be able to care for them as well as she used to. Her daughter says that Gladys has become a bit "more smelly" and has not been showering or washing her clothes as frequently as she used to. Gladys used to enjoy playing cards with the other old women but does not go to the game now because she has trouble remembering the score and card patterns. She also has been accusing her daughter of taking her pension money but her daughter says that Gladys cannot remember buying things at the store.

Gladys is initially assessed by the medical staff at the health centre who determine that she has no organic cause for her condition such as syphilis, vitamin B deficiency or thyroid disease. She is then referred to the regional psychiatric team. The team's assessment, done in co-ordination with Gladys' daughter, results in a conclusion that they do not feel that she is suffering from depression or psychosis. Testing with the Kimberley Indigenous Cognitive Assessment reveals a score of 30/39 with deficits in recall, language fluency and executive function. Gladys is diagnosed as suffering from Alzheimer's Disease. She is referred to the regional geriatric service for further assessment and management. The team work with Gladys and her family to make her house safer for her and to enable her daughter and other family members to cope with her illness.

PSYCHIATRIC COMPLICATIONS OF INTELLECTUAL DISABILITY

There appears to be increasing evidence of mental health problems for people affected by intellectual disability[71-73] with the life time prevalence of severe psychiatric disorders in people affected by intellectual disability estimated to be five times that of the general population.[74] Organic factors such as genetic factors, brain injury, trauma, disease and infection can contribute to this issue.[72] Social factors such as poverty, unemployment and lack of social supports are also recognised as contributing factors.[72] Kerker et al.[71] comment on psycho-developmental stressors for people affected by intellectual disability that may result in mental illness:

> *Individuals with intellectual disability are capable of experiencing the same disappointments and difficulties as those without intellectual disability. In addition, individuals with intellectual disability who are aware of their limitations may be at high risk for mental health problems, as such recognition may lead to self-concept problems, emotional disturbances, and depressive reactions. Parental and peer rejection, negative social relationships, limited supports, and exposure to degrading situations also may make functioning in the community difficult for those with intellectual disability. Children with mild intellectual disability, for example, have been found to be more rejected by peers and express more dissatisfaction and anxiety about peer relations than those without intellectual disability. Such feelings may affect an individual with intellectual disability more than someone in the general population because those with intellectual disability tend to have greater sensitivity and fewer interpersonal coping skills.* [71(p410)]

The reasons for the high rate of psychiatric illness in individuals affected by intellectual disability are complex, manifold and interacting. The brain damage or dysfunction can affect biological aspects of frustration, tolerance and impulse control leading to emotional and behavioural problems. Underlying genetic conditions may predispose to psychiatric disorder, for example, psychotic and mood disorders in people with velocardiofacial syndrome and alzheimer-type dementia in people with Down syndrome. Comorbid conditions such as ASDs and ADHD are themselves associated with a high rate of mood disorders. Higher prevalence of epilepsy may also predispose to epilepsy-related psychiatric disorders such as depression, psychosis related to epilepsy, etc. Endocrine disorders such as thyroid dysfunction in people with Down syndrome may also lead to psychiatric disorder. People with intellectual disability are also more susceptible to adverse life events and psychosocial stressors which may predispose or precipitate psychiatric events. Communication difficulties may compound other problems such as bereavement, making it more difficult to come to terms with grief.

Diagnosis of Psychiatric Illness

Bradley et al.[72] note that diagnosis of psychiatric illness may be challenging in people affected by intellectual disability where symptoms may not be sufficiently recognised or attributed to the underlying intellectual disability. Other issues such as communication problems and sensory impairments, seizure disorders and contributing medical complications (such as cardiovascular disease, thyroid disease and pain from unrecognised bone fractures, infections and other causes), can further complicate effective diagnosis.[72] As a result, the authors recommend the following steps to achieve the best outcome in diagnosis:

1. Generate the best diagnostic hypothesis using information currently available;

2. Collect data to confirm or refute this hypothesis;

3. Review this data along with the results of assessments in other areas (e.g. psychological, communication, environmental, expectations).[72]

The diagnosis of psychiatric disorders for Aboriginal and Torres Strait Islander peoples affected by intellectual disability is complicated by the communication difficulties which people with more severe intellectual disability and those with autism display. It is important to obtain corroborative history from family members and carers. Changes in sleep pattern, appetite, mood, self-help skills and sociability can provide valuable clues in diagnosis. It may also be necessary to see the person on several occasions and in familiar settings to come to a diagnosis. The DSM-5 has removed the multiaxial system of diagnosis and replaced it with a nonaxial documentation of diagnosis. It combines the former Axes I, II, and III, with separate notations for psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V). This new method will be used to assess the level of intellectual disability, underlying physical disorders (including any underlying syndrome and epilepsy), psychiatric disorder (including any developmental disorder) and psychosocial issues (e.g. bereavement) and provide a comprehensive framework of the individual's needs to be addressed. These issues have been reconsidered in DSM-5 which now identifies Major and Minor neurocognitive disorders due to a range of causes.

Rates of intellectual disability and mental illness, often in the context of comorbid misuse of substances such as alcohol and cannabis, are significant in certain groups of Aboriginal and Torres Strait Islander peoples. Hunter et al.[75] report that approximately 40 per cent of Aboriginal people in Cape York who suffered from a psychotic disorder were also affected by intellectual disability. However, the question is whether it is actually intellectual disability or cognitive impairment associated with acquired brain injury or dementia. Similar comorbidity data may be emerging for Aboriginal people resident in the east Arnhem region of the NT (Krigovsky personal communication, 16 Sept 2012).

Issues for Families

There are a range of issues affecting the families of children with intellectual disability that impact on their function and ability to care. These are the emotional and physical material wellbeing of family members, their parenting skills, and the disability-related supports they may or may not receive.[76] There are significant issues for the optimal functioning of Aboriginal and Torres Strait Islander communities in view of the history of generational trauma that can often disempower families and communities.[77, 78] Other issues relating to the impact on carers are also relevant in the context of caring for a person with intellectual disability (for a carer perspective, see Chapter 14, Wright).[79] Cultural safety is a particularly important element in the assessment of such caring abilities given the important contribution of Aboriginal and Torres Strait Islander traditions and attitudes to children, family and community (see Chapter 12, Walker, Schultz and Sonn). A further issue is the potential to overwhelm people who may not be able to perform a caring role because of their age and own health issues in addition to pre-existing family, community and tribal responsibilities.

O'Neill et al. describe a number of further complications in respect to the care of Aboriginal and Torres Strait Islander peoples with a disability such as dementia:

> *Many Aboriginal and Torres Strait Islander peoples live in poverty and often cannot afford to care for more needy members of their group—the added expense entailed in caring for a person with a disability can disadvantage other members of the family. People with a disability can be very vulnerable to exploitation in environments where alcohol misuse and family breakdown have occurred. The burden of grief and stress carried in many communities can lead to inconsistencies in care. Family allegiances can make accessing services difficult and many people are disadvantaged by not knowing how to care and what services are available.*[80(p4-5)]

A recent study by Smith et al. evaluated the opinions of Aboriginal carers of people affected by dementia in the Kimberley.[81] The carers expressed views that they hoped that their relatives could stay in their communities as long as possible because they would remember familiar things and be close to country. The carers also felt that the availability of more Aboriginal dementia workers, cultural training for service providers and external community care staff, dementia training, and Elder abuse training would be advantageous. Aboriginal carers nominated overcrowded houses, the exaggerated expense of living in remote communities, and a lack of public and private transport to access health care as having a significant impact on the care of the elderly. Aboriginal carers also had a view on the quality of service provision. They felt that there needed to be improved communication and coordination amongst service providers. Intolerance and 'defeatist' attitudes by some service providers, in addition to a lack of flexibility and clinical pathways and protocols, were of concern to the carers consulted. They also felt that the lack of access to interpreters, community support services such as house cleaning; caregiver support organisations; as well as the lack of opportunities for the person affected by dementia to have meaningful activities and have respite care available, significantly impacted on the person's illness and their role as carers.[81]

A report by LoGiudice et al.[82] on a pilot model for dementia/disability care in a remote Kimberley community showed that a number of the above concerns can be successfully addressed given the right level of resources, coordination and community engagement. The project to improve services to people affected by dementia and other disabilities in the Looma community involved the coordination of a Steering Committee, Facilitator, Local Action Committee and Project Co-ordinator to develop a more effective use of, and access to, available resources. The project resulted in an increase in services in all domains (such as

home maintenance and social support, advocacy, provision of equipment, caregiver and wider community education) from 140 per month prior to the project to 2,356 per month during the project, leading to a much higher standard of care for the disabled members of the community.

Forensic Issues

Sotiri et al. note that:

> *Indigenous Australians with cognitive impairment are over-represented in criminal justice settings across Australia. This group (compared to the non-disabled population) is more likely to come to the attention of police, more likely to be charged, more likely to be remanded in custody, and more likely to be sentenced and imprisoned. They spend longer in custody than people without cognitive impairment, have far fewer opportunities in terms of program pathways when incarcerated and are less likely to be granted parole. They also have substantially fewer program and treatment options, including drug and alcohol support, both in prison, and in the community when released, than their non-disabled and non-Indigenous counterparts. In some Australian jurisdictions, Indigenous people with cognitive impairment are detained indefinitely.*[14(p19)]

The issues of Aboriginal and Torres Strait Islander peoples affected by intellectual disability and mental illness and their contact with the justice system are dealt with more fully in Chapter 10 (Heffernan and colleagues).

Intelligence and Rating Scales

The definition of 'intelligence', particularly in cross-cultural situations, may be controversial but elements of intelligence such as information processing and adaptive function appear to be core features.[83] Such 'intelligence' would have been well satisfied through traditional Aboriginal and Torres Strait Islander economic, cultural and spiritual practices that existed for over 40,000 years and are described in Chapter 2 (Parker and Milroy).[84, 85]

Neuropsychological assessment is valuable as a non-invasive means of assessing strengths and changes (or weaknesses) after brain injury of any aetiology. Such tests can be particularly useful when imaging is unable to demonstrate the presence of structural damage. Neuropsychological assessment is a series of paper-and-pencil tests standardised on a normative population to gauge a person's performance relative to that general population. Responses to this series of tests allows the neuropsychologist to better understand the effects of injury and advise the individual, his or her family, and other treating clinicians as to adaptive strategies that might best suit the injured individual. It also allows for the gauging of improvement over time, as the assessment is repeated at intervals.

There are significant issues in terms of limitations of psychometric assessment of intellectual functioning when used with Aboriginal people. Many psychometric tests rely on a question and answer format, frequently using the English language. Written responses require formal education in western-based schooling systems. These are significant factors in some cultures which do not have a written language. The one-on-one encounter with a practitioner administering the test may affect performance in a culture which may consider it rude to be asked numerous questions by strangers from another culture.[86] Overall, most psychometric instruments developed for cognitive assessments in Aboriginal and Torres Strait Islander populations have been inadequately validated and require further evaluation (see Chapter 16, Adams, Drew and Walker).[87]

The identification of intelligence or its deficits as defined in the usual standard tests such as intelligence quotient (IQ), the Wechsler Adult Intelligence Scale (WAIS) and Wechsler Intelligence Scale for Children (WISC), and their applicability for Aboriginal and Torres Strait Islander peoples is somewhat more controversial. Practising Aboriginal psychologist, Yolonda Adams (personal communication, 12 April 2013) makes the point that practitioners need to draw on the strengths that enhance testing for Aboriginal and Torres Strait Islander peoples i.e. use tasks that rely on visual skills. Tests that rely heavily on terminology/verbal and time testing such as the WAIS and WISC may disadvantage Aboriginal people and affect performance on these types of tests. Administering tests and interpreting the results within context is reliant on the skills, abilities and cultural competency of the practitioner.

There is increasing recognition that testing needs to be culturally appropriate and within context. For instance, Sedighdeilami and Gindi[88] allow that standard unmodified tests may be of use amongst individuals from diverse cultural backgrounds affected by intellectual disability as long as the practitioner conducts the tests:

- in a culturally safe manner;
- to take account of the client's history, culture, language, customs, norms and life experiences and their impacts; and
- in the knowledge that such issues will impact on the accuracy of measurement within the test.

See Chapter 16 (Adams, Drew and Walker) for further discussion of culturally appropriate assessment, and for a discussion of the Cultural Formulation Interview in the recently released DSM-5. Speech Pathology Australia[89] lists a number of tests that have been developed, primarily in Western Australia, for working with Aboriginal children to assess language proficiency.

TOOLS FOR ASSESSMENT OF INTELLECTUAL DISABILITY

In the context of the considerable limitations described above, there are some tests that, while usually used for the assessment of dementia, appear to be increasingly used for assessment of intellectual disability in Aboriginal and Torres Strait Islander peoples. When using such tests, it is important to consider the person being tested in the context of their prior education and abilities. As an example, it may be quite appropriate to consider the use of the standard Mini Mental State Examination[90] to assess residual cognitive impairment in an Aboriginal university academic who was severely concussed in a motor vehicle accident, whereas the KICA[67] may be more appropriate to assess cognitive impairment in an Aboriginal and Torres Strait Islander person with pre-existing limited education and language skills following a traumatic head injury.

The Kimberley Indigenous Cognitive Assessment

This assessment tool was developed with Aboriginal and Torres Strait Islander health and aged care organisations in the Kimberley, and comprises cognitive, informant and functional sections. LoGiudice et al. note:

> The KICA-Cog assesses orientation, free and cued recall, language, verbal fluency, copying sequence pattern and ideational praxis. Many test questions rely on the use of culturally appropriate pictures requiring adequate vision, and commonly found objects (i.e. matches, comb and pannikin cup) were used. [67(p276)]

The test is validated for Aboriginal and Torres Strait Islander peoples aged over 45 and a cut-off score of 33/39 may indicate that the person being tested could be suffering from dementia. However, the tests may also be useful for informally testing a specific cognitive deficit or a range of cognitive deficits to assist in diagnosis and management. [67]

The Westmead Post Traumatic Amnesia Test

This test was developed as a prognostic screening tool for outcomes in people affected by mild traumatic brain injuries which constitute 70-90 per cent of all head injuries.[91] The test may be a good indicator of diagnostic accuracy for outcomes in people affected by mild traumatic brain injury and is also used to assess ongoing improvement and deterioration for Aboriginal and Torres Strait Islander and other patients suffering from PTA in Royal Darwin Hospital. Speech Pathology Australia[89] note that an adapted form of the Westmead PTA Test, *the Adapted Westmead PTA Scale for Indigenous Australians,* may also be useful for Aboriginal and Torres Strait Islander peoples affected by PTA.[91]

Cognistat

Cognistat[92] is a further tool that may be useful[93] and is also used to review the progress of both Aboriginal and Torres Strait Islander and other patients suffering from PTA in Royal Darwin Hospital (Robert Parker, personal communication, 12 Dec 2012). However, there is also information that education and racial differences may have an impact on the outcome. This may need to be taken into account when using the instrument in Aboriginal and Torres Strait Islander peoples.[94, 95]

Cogstate

The Cogstate battery[96] is a battery of neuropsychiatric tests that includes measures of visuomotor function, psychomotor/processing speed, visual attention/vigilance, attention/working memory, verbal learning and memory, executive function (spatial problem-solving, set-shifting), and social cognition.[97] The assessment is in the form of a computerised non-verbal assessment that can be downloaded from the Internet and administered on any computer. Dingwall and Cairney[86] note its potential popularity for Aboriginal and Torres Strait Islander peoples because of the role of playing cards in the tests and the popularity of card games in many Aboriginal and Torres Strait Islander communities. Research using a modified form of the test was able to demonstrate cognitive impairment in Aboriginal and Torres Strait Islander peoples resident in rural communities in the NT and affected by alcohol dependence.[98]

PREVENTION OF INTELLECTUAL DISABILITY

Prevention of the high rates of intellectual disability currently experienced by Aboriginal and Torres Strait Islander peoples needs to be an important priority for health policy makers and health professionals. There are a range of primary, secondary and tertiary prevention strategies (see Table 18.3) that can be implemented to eliminate or significantly reduce intellectual disability in Aboriginal and Torres Strait Islander populations.

Table 18.3: Primary, Secondary and Tertiary Strategies for Prevention of Intellectual Disability

Primary Prevention	
Cause	*Prevention*
Genetic causes	Counselling, Screening, Amniocentesis
Infection in utero	Immunisation for Rubella, Measles, etc.
Toxins in utero	Culturally sensitive programmes to reduce alcohol, tobacco and drug use during pregnancy
Nutritional factors	High folate during pregnancy
Endocrine and metabolic factors	Screening for hypothyroidism, phenyl ketonuria
Perinatal factors	Improved access to antenatal care and improved obstetric care
Post natal infections	Early diagnosis and treatment of infections
Accidental Injury	Accident prevention
Non-accidental injury	Improved surveillance and early diagnosis
Societal factors	Empowerment of Aboriginal and Torres Strait Islander communities to improve their physical environments
Secondary Prevention	
Secondary prevention aims at treating or ameliorating the effects of the underlying cause to prevent or reduce disability. An example would be thyroxine replacement in a child with congenital hypothyroidism.	
Tertiary Prevention	
Tertiary prevention focuses on minimising the sequelae of an existing disability. Examples include regular hearing, visual and thyroid checks for people with Down syndrome. Intensive interventions for motor and communication delays can help to ameliorate the physical and psychological effects of under-stimulating home environments. Early diagnosis of epilepsy and comorbid psychiatric disorders will also reduce associated disabilities.	

CONCLUSION

The discussion throughout this chapter confirms a disturbing incremental growth in risk factors for intellectual disability for Aboriginal and Torres Strait Islander peoples with childhood vulnerability (i.e. low birth weight, fetal alcohol syndrome, malnutrition and reduced participation in education) that translates into higher risk for acquired brain damage (e.g. high levels of smoking, excessive harmful use of substances and exposure to injury) that have an end point as high rates of dementia. The background social, historical and cultural factors are also very relevant in this regard[14, 16] and further detailed in Chapter 1 (Dudgeon and colleagues). Hunter[99] has recently pointed to similar additive factors around the significant social and health disadvantage of Aboriginal people in Cape York leading to very high rates of psychosis in the region, and a similar emerging epidemic of dementia in Aboriginal and Torres Strait Islander peoples nationally is of major concern. Any proposed solutions to the apparent very high rates of intellectual disability need to be approached by mental health practitioners and service providers in a broad context of cultural empowerment and social reform as much as targeted services for those affected. This will require genuine working partnerships with Aboriginal and Torres Strait Islander community controlled organisations as well as practitioner and system-wide commitment to cultural competence.

REFLECTIVE QUESTIONS

1. Examine the various factors that may contribute to the development of dementia in elderly Aboriginal and Torres Strait Islander peoples. In this process, you may wish to construct your own graph (as per Figure 18.1) and develop an argument for the various factors that you feel are important.

2. Consider the factors that may impact on the validity of standard tests of intelligence for Aboriginal and Torres Strait Islander peoples.

3. Consider the ways that your role as a member of a multidisciplinary team may contribute to the assessment and management of an Aboriginal adult (such as David) with acquired brain injury.

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Part 5

Working with Children, Families and Communities

Focuses on the complex issues surrounding young Aboriginal people and explores ways for families and communities to deal with these issues. Issues discussed include factors influencing parental and infant mental health, addressing fetal alcohol spectrum disorder and understanding the lives of Aboriginal children and families using case studies. Also discussed are ways of working with behavioural and emotional problems in young people and how to move forward when family violence occurs.
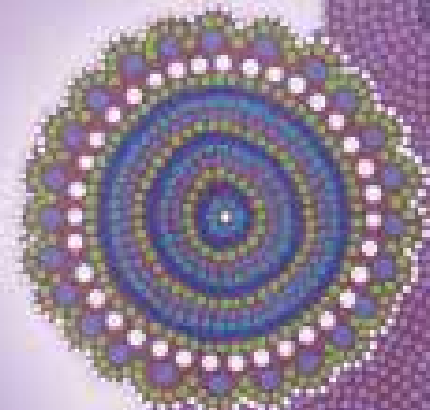
Chapters

19   Factors influencing parental and infant mental health and wellbeing, such as perinatal depression and anxiety are outlined. The significance of infant attachment in the perinatal period, the importance of culture and ways of working with families in this sensitive life stage are described. Assessment tools and issues related to culturally appropriate diagnosis, treatment and prevention of perinatal depression and anxiety and its potential impacts are outlined along with key policies and preventative programs.

20   Fetal Alcohol Spectrum Disorder (FASD) and examples of its reported prevalence in the national and international context are highlighted. The burden of FASD and actions that have been taken in Australia to address FASD are examined. Stories of people from rural and remote communities, led to the development of the Life Cycle model. This model has been adapted to address the complexities of FASD in the Aboriginal population.

21   Case studies representing the lives of young people in Aboriginal families affected by loss, grief and other traumatic life episodes are presented with the intention of engaging the reader in the life course of young people. Mental health practitioners, teachers, social workers and other community service providers will gain a deeper understanding of the clinical and cultural complexities that need to be addressed when working with children and young people.

22   Examines the behavioural and emotional problems and the more common mental health disorders affecting young Aboriginal people who are at high risk of developing such problems. The importance of recognising psychosocial, cultural and environmental factors when assessing and treating young people and the delivery of both universal and culturally responsive prevention and intervention programs to address social and emotional wellbeing are discussed.

23   The context in which violence occurs and how it is defined and contextualised in families is explored in order to determine pathways forward for healing of the victim, the offender, their families and the broader kin network. Drawing on the available evidence, several key considerations are presented for the development and implementation of interventions to address this violence in what is often a maze of complexities.

19

Perinatal and Infant Mental Health and Wellbeing

Rhonda Marriott and Sue Ferguson-Hill

OVERVIEW

This chapter considers factors influencing parental and infant mental health and social and emotional wellbeing. Perinatal depression and anxiety is a significant health problem affecting not only mothers but also their infants, other children, partners, extended families and communities generally. The significance of infant attachment in the perinatal period (from conception to the end of the first year after the baby is born) and the importance of culture and ways of working with families in this sensitive life stage are described.

Perinatal mental health is about the emotional wellbeing of pregnant women and their infants, partners and families during this time. This chapter discusses the risk and protective factors that impact on parental mental health and social and emotional wellbeing. It refers to processes of assessment and the issues related to culturally appropriate prevention, diagnosis, and treatment of perinatal depression and anxiety; and its potential impact on the infant, other children, parents, family and community. The key policies that impact on perinatal mental health and relevant preventative programs are briefly described.

INTRODUCTION

The available literature assures us that a strong family unit displays signs of being further strengthened during this transitional life stage, as adjustment followed by adaptation to the new situation of being a parent occurs. From a social and anthropological perspective, childbirth is a 'rite of passage', a transition where the relationship between the parents and wider family combines to trigger a secure environment for the developing infant.[1]

However, perinatal mental health research has also identified that in this period women and their partners may have difficulties in adjusting to pregnancy and changing roles and relationships. They can experience social and emotional stress, psychological distress and anxiety and mood disorders. We also know that, physiologically, alterations in cerebral serotonin and noradrenalin metabolism and uptake, and hormonal changes —along with the interplay of psychosocial stressors such as stress of pregnancy, childbirth and constant caring for an infant, lack of support, concerns about the infant, sleep deprivation, and financial worries— may lead to syndromes of anxiety and depression[2] which can have long-lasting effects on the foetus, infant and family in the perinatal period.[3]

PERINATAL DEPRESSION AND ANXIETY

Depression accounts for the greatest burden of disease within all mental illness. Of particular concern and significance is the rate of depression among women and men during the perinatal period.

Maternal Depression

Between 50 to 80 per cent of women will experience baby 'blues' in the first few days after the birth.[3] This stage is characterised by a depressed mood and negative thoughts that occur shortly after birth with symptoms that are not severe and resolve spontaneously within a few days or weeks in a supported environment.[4] Reassurance and support by knowledgeable health professionals through this period assists mothers to strengthen their developing relationship with their new born child and to avoid misinterpreting risk factors or symptoms as representing a depressed state, or a state of illness.

There are questions as to whether perinatal distress is related to the psychological, sociological, environmental or biological phase of adjustment to parenthood, or if it is considered a mental health disorder. Media images of smiling, relaxed, in-control mothers and fathers continue to set expectations that are difficult to achieve—even in well-supported families. Buist[2] notes that nearly 30 per cent of women experience significant adjustment to parenthood difficulties, with the weight of the perceived role of motherhood creating levels of mental and emotional stress not previously seen.

Antenatal anxiety and depression frequently occur together and may lead to postnatal depression and anxiety.[5] Approximately 10 per cent of women in the Australian population experience antenatal depression with one-half of those developing depression in the postnatal period.[4] Yet, despite this prevalence, postnatal anxiety and depression is frequently unrecognised and untreated[6] in women in the general population and is increasingly described in Aboriginal women.[7] Despite the known occurence of perinatal depression and anxiety in the general Australian population, there is reason to research the topic further, as the extent of diagnosis and treatment in Aboriginal and Torres Strait Islander women remains unknown.

While estimates of the prevalence of postnatal depression vary between 14–16 per cent,[4,8] at least one-in-six women in Australia who birth will experience postnatal depression.

Additionally, there is increased risk of depression in young people, with Swann et al.[9] reporting that young mothers (under the age of 20 years) are up to three times more likely to experience postnatal depression than older mothers.

Comorbid anxiety is reported in postnatal depression in 30–40 per cent of cases[10]; and suicide during the perinatal period is the equal (with haemorrhage) as the leading cause of maternal death in Australia.[6] Also, a rare but alarming consequence of severe mental illness is infanticide.[3] Co-occurring drug or alcohol use, with and without the added burden of domestic violence, increases the likelihood of affecting the mental health and wellbeing of a woman, her infant and other children, her partner, and others in the community.

Dysfunctional personality characteristics may become apparent in the perinatal period if negative emotions and memories of past experiences come to the surface. Fraiberg and colleagues refer to a mother's past experiences that continue to influence her ability to form a nurturing relationship with her child as 'ghosts in the nursery'.[11] These past experiences may be rekindled through retraumatisations in the perinatal period and it could follow that mental health disturbance, substance use and continuing inter or transgenerational patterns of abuse and neglect of children may occur.[12] See Chapter 17 (Atkinson and colleagues) for a discussion of transgenerational trauma.

Paternal Depression

A review by Goodman[13] concluded that paternal depression ranges from 1.2 to 25.5 per cent the first year after the birth of an infant, and from 24 to 50 per cent among men whose partners were experiencing postnatal depression. In addition, fathers may experience increased rates of anxiety, restlessness or unhappiness (also known as dysphoria).[14] Paternal depression 'can seriously affect infant development'.[15(p461)] The highest rates of depression in fathers occurred between 3 and 6 months of the infant's first year of life—a critical time of development in the infant.[16]

There is a growing awareness across Australia of the need to support fathers in the perinatal period of transition to parenthood and there are programs and policy plans developed because it is recognised that:

- perinatal depression in fathers leads to poorer outcomes in children (just as maternal depression does);

- mothers experiencing perinatal depression will recover more effectively if the father is involved in the care of children;

- infants of mothers experiencing perinatal depression will be less affected if fathers (and extended family) are involved in their care.

The *New South Wales Men's Health Action Plan 2009–2012* is an example of a Father-Inclusive Practice Framework that has been developed to align services with the needs of fathers.[17]

PERINATAL MENTAL HEALTH – A CULTURAL PERSPECTIVE

Differences may exist within Aboriginal and Torres Strait Islander contexts of the experience of mental health disorders. Westerman[18] reflects on the relevance of applying mainstream diagnostic criteria across cultures where possible differences in symptom presentation exist (e.g. more physical symptoms), and causality (e.g. external forces arising from 'doing something wrong culturally'), which are also significant considerations when managing perinatal mental health.

Vicary and Westerman[19] contend that, because mental health problems may show themselves spiritually and culturally, resolution can only be achieved in the same manner. Many Aboriginal people ask that 'workers in community agencies apply an 'Aboriginal lens' and consider additional factors and approaches' when working with Aboriginal people.[20(p2)] See also Chapter 25 (Dudgeon and colleagues). Social and emotional wellbeing (SEWB) workers and Aboriginal mental health workers (AMHWs) are well placed to assist their colleagues—see Chapter 13 (Schultz and Walker and colleagues) regarding interdisciplinary team care.

Traditional Cultural Beliefs and Practices Strengthen Wellbeing

In traditional Aboriginal cultures, birthing and child-rearing practices were strongly related to the land and plants that provided the necessary elements for rituals relevant to this life stage.[21] Connection to country or 'homeland' was, and still is in most Aboriginal communities, an extremely significant feature in ensuring the wellbeing of the mother, infant, family and community in general.

In many rural and remote areas in Australia, pregnant women face removal from a partner, family, friends, community, country, and culture for the birth of their child/ren due to the emphasis on medical risks at the expense of cultural and family considerations. Such separation is highly likely to have a significant impact on the wellbeing of women and their families and is the heart of a report commissioned by the Maternity Services Interjurisdictional Committee for the Australian Health Ministers' Advisory Council (AHMAC).[22] Furthermore, excessive stress,

isolation from familiar and nurturing people, surroundings and cultural ways, may lead to fear, sadness and loneliness at this critical period.[22] While many urban centres share a philosophy of family-friendly birthing environments and provide options for community midwifery services, many women living in remote settings experience displacement from their families and communities when birthing in unfamiliar settings[23] —both significant factors in creating high levels of stress for women.[24] Birthing away from country, and away from significant family members who would normally nurture, guide and assist the woman in the cultural practices associated with birthing, may well upset the normal process and rhythm of birth as well as subsequent mother–child interactions and child behaviour and development.[25] This can have potential negative impacts on the child's health, especially the immune system.[24] There is evidence to show that an individual's coping abilities are decreased when they have no control over what happens to them—and passive submission results.[24] This may occur when medical practitioners discount a woman's cultural and spiritual values and women leave their family and country for birthing.

The women of Warmun community in the East Kimberley region of Western Australia (WA) have highlighted the importance of safeguarding both the physical and spiritual health of the mother through *'Adherence to traditional women's Law, ceremonies and rituals for a healthy mother and baby'* in recounting their traditional birth and child-rearing stories.[26(p6)]

Werra Werra team members Peggy Patrick, Mona Ramsay and Shirley Purdie shared stories indicating the importance of cultural birthing practices:

> 66 *When we were ready to have our babies the older women would take us away from the camp where men can't see us. They would keep us there till the baby was born. They would pray over us and put warm paperbark on our back, belly and sides to help ease the pain…* 99

> 66 *When we smoke the girl we allow the strength of very strong spirits to give her strength and health. The water we use to sprinkle on the girl is water from the Dreamtime for us (mantha). This is done to welcome the new baby before it is born and that is why the baby is born healthy and stays strong. The baby feels welcome and wants to come to us even before it is born. The baby and mother won't get sick easily either…Singing over the girl means the same as the water blessing.[26(p6-7)]* 99

Connecting with Country and Relationships

The role of spirituality and the relationship with family, land and culture are intertwined and play a significant part in Aboriginal and Torres Strait Islander SEWB.[21,27] See also Chapter 4 (Gee and colleagues) and Chapter 6 (Zubrick and colleagues) for discussion regarding the significance of country, cultural and family connectedness.

In respecting the importance of culture and birthing practices, it is important to minimise the impact of disconnectedness when birth occurs away from homelands. For example, offering Aboriginal and Torres Strait Islander women the opportunity to take the placenta (or part thereof) home for burial or special ceremonies may enable the creation of physical and symbolic links between mother, baby and the homeland.[28]

PERINATAL MENTAL HEALTH RISK FACTORS

It is generally understood that the more risk factors present, the greater the chance that the mother, father and child/ren require extra mental health support or intervention in the perinatal period. An increase in couple mental illness throughout the first year after the birth of a child, with rates of distress being at the highest point for both partners at one year, has also been identified.[29] The range of risk factors for parents, highlighting the different factors that impact on mothers and fathers, follows.

Psychosocial risk factors have been shown to be associated with an increased risk of depression.[30] Essential considerations are listed below.

> **Parental Psychosocial Risk Factors**
>
> - a lack of current emotional or practical supports;
>
> - poor quality of relationship with, or absence of, a partner;
>
> - domestic violence (past or present);
>
> - traumatic birth experience or unexpected birth outcome;
>
> - current major stressors or losses such as bereavement, or moving house or financial strain[30];
>
> - past history of depression and anxiety disorder or other psychiatric condition;
>
> - depression in partner, either antenatally or during the early postnatal period;
>
> - poor quality of relationship with partner;
>
> - difficult relationship with own parents;
>
> - poor social functioning;
>
> - unemployment;
>
> - current major stressors or losses; and
>
> - drug and/or alcohol misuse.[13]

PERINATAL MENTAL HEALTH PROTECTIVE FACTORS

It is recognised that rather than trying to modify risk factors, a more effective way of promoting mental health and enhancing family wellbeing in the perinatal period is to increase a person's or family's, inner strength, level of resilience, or coping capacity, through the enhancement of protective factors relevant to the particular family. In population-based community health, strengthening or resilience-building concepts are often referred to as 'protective factors' because it is believed that these factors have a role in shielding a person from developing serious mental health problems resulting from stress or hard times.[31] Protective factors for early child development and wellbeing are discussed in detail in Chapter 6 (Zubrick and colleagues). Preventive practices which acknowledge cultural and innate personal and community strengths should form the basis of all practice in primary health settings. Therapeutic modalities recommended and described by Aboriginal authors include narrative and demonstration, personal stories and anecdotes, open-ended discussion, yarning, and grief and loss therapies.[32]

There are many protective factors that assist in the management of stressors over a life course and over many generations. Ypinazar et al. (2007) summarised protective factors for parents (and infants), with each defining, influencing and impacting on the other.[27] A list of protective factors for perinatal and antenatal mental health and wellbeing and continuity of care adapted from Ypinazar et al.[27] follows:

Protective Factors for Parents

- cultural traditions, especially around the birthing process and perinatal period;
- interconnectedness of cultural practices, spirituality, identity, family and community, connection to land/country;
- strong family relationships and connections;
- belief in traditional healing activities which assist the management of life stressors;
- personal sense of wellbeing, satisfaction with life, and optimism;
- high degree of confidence in own parenting ability;
- presence of social support systems;
- access to appropriate support services;
- economic security;
- strong coping style, and problem-solving skills; and
- adequate nutrition.

Protective Factors for the Infant/Child

- healthy infant;
- nurturing sensitive caregiving (i.e. sensitive interaction, age appropriate stimulation/ sleep habits, and physical care of the infant such as feeding);
- 'easy' temperament;
- safe and secure base with positive attention from a supportive, caring mother/family;
- strong mother–infant attachment;
- father–infant attachment;
- family harmony;
- sense of belonging, sense of connectedness; and
- strong cultural identity and pride.

INFANT MENTAL HEALTH

Understanding Secure Attachment in Infants

The first year of a child's life is a critical period in the creation of secure parent–infant attachment. It is also the time when neuronal connections in the infant's brain are being made, especially in the area of self-regulation of behaviour and emotions.[33] There is increasing emphasis on bonding and attachment and its importance on child wellbeing.

Further, insecure patterns of behaviour in the child may be a result of intergenerational transmission of insecure attachment.[34] Negative behavioural and emotional outcomes in childhood are associated with the presence of an insecure attachment, or insecure base, with primary caregivers in the stage of infancy.[35] Strained or inadequate mother–infant interactions may exacerbate a woman's depressed mood, reinforcing her feelings of being a poor parent.[13]

Yeo contends that assessment of Aboriginal children in relation to attachment does not take into account the historical context or Aboriginal cultural values.[36] The challenge to health professionals when assessing infant attachment and maternal bonding with Aboriginal parents is to ensure they have developed a rapport with parents to include the context of Aboriginal values and culture in their clinical consideration, and to promote and support the protective factors identified above.

Impacts on the Development of Secure Attachment

Complex and diverse situations for many Aboriginal and Torres Strait Islander families have an impact on personal and family growth, role adjustment, and parenting knowledge and skills in the perinatal life stage.[35]

It is important to recognise that fathers have a valuable role to play in their child's development. However, research indicates that depression in fathers may lead to more negative interaction and less positive social interaction with their children, which correlates to anti-social and peer interactional problems for the child later.[29,37] Aggressive behaviour in males may indicate depressive mood and hence possible risk to mother and baby. Given the importance of the early years in a child's development and wellbeing, more research is needed on the rates of depression in fathers of toddler-aged children and the effects on relationship with the mother and child/ren.

Chronic psychosis in mothers may lead to a lessened ability to form secure attachments with their infants. The children of affected mothers are more prone to neglect, abuse and high rates of foster care, with a possible outcome of infanticide in extreme cases.[45] Thus the need for immediate and appropriate psychiatric care (e.g. admission to a Mother Baby Unit) in these rare cases is highlighted, increasing the possibility of positive outcomes for mother and baby.

According to various authors,[17,38] ongoing psychological reactions to the policies and practices of the past are evident and include:

- inconsolable grief and loss
- post-traumatic stress disorders
- low self-esteem
- powerlessness
- anger
- depression
- anxiety

- alienation from kinship ties
- personality and adjustment disorders
- poor parenting skills
- lack of cultural identity
- substance misuse
- violence
- guilt, self-harm and suicidal behaviours.

For a detailed discussion of the issues surrounding transgenerational trauma, see Chapter 17 (Atkinson and colleagues).

Health professionals might consider applying the Circle of Security model to understand what it is that an infant or young child requires a parent or carer to do to support the development of secure attachment while at the same time allowing strong child self-esteem and confidence to develop.[35]

Lee and colleagues (2010) used case studies to describe the development and evaluation of The Boomerangs Aboriginal Circle of Security Parenting Camp Program, an intervention based on an attachment framework using the Circle of Security and Marte Meo programs as a base and drawing on traditional Indigenous culture. Circle of Security is an early intervention group program based on attachment theory, which aims to improve parents' caregiving behaviours and prevent child mental health problems.[35]

Possible Infant/Child Outcomes

Perinatal depression, as well as other mental illnesses can adversely affect the mother's care giving capacity, creating the potential for impairment of sensitive or attuned mother-infant interactions. Potential negative impacts on the infant include:

- spontaneous preterm birth;[40]
- impaired mother–infant relationship;
- cognitive, emotional, behavioural and physical development;[41]
- crying and unsettledness;[42] and
- diarrhoeal illness.[43]

There is evidence that excessive maternal stress, anxiety and depression may result in increased infant irritability and poorer neurological scores at birth.[44] High maternal anxiety scores in the last trimester of pregnancy have also been shown to increase risk of hyperactivity in the child at four years of age.[45]

PERINATAL MENTAL HEALTH IN YOUNG MOTHERS

Understanding the adolescent stage of life provides an opportunity to appreciate the potential for extra pressures and challenges faced by a young mother, her infant, partner and family. The energy and interest in new experiences and learning that young people enjoy usually ensures positive interactions with infants. However, if a support system is not readily available, parental or child mental health and social and emotional wellbeing are a concern. For many young people, social opportunities for 'time out' or for 'time to be young' are scant, and there are added stressors imposed on a young family which may impact on perinatal mental health.

One program that is proving highly successful is the Balga Teen Parent Program which support young mothers to achieve their education and career goals. The program is run through the Teen Family Centre to help to minimise the barriers to education and training for young parents. Education is seen as a way for a family to enhance their future prospects by providing economic independence as well as improving psychosocial, health and life skills outcomes.[46]

A research project conducted by the Western Australian Perinatal Mental Health Unit in 2011[46] interviewed young women to find out how services are best adapted to meet the needs of young Aboriginal clients in particular. The project's baseline report provides examples of Aboriginal women's reflections about the challenges faced by young mothers when confronted with the realities of motherhood:

> *66 Young mums isolated socially, missing out. Difficult to get out—leads to depression. 99*

> *66 Young mums frightened to seek help, worried about welfare and kids being taken away. Stigma is a big problem. 99*

> *66 Mums don't know they're depressed, they just know they feel awful. 99*

> *66 Many girls don't recognise symptoms. 99*

> *66 We older women ask our daughters what's wrong but they are frightened to ask for help. They put on a brave front so we don't know they are in trouble. They are frightened and ashamed to go to a service. 99*

> *66 Practical support really needed… 99*

> *66 Families support mum, try to understand, but may not know anything about depression.[47(p18-22)] 99*

Multidisciplinary teams incorporating the knowledge and wisdom of Aboriginal Health Workers (AHWs) and Aboriginal Health Practitioners (AHPs) are essential in order to address the barriers to accessing services, and the 'shame' described and experienced by many young Aboriginal mothers when interacting with mainstream services.[23]

Barriers to service access by young Aboriginal women must be understood in order to determine through collaborative processes ways to overcome them. *beyondblue* notes that understanding and overcoming barriers is the key to increasing early intervention, in association with routine screening.[3]

RELEVANT PERINATAL DEPRESSION SCREENING OPTIONS

The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool to be used in conjunction with an individual's health history and self-report, and the health professional's observations and understanding of their client's family and community context. Currently, translation of the EPDS[48] into traditional Aboriginal languages or Aboriginal English is being explored in different Australian contexts. Different areas of Australia have begun to develop and evaluate adaptations to the EPDS for Aboriginal women. For example, an adapted EPDS trialled in Townsville and Mt Isa was found to be suitable for some women.[49] However, findings from the Victorian Antenatal Intervention Initiative indicate that Aboriginal women scored no differently on the language-specific EPDS than on the mainstream EPDS, or on the suicidal ideation question (Q10) in the population in their 2001–05 trial suggesting that[8] the EPDS is generally acceptable, provided adequate explanation is given. Using the EPDS with an AHW/AHP present would ensure better understanding by the women.

Yelland et al. (2009) caution that not all women (or men) will agree with the correlation of their EPDS score to their mental health status.[50] Over or underestimation may occur either because of the misinterpretation of the questions, or intentionally. As consent for screening is required, it is important that health professionals concerned about their client's SEWB explain the value of using the tool, at the same time informing the client of the right to decline administration of the formal EPDS. See Chapter 16 (Adams, Drew and Walker) for further information on screening for perinatal depression.

Culturally Appropriate Perinatal Assessment

Research and education programs based on culturally appropriate service provision, including training in the use of the EPDS in diverse contexts, is undertaken by the WA Perinatal Mental Health Unit, funded by the State Government. The National Perinatal Depression Initiative (NPDI) key activity in the last five years has been on workforce training and development, and has been federally funded. A number of e-learning packages have been developed by *beyondblue* and in South Australia. All states and territories have undertaken face-to-face training, inclusive of AHW/AHPs. It is expected that these initiatives will further assist in the assessment and management of perinatal mental health problems in Aboriginal populations and communities.

Aboriginal Community Controlled Health Services (ACCHSs) provide culturally specific mental health services, and are initiating local adaptations to existing screening tools and developing culturally appropriate programs to address the issues. The *Kimberley Mums Mood Scale* (KMMS) a version of the EPDS, is currently being validated across the Kimberley in WA. While routine use of the EPDS is incorporated in all Kimberley health care provider perinatal protocols, its use is fraught with difficulties and inconsistencies.

An assessment of perinatal mental health screening trends and management practices among Kimberley maternal and child health nurses and midwives in late 2009 found 100 per cent of respondents reported poor screening practices for perinatal depression among Aboriginal women (personal comm, Jayne Kotz, 28th January, 2012). All respondents recognised that the language in the EPDS was complex and confusing for many Aboriginal women. Responding to this concern, the Kimberley Aboriginal Health Planning Forum, Maternal and Perinatal Mental Health subcommittee, decided to develop a culturally relevant universal screening tool, as well as protocols and accessible management pathways. Subsequently, the development of a Kimberley version of the EPDS, the KMMS, was commenced, with a collaboration of perinatal health care providers across the Kimberley and more than 114 local Aboriginal women from various language groups. This tool uses Kimberley English, locally developed graphics and a visual Likert scale to screen for depression and anxiety, and is based on the original items developed in the EPDS. The validation process is anticipated to be completed by mid-2014.

CHILD ASSESSMENT

The physical, social and emotional wellbeing of children is fundamental to communities experiencing optimal health in the future. There are many factors that impact on the parent-child relationship and compromise a child's growth and development. These include the use of certain medications, or smoking and alcohol-use by women during pregnancy and while breastfeeding, in addition to high levels of stress and perinatal mental illness.[51]

Child and community health practitioners play an important role in the ongoing assessment of infant and child health wellbeing. The recommended child and family visiting schedules provide an opportunity for assessments and support in the first weeks and months after birth and allow for the prevention or early detection and management of problems.

Infant assessment involves:

- observation of the two-way interaction (parent-to-child, and child-to-parent) and regular assessment of the child's growth, development and behaviours.

- asking about feeding patterns, sleep and settling patterns, interaction and responsiveness, attainment of development milestones, and general health and wellbeing status. Negative responses to any assessment require review, and if concerns persist, referral to paediatric services.

IMPLICATIONS FOR PRACTITIONERS

Working in Partnerships

It is important that, where perinatal depression has been diagnosed, community and child health nurses are able to work in partnership with families, their child/ren and the community, Aboriginal Medical Services, psychiatrists, and remote area mental health nurses to provide optimal care. Working with AHW/AHPs and Aboriginal Mental Health Workers (AMHWs) ensures that cultural advice is available. As well as AHW/AHPs, many communities have Strong Women workers or Community Care Workers who provide valuable understandings of cultural and contextual features of cases, as well as language interpretation.

Home visiting programs are currently in place or being trialled in different communities across Australia, including the Australian Nurse-Family Partnership program with Indigenous Family Partnership Workers. The program is supported by the Australian Government Department of of Health and Ageing (now Department of Health) (DoHA). The Halls Creek Mothers Support Initiative is an example of an Aboriginal-led, home visiting program that focuses on culture and family to promote positive parenting and perinatal wellbeing.[52]

Schultz, Walker and colleagues (Chapter 13) discuss the role of interdisciplinary teams adopting a bio-psycho-social-cultural-spiritual approach in providing culturally responsive care to support client's mental health and SEWB. Community health, women's health services, and local community centres can also provide community-based programs for women and families which focus on strengthening SEWB and mental health. These programs can lead to greater understanding for the health professional of the social, cultural and historical factors and associated social determinants impacting on families, and promote cultural information exchange.

The '*Making Two Worlds Work Project*' developed by Mungabareena Aboriginal Corporation and Women's Health Victoria, is a partnership addressing all aspects of women's and children's health care. The program provides an example of ways of working in community using stories and art to demonstrate communities and services working together through symbolic interaction.

A National Plan to Enhance Perinatal Mental Health and Wellbeing

There are numerous reports about initiatives, strategies and programs related to perinatal mental health and maternal and child health in Aboriginal and Torres Strait Islander contexts, including:

- The *beyondblue National Postnatal Depression Program, Prevention and Early Intervention 2001–2005, final report*, June 2005 and the 2011 guidelines;

- *State Perinatal Mental Health Initiative Report 2003–2007*, State Perinatal Mental Health Reference Group and WA Perinatal Mental Health Unit, 2007;

- Western Australian Perinatal Mental Health Unit, Women and Newborn Health Service (2011). *Aboriginal perinatal mental health service expansion: Final evaluation*;

- *Two years into the 'Healthy Parents, Healthy Minds' Service in Carnarvon*. Western Australian Perinatal Mental Health Unit, Women and Newborn Health Service (2011); and

- *Lessons learnt about strengthening Indigenous families and communities: Stronger Families and Communities Strategy 2000–2004*, Occasional Paper No. 19, 2008.

Many issues raised in these reports highlight the importance of effective and collaborative communication about perinatal mental health care. It is evident that misinterpretation, misunderstanding and miscommunication when diagnosing, treating and giving care, results in negative experiences for women and requires solutions that respect cultural sensitivity, demonstrate cultural competence, and adopt culturally appropriate methods and language related to the perinatal stage of life.[53] See also Chapter 12 (Walker and colleagues) on cultural competence; Chapter 13 (Schultz, Walker and colleagues) on interdisciplinary care; Chapter 14 (Adams and colleagues) on assessment; and Chapter 15 (Dudgeon and colleagues) on communication issues.

The Need for Integrated Care and Early Intervention

The need for integrated care and early intervention for mothers and infants in the perinatal period has been recognised and now includes screening and assessment to identify women currently experiencing, or at increased risk of, distress, depression or related functional impairment.[3,54] Also, the awareness of potential difficulties for fathers is now recognised, with screening for postnatal depression in men becoming more frequent.[27]

The *beyondblue* Clinical Practice Guidelines identify the importance of follow-up through:

> *a pathway or 'map' by which the woman and her family can access the most appropriate care and support during the perinatal period. The pathway to care will depend on the severity of the woman's risk or symptoms, together with her preferences and social context.*[4(pvi)]

Referral

Referral to a doctor is required if there is concern about mental health status in the perinatal period, if there is an EPDS score greater than 12, or a positive response to question 10 of the EPDS (which pertains to self-harm).

It is important that health professionals have an interdisciplinary perspective and where appropriate are proactive in referring a woman and her family on to the relevant health practitioners for assessment, monitoring, counselling, treatment such as medication, and hospital admission.

Medication

Decisions about the use of antidepressants or other psychiatric medications in the perinatal period, especially if the woman is breastfeeding, require particular consideration by medical practitioners, with review and ongoing attention by qualified health personnel.

Suitable medications and safety considerations, particularly during the perinatal period, is a continually evolving field of research with new information constantly emerging.

However, following appropriate referral and assessment, including consideration of potential side effects to the mother and her infant, any one of a number of medications may be decided upon after consultation with the patient, and her family as appropriate.

Appropriate Resources

The *beyondblue National Postnatal Depression Research Program 2001–2005* was conducted Australia-wide (with the exception of the Northern Territory), providing information and resources about postnatal depression to health professionals as well as the wider community during that time.

Policy Initiatives

Several Australian Government initiatives for the implementation of a perinatal depression plan took place from 2008–09. The goal is to have:

- routine screening for depression during pregnancy and at two months following the birth;

- support and care for women determined to be at risk of, or experiencing, depression; and,

- training for health professionals in perinatal mental health screening and assessment.[49]

In February 2011, the Chief Executive Officer of the National Health and Medical Research Council (NHMRC) approved the comprehensive *beyondblue Clinical Practice guidelines for depression and related disorders—anxiety, bipolar disorder and puerperal psychosis—in the perinatal period* for a period of 5 years (to early 2016).[4] *beyondblue* produced the clinical guidelines as part of the NPDI requirements.

Research Directions

An urgent need for further research into the assessment and experiences associated with the perinatal mental health of Aboriginal and Torres Strait Islander women has been identified. Several authors claim that researchers have failed to consider the impact that SEWB has on health behaviours and pregnancy outcomes in Aboriginal women, and impacts on infants/children.

Research to evaluate the impact of the planned expenditure of $85 million is underway to identify outcomes and benefits transpiring; and whether there is translation into a reduction in the number of women affected by perinatal depression and anxiety.

The three year policy evaluation study (by UNSW, UWA, Deakin and *beyondblue*) is being funded by NMHRC and *beyondblue* and will conclude in March 2015. It will provide an indication of the utilisation and cost and whether there is translation into a reduction in the number of women affected by perinatal depression and anxiety.

CONCLUSION

This chapter has emphasised the promotion of perinatal maternal, paternal and infant mental health and wellbeing through prevention and management strategies and initiatives that are holistic in nature and encompass the special worldview of Aboriginal and Torres Strait Islander peoples. It has argued that, where there is a need for medical management of perinatal mental illness (through appropriate screening and assessment), collaboration with Aboriginal Maternal Health Workers and AMHWs who are recognised as experts in community-relevant knowledge, will allow the healing journey for the person affected to be greatly assisted.

At present there is still little known about the incidence and experience of perinatal mental illness in Aboriginal and Torres Strait Islander women and men. Nevertheless, the empirical evidence that is available has been presented, together with the valuable knowledge garnered from experienced AHW/AHPs in metropolitan, rural and remote settings, which support generalised psychosocial and wellbeing assessment and management strategies in the Aboriginal and Torres Strait Islander context. There is an urgent need for a culturally oriented and contextually sensitive yet comprehensive service model that includes high skill levels in prevention, recognition and management of perinatal mental health issues, collaborative practice, and the ability to be locally responsive to community needs in order to strengthen perinatal mental health and SEWB.

All practitioners working in the area of perinatal mental health have a key role to play in promoting maternal, paternal and infant SEWB, and in detecting and managing the risk factors that may impact negatively on a child's wellbeing throughout the perinatal period and in the long term.

Following an induced labour and birth for maternal elevated blood pressure at 37 weeks gestation, Zadalia (aged 19) and her baby, Jonoky, are discharged from the regional hospital two weeks after the birth and arrive back in their community after eight hours of road travel. Zadalia had difficulty sleeping in hospital, and cried often during that time. Breastfeeding was well established, and a normal postpartum recovery period occurred.

During the following weeks Zadalia's husband, Brettan, frequently takes Jonoky to the community health clinic for a 'check-up' as he believes there is 'something wrong' with him. At each visit, Jonoky is reported to be growing well with no obvious signs of a problem and Brettan is reassured by clinic staff.

At six weeks postpartum, Zadalia is breastfeeding Jonoky who is gaining weight and progressing, but who is noted to be restless, irritable, and difficult to settle. It is noted that Zadalia is talking to Jonoky a lot but not actively attempting to settle him.

Zadalia's mother had passed away the previous year, she has limited family supports, but strong peer group support. The community has strong connection to cultural ways. Brettan has limited family support also and has a previous history of self-harm.

The family has come to the community health clinic at your request for a review at six weeks according to the recommended schedule of postnatal follow-up care.

As part of routine health services, an EPDS was administered with Zadalia in conjunction with an informal yarn about her wellbeing. The tool was used informally, as you asked questions from the EPDS and, at the request of Zadalia, was recorded by you and scored after explanation. The score recorded is 10 in total with 4 points noted in total to questions 3, 4, and 5, and 0 score on question 10.

Questions for Reflection

- Review the steps in the psychosocial assessment and the use of the EPDS for the mother and the father to determine findings related to this family's mental health and wellbeing status.

- What extra information do you require to best assess and support the family?

- What actions will you take following this assessment?

Make a list of possible actions you could take with the family to inform and support them at this time.

Wise Places

These are the places you might go in your head and in your heart for practice wisdom. What are your instincts telling you about the wellbeing of this family? Where might you go for further guidance and assistance in taking the most appropriate action for the mental health and wellbeing of this family?

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20

Addressing Fetal Alcohol Spectrum Disorder in Aboriginal Communities

Lorian Hayes, Heather D'Antoine and Maureen Carter

OVERVIEW

This chapter begins with a description of Fetal Alcohol Spectrum Disorder (FASD) and examples of reported prevalence of FASD in the international context. It then draws on international and Australian studies to describe the burden of FASD, including studies relevant to the Aboriginal population. The section on the Australian context provides a description of some of the action that has been taken in Australia to address FASD. The section on the Life Cycle model includes stories of Aboriginal people, from a major city and rural and remote communities in northern and southeast Queensland, on their experiences and perceptions of alcohol. These stories, collected by Hayes in 1997 and 1998, led to the development of the Life Cycle model. This model can be adopted to address the complexities of FASD in the Aboriginal population. The final section describes initiatives driven by local Aboriginal communities, and accepted as best practice, for addressing FASD in their communities. The chapter concludes with questions for reflective practice and FASD.

INTRODUCTION

Concern about the use of alcohol in pregnancy dates back to biblical times,[1] but it was in 1968 that Paul LeMoine, a French paediatrician, provided the first description of dysmorphic facial features and growth delays that were similar in infants born to mothers who drank alcohol during their pregnancies.[2] Five years later, the term Fetal Alcohol Syndrome (FAS) first appeared in two papers by a team of clinicians from Seattle at the University of Washington.[3, 4] This team described characteristics in eight unrelated infants from three different ethnic backgrounds born to mothers who were chronic alcoholics. These children showed a similar pattern of craniofacial, limb, and cardiovascular defects associated with prenatal-onset growth deficiency and developmental delay.[4]

Research conducted on the effects of prenatal alcohol exposure has shown that FAS is part of a spectrum of disorders. FASD was adopted as an umbrella term to cover the range of outcomes associated with all levels of prenatal alcohol exposure.[5] There are a number of guidelines used to diagnose FASD internationally[6-8] and Australian guidelines are currently being developed.[9] According to the Canadian Guidelines, conditions under the umbrella include:

- FAS – includes central nervous system abnormality or dysfunction, three characteristic facial features, growth restriction and confirmed (or unconfirmed) alcohol exposure;

- Partial FAS (PFAS) – includes changes to the brain, proven prenatal alcohol exposure and two out of three facial changes;

- Alcohol related neurodevelopmental disorders (ARND) – includes changes to the brain and confirmed prenatal alcohol exposure; and

- Alcohol related birth defects (ARBD) – describes body changes due to prenatal alcohol exposure, often including kidney problems, or heart septum problems.[7] These guidelines recommend that the diagnosis of ARBD should be used with caution.[7]

Prevalence of FASD in International Contexts

Establishing population-based prevalence of FAS and FASD is challenging as the studies are small in number and vary in methodology, therefore limiting the generalisability of the study population to the general population.[10] Higher rates of FAS are reported in studies using active case ascertainment methodology when compared to clinic-based studies or studies using a passive surveillance system.[11]

Despite this, there have been efforts to estimate population prevalence of FAS and FASD. In the United States, it is estimated that the prevalence of FAS in a 'typical' population is 2 to 7 per 1,000 births[10] while other studies using active case ascertainment have reported rates ranging from 1.8 to 9.8 per 1,000 births.[11]

In-school studies, which have been rare until recently, are more likely to be representative of the local population.[10] A study of first grade children in schools near Rome, using active case ascertainment, estimated the rate of FAS to be between 4 and 12 per 1,000 children and the rate of FASD to be between 23.1 and 62.6 per 1,000 children.[12] Recently, a high rate of FASD has been reported in a South African population— from 135 to 207 per 1,000 children enrolled in first-grade.[13]

BURDEN OF FETAL ALCOHOL SPECTRUM DISORDERS

The most profound effect of prenatal alcohol exposure is on brain development which results in cognitive and behavioural difficulties.[14] O'Malley provides a description of how this affects the individual; '…the developmental disability of FASD is a complex learning disorder affecting multiple domains of functioning including working memory, attention, impulsivity, learning, interpersonal relatedness, social skills and language development'.[15(p5)] Comorbidity is the rule rather than the exception in people with FASD, beginning with infancy and continuing throughout the lifespan.[15]

The cost of FASD is significant. The estimated lifetime costs for a person with FAS may reach $US2 million.[16] The adjusted annual average cost per child with FAS and Fetal Alcohol Effects (FAE) aged one to 21 years in Canada was $14,342 and the cost of FASD annually to Canada for that age group was $344 million.[17] The estimated costs are based on a prevalence rate of FAS/FAE of approximately 3 in 1,000 people.[17] No cost of illness studies on FASD have been conducted in Australia.

Lifelong Consequence of Prenatal Exposure and Mental Health Problems

A long term follow-up of a cohort of people with FAS and FAE reported a number of adverse outcomes. Inappropriate sexual behaviour, including inappropriate sexual advances, promiscuity, exposing behaviour and voyeuristic behaviour was the most frequent adverse outcome across the lifespan, increasing slightly with each age category—from 39 per cent in children to 48 per cent in adolescents and 52 per cent in adults.[18] Among adolescents and adults, 35 per cent were incarcerated for a crime, 23 per cent hospitalised for a psychiatric problem and 15 per cent had been hospitalised for alcohol and drug treatment. This study reported that one of the strongest correlations of adverse outcomes was the lack of early diagnosis (before 12 years of age). The authors acknowledged that these findings were from a clinical sample, therefore limiting their generalisability.[18]

A prospective Australian study reported that children with FAS are likely to be born preterm (35 per cent), be of low birth weight (65 per cent), have growth deficiency (56 per cent), have microcephaly (53 per cent), have additional birth defects (24 per cent), have speech/language disorder (60 per cent), have sensorineural hearing loss (5 per cent), and have visual impairment (4.3 per cent).[19] A separate study reported that one-third of children diagnosed with FAS had intellectual disability.[20]

Rates of intellectual disability and mental illness, often in the context of comorbid misuse of substances such as alcohol and cannabis, have been found to be significant in certain groups of Aboriginal people. Hunter reported that approximately 40 per cent of Aboriginal people in Cape York who suffered from a psychotic disorder were also affected by intellectual disability.[21] A study in WA reported that maternal alcohol-related diagnosis was the leading known cause of intellectual disability, with no identified genetic origin, and accounted for 3.8 per cent of all intellectual disability in WA.[22] Potentially, 1.3 per cent of intellectual disability in non-Aboriginal children and 15.6 per cent of intellectual disability in Aboriginal children of mothers with an alcohol-related diagnosis could be prevented by eliminating heavy alcohol use by these mothers during pregnancy.[22]

Impact of FASD on Families and Individuals

Despite the documented importance of the quality and stability of the home environment,[18] little is known about families with FASD.[23] Testimonies from birth parents in the United States reported feelings of loss, guilt, shame and blame.[24] A review of a limited body of systematic research findings in this area found that having a child/ren with FASD was associated with financial strain, frustration with the lack of knowledgeable professionals, stress related to the judicial system, and multiple time demands.[23]

A qualitative study of children living with FASD described how they understood the nature of the disability and how it affected their day-to-day life:[25]

> *Sometimes I have trouble concentrating. I am concentrating on one (activity), then I get distracted.*

> *Learning is hard. The teachers don't explain things (in a manner that allows her to understand).*

Many expressed difficulty in making and keeping friends:

> *No one likes me. No one plays with me at recess.*

The children described feeling supported by their parents:

> *My mum plays with me and my dad takes me fishing.*

All children talked about how they tried to participate in life despite their disability, but feeling different emerged as an overarching construct.[25]

AUSTRALIAN CONTEXT OF FASD

This section provides a description of some of the action that has been taken to address FASD in Australia. It begins with a description on alcohol and pregnancy; studies reporting the prevalence of FAS; the challenges facing diagnosing FASD in Australia; and includes an example of action taken at a policy level.

Alcohol and Pregnancy

Understanding the pattern and context of alcohol consumption is crucial in preventing FASD. This essential information can be used to inform interventions to address alcohol and pregnancy. An Australian example is provided of how alcohol and pregnancy is being addressed.

Australian studies have reported rates of alcohol consumption in pregnancy ranging from 34 per cent[26] to 59 per cent.[27] A survey of non-Aboriginal women who had given birth between 1995 and 1997 found that 47 per cent had not planned their pregnancy[27] and a national survey of Australian women of child bearing age reported that 24 per cent of women indicated that they would continue to drink alcohol if they became pregnant.[26]

Drinking alcohol in the last pregnancy was a strong predictor of a woman's intention to drink alcohol if she were planning another pregnancy.[28] Women reported that they would be less likely to drink alcohol if their partner encouraged them to stop or cut back (38 per cent) or if their partner stopped drinking alcohol during the pregnancy (30 per cent). Women with high levels of education and women who had given birth previously were more likely to drink alcohol in pregnancy.[28]

In the Aboriginal population, 23 per cent of birth mothers of Aboriginal children reported drinking alcohol in pregnancy.[29] There are no published data on what proportion of Australian Aboriginal women plan their pregnancies, but a qualitative study conducted in a Native American population reported that Native American women were unlikely to plan a pregnancy.[30]

Whilst the rates of reported alcohol consumption in pregnancy are higher for non-Aboriginal women, Aboriginal women are more likely to consume alcohol at harmful levels. A Western Australian (WA) study of women who had given birth over a 10-year period, found that Aboriginal women were 10 times more likely to be diagnosed with an alcohol diagnosis when compared with non-Aboriginal women—23 per cent and 2.3 per cent respectively.[20] Hayes has done extensive qualitative work to describe the complexities around alcohol consumption in pregnancy in Aboriginal communities.[31] Examples of this are provided in the sections 'Adopting a Life Cycle Model' and 'Best Practice Examples of Aboriginal Responses to FASD' further on in this chapter.

Women expect health professionals to ask about, and advise them on, alcohol use during pregnancy[26] but a survey of health professionals reported that most health professionals did not routinely ask pregnant women about their alcohol use or provide them with information about the effects of alcohol on the unborn baby.[32] A qualitative study of health professionals revealed barriers in addressing alcohol use with pregnant women.[33] The authors provided strategies for overcoming the barriers. For example, a barrier included the perception that most women do not drink much alcohol during pregnancy, however Australian research has reported high rates of women drinking alcohol in pregnancy. Rather than assume that pregnant women are not consuming alcohol, a critical strategy in addressing this is to encourage all health professionals to routinely ask all women about their alcohol use.[33]

Resources for Health Professionals in Australia

Health professionals in WA requested resources to support them in addressing alcohol use during pregnancy.[32] Resources were developed in response to this request focusing on enhancing the knowledge, attitudes and practice of health professionals related to alcohol use and pregnancy.[34, 35]

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Resources available to Address Alcohol Use and Pregnancy [35]

1. A 38-page booklet containing information on the consequences of drinking alcohol before and during pregnancy, the clinical features of FASD, the role of the health professional, and contact numbers for referrals for women and children. The key message in this booklet is *No Alcohol in Pregnancy is the Safest Choice*;

2. A double-sided laminated fact sheet which summarises information from the booklet;

3. A wallet card for health professionals to give to women, which includes a list of statements to help women say no to alcohol during pregnancy; information about the possible effects of drinking alcohol in pregnancy; contact numbers of alcohol and drug information services; and the message *No Alcohol in Pregnancy is the Safest Choice;*

4. A desktop calendar with month view displaying the message *No Alcohol in Pregnancy is the Safest Choice.*

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Prevalence of FASD in Australia

Rates of FAS have been reported at 0.06, 0.18 and 0.68 per 1,000 live births in a national prospective study[19] from the WA birth defects registry[36] and a review of medical records for the Top End of the Northern Territory (NT)[37] respectively.

The above studies have shown that Aboriginal children with FAS are over-represented, with rates of 2.76 per 1,000 live births for Aboriginal children in WA—100 times higher than the reported rate of FAS in other Australian children;[36] 1.8 per 1,000 live births in the NT;[37] and 65 per cent (n = 92) of the children diagnosed with FAS in a national study were Aboriginal.[19] Up to 51 per cent of children with FAS may have a sibling with FAS[19] and some Aboriginal children with FAS may have two siblings with FAS.[37]

Diagnosing FASD

Early diagnosis and intervention may be beneficial to children with FASD.[18] However, the range of expression of dysfunction related to prenatal alcohol exposure makes the diagnoses of FASD, which relies entirely on a clinical assessment and history taking,[37] complex.[7] Guidelines have been developed to assist health professionals in the assessment and diagnosis of FAS[6] and FASD.[7] Some countries have established specialised diagnostic clinics, but these are concentrated in North America (29 of 34 clinics) with none in Australasia.[38] Nearly all of those clinics (97 per cent) had a multidisciplinary team and, for 94 per cent of the clinics, at least one member of the team had specialist training in the assessment of FASD.[38]

Whilst it is recognised that diagnosing FASD is complex, in Australia it is further complicated as health professionals have limited knowledge of the diagnostic criteria for FAS[32,39] when compared with health professionals in Canada.[40] In addition, 52 per cent of health professionals (general practitioners, Aboriginal health workers, allied health, community nurses and obstetricians)[32] and 70 per cent of paediatricians in Australia believed that making a diagnosis of FAS might stigmatise the child or family.[40]

In regards to diagnostic guidelines for Australia, a Delphi survey of health professionals found support for the diagnostic criteria for FAS.[9] Participants indicated a clear preference for the University of Washington criteria.[6] There was, however, no consensus for PFAS or ARND.[9] In addition, a model of care for FASD has been developed in WA.[41]

Policy Context in Australia

The National Indigenous Drug and Alcohol Committee (NIDAC) is the leading voice in Indigenous drug and alcohol policy advice. The action that NIDAC has taken on FASD provides an example of the policy context. NIDAC recognise that FASD is not well known or understood in Australia, with most research in this field undertaken overseas.[42] Their discussion paper provides 15 recommendations under the heading of social marketing, policy and practice guidelines, prevention and service provision, data (national surveys) and recognition of FASD as a disability.[42]

ADOPTING A LIFE CYCLE MODEL

It has been identified that very few studies had been conducted that increased practitioners understanding of the '…psychosocial and milieu into which children with FAS and FAE are born or how this might affect their lives at different stages of development'.[18(p229)] The case studies in Chapter 18 (Parker and colleagues) and Chapter 21 (Milroy) provide greater understanding of the realities experienced by some Aboriginal children.

The reasons why Aboriginal people consume alcohol at harmful levels are complex. Studies conducted by Hayes in both urban and rural Aboriginal communities in Queensland identified a number of issues that impacted on the everyday lives of children, young people and families.[31] Many of these issues were both greatly affected by, and contributed to, the drinking environment in Figure 20.1 (page 365) including:

- family break-down;
- disharmony across the community;
- family and community dysfunction;
- alcohol and drug consumption;
- teenage pregnancy;
- peer pressure;
- unemployment; and
- violence within the home and community.[44]

People described a life cycle in which both alcohol and pregnancy were a normal part of life.[43] Hayes argues that programs aimed at changing individual risky behaviour need to acknowledge the way in which the person is '…inextricably tied to the culture in which he or she exists'. Importantly, this involves considering the social, historical and political background and the cultural aspects of drinking in order to begin to introduce prevention and early intervention strategies to address alcohol use and pregnancy among women.[44]

Stories of Aboriginal Women

Some years ago, with input from Aboriginal community members, Hayes developed a framework which is consistent with Erikson's early life stages to assist in understanding the development of identity and the resulting changes of emotions and physical boundaries across the lifespan.[31] This model proposes an expanded view on the use of alcohol in Aboriginal communities and is informed by stories from Aboriginal people.[31] Some of these stories have been published.[44(p21)] The following story-lines, in addition to those already published, provide examples of interview respondents' views.

He got problems now

There was a lot of concern among respondents about women drinking and smoking marijuana while pregnant. Several young women explained:

> *That's another thing besides Fetal Alcohol Syndrome they are smoking marijuana too you know, right up until they have the baby.*

> *There are a lot of women here who use drugs when they are pregnant, I suppose alcohol and drugs can affect the breast milk too.*

> *They drink all through their pregnancy and use yandi (marijuana) too you know, they got no shame.*

Marjorie is a mother who drinks alcohol to try and heal the pain and suffering from domestic violence but recognizes the affect that prenatal exposure to alcohol is having on her children. She explained that her babies were getting smaller and smaller, she drank right up till they were born, spirits, then wine and beers, throughout her pregnancy:

> *My baby he got problems now cause of the grog.*

Story 2   **Growin 'emselves up**

An older woman spoke of the link between alcohol and the entire life cycle in this way:

> *These kids basically got to raise themselves, the grannies burn out. Some women just keep on having kids, some have seven kids and can't look after them, and they keep the money and dump the kids on other unruly family members. It's really sad, especially if the grannies don't care for them.*

> *Them mothers drink on the river bank, go to bingo, play cards and neglect the kids, the grandmothers have to look after them, the mothers are not being responsible and you end up with kids having kids.*

> *They (mothers) should be encouraged to get off the drugs and grog and be responsible for their kids and stop making excuses for them, these old girls are on their last legs.*

> *There is too much abuse here it's intergenerational, someone's got to do something.*

Story 3   **Testing the waters of independence – Fending for themselves**

Most respondents agreed that when a child is two to three years old, he or she should be allowed to fend for themselves and to be responsible for themselves. Women in the community said things like:

> *They have to do things for themselves*

> *You see them kids walking all over the community. They know how to cross the road and look after their little friends you know. They think they are all grown up.*

> *They look after their little brothers and sisters and their friends, sometimes they got nobody around to look after them, cause they are all drunk or yarndied up. They are responsible for their own feed, they know what they want, they [the young children] are not safe you know.*

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Alternatively, children themselves are taking on the responsibility of their parents at a very young age, helping out their own parents, and caring for siblings. One concerned participant stated that:

❝ *We see a lot of that, the parents, like they send the little toddlers down into the park here pushing their younger brothers and sisters around.* ❞

❝ *These kids are three and four year old, with younger babies in the strollers and we've had to help the kids push the prams back up so they can head home, while the mothers are sitting at home playing cards or whatever, doing their own thing. You know you'll see other kids who are in the park well they'll help look after them and each other too; they show responsibility for each other.* ❞

Story 4 ▶ **Mimicking adult behaviour – Craving for love and affection**

In a remote Aboriginal community in the study, when a young person reaches the youth stage (11–13 years of age), they are well accomplished at mimicking the behaviour of adults around them. The children in this age group are searching for affection which leads to risky sexual liaisons; however, sadly, their own identity has not yet developed.[42]

A number of concerned respondents believed that:

❝ *Young people are craving for love and affection, and if the girls say no to the male they get bashed anyway, and the man will go and find someone else and they will be left alone* [meaning they would not have a source of affection]. ❞

❝ *The girls don't care if they get bashed, it's like they need to be with someone only if it's for a short time.* ❞

One distressed informant stressed that:

❝ *There are children [ten and eleven years-old] placing themselves at risk and being sexually active.* ❞

Other respondents confirmed this:

❝ *Yes that's right like even younger than the ten year-olds you've got a lot of the eight and nine year-olds following the older siblings and they are getting into the same practice.* ❞

❝ *There are nine and ten year-olds around here, who drink and smoke yarndi some are sexually active, they walk around at night looking for man.* ❞

GETTING CAUGHT UP IN A LIFE CYCLE OF ALCOHOL AND PREGNANCY

People described a life cycle in which both alcohol and pregnancy were a normal part of life.[42] The relationship between alcohol and pregnancy went deeper and was more complex than the physical effects of either of these issues. People described a set of interconnecting factors that are depicted in the life cycle model which tracks the stages an individual goes through from birth to death, in a community where harmful levels of alcohol are used by some men, women and children. The model shown in Table 20.1 describes various stages across the life course through which an individual progresses.[43]

Table 20.1: Erikson's Psychosocial Stages Summary Chart

Stage	Basic Conflict	Important Events	Expected Outcomes	Aboriginal Child Experiences in a Drinking Environment
Infancy (birth to 18 months)	Trust vs. Mistrust	Feeding	Children develop a sense of trust when caregivers provide reliability, care, and affection. A lack of this will lead to mistrust.	If caregivers and parents are consistent in satisfying the child's needs, trust is developed. If the caregiver or parent is inconsistent in satisfying the child's needs, the child is likely to feel mistrust. Nurturing is carried out by the parents but, in addition, a pool of caregivers representing the extended family, including other children, provide nurturing.
Early Childhood (2 to 3 years)	Autonomy vs. Shame and Doubt	Toilet Training	Children need to develop a sense of personal control over physical skills and a sense of independence. Success leads to feelings of autonomy; failure results in feelings of shame and doubt.	The child becomes more responsible for self-learning and independence is evident. This absence of parental expectations eventually places the child in a position where they learn to be irresponsible in terms of their own wellbeing while, paradoxically, they develop caring responsibilities for other children.
Preschool (3 to 5 years)	Initiative vs. Guilt	Exploration	Children need to begin asserting control and power over the environment. Success in this stage leads to a sense of purpose. Children who try to exert too much power experience disapproval, resulting in a sense of guilt.	The need to become independent and to take care of oneself is a priority, as they have been emotionally abandoned by their carers. Beforehand, these children mimic adults unconsciously but at this stage they are quite aware of actively interacting in this role. At three and four years of age, children are expected to take on responsibility for themselves and for other children. This stage flows into the next stage.
School Age (6 to 11 years)	Industry vs. Inferiority	School	Children need to cope with new social and academic demands. Success leads to a sense of competence, while failure results in feelings of inferiority.	The children appear to have developed a sense of responsibility through the need to care for other siblings which, in turn, will become a catalyst for further pain. It becomes clear that the caring and nurturing process is a way of fulfilling their own needs, especially when they are craving for love and affection, which their own parents or caregivers fail to provide.
Adolescence (12 to 18 years)	Identity vs. Role Confusion	Social Relationships	Teens need to develop a sense of self and personal identity. Success leads to an ability to stay true to yourself, while failure leads to role confusion and a weak sense of self.	The model shows children who are continually exposed to examples of negative adult behaviour develop patterns of behaviour for their later life i.e. children learn to be irresponsible for their own actions as a result of witnessing negative adult behaviour. Paradoxically, children also develop early caring responsibilities for other children, which may eventually lead to damage of the family's abilities and strengths to guide sensible adult behaviours.

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Stage	Basic Conflict	Important Events	Expected Outcome	Aboriginal Child Experiences in a Drinking Environment
Young Adulthood (19 to 40 years)	Intimacy vs. Isolation	Relationships	Young adults need to form intimate, loving relationships with other people. Success leads to strong relationships, while failure results in loneliness and isolation.	Responsibility and maturity do not always carry the same expectations for children forced into responsibility at a very early age as it would be the broader population.
Middle Adulthood (40 to 65 years)	Generativity vs. Stagnation	Work and Parenthood	Adults need to create or nurture things that will outlast them, often by having children or creating a positive change that benefits other people. Success leads to feelings of usefulness and accomplishment, while failure results in shallow involvement in the world.	People enter a new stage in their life cycle as they get older. They begin to think more clearly and to recognise their own physical and emotional health needs, guided by the realisation that life experiences have taught them their kind of lifestyle is not sustainable. Flows onto the next stage.
Maturity (65 to death)	Ego Integrity vs. Despair	Reflection on Life	Older adults need to look back on life and feel a sense of fulfillment. Success at this stage leads to feelings of wisdom, while failure results in regret, bitterness, and despair.	They become tired and cannot carry the burden of violence and abuse which they have endured for so long throughout their lives.

Table 20.1 lists each of the development stages identified in Erikson's life cycle model. These stages of the life cycle outlined by Erikson convey typical points of conflict that individuals experience as they grow up. The stages are juxtaposed with the experiences of children and young people described by Hayes in her research with the Aboriginal communities.

Hayes attempts to depict how the cultural world or environment one grows up in 'shapes' the specific manner in which one expresses his or her feelings. The experiences help to illustrate how early social contact by young children with adults serves to teach them the cultural, gender-related and personal rules involved in managing their emotional reactions. This position integrates the roles of nature and culture in individual development. In a strong and functioning family environment these elements are protective. However, when a child is raised in an environment surrounded by dysfunction associated with drinking, these developmental phases are very different. These patterns are reflected in the stories included from Hayes' study.

The case studies and research by Hayes highlights that these areas of 'basic conflict' outlined in Erikson's model are, for Aboriginal children (sometimes with FASD), often far more complex (and potentially negative due to intense exposure to risk factors over protective factors). Further, the stories show that when a child's development is overlayed by the experiences that occur in an environment where drinking occurs at unsafe levels, as part of the child's everyday life throughout their early development—it can often lead inevitably onwards, to a life cycle of addiction and regret (see for example Figure 20.1), as well as continuing that cycle by drinking throughout pregnancy—leading to FASD children.

There are a number of Aboriginal initiatives described in this chapter (page 366) highlighting how Aboriginal communities are working to break this cycle.

According to Erickson (1998), when an individual is placed in a position where they may begin to reflect back on their lives and are possibly facing the prospects of death, they then come to terms with the meaningfulness of life through overcoming their potential despair.

The older person begins to think clearer and begins to recognise their own physical and emotional health needs, as they realise that life experiences have taught them that their kind of lifestyle is not sustainable. Hence, they become tired and cannot carry the burden of violence, and abuse, which they have endured for so long throughout their lives. Grandmothers don't involve themselves in a materialistic world—they measure their success and strength by being connected to the spiritual world, returning back to culture. Through this process they see the importance of grandchildren, who in turn trigger an awareness of responsibility and nurturing. They realise the children are the lens to the future.

Factors Influencing Community Drinking

Hayes has used this model to identify people that were describing a set of interconnecting factors that are described back to the life cycle model. A whole range of factors feed into the life cycle described previously creating a drinking cycle that leads to alcohol being an accepted way of life and death.[31]

Figure 20.1: Drinking Influences
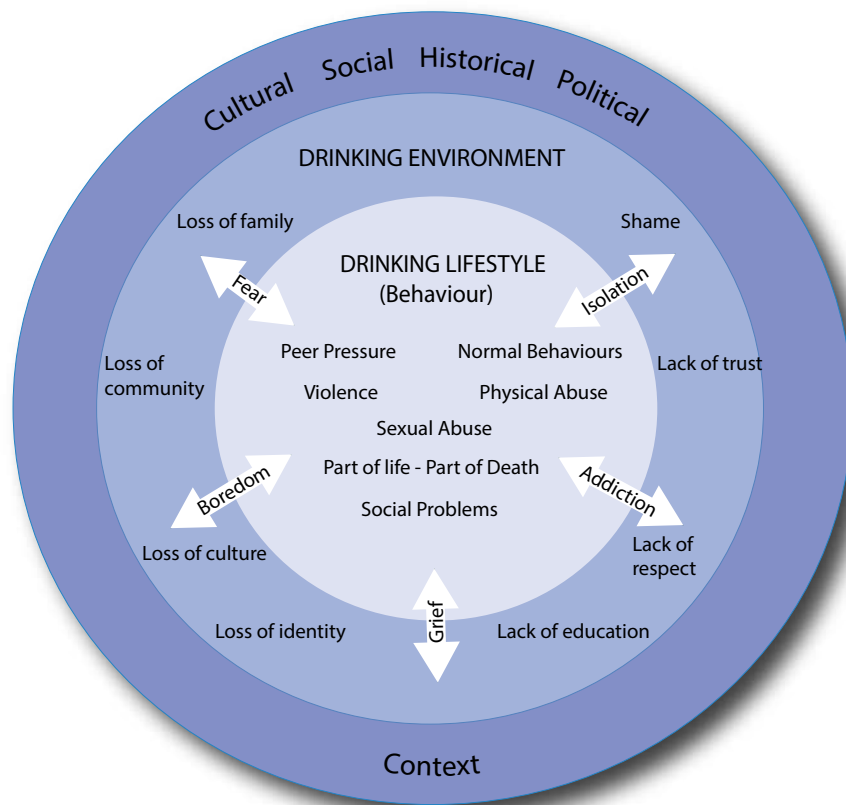
© Roz Walker
Design: Chrissie Easton

Hayes found in her discussions with community people that it was not possible to isolate a set of clinical disorders, such as FAS, from the impact of drinking generally. Nor was it possible to discuss the physical impact of drinking, without giving study participants an opportunity to contextualise drinking within the stories about their whole-of-life experiences. The model highlighted in Figure 20.1 encompasses an approach to drinking that is interactive, holistic and grounded in people's historical, cultural and economic circumstances.

PART 5

BEST PRACTICE EXAMPLES OF ABORIGINAL RESPONSES TO FASD

Aboriginal people are concerned about the effects of prenatal alcohol exposure in their communities and, in some areas, they have taken measures to address this. The best practice examples below attempt to address many of the complexities described by Hayes that need to be considered in addressing FASD in the Aboriginal population. They include four examples of Aboriginal responses to FASD. The first describes the action taken by the Drug and Alcohol Office (DAO) in WA to develop strategies and resources for women in pregnancy.

Strong Spirit Strong Future

The DAO has developed resources in consultation with Aboriginal people from across WA called *Strong Spirit Strong Future*.[45] These resources use Aboriginal ways to reduce harm from alcohol and other drugs. These resources are only available through participation in a training workshop. The resources include:

1. A booklet 'Promoting Healthy Women and Pregnancies' with information for health professionals and the role of the mother;

2. A double-sided laminated sheet with information on AUDIT–C for healthy women; and

3. Story Telling Cards promoting healthy women and pregnancies.

Also see Chapter 26 (Casey) for further discussion of the concepts and resources underpinning the *Strong Spirit Strong Mind* model and the understanding of working with Aboriginal women in pregnancy from an Aboriginal perspective.

Ord Valley Aboriginal Health Service: 5-Point Plan

The Ord Valley Aboriginal Health Service (OVAHS), an Aboriginal community-controlled health organisation in the East Kimberley, is an example of a primary health care service that is actively addressing alcohol consumption in pregnancy. OVAHS has endeavoured to gain an understanding of the local drinking patterns and the perceived needs of the women and their families. They have implemented a 5-Point Plan which targets five groups to prevent prenatal alcohol exposure.[46] One of the target groups includes all antenatal clients attending OVAHS. Pregnant women are provided with education on FASD, alcohol and other drug assessment and, if needed, one-to-one counselling.[46] These interventions are also provided to the partner, other family members and the community.

A challenge for delivering the program has been the social acceptance of heavy alcohol use in both the Aboriginal and non-Aboriginal population. Evaluation of FASD education reported that over 95 per cent of women indicated that information provided to them and their families was very useful.[46]

Apunipima Cape York Health Council (ACYHC)

In 2002, due to successful community engagement and consultations with two Cape York communities, Kowanyama and Wujal Wujal, a pilot FASD program was delivered using a health literacy approach to provide education and raise the awareness of FASD in Cape York communities.

The aim of the project was to increase preventative health care measures related to excessive alcohol consumption; coordinate preventative health care development in line with Queensland Health's Chronic Disease Strategy; increase awareness of the adverse effects of alcohol misuse during pregnancy and postnatal care; identify barriers and investigate solutions; investigate means of providing 'safety' for those at risk; and complement mother and child care services.[47]

A health literacy model developed by Hayes sought to engage community groups in the development of health promotion materials—while at the same time increasing their literacy levels, problem solving and critical thinking skills—to facilitate and develop a sustainable health education ethic within the community.[47]

The transferring of knowledge and information about the dangers of drinking during pregnancy and the outcome of FASD provided the women, who participated in the groups, with improved literacy skills and raised their level of confidence to educate others in their community about the damage done to the unborn child.[47]

Fitzroy Valley Program – Marulu Strategy

The Fitzroy Valley is a remote area located in the Kimberley region of WA. The Marulu Strategy is an example of a community-driven initiative to address excessive alcohol consumption in their region. In 2007, members of the Aboriginal community were concerned about widespread alcohol use and the relationship to alcohol-related deaths, suicides and violence and crime.[48] They lobbied for alcohol restrictions and, in September 2007, the Director of Liquor Licensing released his decision on restricting the sales of packaged liquor in Fitzroy Crossing.[49] An evaluation of the restrictions demonstrated a reduction of sales of takeaway alcohol from September 2007 to September 2009—8,541 litres to 458 litres respectively at the Crossing Inn.[49] The social benefits that resulted from these restrictions included a reduction in the severity of domestic violence, reduced street drinking and families purchasing more food and clothing.[49]

In 2008, a Women's Bush Meeting identified the need to address FASD. As an outcome of this meeting, Marulu was developed as a strategy that includes diagnosis and prevention of FASD, community education and support for parents and carers of affected children. Marulu is a Bunuba word meaning 'precious, worth nurturing'.[48] Bunuba is one of the five language groups in the Fitzroy Valley. To progress Marulu, two key agencies in Fitzroy Crossing, Nindlingarri Cultural Health Services and Marninwarnitkura Women's Resource Centre, entered a partnership with the University of Sydney Medical School and The George Institute for Global Health.[48] As a result of the partnership, a population-based, active case ascertainment study of the prevalence of FASD is being implemented in the Fitzroy Valley.[50] This study is being conducted in response to the local community initiative and from extensive community consultation. This will be the first study to ascertain FASD prevalence in Australia using a rigorous research design.[50]

CONCLUSION

The prevention of FASD would make an important contribution to improvements in the mental health of children that includes: intellectual disability, cognitive impairment, learning difficulties, speech and language delay, behavioural and emotional problems. This requires supporting women to not consume alcohol during pregnancy. It also requires early detection of FASD to prevent secondary disabilities such as mental health problems and chronic diseases. Steps have been taken in Australia to prevent and address FASD. These are challenging issues that several countries, including Australia, are addressing.

However, understanding issues such as FASD in Aboriginal communities can only result from listening to the Aboriginal perception of health and illness and begin from the beginning as identified by Aboriginal people themselves. Aboriginal people insist that the problem of alcohol in the communities must be viewed from the perspective of a range of social, cultural and historical factors that bridge generations and shape whole lives. Hayes has developed a life cycle model to understand the complexities of alcohol consumption during pregnancy in Aboriginal communities to inform and underpin interventions.

REFLECTIVE EXERCISES

1. Refer back to Story 1 and consider the various factors that may contribute to the developing fetus if a woman drinks alcohol during pregnancy. How does alcohol consumption during pregnancy contribute to small head circumference? What resources could you use as a health practitioner to help you provide a brief intervention? What else could you do?

2. Refer back to Story 4 and consider, as part of a team, what prevention programs you would put into action to prevent risky behaviours in children and youth.

3. What is Fetal Alcohol Spectrum Disorder? Is there a difference between Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorder?

4. Consider the ways that your role as a member of an interdisciplinary/multidisciplinary team may contribute to the assessment and management of an Aboriginal child diagnosed with Fetal Alcohol Syndrome.

5. Describe from a perspective of your role, what you would do to ensure that you listen to, and respond to, Aboriginal perceptions of health and social and emotional wellbeing.

    *   what do you see as barriers for your role?

    *   what do you see as the strengths you could offer in your role?

    *   what steps would you implement with the women in the community in your role?

RESOURCES

No Alcohol in Pregnancy is the Safest Choice

For people residing in WA, orders for these resources can be placed through the online order system and they will be supplied at no cost. These resources can be viewed on: http://alcoholpregnancy.childhealthresearch.org.au/alcohol-and-pregnancy-resources.aspx

Strong Spirit Strong Future

The Drug and Alcohol Office (DAO) have developed resources in consultation with Aboriginal people from across WA, called *Strong Spirit Strong Future*.[46] Information on these resources can be found on the Drug and Alcohol Office web site: www.dao.health.wa.gov.au

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21

Understanding the Lives of Aboriginal Children and Families

Helen Milroy

OVERVIEW

Two case studies representing the lives of young people in an urban and rural context, respectively, are presented in this chapter with the intention of engaging the reader in the life course of young people in Aboriginal families affected by loss, grief and other traumatic life episodes. The resilience of these young people is highlighted, along with cultural and familial trajectories as a guide to consider the most appropriate pathways for action. This chapter aims to provide mental health practitioners, teachers, social workers and other community service providers with a deeper understanding of the clinical and cultural complexities that need to be taken into account when working with children and young people. These case studies also highlight the need for practitioners and policy-makers to address the many social determinants that influence Aboriginal children and young people's health, education and social and emotional wellbeing outcomes. The case studies resonate with many of the chapters in the book, which often describe in statistical and theoretical terms the key issues impacting on young people's lives.

INTRODUCTION

Understanding child and youth mental health can be challenging especially when considering the cultural context, historical legacy, and social determinants as they apply to child development. As with the adult population, there is ongoing concern regarding appropriate assessment and diagnosis as well as effective interventions for children in regard to mental health concerns.

The general approach to understanding child mental health problems comes from both developmental and child psychiatry perspectives. To work effectively with children, it is important to understand developmental milestones and how development impacts on language and cognition, behaviour, emotional regulation and relationships. In addition, it is important to understand how the child develops their sense of self and identity, how they see the world and develop coping strategies and life skills, and how they are able to adapt across the life span.

All of these issues can be affected by a number of risk and protective factors that are well known and include genetic predisposition, family history, life stress events and experiences, as well as personal attributes such as gender, perceived intelligence, appearance and temperament. Many of these life stressors are discussed in Chapter 6 (Zubrick and colleagues) and Chapter 17 (Atkinson and colleagues). A report produced by the previous Department of Health and Ageing (DoHA) on '*promotion, prevention and early intervention for mental health: a monograph*' provides an important and comprehensive overview for understanding the various individual, family, community and cultural factors relevant to mental health, with an emphasis

on successful negotiation of developmental transition points across the lifespan.[1] Hence, the understanding of child and youth mental health is vital to understanding mental health and illness in general, as many adult chronic health problems and mental health disorders have their antecedents in childhood.

ADOPTING A PUBLIC HEALTH APPROACH

The DoHA report outlines the importance of adopting a public health approach to 'protect, support and sustain the emotional and social wellbeing of the population by promoting the factors that enhance mental health.'[1(p30)] Ideally this approach is implemented across the whole spectrum of health, starting when people are well, and aims to optimise mental health and wellbeing in individuals, families and communities. The concept of the 'promotion of emotional and social wellbeing' is generally preferred by Aboriginal people as it is compatible with holistic concepts of mental health held by Aboriginal peoples. The report emphasises the importance of improving the social, physical and economic environments that affect mental health and wellbeing and strengthening the capacity of communities as well as individuals.

When applying these principles of promotion and early intervention across diverse cultural groups, there are additional complexities to consider. The report acknowledges the significant level of risk operating in many Aboriginal and Torres Strait Islander communities and the difficulties for programs to be effective when faced with social disadvantage, racism and discrimination and a lack of basic health and mental health service.[1] Hence, when considering the issues relevant for Aboriginal and Torres Strait Islander children, the additional and often unrelenting burden of loss and grief as well as trauma complicate how mental health problems are perceived, assessed and managed.

In addition, how a child responds to adversity will be affected by their cultural beliefs, family system and community capacity, all of which can be under considerable stress. These adversities can be counterbalanced through resilience and strengths of both the individual and communities. Teasing out and identifying the differences between a mental health disorder and the overwhelming nature of disadvantage and transgenerational trauma and loss can be difficult, especially in children. However, as Hunter observes, it is:

> disarmingly easy and dangerous to minimise or deny mental health disorders within the cross-cultural context, and clinicians need to retain their clinical vigilance whilst not pathologising culture in order to provide effective interventions for mental health problems.[2(p8)]

One of the common problems encountered in child mental health services is developing an understanding of what drives behaviour and how behaviour is labelled. This is particularly important in younger children where language may be limited. Malchiodi (2008) notes that 'children relive their traumas not only in their minds but also through their actions.'[3(p16)] In order to work effectively with Aboriginal and Torres Strait Islander children, understanding cultural behaviours and child rearing practices as well as individual responses to trauma is vital to avoid misdiagnosing and mislabelling, and to developing effective interventions.

FACTORS INFLUENCING MENTAL HEALTH

Although there is a paucity of data on specific child mental health conditions for Aboriginal and Torres Strait Islander children and youth, there is evidence of:

- greater risk for emotional and behavioural difficulties;
- greater exposure to risk factors and stressful life events;
- higher rates of suicide;

- higher rates of hospital admissions for mental health problems;

- higher rates of incarceration; and

- higher numbers of removal of children under child protection compared with the general population.[4, 5]

Added to this is the increased risk for:

- developmental disability;

- low birth weight;

- physical health problems; and

- poorer educational outcomes,

suggesting the need to consider a comprehensive approach when considering mental health disorders in Aboriginal and Torres Strait Islander children and young people.[6-8]

ILLUSTRATING THE COMPLEXITIES AND ISSUES

The following constructed case studies illustrate some of the complexities and issues as well as the potential interventions to consider when working with Aboriginal and Torres Strait Islander children and youth.

Case Study   Marla

Marla is a ten year-old Aboriginal girl living with her family in a three bedroom state housing town-house in a large city. She has two brothers aged six years and six months respectively. In the last 12 months, she has suffered the loss of her maternal grandmother aged 54 years through chronic illness, her father aged 30 years from an acute myocardial infarction and a male cousin aged 16 years from suicide. Three years ago, her sister died from sudden infant death syndrome aged 13 months.

Marla has lost all interest in attending school and has been spending most of her time at home helping her mother with the baby. Previously, she had been described as a pleasant student and achieved average grades, with good physical health and normal developmental milestones.

Marla's mother is concerned about her school refusal, and admits her school attendance has also been patchy over recent years. She is concerned about the school reporting the family to child welfare services and reluctantly accepted the referral to child and adolescent mental health services for assessment.

Marla's family is supported by an extensive family kinship system with several aunties and paternal grandparents and there are often additional relatives staying in the home.

Marla presents as shy and stays close to her mother often fussing over the baby. She says very little in the interview but admits she enjoys staying home to look after her brother. She denies most symptoms presented to her but has trouble sleeping and usually ends up in her mother's bed at night. She displays little emotion but brightens up when interacting with her baby brother. She appears disinterested in the toys in the room, makes very little eye contact and refuses to stay without her mother present in the room.

Diagnosis, Management and Prognosis for Marla

There are a number of contributing factors to consider in this story prior to understanding Marla. The magnitude of grief and loss for this family is enormous and when the full history unfolds, there is an even greater level of complexity. Marla's maternal grandmother was part of the Stolen Generations and had subsequently suffered the loss of her own children at times under child protection, including Marla's mother.

This generational impact was a common outcome reported in the *National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, as a consequence of removal as children.[9] The grandmother had significant mental and physical health problems throughout her life and Marla's mother had provided most of her care until her death. Over generations, the family had experienced many good events but also many bad experiences with health and mental health services, child and family welfare and education systems and were wary of services in general.

Marla is a remarkably resilient child and a very capable carer for the family. At the age of ten, she has experienced far too much for her young years and is hardened to the realities of life. The fear of losing more family members through death or removal is very real and makes school attendance seem insignificant. The cultural obligation to care for family was taught from a young age and this is clearly one of Marla's strengths, even if this obligation is at the expense of her own childhood and impacts on her school attendance.

As the extended family are all suffering from the same levels of grief and trauma, there is likely to be significant health and mental health issues, and the eldest children may carry the burden of care for sick and suffering adults. Due to the shortened life expectancy, high burden of disease and the altered population age structure, there are fewer Elders in the community to buffer families and support children, and fewer adults healthy enough to provide care for sick relatives or earn sufficient income for families contributing to overcrowding and social disadvantage.[6] The stark realities of this diminished capacity for Aboriginal families and communities is outlined in Chapter 7 (Parker and Milroy) and Chapter 18 (Parker and colleagues).

Addressing Trauma and Loss

To really understand Marla, there must be an understanding of the generational history and the present reality of family and community burden as well as the resilience and strengths that allow a young girl like Marla to cope with life. As noted in the *Closing The Gap* clearinghouse resource sheet on social and emotional wellbeing, those programs that 'operate in isolation from, or do not address the legacy of, past trauma, past and current racism and issues such as poverty and homelessness' are unlikely to be effective.[10(p2)]

There is a pervasive sense of sadness but it is unlikely to represent as an isolated depressive episode. There is also a level of transgenerational trauma and fear that contributes to the need for Marla to stay home and be close to her mother as well as cultural practices and obligations to care for her brothers that may not represent an anxiety disorder. The withdrawal and avoidance behaviour following the repeated grief and loss are predictable reactions—but do they need clinical or interdisciplinary intervention?

Strategies for Working with Marla and her Family

The school refusal can be understood as a reaction to overwhelming stress but may also be seen in light of Marla's perception of the lack of usefulness of school in her current situation, especially if the education she is receiving does not affirm her cultural identity or alienates her from her family. For both teachers and practitioners who are involved with Marla, there will be diagnostic uncertainty, yet the need for a holistic approach to assist Marla is obvious given the present scenario. There is a tension between labelling for the purposes of treatment and medicalising historical, cultural and social factors that is disempowering. Finding the balance between a strengths-based approach whilst treating mental illness is challenging. But what is clear is that Marla is suffering and at risk if she is unable to resolve the grief and loss and continue to reach her potential.

It would be important for Marla's family to feel they have been understood across the generations of burden they carry and the strength of survival they have shown. Marla's mother may seem dismissive of Marla's lack of school attendance but, in the context of their family

life, this is a low priority and not due to neglect. Supporting Marla's mother may be the key to alleviating the burden on Marla and allowing Marla the freedom to play and experience her childhood as a child should. For teachers, school counsellors and social workers involved with Marla, working to support Marla and her family may be achieved through good engagement practices such as cultural vouching, obtaining the assistance of Aboriginal Education Workers, Aboriginal mental health workers or Elders from the community.

Supporting Cultural Connections

Engaging Marla in a narrative approach may help her to understand the historical burden she carries, provide the opportunity for an empathetic response by the clinician to her present predicament, promote her strengths and create a new story for her future. Dowling and Vetere (2005) describe 'narrative approaches as inviting self-disclosure in the form of story-telling' thereby allowing the child to explore their own life with the clinician.[11(p19)] Narrative approaches allow the child and therapist to reflect on what has happened over time, including over generations, from both the difficulties and strengths perspectives, in order to develop a cohesive sense of self.[12] There is also a goodness of fit, with cultural norms using storytelling to convey important lessons in life. Marla will be better able to assist her family if she is re-engaged with school and achieves a good education.

Incorporating cultural concepts and beliefs around ancestry, spirituality and cultural connections can support the grief process and affirm cultural identity. As Aboriginal and Torres Strait Islander children often grow up in a family system that supports early autonomy and self-reliance,[13] Marla may well bounce back quite quickly with the right support and respond well to learning new strategies. This will promote resilience when facing adversity in the future. Marla may well benefit from having a strong therapeutic relationship outside the family system where she can be free from her burdens and feel supported.

Case Study ▸ Brandon

Brandon is a 14 year-old Aboriginal adolescent from a small remote community. He had been acting strangely for some time but more recently had become aggressive towards his family. Brandon had been using marijuana quite heavily over recent months, had disturbed sleep and often walked around the house at night. He was seen talking to himself, sometimes shouting abuse and isolating himself in his room. He had threatened to kill everyone if they didn't leave him alone. He was taken to the health centre and subsequently evacuated under the Mental Health Act to an authorised mental health adolescent inpatient unit for assessment for psychosis.

On admission to the ward, he was quiet and guarded, mostly staring at the floor. He ignored most questions but at times would look around the room suspiciously and stated on several occasions he wanted to go home. At times Brandon would pace around the room clenching his fists and banging his head on the wall. He was given some sedation and over the next few days appeared to settle. He admitted to hearing several voices, one was his deceased grandfather calling his name and the others he didn't recognise but they said bad things about him and his family. He was worried he was going to be punished at night when he was asleep but couldn't say what he had done wrong. These symptoms had been getting worse over a six-month period and he had used the marijuana to try and 'chill out' but it appeared to make things worse. He had thought about hanging himself but had not acted on these thoughts.

Diagnosis, Management and Prognosis for Brandon

Brandon has a combination of both cultural and psychotic phenomena and it is important to understand how cultural beliefs and experiences can influence symptom formation and meaning. Hearing his grandfather's voice may be an expected culturally acceptable spiritual experience depending on how this experience is understood by his family and cultural belief

system. Hearing and seeing ancestors may be a comfort in times of sadness or illness but may be alarming when present during everyday life.

The unknown voices, however, are more likely to be psychotic in nature as they are derogatory, threatening, unfamiliar and distressing and could be secondary to the marijuana use. Delusional beliefs similarly need to be understood in the context of culture. If there is any doubt, engaging an Aboriginal mental health worker, Elder, traditional healer or family member may assist in differentiating what is a cultural norm in regard to symptoms and changes in behaviour.

In regard to the wrong doing, if indeed Brandon has transgressed traditional law, his fear of retribution may be real and cause significant anxiety and agitation. He may not be able to speak about the incident outside of his cultural group and this may require a cultural solution. If so, this issue may not resolve until Brandon returns to his community and even then there may be concern for his safety. It would be useful if an Aboriginal health worker was able to speak to Elders within the community regarding Brandon's treatment and intervention regime.

Brandon had a traumatic developmental history with exposure to alcohol in-utero, low birth weight with delayed language and learning difficulties. He was exposed to domestic violence over several years and was sexually abused by an uncle at age seven years. As Brandon struggled at school, he misbehaved and was repeatedly suspended for disruptive behaviour. He mostly wandered around the community with a small group of boys often getting into trouble for vandalism.

Brandon and his three younger sisters had been placed with his maternal grandmother six years ago due to the violence at home. He had been using alcohol and marijuana regularly from the age of twelve years, often threatening violence if he was not given money for drugs. Brandon's family had also suffered the loss of many relatives during his life. Brandon's father was in jail for drug related offences and his mother lived in a nearby community. Brandon's grandmother struggled to contain his behaviour and was scared of him returning home due to his aggression. Refer to Chapter 20 (Hayes, D'Antoine and Carter) for a more comprehensive examination of a typical life cycle of children living in a community affected by harmful substance use and an example of positive community response to promote social and emotion wellbeing, and develop community-led prevention and early intervention strategies.

Although the diagnosis may be relatively easy to make as a first episode psychosis, the management and prognosis for Brandon are much more challenging. There are many underlying issues and the potential for other untreated conditions or comorbidities that will make treating a psychosis more difficult. Brandon had never received any developmental or psychological support despite a clear history of developmental disability and significant exposure to trauma. Instead, his behaviour early on was seen as disruptive and was treated with disciplinary measures at school.

Many boys often act out aggressively in response to trauma and distress and, given the problems with language development, Brandon probably had difficulty in expressing frustration and strong emotion. As noted by Webb 'all people experience stress, their culture determines whether and in what manner they acknowledge this distress.'[14(p14)] As well, both internalising and externalising behaviours are common, as reactions to traumatic stress and may include violence, sexualised behaviours and dissociation, making their conduct at school difficult to understand and manage.[15] See Chapter 22 (Walker and colleagues) for a more extensive discussion of behavioural and emotional problems in young people.

The constant disruptions in Brandon's development may have left him with poor communication and social skills, low self-esteem, poor sense of mastery and little hope for the future. At his age, he may be too shamed to admit he has problems reading and writing and may try to cover his deficits by being aggressive, oppositional or defiant. Trying to assess cognitive function at this age is complicated and there are few validated assessment tools for Aboriginal and Torres Strait Islander adolescents available. However, some assessment of the

level of intellectual functioning may be useful in regards to services and supports. As well, when assessing formal thought disorder (given that disorganised speech, is one of the central signs of schizophrenia.),[16] one must consider the presence of his language difficulties, English as a second language and Aboriginal forms of English as expressions.

Brandon has no strong male role models in his family and may struggle to know how to form a strong male identity and role in the family and community, especially if Brandon is no longer able to return to the care of his grandmother due to his behaviour. His trauma and grief issues may be difficult to address due to his limited cognitive capacity or psychological mindedness. His current trajectory may see him on a path towards juvenile justice, further harmful drug use and chronic illness. In this case, it is even more important to find his strengths, build his life skills and give him a sense of achievement and restore a sense of purpose and hope. Gender issues may impact on his engagement with female clinicians and he may benefit from a male mentor or strong men's group.

Treating the psychosis effectively will also help to alleviate distress and assist Brandon in managing his behaviour and sleep disturbance. Good communication and education about his condition, while not making him feel ashamed, is important for engagement in ongoing treatment. Open and positive communication between Brandon, the health team, service providers and the community, and education and awareness about Brandon's condition in a manner that does not make him feel ashamed, is important for engagement in his ongoing treatment. Dealing with the substance use must incorporate an understanding of the underlying developmental disruptions and traumatic exposures to be effective.

Using Culturally Appropriate Resources

Use of culturally appropriate resource material with strong visual elements such as those produced by the Australian Integrated Mental Health Initiative (AIMhi) in the Northern Territory and Queensland may assist in understanding Brandon's current position and the '*Stay strong*' plans may be useful in empowering him Brandon to identify what works for him and how to get further help.[17, 18] The *Strong Spirit Strong Mind* materials developed through the Western Australian Drug and Alcohol Office have also proved effective in supporting young people to deal with harmful substance use—see Chapter 26 (Casey) and Chapter 8 (Wilkes and colleagues) for further discussion on addressing harmful substance use in culturally affirming ways. Engaging Brandon back into education through practical programs that support life skills development and mastery will assist in improving his self-esteem.

Although Brandon's best support is likely to come from his grandmother, her health and wellbeing as well as the safety of his sisters requires consideration. Monitoring and follow up in remote communities can be difficult, especially if services only visit monthly and there is little opportunity to develop strong relationships. The longer Brandon stays in hospital, the more likely he will become homesick, especially if his family were unable to come to the city to support him. The choice between returning home and maximising his recovery in the city is a difficult one to make, especially if relapse is a likely possibility. It is critical in such cases to adopt an interdisciplinary approach that will enable and support a continuity of care plan for Brandon.

CONCLUSION

These case studies illustrate some of the historical, cultural, spiritual, social, psychological and political complexities involved in identifying, assessing and managing significant mental health issues in Aboriginal and Torres Strait Islander children and young people. Although the presenting problems may seem simple at first, the full breadth and depth of the issues may only be revealed over time and with the development of trust and good engagement. The possibilities for recovery, however, are also enhanced due to the resilience and resourcefulness of children, the richness of culture and the potential that resides in their development.

REFLECTIVE EXERCISES

1. How would you consider the transgenerational impact of grief and trauma on child development today?

2. How does considering the issues through a trauma informed and cultural lens influence the approach to assessment and management of children with mental health problems?

3. How does your service promote strong cultural identity?

4. What options for cultural therapies are there for inclusion in management?

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Working with Behavioural and Emotional Problems in Young People

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OVERVIEW

This chapter outlines specific issues relating to behavioural and emotional problems in Aboriginal and Torres Strait Islander young people. It describes the most common disorders and their consequences, and how young Aboriginal people are at higher risk for developing such problems than other young Australians. The chapter also discusses the importance of psychosocial, cultural and environmental issues that need to be recognised in assessing and treating Aboriginal young people with behavioural and emotional problems. Issues concerning the delivery of both universal and culturally responsive prevention and intervention programs to address social and emotional wellbeing and mental health are discussed and possible interventions to enhance student engagement at school are provided. Finally, a range of mental health services for Aboriginal families which offer a culturally responsive approach to mental health treatment are listed.

WHAT ARE BEHAVIOURAL AND EMOTIONAL PROBLEMS?

In line with global figures, around one-in-five Australians will experience some form of behavioural or emotional problems during childhood and adolescence.[1] Such problems can be categorised into *internalising* disorders, where behaviours are often directed inwards towards the self (e.g. anxiety, depression, withdrawal) or *externalising* disorders, where behaviour is directed outwards away from the self (e.g. aggression, conduct problems, Attention Deficit Hyperactivity Disorder (ADHD), delinquency).[2] However, internalising and externalising disorders can be comorbid and therefore difficult to distinguish into these two categories.[3] For example, ADHD may be more difficult to diagnose when there is a comorbid depressive disorder, which occurs in 13 to 27 per cent of cases of ADHD, with the comorbidity as high as 60 per cent in some clinical contexts.[3]

Anxiety, depression, conduct disorder and ADHD are some of the most common behavioural and emotional problems observed in children and young people.[4] Anxiety can be described as a response to a threat or a feeling of uneasiness, the source of which is uncertain or vague, but with debilitating effects as if that source was real or specific. It may involve fear of being apart from significant people or being left alone; avoidance of certain situations or activities for fear of embarrassment; worrying about normal life issues; repetitive thoughts and behaviours; or panic attacks.[5] Depression is recognised by symptoms such as loneliness, crying, withdrawal from others, lethargy and persistent tiredness, feeling unloved, guilty, sad or worthless.[5] Another behavioural and emotional problem that is increasingly common is Attention Deficit Disorder (ADD) and ADHD, with symptoms such as having difficulties with concentration, sitting still, processing and learning, as well as impulsivity and daydreaming. Conduct disorder symptoms include: bullying, threats and intimidation, lying, cheating, breaking rules, stealing, a lack of guilt

and remorse, arguing, attacking others, distrusting others and general disobedience within the family and community.[5]

It is well established that mental health in childhood has a significant influence on subsequent mental health outcomes, with those who experience behavioural and emotional problems in childhood being more likely to experience ongoing mental health problems as adults.[6] Poor mental health in early childhood also has a negative impact on the child's physical health and school achievement, and in this way it relates to further disadvantage later in life.[4] Furthermore, many children will experience more than one behavioural or emotional problem at a time.

Parents and teachers might argue that every child at one time or another displays behaviours or emotions that fit the descriptions of those described above, but this does not mean they have a mental health problem. The distinction between what is typical behaviour and what constitutes a more serious problem is important. A behavioural or emotional disorder is distinguishable from typical behaviour and emotions by the duration of symptoms beyond what would reasonably be expected and the severity of the behaviour in relation to the situation.[5] When young people are no longer able to participate fully in their usual activities due to their behaviour or emotions, there is cause for concern. While the last 15 years have seen research into childhood behavioural and emotional problems increase significantly, little of this research has been done among Aboriginal young people to help us to understand the overlay of intergenerational trauma.

Incidence of Behavioural and Emotional Problems

One major study, the Western Australian Aboriginal Child Health Survey (WAACHS), has examined mental health and social and emotional wellbeing (SEWB) among Aboriginal children and youth. This comprehensive study showed that Aboriginal young people have a higher overall incidence of mental health problems than non-Aboriginal young people.[7] Twenty-six per cent of Aboriginal young people compared with 17 per cent of other children in the 4–11 year-old age group were shown to be at high risk of suffering mental health difficulties. Of even greater concern, 21 per cent of Aboriginal 12–17 year-olds were likely to be at risk of mental health difficulties compared with 13 per cent of other young people. Aboriginal youth have many strengths and exhibit considerable resilience, however there is evidence to suggest that this group are more at risk of behavioural and emotional problems than their non-Aboriginal counterparts, especially given the many stress-inducing issues in their lives.[7]

Impact of Life Stressors

Aboriginal young people are exposed to many life stressors. The WAACHS linked clinically significant emotional or behavioural difficulties to a number of major life stress events experienced in the previous 12 months:

- family and household factors, specifically dysfunctional families and poor quality parenting;
- being in the care of a sole parent or other carers;
- having lived in five or more homes;
- being subjected to racism in the past six months;
- physical ill health of the child and carers;
- speech impairment;
- severe otitis media;
- vision problems;
- carer access to mental health services; and
- substance misuse.[7]

The *Bringing Them Home* report showed that forced separation and institutionalisation of Aboriginal people resulted in health problems and a range of emotional distress in adults and also impacted on children and young people (see Chapter 17, Atkinson and colleagues and Chapter 21, Milroy).[8] Further, the report showed that children of depressed parents were more likely to show higher levels of anxiety and depressive symptoms.[8] Generational poverty also contributes to psychosocial stress. The Human Rights and Equal Opportunity Commission noted that social and economic disadvantage placed Aboriginal youth at greater risk of behavioural and environmental problems that affected physical and mental health, resulting in self-harming tendencies.[9] The WHO Fact Sheet states that an estimated 20 per cent of young people suffer mental health problems and includes depression and anxiety as the most common. Moreover, the risk of experiencing mental health problems is increased by experiences of violence, humiliation, devaluation and poverty; and suicide is one of the leading causes of death in young people.[10]

Consequences of Behavioural and Emotional Disorders

The life course pathways for young people experiencing behavioural and emotional disorders are often less than optimal. Even after adjusting for socioeconomic status and other demographic factors, clinically significant internalising or externalising problems predict mental health difficulties in adulthood.[4] Mental health morbidity in childhood also predicts other negative outcomes in later life including:

- high school non-completion;[15]
- physical health problems;[16]
- drug and alcohol misuse;[17]
- marital difficulties;[18]
- increased mortality;[19] and,
- involvement in the criminal and justice system.[20]

To use an example of an educational setting to describe the pathway from mental health problems in childhood and later poor outcomes, a child with behavioural and emotional problems may have difficulty remaining on task, have problems interacting with peers and forming and maintaining friendships, or may avoid school or classes. Consequently, children with behavioural and emotional problems often have difficulty in responding appropriately to typical developmental challenges and many underachieve in school (the case studies discussed by Milroy in Chapter 21 highlight such challenges for Aboriginal children and young people).

Excessive school absenteeism, reduced learning opportunities and impaired peer relationships associated with behavioural and emotional problems can then lead to poor adjustment to adulthood. There is also preliminary evidence to suggest that behavioural and emotional problems may predispose adolescents to developing substance use disorders, which in turn can lead to adverse health and social consequences as described by Wilkes and colleagues, Chapter 8.

CULTURAL DIFFERENCES IN EMOTIONAL WELLBEING AND ANXIETY

While behaviour and emotions are part of a universal human condition and there will be similarities across cultures, differing constructs of mental health and SEWB may also result in differences in the presentation of some symptoms and in the importance placed on symptoms and the meaning attached to them. Due to the complexity and diversity of Aboriginal groups, there are likely to be constructs and opinions of SEWB including mental health that differ from Western-held beliefs. Reflecting the holistic nature of Aboriginal views of health, SEWB is often defined as 'not just the physical wellbeing of the individual, but the social, emotional

and cultural wellbeing of the whole community.'[11] This construction reflects belief systems that are based on complex social relationships between people, land and all living creatures and the 'interconnectedness of relationships between spiritual, emotional, ideological, political, social, economic, mental, cultural and physical factors on health outcomes for individuals, communities and populations.'[12(p22)] Chapter 4 (Gee and colleagues) explores the concept of mental health SEWB and the importance attached to connections to identity, culture and family.

Identification of Behavioural and Emotional Problems

While accurately assessing behavioural and emotional problems in children and young people is generally complex, there are additional factors to be taken into account when assessing Aboriginal children and young people.[13] Bias, validity and reliability concerns in the assessment of Aboriginal people have long been an area of contention due to the failure of tests to account for cultural differences (these issues are discussed in detail in Chapter 16, Adams and colleagues). Several authors argue that any assessment is culturally biased unless it takes into account all potential factors regarding the development and maintenance of the problem and the impact on any intervention. Problems in obtaining an accurate picture of functioning can include:

- the use of culturally biased assessment tools;

- inappropriate comparison of data;

- a poor relationship between the assessor and the participant;

- the assessment setting;

- whether similar performance is seen in the cultural context; and

- recognition of cultural factors such as culture-bound syndromes or differences in conceptualisation of mental health.[26]

Mental health professionals (teachers, school psychologists and pastoral care workers) working with Aboriginal young people need to acknowledge the critical importance of family and identity issues and the possible physical health and social and environmental factors that may complicate a diagnosis (see Schultz and Walker and colleagues, Chapter 13).

Culturally Appropriate Assessment Measures for Children and Young People

One culturally appropriate psychological measure that has been validated for use with Aboriginal youth in Australia is the *Westerman Aboriginal Symptom Checklist—Youth* (WASC-Y).[14] This is a tool aimed at early identification of depression, anxiety, suicidal behaviours and self-esteem issues in Aboriginal young people in the 13–17 years age group. In conjunction, a model to assist in considering cultural factors that affect validity in assessments has been developed.[15]

Current research into Aboriginal mental health, including the work being done by Cheryl Kickett-Tucker in developing the IRISE_Y (youth inventory), is trialling more culturally appropriate measures which take account of the mediating factors of racial identity and related self-esteem that influence Aboriginal people's mental health and SEWB. This work entails a range of age-specific initiatives to strengthen the cultural, SEWB of Aboriginal children aged 4–12 years, young people aged 13–17 years and adults from 18 years of age onwards.[16]

SUPPORTING ABORIGINAL STUDENTS WITH BEHAVIOURAL AND EMOTIONAL ISSUES

When planning support for Aboriginal youth with behavioural and emotional problems, an understanding of the various levels of influence on their SEWB is essential, including individual, family, community and structural/systems levels.[12] Such an approach acknowledges the holistic constructs of Aboriginal SEWB and is likely to have greater success. At an individual level, self-esteem, resilience, emotional and cognitive development of individuals can be supported by schools.

At a system level, there is a need to improve access to mental health services for Aboriginal families and to adopt a more holistic approach to mental health treatment. Australian governments have recognised the school as an appropriate place for delivering programs that promote mental health and consequently have implemented such initiatives as *MindMatters* and *KidsMatter*. As well as a venue for providing preventive programs, the school is also seen as the front-line for the identification and referral of students with major needs in the area of mental health to counselling services.[17]

School Attendance and Participation

It is widely recognised that there is a strong correlation between educational attainment and a range of indicators of social wellbeing including: economic participation, income, health outcomes and determinants such as health risk behaviours and preventative service use, social participation and involvement in crime and justice. Education is a major focus in the strategy to 'close the gap' in a range of outcomes including health and SEWB outcomes between Aboriginal and non-Aboriginal people. While there have been notable gains in some of the key education indicators in recent decades, there continues to be substantial gaps in attainment and achievement outcomes. Recent data highlights that 66 per cent of Aboriginal people aged 15 years and over completed at least Year 10 and 22 per cent completed Year 12. While these figures represent a considerable advancement on the levels recorded in 1994 (47 per cent and 9 per cent respectively)—and stand in stark contrast to data from 1970, which suggest that fewer than 10 per cent of Aboriginal students attended secondary school—they are well short of the levels among non-Aboriginal populations (84 per cent and 51 per cent). These disparities are also evident with respect to tertiary education attainment, with 6 per cent of Aboriginal adults holding a bachelor degree or above compared with about one-in-four (24 per cent) non-Aboriginal adults in 2008.[18] Despite gains in Aboriginal education over recent years, there still remains a significant gap in attainment outcomes at higher levels.

However, many Aboriginal students continue to have infrequent school attendance and poor school completion rates. This poses a challenge for the delivery of prevention and intervention programs to Aboriginal students in school to address behavioural and emotional disorders. While there are no studies that specifically address the links between Aboriginal youth, mental health and school participation, it has been identified that remaining at school until Year 12 is positively associated with health, with 59 per cent of Aboriginal people aged 15–34 years reporting excellent or very good self-assessed health.[19] Another study shows that 'evidence-informed' school-based health education programs can help to strengthen Aboriginal young people's general education and health-specific knowledge and skills.[20]

Blair and colleagues argue that the expansion of human capabilities through programs that build Aboriginal empowerment, equality, sustainability and productivity are required to improve physical and mental health outcomes.[21]

Given the potential life stressors and factors identified as affecting school attendance and completion, it is likely that significant numbers of Aboriginal young people are suffering mental health problems severe enough to impede their involvement in school. Absenteeism has been recognised as a protective mechanism that allows students to avoid the aspects of school they find undesirable, frustrating, and a cause of shame or, possibly, anxiety. Existing evidence shows that poor attendance has been associated with the adoption of risky health behaviours including tobacco smoking and substance misuse.[22]

The alienation felt by some Aboriginal students and their families towards schools is associated with less consistent school attendance and high dropout rates.[23] Formal education systems make cultural assumptions that many Aboriginal families and students find perplexing or stressful. For example, while child autonomy may be highly valued as a child-rearing practice in Aboriginal families, being autonomous does not necessarily fit with behavioural expectations at school. While many Aboriginal children bring a rich cultural competence to school, they find that this is not recognised and valued by teachers and mainstream systems of education.[24] It could be expected that for some children, behavioural and emotional problems, including anxiety, would be connected to the discomfort and lack of connection they experience at school. The case studies developed by Milroy, (Chapter 21), highlight many current social circumstances contributing to the sense of disconnect. Furthermore, parental anxiety, linked to concerns about mainstream institutions and negative personal experiences, has been suggested to partly account for the low levels of preschool enrolment and attendance of very young Aboriginal children.[25] Shepherd and Walker have outlined a range of strategies to support and engage Aboriginal families in enhancing school readiness of young children.[26] There is also growing recognition that schools need to be ready for Aboriginal children rather than solely a focus on getting young children ready for school.

Emotional difficulties have been linked to low academic performance and poor attendance of Aboriginal youth.[27] One of the many interlinking factors for lower Aboriginal retention rates in schools identified by Schwab, is fear of failure, embarrassment and shame.[28] Many Aboriginal children experience learning delays linked to poor readiness for school or physical health issues, such as speech and language development, impaired as a result of sensory deprivation from otitis media.[27] Students who do not speak Standard Australian English fluently may feel alienated. Low achievement levels have been attributed to absenteeism and low literacy and numeracy levels are associated with increased rates of early school leaving.[28] It is significant, then, that Aboriginal national benchmark results in literacy and numeracy at Years 3, 5 and 7 are generally about 20 per cent below the national average and that gap in knowledge as a result of absenteeism is likely to add further shame, stress and anxiety.[29]

Furthermore, the transition from primary to secondary school can be stressful for Aboriginal youth, particularly for those forced to leave their communities to continue their formal education. There are also cultural issues related to some young males going through law and the need for schools to recognise this as a transition to adulthood requiring new ways of relating to Aboriginal young people in such instances. Cultural, social and language differences, being inadequately prepared, being away from familiar support and feeling shame at not having higher achievement levels may lead to behavioural and emotional problems and early school leaving.[25] Finally, Aboriginal youth share the universal development tasks/milestones of their age group with their non-Aboriginal peers. These include the need to develop a strong sense of personal identity and self-esteem. Aboriginal youth, however, have a distinctive sense of identity as Aboriginal people and in early adolescence this may be a source of confusion.[24] This is not made easier by racism, discrimination and harassment often experienced by Aboriginal youth, which can further result in marginalisation and low self-esteem.[30] Social exclusion, economic hardship, marginalisation and colonisation have been closely linked to mental health because they limit access to resources, networks and support, and increase stress (see Chapter 1, Dudgeon and colleagues, where the social, cultural and historical context of Aboriginal people are discussed).

In addition, studies examining the impact of racism have shown that attacks on an individual's sense of self can lead to mental health problems such as anxiety and depression.[31] Paradies shows an association between racism and mental health conditions such as psychological distress, depression and anxiety; as well as links with health risk behaviours such as smoking, alcohol and substance misuse.[32]

Anxiety is linked to depression, and the combination of these disorders can lead to a higher risk for suicide. This is significant for Aboriginal youth, as suicide rates in this group are disproportionately higher than for non-Aboriginal youth. It is now recognised that there are suicidal risk factors that are uniquely Aboriginal; these include the transgenerational grief and loss resulting from colonisation, disruption to cultural identity, forced removal, substance misuse, social isolation and racism (see Chapter 9, Silburn and colleagues). As the case studies presented by Milroy in Chapter 21 powerfully illustrate, these factors need to be considered when assessing the ongoing SEWB and mental health of children and young people.

Strategies for Encouraging School Attendance and Participation

One of the first avenues to addressing behavioural and emotional problems in Aboriginal youth is to create opportunities for participation, social support and development of connectedness and a sense of belonging in school. The importance in terms of emotional wellbeing and school participation has been emphasised in the literature.[25] Aboriginal parents wanted to know more about school processes, curriculum and financial issues related to schooling, but many Aboriginal parents and caregivers find schools alienating and far removed from the experience of their everyday lives.[33] Parent interest is increased along with greater numbers of Aboriginal people working in schools through establishment of school and community networks, and community liaison improves home and school communication.[25]

LINKING FAMILIES AND SCHOOLS

The Department of Education, Training and the Arts' *Linking Families and School Initiative* in Queensland has been developed specifically to promote and support positive relationships between Aboriginal communities, students and school staff and aims to nurture partnerships, thereby improving attendance, retention and learning outcomes for Aboriginal students.[34] The value of healthy relationships between teachers, Aboriginal families and students is recognised for student success.

Families as First Teachers (FaFT)

The Families as First Teachers (FaFT) – Indigenous Parenting Support Services Program works to strengthen positive relationships in families, promote positive behaviour in children and build confidence in parenting.[35] This is done through modelling behaviour management at the early learning sessions, encouraging families in their interactions, group discussions, parenting workshops, home visiting and individual consultations. The program takes a strength-based approach to parenting, working from the belief that all families want the best start in life for their children.

Families And Schools Together (FAST)

Families And Schools Together (FAST) is an eight-week, early intervention/prevention program, designed to strengthen family functioning and so build protective factors in children.[36] In the Northern Territory (NT) the program is run in remote and urban/regional contexts. Success factors include a high level of community ownership, and key leaders playing a crucial role in supporting the program to enable local families to achieve their own goals.

Teachers identified three out of 13 children who had improved their behaviour given more respect or improved their peer relationships as a consequence of FAST. The evaluation of FAST identified changes in child behaviour, increased helpfulness, better respect and improved school attendance for children. Outcomes for parents, included improved family support and greater self-efficacy.

Holistic Planning and Teaching Framework

Another model that may have wide application in schools for developing support programs is the *Holistic Planning and Teaching Framework* first developed by Grant in 1998 for use by teachers with Aboriginal students.[37] The Framework is a holistic approach to learning that encompasses Land, Language and Culture by contextualising Time, Place and Relationships. This can be used in many situations for a wide range of purposes including field trips, research, writing and planning. This gives students the opportunity to learn about the importance of the interconnectedness of all aspects of their lives and that emotional difficulties, including anxiety, may be meaningfully addressed, thereby allowing students to better participate in life and school.

Home Interaction Program for Parents and Youngsters (HIPPY)

An evaluation of the *Home Interaction Program for Parents and Youngsters* (HIPPY) program across five sites in Australia, which aims to enhance parent and child interactions and improve social and emotional and cognitive development, showed positive results. The study found that engagement in HIPPY resulted in improved SEWB and education outcomes for young Aboriginal people. And that importantly, with some adaptations, it holds significant promise as an appropriate and acceptable program with Aboriginal people, with important benefits to parents, children, families and communities. The key lessons for program effectiveness include:

- effectively engaging Aboriginal families requires developing trust and connection between the partner agency and the local Aboriginal community;

- trust is strongest where the partner agency is well integrated with other Aboriginal children and family services and/or schools;

- programs may require flexible centred-based delivery (an alternative 'safe place' outside of the home) as homes are not always an appropriate or safe place for the delivery of HIPPY. Some families live in very stressful environments including inappropriate housing for harsh weather conditions (heat, heavy rain) that necessitate mobility; some may be embarrassed about overcrowding, and/or alcohol and drug and domestic issues;

- English as second language and parent's education background means that home tutors may need to deliver the program to the children in the presence of the parents to build their confidence to work with their child;

- adapted teaching materials to incorporate Aboriginal stories, songs and other cultural activities to teach literacy and numeracy;

- transport is required to overcome one of the largest barriers to participation in *HIPPY* by families; and

- Attracting and retaining good tutors and coordinators is critical for a program built on trusting relationships.[38(p105-108)]

Home-based Intervention Programs

A recent systematic review of appropriate interventions for child and adolescent mental health issues in Australia found that home-based intervention programs could be both successful in reducing mental health problems and cost-effective.[39] Such programs have been trialled in the US as the *Nurse Home Visitation Program*[40] and the *Family Check-Up*.[41] A review of grey literature also identified the *Halls Creek Mothers Support Initiative*, an Aboriginal-led home

visiting or outreach program which aimed to improve the health and wellbeing of mothers and children up to the age of five.[42, 43] By being based in the home and within a community environment, such programs may be more suitable for the context of Aboriginal child mental health as they remove the reliance on school as a medium for the delivery of mental health interventions, and they have been found to be effective from infancy through the pre-school years, which may increase later engagement in school.[39] In addition, while young people in general can be reluctant to seek help for mental health problems, Aboriginal and minority groups tend to be less likely to attend mental health services in the community.[44] Young people are also less likely to be connected to a GP or other health professional that can assist in the identification and management of their mental health.[44] Service delivery that is based on the service providers coming to the home or other agreed safe place and working with families may be more effective at engaging these young people.

Aboriginal Involvement in Program Development

To be effective it is important that support programs include Aboriginal constructions of reality and involvement of Aboriginal people from the initial assessment through to intervention and evaluation.[45] Program development requires extensive consultation with the Aboriginal community, including the young people for whom it is intended to ensure that it is meaningful and that there is ownership of both the materials produced and strategies for use or distribution.

Furthermore, it is important that all those involved in program development see it as a priority as often when people are living in adverse circumstances mental health may not be considered a high priority. Differences between Western and Aboriginal concepts of mental health need to be taken into account (see Chapter 4, Gee and colleagues, for a discussion on Aboriginal perspectives of SEWB and mental health).

EFFECTIVE TREATMENTS FOR YOUNG PEOPLE WITH ANXIETY AND BEHAVIOURAL PROBLEMS

Research in the general population indicates that cognitive behaviour therapy (CBT) is an effective treatment for young people with anxiety.[46] As Casey points out in Chapter 26, the theory of Inner Spirit being linked to the mind, and influencing people's feelings, behaviour and decision making, has enabled the concept of Inner Spirit to be applied in a therapeutic context and incorporates culturally secure CBT approaches. In addition the *Strong Spirit Strong Mind* program articulates the importance of strengthening the Inner Spirit to enhance good decision making and support behavioural change not only at an individual level, but also with family and community. It is suggested that modular and worksheet based CBT approaches may not match the needs, motivations and learning style of young Aboriginal people. A study found that systems-based interventions have good 'face validity', and may work better with young people than a CBT approach alone.[47]

The *Youth Plan* emphasises that there is 'an acute demand' to address youth suicide and bullying in our schools and communities. The Department of Education assisted schools to plan for and implement a range of evidence-based programs that related to mental health and wellbeing, including *Promoting Alternative Thinking Strategies, Youth Mental Health First Aid, the Positive Parenting Program, KidsMatter, MindMatters* and PACE, a Participation and Community Engagement program.[48]

Importantly, teachers and school counsellors need to have an understanding of suicidal risk factors and be confident that they will be able to recognise suicidal warning signs, assess a student's level of risk, offer support to a student at risk and take the appropriate intervention steps or referral if they consider a student is at high risk.

THIS WAY UP Schools

THIS WAY UP Schools is an Internet-based learning system that provides health and wellbeing courses for school students to assist them in making good choices. Students learn about ways to avoid poor decisions and to optimise their physical and mental health. THIS WAY UP Schools is a universal prevention program not designed specifically for young people in difficulty. It is an initiative of the Clinical Research Unit for Anxiety and Depression (CRUfAD) at St Vincent's Hospital, affiliated with the School of Psychiatry and National Drug and Alcohol Research Centre (NDARC) at the University of New South Wales, Sydney, Australia. CRUfAD has developed a range of web-based courses to improve the management of:

1. stress

2. anxiety

3. depression

4. alcohol use

5. cannabis use

6. psychoactive drug use by high school students.

The program gives teachers access to a collection of web-based courses incorporating text, illustrations, videos, class exercises and teacher resources to assist them to teach about, and support, the health and SEWB of their students. All of the courses address Health and Personal Development syllabus outcomes, especially those concerned with mental health and wellbeing.[49]

THIS WAY UP Schools Course Scenario

This course helps students to identify the symptoms of anxiety and shows how to deal with anxiety effectively. By the end of the 6 to 8 lessons, high school students are able to:

- recognise the signs and common triggers of anxiety and how to effectively deal with it;

- understand how thinking styles can make anxiety worse, and why unrealistic thinking can cause people to feel anxious;

- describe how to change their thinking to control their anxiety;

- face up to their worries and fears and to use the step ladder approach to deal with them;

- describe the three main communication styles and explain how to be assertive; and

- describe predictive thinking and to use the 'experimenting with reality' strategy to challenge their predictions, know where to get further information about anxiety and other mental issues and where they can access effective help.

Culturally Appropriate Models of Intervention

In Chapter 30, whilst talking about offender programs, Hovane proposes a model of intervention that engages Aboriginal people in culturally appropriate ways. While it is involved and time-consuming, it increases the likelihood of successful engagement. The model is strongly focused on building relationships and trust and developing networks. It requires non-judgmental practice and modification of counselling skills, primarily the use of language. Central to the model is the use of a cultural consultant, a person chosen by the community to assist with networking and cultural understanding throughout the entire program development and beyond. It is therefore likely that it would be more successful to involve cultural consultants and/or Aboriginal SEWB counsellors or mental health workers (MHWs) in the development and dissemination of programs or to vouch for Aboriginal communities. The recent community

consultation by Dudgeon and Ugle, described in Chapter 15, further confirms the value of Aboriginal people being involved in the development and delivery of programs because of the shared life experiences of most Aboriginal people.

In Chapter 21, Milroy suggests a range of strategies for overcoming sadness or worry which may have application in schools. Art and art therapy can assist Aboriginal people in identifying their cultural beliefs and values and this may have a significant impact on reducing behavioural and emotional problems. Art gives children the opportunity to express fear and confusion without having to talk about these things. Hip-hop therapy has also been used successfully in minority groups to establish narratives, identity and assist in building resilience against mental health problems.[50] Other activity-based challenges, connecting to the land, and cultural activities have also proved effective. Similarly, play may be used as an appropriate intervention in younger people. Play is universal across cultures. In addition to providing a range of developmental benefits, it has been used to alleviate emotional issues with moderate to large positive effects.[51]

Despite the concerns about young people not wishing to speak about difficulties—narrative, personal stories or anecdotes, and yarning are the therapies suggested most often by Aboriginal mental health practitioners and counsellors (see Chapter 21, Milroy). Narrative therapy has been adapted with success for use with Aboriginal peoples. It reflects Aboriginal oral traditions and provides an outlet for alternative stories of marginalised people to be told, thereby empowering them, and it may have applications in assisting Aboriginal youth with behavioural and emotional problems.[52]

CONCLUSION

While there are still significant gaps in the knowledge of behavioural and emotional disorders among youth in the general population, this is more so for differing cultural groups and minority youth for whom the complexities of assessment and prevention are additional barriers to SEWB. The paucity of accurate and current information regarding prevalence of behavioural and emotional problems in Aboriginal young people is of great concern. Culturally appropriate research is required to determine both the prevalence of these disorders in this population and to identify appropriate and effective prevention and intervention options. Hunter[53] and Westerman[54] refer to the desperate need for mental health strategies for all Aboriginal people and there are increasing calls for education systems to develop appropriate support for Aboriginal students with emotional difficulties. While universal programs are required, schools also have a role to play in targeted early intervention programs to support youth at risk of psychological problems. Further research is urgently required to inform intervention and prevention strategies in educational and other settings for Aboriginal youth with behavioural and emotional problems.

REFLECTIVE EXERCISES

1. Refer to the case studies by Milroy in Chapter 21, pages 375 and 377. In your experience, what are some of the ways that Aboriginal students may exhibit behavioural and emotional problems?

2. How would you go about measuring behavioural and emotional problems in Aboriginal young people?

3. How do you think that Aboriginal youth can be assisted to attend and complete school?

4. How do you think the shame factor can be eased for Aboriginal students?

5. Reflect on the factors that may cause behavioural and emotional problems in Aboriginal youth and discuss possible interventions.

RESOURCES

Embrace the Future Resilient Youth website

The Embrace the Future Resiliency Resource Centre is a website for teachers, parents and other people who work with, or care for, children. It provides information about resiliency and how to foster it in children. Although much of the information provided here will be relevant to adolescents as well, the focus of this site is on primary school-age children.
http://www.embracethefuture.org.au/youth/

THIS WAY UP Schools

An Internet-based learning system that provides health and wellbeing courses for school students. The knowledge gained about health education will assist students in making good choices. Students learn about ways to avoid illness and to optimise their physical and mental health.
https://thiswayup.org.au/schools/

Working with Aboriginal Young People: A Guide for Youth Workers

http://www.yapa.org.au/youthwork/facts/aboriginalyoungpeople.pdf

Holistic Planning and Teaching Framework

A DVD has been produced explaining the framework and providing practical demonstrations of the use of the framework by teachers and schools.
http://www.learningplace.com.au/deliver/content.asp?pid=44292

AIME

AIME provides a dynamic educational Program that gives Indigenous high school students the skills, opportunities, belief and confidence to finish school at the same rate as their peers. AIME has proven to dramatically improve the chances of Indigenous kids finishing school. AIME also connects students with post Year 12 opportunities, including further education and employment.
http://aimementoring.com

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23

Family Violence: Pathways Forward
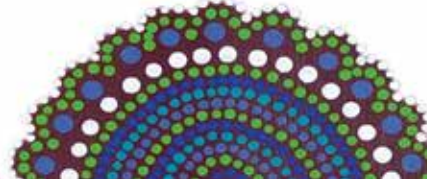
Kyllie Cripps and Michael Adams

OVERVIEW

This chapter briefly examines the context in which various types of violence occurs in Aboriginal and Torres Strait Islander families. In particular, it explores how they define and contextualise the violence they or their family members are experiencing. This context is important in determining pathways forward for healing for the victim, the offender, their families and the broader kin network who inevitably feel the ripple effects of such violence. Drawing on the available evidence, several key considerations are presented for the development and implementation of interventions to address this violence in what is often a maze of complexities.

THE CONTEXT

The issue of violence and abuse in Aboriginal communities across Australia, but more specifically the Northern Territory, has been the subject of intense media coverage over the past decade. It is not a new issue. State-commissioned inquiries and government reports since 1999 have consistently reported that the occurrence of violence in Aboriginal communities and among individuals is disproportionately high in comparison to the Australian population as a whole. They have also highlighted that women and children, but also men, are equally the victims of such violence perpetrated by other men and also women.[1-9] Indeed, the 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) confirms that, of the 23.4 per cent of Aboriginal people reporting to be victims of physical violence or threatened violence in the 12 months prior to the survey, men and women had similar levels of victimisation.[10]

Mainstream approaches to healing and justice have consistently been identified as problematic and requiring reform. The extent of progress in achieving the reforms recommended in each of the commission reports is discussed in this chapter. While there has been a burgeoning growth in services and programs to address the levels of violence over the past decade from both Aboriginal and mainstream organisations, there still remains a lack of knowledge about their effectiveness in responding to and reducing the violence in the communities in which they operate. This situation arises from a minimal investment in evaluation processes. The lack of formal evaluations does not mean that there has not been change in individuals or that program initiatives and services are not working, often despite immense odds, to tackle the violence within communities. The problem is that they are rarely recognised publicly for their efforts.[11]

DEFINING VIOLENCE

It is widely recognised that the naming and defining of violence as it occurs within families has constituted one of the most extensive, ongoing and controversial issues in the discourse on familial violence.[12] The communicative choices and discursive practices have, over 40 years, variously defined this problem according to a Western scientific discourse, that has been inconsistent in its use of terms and definitions. In part, this is due to the changing social values in society, but it is also due to differing interpretations from individual to individual, service to service, culture to culture and from one research discipline to another.[13,14] This problem becomes further entangled when common slippages occur both in the literature and in practice between terms such as family violence and domestic violence, or when such terms are used to cover all types of abuse that occur within families, including sexual assault and/or child abuse and neglect.

For people outside the professions and discourses, namely those experiencing the violence first-hand, it is not surprising that they often lack the knowledge, language and communicative resources to interpret and apply these various definitions to their own experiences. Bagshaw, et al.[15] found in their national study of Australian domestic violence, that many participants had not identified their situations as domestic violence until they read the behaviours and feelings described in posters distributed as part of the study.[15] Cripps[16] found that phrases such as 'um [pause] well we were arguing', 'my husband was acting up', 'he was being cheeky', 'it was just a little fight' and 'we were drinking' are commonly used by victims, perpetrators and community members to describe the violence taking place in Aboriginal communities.

To the untrained professional, such statements may not cause concern, but to those who have worked in the area for some time and who are familiar with this language, in reality these terms can mean that in fact 'she was beaten with a 2×4 [piece of wood]' or 'she was raped'.[16(p71-72,154-156)] Words such as family violence, domestic violence, sexual assault or even rape are very rarely used in these contexts because many people find them to be too confronting and fear the consequences should they use them.[17] Victims and their families often use a 'language of minimisation'[16] when describing instances of violent behaviour as some everyday, innocuous happening. There are several reasons for doing so. Much of it has to do with protecting families from unwanted intrusion, and in many ways dealing with violence is easier using this language of minimisation because it is not confrontational; it does not require action unless the parties choose it; it does not make anyone look bad and it does not aggravate the situation.[16]

There is also evidence to suggest that just as 'violence has become a normal and ordinary part of life', so too has the language.[18] People have become complacent in not questioning 'we were arguing' or 'it was just a little fight' and few choose to intervene in situations professionals may consider to be family violence or situations of sexual assault or child abuse and neglect because they are of the opinion that 'what I might class as abuse, someone else may accept as being ok'.[19] Thus this ambiguity around words and perceptions can inhibit professionals identifying and acting on verbal or non-verbal cues in ways that empower victims to make choices regarding safety for themselves and their loved ones.

Most States and Territories accept that Aboriginal violence encompasses:

> *a wide range of physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that occur within families, intimate relationships, extended families, kinship networks and communities. It extends to one-on-one fighting, abuse of Aboriginal community workers as well as self-harm, injury and suicide.*[6(p123)]

Lateral Violence

The term lateral violence has also grown in prominence in Aboriginal communities in recent years. It describes the way people in positions of powerlessness, covertly or overtly direct their

dissatisfaction inward toward each other, toward themselves, and toward those less powerful than themselves. As Langton explains:

> those most at risk of lateral violence in its raw physical form are family members and, in the main, 'the most vulnerable members of the family: old people, women and children. Especially the children'.[20(p15)]

Lateral violence occurs particularly amongst Aboriginal peoples where its roots lie in colonisation, oppression, intergenerational trauma and ongoing experiences of racism and discrimination. It is the expression of rage and anger, fear and terror that can only be safely vented upon those closest to us when we are being oppressed. Behaviours included under the spectrum of lateral violence range from gossiping, jealousy, bullying, shaming of others, backstabbing, family feuding, organisational conflict, attempts at socially isolating others and extreme situations such as physical violence.[20,21] By recognising these actions as violence, we can better appreciate that this kind of assault can be as damaging as other forms of violence occurring in Aboriginal communities. This violence can take place alongside other forms of violence and as a consequence can make the context of individual, familial and community experiences with violence all the more complex.

REPORTING VIOLENCE

The accurate recording of data specific to violence is crucial if we are to ensure access to adequate support services in the areas most in need. This relies on individuals reporting their experiences of violence to professionals and service providers who maintain such records. Information from surveys and inquiries suggests a high proportion of violent victimisation is never disclosed. Willis has argued that non-disclosure of violence is as high as 90 per cent against Aboriginal women, and that most cases of child sexual abuse involving Aboriginal children are not disclosed.[22(p1)] This low disclosure rate is influenced by a victim's fear of reprisals from the perpetrator, their kinfolk and family, fear of the justice system and evidence of cases before the courts demonstrating that the fears are justifiable with threats, intimidation and further violence being perpetrated against the victim and members of their family as a consequence of their reporting.[4,7,9(pxiv)]

A useful way of understanding the thinking that occurs in the minds of victims in the reporting process, and an idea of how many people report at varying levels, is depicted in Figure 23.1.[23] This diagram illustrates the number of victims/survivors of violence in the bottom bar. While some victims may never go on to tell anyone about their experiences of violence due to feelings of shame, a portion of victims/survivors do go on to report their experience to a family member or friend, depending on the reception they receive from their disclosure and the advice given by the person they disclose to; some of these people will then go on to see a health professional to have treatment for physical injuries and support for psychological injuries, including being tested for pregnancy or sexually transmitted diseases.

Again depending on the reception and information provided by the health professional, a victim/survivor will choose whether they wish to report the incident to police. Additional factors may also play a part in the decision, including any mandatory reporting requirements of the health professional, the extent of the injuries inflicted, and any previous relationships or experiences that the victim/survivor and/or their support persons may have had with the health services, police or the courts. Of those that do report to police, the decision is made by the police as to whether the evidence has enough weight and credibility to go to court. Of the cases that do reach the courts, only a small number result in a conviction, as Figure 23.1 illustrates.

Figure 23.1 provides an insight into the reporting process; it is not prescriptive. Some victims/survivors will choose to go to the police instead of health professionals—it may be that family

members and individual circumstances will influence how a victim/survivor chooses to negotiate the groups identified in Figure 23.1.[4(p250)] For example, a number of commissioned reports have found that, in the context of child sexual assault, when children have disclosed their experience, some parents and grandparents who have been victims of child sexual assaults themselves were not protecting their children—in some instances the abuse was seen as a normal part of growing up or 'something you had to go through'.[5(p51)]

Figure 23.1: Process of Reporting Victimisation
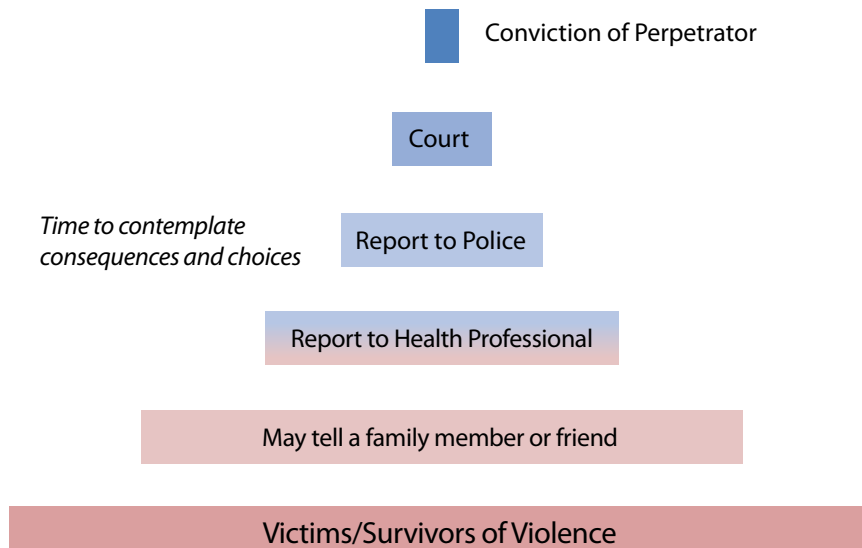
Source: Cripps, K (2008)[23]

In the NSW *Breaking the Silence* report, the following comment was documented:

> *A young mum. She said to me, "Well, you know, she should put up with it, you know. I had to put up with it, why can't she?" Like it's a rite of passage, like that's acceptable.*[5(p51)]

Responses such as this demonstrate the power and damage that intergenerational abuse can inflict on present and past generations. It also provides a clear example of how a disclosure of abuse in such circumstances will no doubt close down any further reporting and possibly seeking help on the part of a child victim.

However, it should also be noted that there are many examples of unsung heroes responding appropriately to disclosures of abuse—in particular our sisters, mothers, aunts and grandmothers for women, and for men, our brothers, uncles, fathers, and grandfathers. They are the people who often provide emergency shelter, advice and practical support 24 hours a day, seven days a week. Family members do this work often without any form of formal recognition, support or protection.

At every step in the process of reporting, the victim/survivor will also be contemplating the consequences of their decisions. The importance of this process should not be underestimated, nor indeed should the amount of time reporting takes. Communities are small, tight-knit places; inevitably everybody knows everybody else and the flow-on effects from an incident of violence can directly and indirectly affect everyone in the community. Victim/survivors of violence are in a precarious position as they negotiate the choices available to them. Professionals engaged with people should not underestimate the complexity and gravity of their clients' decisions and should be careful not to judge them. The following case study highlights these complexities.

Max, an 11 year-old Aboriginal boy, attends the local Aboriginal Medical Service (AMS) with significant injuries to his arm. It is the first time he has come without his Mum or Dad but his Aunty works at the service. He often comes to visit the service and is comfortable enough with the place and the staff. This time though he appears nervous and withdrawn. John, the health worker, invites him back to a consulting room while they wait for the doctor, and asks 'Do you want me to get your Aunty?' Max answers 'No'. 'What about your Mum or Dad?' He replies 'No'. John then asks him why he's come in today. Max says his arm hurts. John asks as he is examining Max's arm 'How did you hurt your arm mate?' Max discloses that a group of much older boys have really hurt him and it's not just his arm that's hurt. After further questioning by John and the doctor, they discover that Max was held down by his arms and sexually assaulted by the group of boys and that this is not the first time that they have done this to Max or to other kids. John and the doctor tell Max they believe him and that they are really sorry this has happened to him. 'Right now let's fix your arm up and then we need to think about how we tell your parents, we can help you with that—if you want we can tell them. We are also required to tell some other people who can stop those boys from hurting you and those other kids' (a mandatory report to child services). Max is clearly nervous about telling his parents but trusts that John and the doctor will help them understand.

Max's parents are very supportive of him and they are supportive of the AMS making the mandatory reports. They also demand that the police be involved, but this comes at a great cost. The police, after investigating the allegations, arrest and charge the boys who did the assault—the boys are all from well known, powerful Aboriginal families—and as soon as they are arrested, the harassment and intimidation of Max's family to drop the charges begins. It was phone calls at first, then it was the yelling abuse when they were at the shops, then they got their kids to threaten Max and his brothers and sisters at school, then they started going to their house throwing bricks through the windows—it just got so out of hand, it was frightening. The police couldn't do much because those families stuck together said they weren't there, or that they didn't do those things, and they backed each other up.

The effect of the assault and then the harassment on Max have been significant. He stopped talking, he was wetting the bed, he would cower in the corner of the room and Max's parents couldn't get him to move out of that spot. Their other kids were also affected, they didn't want to go to school or leave their parents side. Max's Mum lost her job because she had to be at home all of the time to look after the kids. The family ended up having to move because the families of the boys that hurt Max, they never stopped harassing them.

Study Questions

1. What types of violence have Max and his family experienced? Why is this important?
2. What impact has reporting the sexual assault had on Max?
3. What impact has reporting the assault had on the rest of the family?
4. What supports might have been offered and by what agencies to assist in the reporting process?

Substantiation Rates – child abuse or neglect

The substantiation rate for abuse and neglect of Aboriginal children aged 0–16 years was almost 8 times the rate for other children in 2011–12 (Aboriginal children 41.9 per 1,000 compared with 5.4 per 1,000 for all other children). In terms of rates of substantiations for sexual abuse, Aboriginal children's experiences were substantiated at a rate of 9 per cent compared with 13 per cent for all other children. This lower rate for Aboriginal children should be read with caution as it is likely to be a product of reporting trends (as discussed earlier in this chapter) rather than that the abuse is not happening.[24]

When reflecting on the last question, this case study identifies that the family is connected and feels safe with the use of the AMS. This would be a valuable resource when identifying and considering the support and wellbeing needs of Max and his family. Further considerations would include:

- Does the AMS have the capacity to attend to the psychological needs of the children and/or adults as they go through this process?

- Are there any safety or conflict of interest issues that may arise that may inhibit Max and his family from accessing the AMS after the disclosure or as the police become involved?

- If the AMS cannot provide direct services, can they facilitate this access through referral mechanisms—for example, to a sexual assault service and/or victim services and then, should the family require it, can the AMS be the safe place initially where the consultations with the third party service take place so that the family feels less intimidated?

- Given that the police are already involved, can they assist the family with safety planning as the situation escalates or is this the domain of victim services?

- When the family makes the decision to move, how can the services involved in their care make the transition to other providers seamless?

The need for child-specific healing services that include a cultural overlay has long been identified as a gap in our current service system. Furthermore, it has been identified that the child-specific services required for Max and also for Kyle in the following case study, are often only available in cities and, given their specialist nature, have long waiting lists. Indigenous organisations such as Yorgum Aboriginal Family Counselling Service located in Western Australia have developed specific programming to address the needs of children who have experienced sexual abuse and/or witnessed other forms of violence. Yorgum's practitioners draw on a range of therapeutic approaches to work with their clients. For young people, they have found sand play therapy and art therapy effective in engaging clients who are having difficulty identifying and expressing their feelings and thoughts verbally. Other techniques they utilise to engage with children and their families include one-on-one counselling, yarning therapy, group work and educational workshops. Yorgum's focus is on a holistic response to the individual and the whole family, recognising that the abuse suffered by the child, just as in Max's example, effects everybody within the family.

CONTEXTUALISING ABORIGINAL VIOLENCE

It is not necessary to provide pages of graphs to illustrate the increasing incidence of violence in our communities; many working in this field and/or working in Aboriginal communities are already familiar with this material and have been for the past decade. Aboriginal people continue to experience violence (as victims and offenders) at rates that are typically two to five times those experienced by other Australians and this can be much higher in some remote communities.[22(p1)] Indeed, Mick Dodson stated that 'if Aboriginal people haven't experienced violence personally then we know somebody close to us who has'.[25]

As well as being familiar with the statistics, we are also familiar with the factors contributing to the incidence of violence. Without shifting the blame and dwelling on the past, we understand and acknowledge that the indiscriminate and uncontrolled violence taking place in our communities against our loved one's was never part of our culture or practiced within the family context. As Chapter 17 (Atkinson and colleagues) and Chapter 29 (Peeters and colleagues) describe, the violence experienced today has been significantly influenced by policies and practices of colonisation, in particular the removal of children, and the effects of the violence continue to be felt intergenerationally exacerbating experiences of present violence.[26] Against this background we also know that no one factor can be singled out as the cause of the violence and abuse occurring in

our communities; it can often be attributed to many interrelated factors. Figure 23.2, developed by Cripps, illustrates how these factors can accumulate and result in violence.[16]

Figure 23.2 is versatile in that any one (or more) of Group 2 factors could be contributing to an incident(s) of violence for any population.[27-31] For many Aboriginal people, however, our experience would tell us that any of the factors in Group 1 could also contribute to current experiences of violence. Analyses of NATSISS in both 2002 and 2008 also demonstrate a relationship between reported victimisation and being removed from one's natural family.[10,32]

For Group 2 factors, Weatherburn and Snowball[10] found that the strongest risk factor for being a victim of physical violence was alcohol use. They also found that substance use, lone parent families and financial stress are also significant predictors of victimisation. In addition to these factors, Hayes et al. have found that a history of child abuse increases the risk of post natal depression in Indigenous mothers.[33] Domestic violence is also a significant independent predictor for post natal depression—see Chapter 19 (Marriott and Ferguson-Hill). Further discussion of these social determinants and their more explicit connection with social and emotional wellbeing (SEWB) are provided in Chapter 4 (Gee and colleagues); Chapter 6 (Zubrick and colleagues); Chapter 8 (Wilkes and colleagues); and Chapter 13 (Schultz and Walker and colleagues).

Figure 23.2: Factors Contributing to Family Violence in Aboriginal Communities
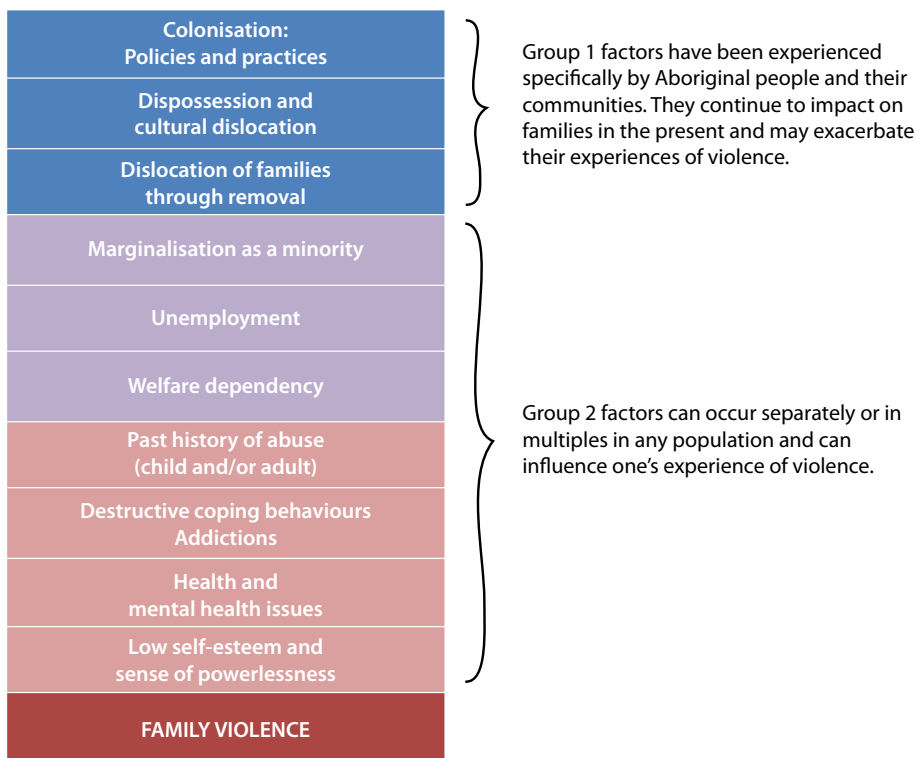
Source: Adapted from Cripps[16(p230)]

Group 2 factors can clearly be caused or compounded by Group 1 factors. The interplay of these factors in individual families' experiences of violence can at times be exceedingly complex, but to ignore the first group of factors and the role they have played and continue to play in families is tantamount to not understanding the violence as it occurs in Aboriginal communities.[9,34] Further, working with individuals and families who are living this reality requires careful consideration of how these combined factors impact on their immediate and long-term safety, on their SEWB, and on their ability to engage with service providers.

Kyle is a 13 year-old boy attending a Christian school on a remote island Aboriginal community. This school has had a long history in the community with many of the children's parents and grandparents having also attended the school. Their parents are also actively involved in the Church.

Kyle and other boys at the school have been telling their parents that a senior member of the Church has been interfering with them and that they don't want to go to school anymore, at least not while he is there. Kyle's parents do not accept his 'story', they are true believers in everything to do with the Church, there is no way that this senior member would do such a thing, particularly given his status and authority.

To complicate the situation further, there are no services on the remote island. The mainland is 200 kilometres away, he has no access to transport, he has no knowledge of where to begin or what service to contact, even if he did the community telephone is damaged and out of order. He cannot trust or speak to other members within the community because most of their sons are in the same situation. He is afraid to report it to the police with the fear of not being believed and the consequences he may receive by reporting such an incident. He has been considering suicide and he knows a few of his mates have been too. One of them was even successful a few weeks back—at least he has now escaped the Church.

Study Questions

1. The above case study demonstrates the power of the first disclosure and how it impacts on future disclosures. Why would Kyle's parents not believe him?

2. What are the potential consequences of this first disclosure for Kyle, his family, his mates, the community, the church? (Think short term, medium term, long term.)

3. How does one get information to this population (e.g. the boys in the first instance, then their parents, the community, the church) on available services and supports? What are the available services and supports?

When reflecting on this case study, consideration of the context is vitally important, both for the parents and the children reporting. Policies and practices of colonisation, dispossession and dislocation from families through removal have, to varying degrees, involved the use of missionaries and Christianity. Indeed, missionaries in some parts of the country offered reprieve and protection from the brutality of colonial occupation of Aboriginal lands. This is also a period in history when assimilationist ideals motivated the political and policy agenda as well as the practice of missionaries.[34] Aboriginal parents and grandparents will recall being brought up on the missions and the mission's influence in the formation of their understandings of spirituality, religion, gender roles, and parental roles and responsibilities. Having been indoctrinated with Christian ideals and to then be confronted with the situation in the case study, the first response of family members may well be one of denial, particularly if their own experiences failed to mirror that of their child and also because this disclosure would make them question all of the teachings that they had received from the missionaries and the Church.

The potential consequences of the first disclosure are significant for Kyle who would be feeling further isolated by his family's refusal to accept his story. He is considering reporting to the police but is afraid, and he is considering suicide, as are his mates. The big issue is, how is Kyle's story going to become known to the appropriate authorities so that assistance can be provided? In recent weeks, one of Kyle's mates committed suicide. Consequently:

- what services have come to town as a consequence of that death?

- what questions are being asked in relation to why his mate committed suicide?

- are services receptive to identifying risk factors of sexual abuse and responding to potential disclosures?

- does the scope of the coroner's inquiry include questions about possible sexual abuse? and

- can the unfortunate death of Kyle's mate leverage assistance for Kyle and the other young men affected by abuse at the school in terms of managing the grief of losing their mate but also identifying and understanding the trauma they have suffered individually and collectively as a result of the abuse?

Furthermore, any assistance provided will need to be gender specific, given that the abuse has been directed at males only. Supports also need to be multileveled, as the family and community will, given their community history, struggle to comprehend the violation of trust and grief associated with the loss of the young men who have taken their own lives, the enormity of the investigations, and the influx of outside services that may overwhelm their community. They may also struggle with how to move forward today but more specifically in 6, 12 or 18 months from now, when all the outsiders have left and individuals and communities are dealing with the aftermath.

One means of providing skills and resources within the community to confront the violence now and into the future is through education and awareness campaigns. In Victoria, for example, a number of commercials are on television regarding family violence. These commercials have been developed by community for the community and importantly include respected Elders and community members in the footage delivering the '*strong families strong culture*—use your strength wisely' message.

| Case Study | **Malia** |

Malia is a 24 year-old single mum of two young children aged two and five. She has recently separated from the children's father. The relationship was fraught from the start. He controlled what clothes she wore, he took all her money, and controlled who she could see and talk to. It was not long into the relationship and he had stopped her from having any contact with her family, she hadn't spoken to them since her oldest child was born, knowing that if she did she would cop a hiding if he found out and he said he would hurt them too. The violence (physical, sexual, emotional, financial) in the last several months had got a whole lot worse, it wasn't just him getting physical with her now, he was also threatening the kids, and several weeks ago the oldest child tried to stop him from hitting her and got a bloody nose as the slap landed on him instead. Malia as a consequence made the choice to leave, she waited for him to go to work, she packed a bag, and she left. Several hours later she called her Mum to ask if she can come home, she needs a safe place to stay. Her mum tells her I've been waiting a long time for you to ring, where are you I will come and get you?

It's now several weeks later, the children's father has found Malia and is threatening her and her family, she knows she isn't safe. She is seeking legal assistance to keep them all safe. But who does she turn to for help, the police? Her family have had really bad experiences with the police, can they be trusted? What about a lawyer? But how do you choose one, let alone how do you pay for it? There are also the issues of how does Malia manage all of the appointments with two little kids in tow? She doesn't have a car, so she relies on public transport. She also has a learning disability so understanding the documents services give her without assistance will be hard. Her Mum works and whilst she is supportive she doesn't want to get involved, she doesn't trust those lawyers and courts 'they've never done our family any good'. But Malia worries if she doesn't get some legal help, the children's father, could seriously hurt her, perhaps kill her and where would that leave the kids. She also knows that he could snatch the kids from her and given his history of violence is worried about what this would mean for the kids and for her?

1. Malia's case study is an all too common scenario in Aboriginal communities. It clearly identifies some of the everyday problems that Aboriginal victims are confronted with as they navigate their experiences of violence. Can you identify the key issues that may inhibit Malia's access to legal assistance?

2. How might these issues be overcome? How can service providers make their services more accessible to people in Malia's circumstances?

3. Are there any other circumstances (e.g. people with physical disabilities, people living in remote regions) that service providers should be considering in terms of making their services more accessible?

In recognition of the difficulty that many Indigenous women have in accessing legal services, the Australian government has, since 2002–03, funded Indigenous Family Violence Prevention Legal Services (FVPLS). Nationally there are now 29 services in largely rural and remote locations, importantly addressing the needs of victims of family violence. They provide culturally appropriate and holistic assistance to people in Malia's circumstances. They offer legal services, information, counselling, referral and practical support. They may also undertake preventative initiatives, such as community education and awareness programs. Information about the location of services in each state are available online.

It should also be noted that, unlike Malia, there will be other victims of violence who will not want to engage with the legal system but will want and need some form of assistance and support to move forward with their lives. There are many programs available that are targeting this population of women and their families. For example, Mudgin-Gal Aboriginal Women's Corporation runs a Healthy Family Circle program based in Sydney. It operates through a range of workshops, activities and informal exchanges, such as lunchtime yarns, and provides women and their children with skills that enable them to identify healthier, safer options for themselves and their children.

Whilst the focus of this case study has been on the immediate safety needs of Malia and her children, we should not forget the needs of her partner. He clearly has a history of violence towards Malia but should this history prevent him from having contact with his children? What services are available to address his needs? This would involve engaging in what may be challenging conversations involving the following questions:

- Why do Aboriginal men choose to take a course of violent action in response to a situation?

- Where does this violent response come from?

- How and why have these choices and actions become patterns of behaviour for men engaging in family violence?

- What is the impact of this behaviour on children and the relationships that they then have with their parents?

- What impact does this type of behaviour have on Aboriginal cultural security—not just the impact on individuals or families but for the collective, including how we maintain and practice our cultural values in light of what has been a 'normalisation' of violence in some families?

This involves carefully considering how values of men can be re-adjusted to ensure permanent change in their choices in behaviours to bring safety to women and children. The area of Aboriginal men's programs responding to the needs of men has grown significantly over the past decade yet, substantively, the number of services available to address men's needs are considerably less than that available for women.

Many men speak of their anger as being related to colonisation.[35] We don't dispute this but rather make the point that colonisation through its policies and practices, including dispossession and dislocation (in particular of families through removal), are 'better understood

as one of the many contexts that constrain the control which people experience in their lives, and limits their personal choices when they are placed under psychological stress'.[35(p30-31)] This situation has been well recognised by Aboriginal men in the Inteyerrkwe Statement, July 2008, when men from around Australia gathered to

> *acknowledge and say sorry for the hurt, pain and suffering caused by Aboriginal males to our wives, to our children, to our mothers, to our grandmothers, to our granddaughters, to our aunties, to our nieces and to our sisters. We also acknowledge that we need the love and support of our Aboriginal women to help us move forward.[36(p1)]*

The men have then, and since, worked

> *to develop strategies to ensure our future roles as husbands, grandfathers, fathers, uncles, nephews, brothers, grandsons and sons in caring for children in a safe family environment.[36(p1)]*

This requires men working through their trauma related issues, and also involves providing them with skills that enable better decision making in times of stress so that violence is not seen as an option. Men's ways of managing their trauma are too often, as Maggie White[37] explains, seen as 'bad' or sometimes 'mad', but rarely as 'sad'. Men are quickly seen as perpetrators but rarely as victims. Their ways of coping tend to bring them into contact with the justice system and it is here that they get their first court ordered behavioural change-type program, whether this occurs whilst incarcerated or whilst on some form of bail or community based order. Evaluations of these types of programs have had mixed results depending on the structure of the group (all Aboriginal or mixed), the Aboriginality of the facilitators, the length of the program, and the extent to which the program incorporates a cultural overlay recognising the significance of historical and present day circumstances, impacting upon and meditating men's understandings and representations of their masculinity and their anger[38]—see also Chapter 30 (Hovane and colleagues).

An international Indigenous-specific behaviour program that has been evaluated with demonstrated success is the Ke Ala Lokahi program conducted in Hawaii between 2000 and 2005. The program provided a culturally based intervention for Native Hawaiian perpetrators of family violence. The intervention was intended to build skills and increase knowledge of Native Hawaiian cultural values, beliefs and traditions. Participants attended 24 two hour weekly sessions with a final two day session held at a cultural site. Participants also had a case manager who maintained contact with probation services and provided individual counselling, advocacy, support and referrals for the men. In a formal evaluation of the program, both victims and perpetrators reported positive outcomes in knowledge about themselves and their relationships by participating in the program. Recidivism rates however, were still quite high at 36 per cent for those who had completed 80 per cent or more of the program. These rates were similar to rates for men in the standard intervention.[39(p3,6)]

A similar Australian-based program is *Red Dust Healing*. This program encourages men to examine their own experiences of being hurt before then examining what it is to be doing the hurting. It asks men as part of the healing journey to feel the emotions as they begin to get to know themselves, where they have come from and begin to envisage how they would like their futures to be. *Red Dust Healing*, like the Ke Ala Lokahi program, is designed to build men's self-esteem, self-confidence, and self-respect through focussed work on identity, responsibilities and relationships to enable men to make better choices for themselves and their families that breaks the cycle of violence. It includes an individual case management plan with appropriate referrals to relevant services. The case management plan is also supported by a mentor system that can assist and enhance completion of individual case plans. This program is not reliant on only court, ordered participants, it has been working with other population groups and has been

expanding to meet the needs of Aboriginal men and male youth. See Chapter 27 (Powell and colleagues) for a comprehensive discussion of the *Red Dust Healing* program.

As highlighted earlier, alcohol and substance misuse is a significant contributing factor to the incidence of violence in Aboriginal communities. For those who recognise that they have a problem, trying to access alcohol or substance rehabilitation is difficult. These people face long waiting lists, and services are often far away from their family and home. Programs such as Ke Ala Lokahi and *Red Dust Healing* will work with the men and referral agencies in an attempt to fast track placements, but this is reliant on such programs having good relationships and partnerships with services to facilitate better access for their male clients. Chapter 8 (Wilkes and colleagues) covers harmful substance use; Chapter 26 (Casey) discusses the *Strong Spirit Strong Mind* model.

For those wishing to build stronger family relationships, having worked on their own individual issues, services that bring the families together to foster the relationship and to build strategies to prevent future abuses are inconsistent particularly in rural and remote areas. This is where holistic programs that engage all family members, as was described in the example of Yorgum Aboriginal Family Counselling Service earlier in this chapter, are essential. Also in the child protection arena, the focus has been on children and their mothers on the basis that the mothers are the primary carers. Not a lot of effort has been invested in maintaining connections with Aboriginal fathers and their children, particularly if the father is aggressive or appears disinterested in child protection proceedings.[40] The immediate, medium and long term impact of this affects all parties, not just the men but also the children in terms of identity formation, cultural and kinship connections, and grief and loss for a relationship denied. These impacts are discussed further in Chapter 28 (Wanganeen).

REPORT RECOMMENDATIONS ON APPROPRIATE INTERVENTIONS

Returning to the plethora of reports commissioned by federal and state governments to address the violence in Aboriginal communities. The recommendations in these reports provide specific information on pathways forward for better service delivery and accessibility for Aboriginal victims of violence.

A comprehensive analysis of the major government reports over the past decade by Cripps identifies several recurring themes. These include:

- recognition of community diversity and needs, and the need to facilitate community choice in response to problems;

- a strong focus on strengthening the capacity of the existing workforce through accredited specialised training and the employment of Aboriginal workers, particularly counsellors;

- mandatory cultural awareness training for all non-Aboriginal workers; and

- the differing needs of women, men, children and Elders must be considered along with the demands for immediate safety, healing, perpetrator accountability, education and awareness, and prevention.[41]

This is not an easy task. It demands that the 'silos' service providers/government agencies so often work in, be broken down in the best interests of clients. Yet, this fundamental shift continues to be the biggest barrier to addressing violence and meeting the needs of all those affected by it. Evaluations and audit reports of progress since the initial state inquiries in this area have found that, whilst governments embrace the language of 'community development' and 'capacity building', attempts to implement a genuinely inclusive, community driven approach to addressing violence have been far from effective. Indeed, their repeated failure to support and promote the development of community initiatives have been widely criticised.[42,43] Governments have also been criticised for their lack of leadership in providing processes which

could support funded organisations to breakdown silos, recognising that working in partnership with other organisations in the best interests of clients, comes at a cost and is resource intensive. This is not factored in to existing funding agreements.[44]

Services recognise that the experience of violence and its aftermath can require the input of several agencies, working together to minimise the re-traumatisation of individuals and families from repeatedly having to tell their stories to every service provider they encounter. An interdisciplinary, case management approach involving all agencies in regular case meetings would be highly beneficial to the client and their families and has been consistently recommended by the many state reports into Aboriginal family violence, child abuse and sexual assault, but this standard has not been implemented in all regions or sectors working in the area of Aboriginal violence[4-9]—see Chapter 13 (Schultz and Walker and colleagues).

CONSIDERING DISABILITY AND THE NEED FOR CASE MANAGEMENT

The following case study provides a clear example of where 'silos' inhibit the access of victims of violence, particularly those with comorbidities.

Case Study ▶ Georgia

Georgia is a deaf Aboriginal woman fleeing a family violence situation with her children. She has in the past used a local disability service for a range of issues as they have staff who understand her signing. She turns up at that service today asking for help. The usual person she works with is on leave and she sees someone new. They immediately identify her as being Aboriginal and when she tells them why she is visiting them today they say 'hey that's really not something we deal with, you're Aboriginal, you should go to Aboriginal service down the road they can help you'. Georgia and the kids leave and go to the Aboriginal service. She is somewhat reluctant to go largely because her partner's sister works there and it might get back to him that she is wanting to leave. She goes into the service, nobody there knows how to sign so she has to write everything down. When she finally gets her story out, the person she's talking to says 'sorry we don't do family violence you will have to go to the shelter', and then they tell her where the shelter is. Georgia gets up again and with the kids, they walk another 45 minutes to the shelter. Just like the last service, they don't have someone who understands sign either so she writes down her story again, hoping this time it won't be for nothing that they will be able to help her. They say 'sorry love, we don't have the disability access you need, nor the beds for the kids, you will have to go to the disability service'. She has spent all day trying to get help, she knows she's going to be in strife if she hasn't found a place to stay soon, or if she isn't home before her partner with dinner on the table. She's been to all these services and no one was prepared to help her, so she goes home, it's all too hard. At least she knows what to expect from him.

Study Questions

1. What should Georgia have reasonably expected from the services?

2. What are the risks for Georgia and the children in going home?

3. Do any of the agencies involved have a duty of care to provide her with information and assistance?

4. Are there any reasons why the agencies would not want to work with this woman? Are these reasons justifiable?

Practical measures for assisting victims involve services working in partnership with the relevant sectors to facilitate better access for clients presenting with these issues. In such situations, one agency would be required to take the lead in arranging services to support and assist the client, prioritising safety in the first instance. This would not require the client to do the initial contacts

as was expected in Georgia's case. The agencies would already have a partnership agreement between them that would dictate how referrals between the agencies were to be managed which would necessitate forward planning and training of all staff involved. This hopefully will prevent inconsistent advice being given to clients. It would also identify any gaps in service delivery for particular groups (e.g. disabilities, mentally ill, substance affected) and allow the service sectors to consider how these groups in violent situations could be adequately supported.

The above case study provided the opportunity for the reader to contemplate how current service systems respond to particular groups with comorbidities. It is also important at this juncture to consider current and future service systems and their ability to provide a continuity of care. Federal and state government reports into Aboriginal violence and abuse have consistently called for long term funding for services that can meet the needs of victims over a life course, recognising that violence has long term effects. The following case study provides an insight into this situation.

CONTINUITY OF CARE

The current service system is crisis driven, and planning for the long term and for the life course has been limited. The following case highlights the need for a continuity of care model.

Case Study	**Mikaylah**

Mikaylah is a six year-old girl who has been sexual assaulted by a member of her extended family. The assault is discovered by her mum as she is getting her ready for a bath. What will Mikaylah need from a service system over her life course? Tonight she will need assistance from medical services, they will make mandatory reports to child protection and the police will also become involved.

Study Questions

1. What will Mikaylah and her family need six to twelve months from now as the matter proceeds through court?

2. What will Mikaylah need three to four years from now when she starts to hit puberty?

3. What will Mikaylah need several years later in her teenage years when she gets her first boyfriend and she is considering intimacy for the first time?

4. What about when Mikaylah's thinking about getting married—are any issues likely to arise at this time?

5. There is a growing evidence base that women with histories of sexual abuse are confronted with specific issues when they are pregnant. How might this affect Mikaylah when she becomes pregnant with her first child?

6. What kind of issues will Mikaylah be confronted with should other members of her family experience a sexual assault e.g. cousin, sister, brother, daughter?

It is clear from the above case study that Mikaylah will need services designed to prevent her from being re-traumatised every time she needs to retell and relive her story when she re-enters the system to deal with 'normal' life events. We are yet to reach this level of funding commitment and, whilst this is significant for 'newer' 'pilot' services which will inevitably be dictated by crisis responses and short term government contracts, for the older more established services where a commitment of funding is more assured, a consideration of Mikaylah in the cultural context that this chapter and this book more broadly provides is important in bridging the divide between crisis responses and genuine healing and support for victims and their broader kin network affected by the violence.

CONCLUSION

The consequences of violence in Aboriginal families and communities continue to be felt long after the bruises fade. The practical response to the problem means thinking about the complexities highlighted in the case studies in this chapter. A decade of reports clearly articulates that any response or intervention must fundamentally involve Aboriginal community members in defining the problem and its context, and in setting the parameters for pathways forward.

To move forward demands drawing on the wealth of knowledge and experience that many Aboriginal and non-Aboriginal community members and professionals already have from working with communities and families. It also requires a commitment to working in partnership with other agencies, towards the mutual goal of healing individuals, families and communities, to breaking the cycle of violence and creating safer, healthier, nurturing environments for our children.

Taking the time to know what is happening locally in terms of the extent of the problem, the current services available, and community members' access to such services is required, along with developing relationships for better service delivery with a variety of key players including other services, Aboriginal organisations, Elders, and most importantly the unsung heroes described earlier.

And finally, moving forward must also involve reflective practice. This can begin with the big picture with questions such as:

- Where have we been?
- Where do we need to go, including how do we challenge our value systems as a society to ensure that the voice of victims of violence are heard and acted on?

Then to the more specific questions of:

- How are our services currently accessed and by whom?
- Are we seen to be culturally 'safe' by the users of our service but also by the broader Aboriginal community?
- How might we reform our practices and/or approaches to become 'safe'? What and who might this involve? (See Chapter 12, Walker and colleagues, where issues of cultural competence are addressed in some detail.)
- Are we meeting the needs of clients with comorbidities? If we aren't, how can we?
- As to a service, how do we move past the crisis and plan for a longer term response? What and who will this involve?

The survival of Aboriginal families means nothing less than the survival of Aboriginal peoples and cultures. Failure to provide the support needed to address the problem of violence in our communities jeopardises our very existence. Our children represent the future. The decisions they make will carry Aboriginal peoples into the next generation. Therefore, navigating pathways forward in what is often a maze of complexity is essential to our combined futures.

REFLECTIVE EXERCISES

1. Why might Aboriginal victims of violence not disclose the reality of their experience(s)?
2. What factors might impact on a victim's choice to access services? How might a service accommodate these factors to ensure victims and others affected by the violence have access? Who might the others be?
3. Who are the unsung heroes? How might they be better supported?
4. What is reflective practice and why might it be important to service delivery?

RESOURCES

Yorgum Aboriginal Family Counselling Service

Information about Yorgum's Aboriginal-specific, community-based, counselling and referral services are available from:

http://www.yorgum.com.au/home.

Family Violence Commercials – Victoria

Television commercials delivering the '*strong families strong culture—use your strength wisely*' message can be viewed at:

http://www.youtube.com/watch?v=JIyKwh9yOyY ;
http://www.youtube.com/watch?v=bM8A7BMEScE ;
http://www.youtube.com/watch?v=okoLytSmOZU.

Family Violence Prevention Legal Services (FVPLS)

Information about the location of FVPLS providers in your state are available from:

http://www.ag.gov.au/LegalSystem/IndigenousLaw/Indigenousjusticepolicy/Documents/Family%20Violence%20Prevention%20Legal%20Services%20providers.pdf.

Healthy Family Circle Program

More information about the Healthy Family Circle program is available from:

http://www.snaicc.org.au/projects/dsp-default.cfm?loadref=83.

The Healthy Family Circle is one of a few programs showcased in the resource *HEALING IN PRACTICE: Promising Practices in Healing Programs for Aboriginal and Torres Strait Islander Children and Families*, available from:

http://www.snaicc.org.au/_uploads/rsfil/02926.pdf.

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Part 6
Healing Models and Programs

A number of culturally sensitive, culturally driven, culturally developed and culturally implemented programs and models provide pathways forward for individuals and communities. Involvement in and implementation of these cultural specific models and programs to assist individual and communities in the healing process and encouraging forward movement and positive participation in community and life are supported.

Chapters

24

Community Life and Development Programs – Pathways to Healing

Helen Milroy, Pat Dudgeon and Roz Walker

OVERVIEW

This chapter provides an overarching framework for understanding the components of healthy communities through a healing and community life development approach. The chapter explores three major themes covering the nature of the trauma that has occurred over many generations and continues to be experienced in the present. These are:

- the extreme sense of powerlessness and loss of control;
- the profound sense of loss, grief and disconnection; and
- the overwhelming sense of trauma and helplessness.

In turn, there are three pathways to recovery to address each of these areas of trauma that have occurred as a consequence of the history of colonisation and its impacts:

- self-determination and community governance;
- reconnection and community life; and
- restoration and community resilience.

Most significantly we argue that Aboriginal worldviews, developing a comprehensive, holistic approach that focuses on individual, family and community strengths whilst at the same time addressing the needs of the community, is both a more culturally acceptable and effective approach to address these issues.

INTRODUCTION

Currently, on all indicators, Aboriginal people suffer significant health and mental health morbidity, shortened life expectancy, as well as significant socioeconomic disadvantage.[1] See Chapter 1 (Dudgeon and colleagues) and Chapter 6 (Zubrick and colleagues) for a detailed discussion of the relevant statistics. Despite the extent of disadvantage and overrepresentation on all health and mental health indices, Aboriginal communities continue to display their cultural strengths and resilience in facing such adversity. There are a number of factors that have contributed to this state of affairs, including the historical legacy of colonisation, many unresolved issues over land rights, self-determination and identity,[2] as well as current levels of trauma and loss, poor economic development and the lack of human capital available to support families.[3] In view of the high level of burden and the multifactorial nature of the issues, no single program is likely to have a major sustainable impact on health and wellbeing.

At present, due to the altered pattern of distribution of the population across the ages, Aboriginal communities are predominantly young with a median age of 19 years. There are very few older age groups to provide buffering and support for children and community life—see Figure 24.1.

In view of the diminished community capability, together with the high level of risk factors present across all health, social, welfare and education indicators, programs intending to address health and mental health and wellbeing need to be sensitive to the realities of Aboriginal life. They also need to have both a focus on short-term gains as well as growing a healthy population to old age to become sustainable over generations. Another consideration will be prioritising the most urgent issues identified by the community whilst continuing to work on long-term sustainable change to improve health and wellbeing, in particular the safe and nurturing development of children.

Figure 24.1: Population Pyramid of Indigenous and Non-Indigenous Populations, 30 June 2011

Proportion of the Population (%)
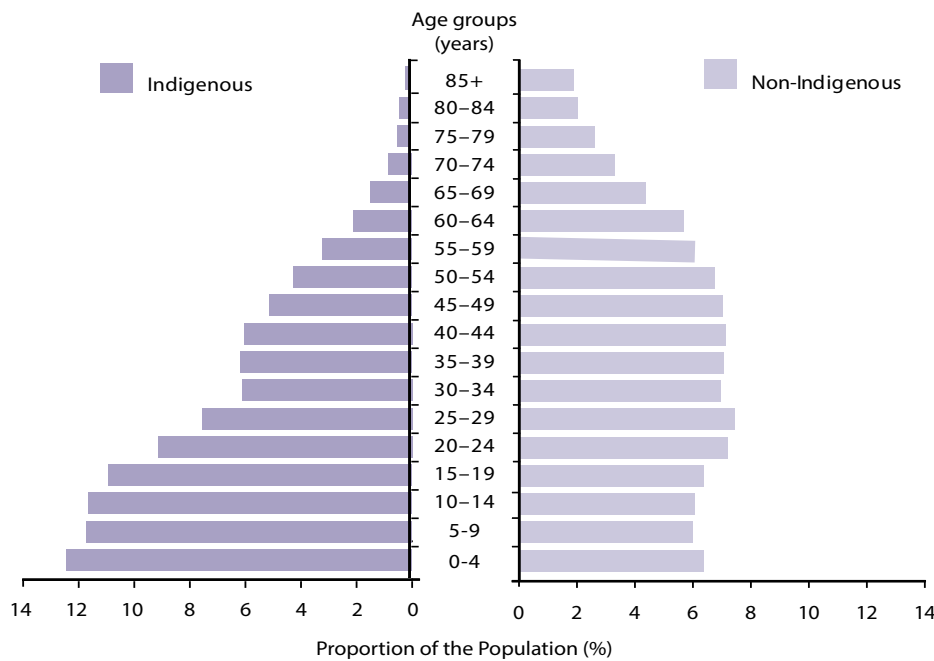
Source: ABS, 2012

Re-establishing Healthy Communities

The first step in re-establishing healthy communities is to acknowledge and understand the impact of the colonial legacy on the lives of Aboriginal people today and the various pathways necessary for healing from historical trauma, using both cultural and contemporary understandings and processes. Although the full history of Australia in regard to the treatment of Aboriginal peoples remains in dispute, there is enough evidence to support the experience of sustained, profound trauma for the entire Aboriginal community over generations, suggestive of genocide. See Chapters 1, 6 and 17 for further discussion.

It is partly the ongoing effects of this process that continue to impact negatively at the individual and community level that require healing before the contemporary issues can be successfully dealt with. Following this, establishing appropriate cultural, community, family and individual support systems and programs to address current needs and developments can occur systematically.

The themes that emerge in the pathways to recovery are:

- self-determination and community governance;
- reconnection and community life; and
- restoration and community resilience.

HEALING FROM HISTORICAL TRAUMA

In order to address these fundamental wounds, each element needs to be dealt with in its own right as well as collectively to repair the social fabric, re-establish community and cultural norms and support the safe development of children and young people.

The Legacy of Genocide

When considering the impacts of trauma experienced historically, there are three major themes that cover the nature of the trauma that occurred over many generations and continue to be experienced. These are:

- the extreme sense of powerlessness and loss of control;
- the profound sense of loss, grief and disconnection; and
- the overwhelming sense of trauma and helplessness.

Powerlessness and Loss of Control

With the imposition of Colonial Rule, Aboriginal peoples and communities experienced various forms of control over all aspects of their lives that undermined the ability to exercise their inherent rights over land, resources, family, children and community life. There were few, if any, avenues for appeal and if resistance or protest was shown by Aboriginal peoples, this was often dealt with in a way that further disempowered families and communities. The sense of powerlessness was in most cases extreme and multigenerational. The sense of degradation and humiliation at being treated as less than human with little regard for the most basic of human rights, remains a source of distress for many families.[4]

Colonial control was exerted through the clearing and taking of land with massacres and dispossession of clan groups; race-based legislation; slave labour; having an 'apartheid' system effectively excluding and alienating Aboriginal peoples from services, society and resources; denial of wages and economic development; imposition of a foreign legal system; and incarceration.[5]

Ways of coping with a sense of powerlessness vary. Some people become passive and are easy prey for further exploitation and abuse. For others, in an attempt to regain control, they may use violence, intimidation or coercion. It has been shown that feelings of powerlessness or lack of control over one's life have been linked to poor health and life outcomes,[6,7] despair and depression, suicide,[8] violence, substance misuse,[9] poor relationships and parenting difficulties. Refer to Chapter 19 (Marriott and Ferguson-Hill). In contrast, having a sense of control over one's life has been linked to better health and life outcomes, wellbeing and prosperity. Internationally, where the community has a sense of cultural continuity and control over services and community life, lower youth suicide rates have been reported in Indigenous peoples.[10]

Loss and Disconnection

It was estimated that prior to colonisation the Aboriginal population was between 500,000 and 1 million people. By the early 1900s, this had reduced to only 60,000, with recent estimates in 2006 at just over 500,000 people.[11] The sheer loss of life would have had a profound impact on families and communities but also has to be considered in the context of other losses. All forms of loss were experienced including the loss of land, culture, heritage, ancestry, identity, language and children. The current lack of human capital is partially due to these historical losses. With the forcible removal of children under government legislation from the early 1900s through to the 1970s as outlined in the *Bringing Them Home Report*, the negative impact on families, children and communities was extensive.[4] The Report noted the negative impact on health and wellbeing as well as difficulties parenting the next generation. As well, the deliberate

fragmentation of kinship systems made it difficult for many people to find their way home and re-establish links culturally and within the community.[4]

The profound sense of loss results in feelings of disconnection and isolation as well as multigenerational grief and existential despair. Currently, it is known that the loss of affectional bonds, especially in childhood, can have significant adverse effects on child development and across the life-course, leaving children and adults with mental health problems, poor coping mechanisms, difficulty in forming relationships and very likely to contribute to self-medication and substance misuse[9]. See Chapter 19 (Marriott and Ferguson-Hill) and Chapter 21 (Milroy) regarding the importance of affection in supporting positive outcomes.

As well, the death of a spouse can contribute to poor health and shortened life expectancy. Chronic grief can also reduce immune function and increase the risk for a range of chronic illnesses.[12] In some cases, communities have become extremely tolerant of abhorrent behaviour due to the chronic state of grief and to avoid experiencing any further loss. The extent of the impact of profound and continuing loss as currently exists in Aboriginal communities is unknown but this must act as a significant risk factor for poor health and life outcomes, especially during critical developmental periods in childhood. In contrast, having good social supports; strong family and attachment relationships; sensitive, nurturing care-giving in infancy; and a strong identity are protective factors for good health, social and emotional wellbeing (SEWB) and life outcomes (see Chapter 4, Gee and colleagues and Chapter 6, Zubrick and colleagues for further discussion on this topic).

Trauma and Helplessness

For Aboriginal peoples across Australia, all forms of trauma were experienced over time including the frontier violence and massacres; the deliberate introduction of diseases and poisoning; sexual abuse; economic and political abuse; as well as neglect, alienation and discrimination. Cultural and spiritual trauma was also experienced through the denial and denigration of cultural and spiritual beliefs and practices, the mislabelling of behaviours and experiences, and sacrilege through the decimation, destruction and removal of sacred sites, objects and deceased persons.

One of the central experiences of overwhelming and sustained trauma is a sense of utter helplessness and, combined with the ongoing fear and distress associated with traumatic experiences, many adverse outcomes can occur. These experiences can result in an inability to cope with life, disrupt emotional self-regulation, and reduce recovery to one's former potential. This can lead to mental illness and physical health problems, a sense of a foreshortened future, and an inability to develop mastery in life.

Trauma can impact negatively on behaviour, interpersonal relationships, family and community functioning, and may result in deliberate self-harm and self-medication with drugs and alcohol. Living in states of chronic stress can lead to physical problems and chronic disease, such as diabetes, hypertension and heart disease; and psychological problems, such as depression. Some people may cope by living very disrupted and chaotic lives while others may take too many risks and leave themselves and others exposed to further harm.

Trauma in childhood can have an array of adverse developmental impacts including the ability to focus on learning.[13] Trauma can also impact on psychological development in a variety of ways including effects on the sense of self and identity, on self in relation to others and on worldview. For example, repeated trauma in childhood can result in loss of trust, difficulties forming intimate relationships, poor attachment, poor identity formation and maladaptive coping mechanisms. In some cases of abuse, children may be at risk of becoming perpetrators of violence and sexual abuse on others and the cycle of abuse becomes transgenerational.

Although the experience of trauma can impact at any age, certain developmental stages are especially vulnerable. Infants, very young children, as well as old people, are dependent on others for protection and care. Teenagers can be very sensitive due to the developmental changes they are experiencing, and as the accumulation of trauma becomes more evident, the young person may feel alone and unsupported.[14] New mothers and fathers may also feel vulnerable as parenthood can rekindle their own traumatic childhood experiences (these issues are discussed in greater detail in Chapter 19, Marriott and Ferguson-Hill).

In contrast, having a sense of personal agency assists with developing personal and social skills and responsibility and good self-regulation and assists with healthy psychological development. For normal development, it is important to be able to self-soothe and reduce tension, to enable adequate sleep and to establish routines early in life. Healthy social and cultural norms with consistency, behavioural limits and nurturing supports are protective for child development.

The Importance of Family, Self-Value and Social Cohesion

Aboriginal culture is more collective than individualistic, held together through a kinship system involving a shared sense of identity, responsibility, care and control.[15] While the extent to which the kinship system influences or dominates family and community life was stronger traditionally, even though it is more fragmented it still remains strong today.[15] The family networks—aunt, uncle, brother, father, sister, mother, husband, wife or various other relations and affinities—govern almost all social interactions. Aboriginal culture is very integrated and, although harmed by dispossession, removal and cultural genocide, the role of extended family networks remain important for parenting children: while aunties, uncles, grandparents, older brothers and sisters are valued members of the parenting and caring system in which the childcare and parenting responsibilities are shared.[15] Nevertheless, many of the determinants impacting upon the health, mental health and SEWB of Aboriginal and Torres Strait Islander peoples are having a cumulative and detrimental impact on the capacity of families to maintain traditional roles and responsibilities.

PATHWAYS TO RECOVERY

Although there is considerable overlap within the three themes, it is important to address each one specifically as well as all three collectively to promote healing and recovery across generations. The themes that emerge in the pathways to recovery are:

- self-determination and community governance;
- reconnection and community life; and,
- restoration and community resilience.

The interrelatedness of the ways in which the ongoing history of transgenerational trauma impacts on individual, family and community SEWB, and specific pathways to recovery, are depicted in Figure 24.2 below. The diagram shows how each of the pathways to recovery outlines a framework for program development and, in combination, they provide a holistic framework to support community life and development detailed in Table 24.1 on page 431.

While each of the circles encompass the specific pathways to recovery related to each of three trauma themes, in combination they affirm that recognition of cultural strengths and facilitation of Aboriginal ways of working (and of leadership, healing and empowerment) is fundamental to promoting sustainable recovery. At the centre where the circles overlap each of the pathways of recovery come together containing the overall strength and recovery which in combination provide the holistic sense of health and SEWB (for individual, family and community). As discussed throughout the book, Aboriginal SEWB encompasses physical, psychological, social, cultural and spiritual elements.

Figure 24.2: Pathways to Recovery from Transgenerational Trauma
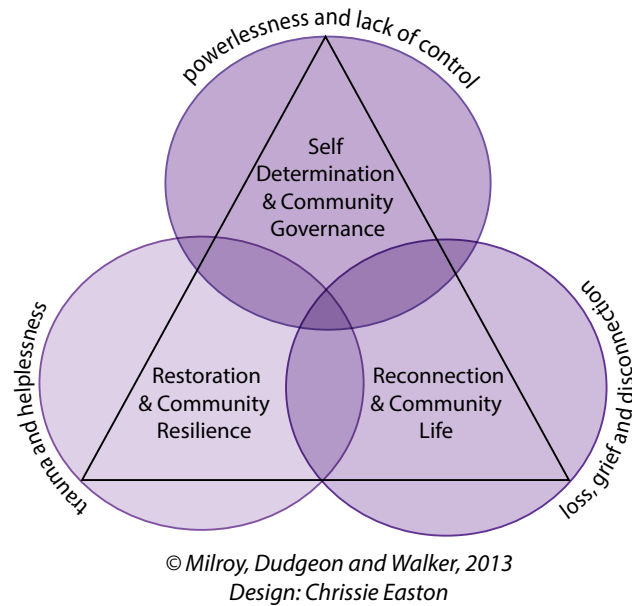
SELF-DETERMINATION AND COMMUNITY GOVERNANCE

One of the vestiges of the colonial legacy is powerlessness. To redress this, pathways to promote and develop self-determination are required. Being able to make decisions and be responsible for oneself, family and community, having choice and being able to participate effectively in society, is important for development and wellbeing.[16] For children, it is important to see their parents and Elders in positions of responsibility and respect in society, in decision-making and leadership roles. In turn it is important that parents and Elders have a sense of self efficacy, sense of control and self-determination. How this is developed from a cultural and community perspective will require further consultation, but some basic principles can be applied. The *Human Rights and Equal Opportunity Commission* (HREOC) *Social Justice Report* 2002, provides a detailed discussion on self-determination and notes the following points:[17]

> *Self-determination is an ongoing process that ensures the continuance of choice, participation, decision making and control over ones destiny:*
>
> - *It involves the freedom to live well, humanly and respectfully according to values and beliefs.*
>
> - *It includes the notion of a collective identity for Aboriginal peoples.*
>
> - *It requires recognition and support with appropriate representation at all levels of society.*

It is important to recognise the difference between those practices that have arisen through the trauma associated with colonisation and those based on traditional cultural principles. Governing through fear and threat or for personal gain is not a cultural norm and, in most cases, governance was a shared process with the aim of having a balanced, harmonious and respectful community life. Empowerment is an important part of this process to enable individuals and communities to speak up on issues or in consultations without fear of reprisal, and for true consensus to be reached.

Questions That Need to be Addressed

Some of the issues/questions that arise for communities and stakeholders in pursuing self-determination and community governance are as follows:

Questions for Self-determination and Community Governance

- How is personal and collective decision-making conducted? What are the cultural protocols in place and are they effective?
- What are the community governance arrangements?
- How is the sense of community identity expressed and transmitted across generations?
- What methods are used for individual and community level empowerment and leadership?
- How is conflict and dispute resolution conducted within a cultural framework?
- What aspects of traditional law are still important and effective in the community?
- Which kinship obligations still work effectively?
- What exposure do children have to effective decision-making and leadership role modelling?
- What community processes support children and youth to be autonomous, responsible and make good choices?
- How are families supported to be both nurturing and protective of children?
- What happens for those families and children who are not doing well?

The program pathways that arise from the discussion between community members could address the issues of taking back control and being empowered through understanding the history, previous mechanisms of control, and contemporary issues of relevance. It will also need to include understanding the ongoing nature of discrimination and disadvantage and how these issues impact on the community.

Program Pathways for Addressing Governance and Leadership

Programs may include those that address the community structure, governance, representational and participation levels, as well as the individual and family models of decision-making, problem solving and relationship structures. It is also important to include educational, economic and career programs to enhance potential and provide opportunity for growth.

Programs may include the following:

Programs to Address Governance and Leadership

- Empowerment, assertiveness and leadership programs
- Governance and management training
- Elders forums
- Community forums to enhance identity
- Community life, harmony and celebration events

Continued . . . .

RECONNECTION AND COMMUNITY LIFE

To redress the generational and current levels of loss and grief it is necessary to strengthen connections to culture, community, family and spirituality. Importantly, reclaiming the history of the group and creating an ancestral and community story of connections to family and country, will help to restore a sense of cultural continuity.

Individual stories of loss and resilience are also important in retaining the community narrative from past to present and into the future. For children, it is important in their development to know where they have come from, where they belong and how this knowledge will be transferred to the next generation. This knowledge can create pride in identity and a sense of being accepted and supported within a larger family and community structure. Having a strongly woven social fabric will support social inclusion, cohesion and reduce feelings of isolation and vulnerability in knowing there is always someone to connect with, to feel supported by, and be held in mind even when separated.

Questions that need to be addressed

Some of the questions around supporting reconnection and community life are as follows:

Questions for Reconnection and Community Life

- What healing ceremonies or practices are required for the varying levels of historical loss, including massacre sites?

- What current practices assist in dealing with the ongoing loss in the community?

- How are families supported in bereavement?

- How are children supported in bereavement?

- What has been available to assist the Stolen Generation peoples?

- How are people re-integrated back into the community after absences such as incarceration, illness, or foster care?

- What current community or cultural practices enhance a sense of connection?

Continued . . . .

- How is life celebrated including new births in the community?
- How are women supported to connect together?
- How are men supported to connect together?
- How are children connected and supported in their development?
- How is attachment in infancy supported?
- How are Elders supported?
- How are family conflicts resolved?

Program pathways for enhancing a sense of cultural connectedness

The program pathways that arise from these issues are about understanding the historical legacy of loss in the broadest sense, cultural and community practices to enhance a sense of connectedness, inclusion and cohesion, and contemporary processes that can assist in recovery. These programs may look at family and community relationships, what processes affirm a strong cultural identity, restoring the community and individual narrative, re-integration and family/community reunion processes, grief and loss issues. It may be important to hold particular ceremonies to address historical losses and promote recovery. Programs may include the following:

Programs for Enhancing Cultural Connectedness

- Bringing them home and Link-up services
- Family re-unification programs
- Grief counselling for individuals and family
- Community grief programs and ceremonies
- Recording of oral histories
- Community cultural celebrations
- Strong men's groups
- Strong women's groups
- Elders' groups
- Cultural renaissance programs, for example, language nests, dance groups, art forums
- Family support programs
- Mothers' and infants' support programs

RESTORATION AND COMMUNITY RESILIENCE

Given trauma has continued on many levels across generations, healing from trauma is a slow and complex process. As genocide was a foreign concept for Aboriginal people, there is no existing complete healing process for trauma of this magnitude. However, there would have been a range of common strategies used to support people, assist in coping, and enhance recovery. The impact of trauma on children is often overlooked, thinking that children are too young to understand or are resilient. However, the earlier the exposure to trauma, the more severe the impact can be. As one of the central themes arising from the experience of trauma is utter helplessness, restoring a sense of mastery is essential.

Achieving a Sense of Mastery

Achieving a sense of mastery is important across all age groups. It assists us to experience a sense of achievement in being able to do things for ourselves as well as others, develop confidence, be responsible, cope with disappointments and be self-regulating.[18] As well, reducing fear and having places that promote a sense of calm and safety are important. Some of the other major issues are being able to trust in yourself and others, feeling safe and protected, being able to respect those in authority.

Restoration of the self, family, community and culture within a cultural framework is required in order to re-establish social and cultural norms for the healthy development of children. While reconnection gives us the social fabric that keeps us grounded in supportive relationships, restoration is the process that strengthens the individual and social fabric from tearing apart.[19] For any group, there are a range of cultural, community, family and individual mechanisms and factors that assist in times of stress and promote positive coping and recovery.

Children often learn how to cope or how to do things by watching their peers, family and community members. It is important for adults to show responsible and caring behaviour if they expect their children to do the same. However, under extreme conditions, maladaptive coping strategies can develop and these can become entrenched in families and communities. Examples of this are evident in stories such as those in Chapter 20 (Hayes, D'Antoine and Carter).

Questions That Need to be Addressed

However, it is important to recognise the strengths and resilience inherent in Aboriginal culture and families, as well as the impact of the historical legacy on coping styles to understand what is currently happening. By understanding what are proper cultural and social norms, healthy coping mechanisms can be restored.

Some of the questions underpinning such programs are:

Questions for Restoration and Community Resilience

- What were the old ways people coped with stress?
- What happens now?
- What cultural and community mechanisms supported people to recover?
- How did the family and community protect children and keep people safe?
- What were the sanctions for those who did harm to others?
- What are the common behaviours people display when under stress or when something bad happens?
- What are the strengths in the community?
- What are the problems in the community?
- Are there cultural ceremonies/practices for healing from trauma?
- Are there cultural ceremonies for restoring the spirit?
- Are there places in the community where bad things happened that need a healing process?
- Are there places for healing in the community?

Continued . . . .

- Are there places for sanctuary, where you can be quiet, calm and peaceful?
- Are there safe places in the community?
- How do people show respect for these places?
- Are there community counsellors?
- How does the community intervene if families are not safe for children?
- How does parenting work in the families and community?
- How are morals and responsible behaviour taught (right way)?
- How is joy and happiness experienced in the community?
- What are the community's cultural values or principles?
- How are these upheld in the community?
- What are the ways to restore justice in the community?
- What are the barriers to changing bad behaviours?

The program pathways that arise from these issues take into account the behaviours and experiences of the community in order to meet the needs appropriately.

Program Pathways for Building Community Capacity

The programs should aim to build community capacity for the establishment of wellbeing, as well as strengthen positive coping and recovery. This can be achieved by enhancing the individual, family and community's ability to recognise problems, deal with them proactively, seek help as required and improve the responsiveness and appropriateness of services.

Programs may include:

Programs for Building Community Capacity

- Restoring the cultural narrative and promoting strengths in the community
- Mental health first aid education
- Child emotional development programs
- Community protocols promoting cultural values
- Drug and alcohol programs
- Counselling programs
- Mental health programs including individual and family intervention
- Recovery-focussed rehabilitation
- Offender programs
- Support groups
- Family violence programs
- Child protection programs

Continued . . . .

- Safe houses
- Restorative justice programs
- Relaxation, sport and recreational programs
- Healing Centres
- Cultural Healing Programs

MOVING FORWARD

Although there are three themes outlined above, there is clearly a lot of overlap in some of the impacts and pathways for recovery. It is important however, to make sure there is consideration given to each of the different themes to understand the magnitude of the issues and various aspects of recovery.

Questions for Moving Forward

There are also several other questions and issues of importance when considering the broader aspects of healing and moving forward. These include:

- What used to work well and why?
- What doesn't work well anymore and why?
- What are the critical elements of culture to be carried forward?
- How can this be done?
- How is this integrated into the programs?
- What can we learn from Western knowledge?
- How can this be applied appropriately (with cultural safety)?
- What are the strengths, weaknesses, opportunities and threats (SWOT) to recovery and prosperity?

The *Australian Human Rights Commission* (AHRC) paper concludes that Australian government policies and programs tend to adopt a 'crisis management' approach to Aboriginal and Torres Strait Islander policy 'which feeds the sense of inequality experienced by Aboriginal Australians through paying for poor health, education, housing, employment status and so on'.[2] Despite record levels of expenditure, the current policy formulation and implementation process (including Close the Gap initiatives) does nothing more than manage the inequality that Indigenous peoples experience.

> *Clearly, what is needed is an approach based in partnership and mutual respect which seeks to facilitate Aboriginal and Torres Strait Islander participation on an equal basis, or to allow Indigenous peoples in the words of Madame Daes to 'live well'.*
>
> *Nothing less than the recognition of our right to self-determination is needed to begin to remedy our current situation.[2]*

CONCLUSION

This chapter has outlined a range of factors that impact on Aboriginal mental health and SEWB. It proposes a number of key themes that need to be acknowledged if we are to address many of the complex and interrelated issues that impact on Aboriginal and Torres Strait Islander communities. Importantly, we have outlined the various pathways to recovery that are required to build on existing cultural strengths, and empower individuals, families and communities to move forward.

REFLECTIVE EXERCISES

1. Read the case studies from Chapters 21 and/or 23 and, for each case study, choose the program pathway you would begin with.

2. Look at the questions in the following tables and consider, in your role as a practitioner, community member or policy maker, the steps you would take to address either individual, family or community mental health and wellbeing.

Table 24.1: Programs Development Summary

THEME 1	
Powerlessness and Loss of Control	
Questions to be asked	How is personal and collective decision-making conducted? What are the cultural protocols in place and are they effective?
	What are the community governance arrangements?
	How is the sense of community identity expressed and transmitted across generations?
	What methods are used for individual and community level empowerment and leadership?
	How is conflict and dispute resolution conducted within a cultural framework?
	What aspects of traditional law are still important and effective in the community?
	Which kinship obligations still work effectively?
	What exposure do children have to effective decision-making and leadership role modelling?
	What community processes support children and youth to be autonomous, responsible and make good choices?
	How are families supported to be both nurturing and protective of children?
	What happens for those families and children who are not doing well?
Self-determination and Community Governance	
Pathways to recovery	Empowerment, assertiveness and leadership programs
	Governance and management training
	Elders forums
	Community forums to enhance identity
	Community life, harmony and celebration events
	Community life skills programs
	Family mediation and conflict resolution
	Parenting programs
	Child development and school/education programs
	Continued . . . .

Table 24.1: Programs Development Summary (continued)

THEME 1 *(continued)*	
Self-determination and Community Governance *(continued)*	
Pathways to recovery *(continued)*	Healthy lifestyles, healthy choices and promotion of health and wellbeing activities
	Individual and clinical programs to support problem solving, coping skills, self-esteem, motivation and responsibility
	Economic development, career and work programs
	Understanding and dealing with racism and discrimination
THEME 2	
Loss and Disconnection	
Questions to be asked	What healing ceremonies or practices are required for the levels of historical loss, including massacre sites?
	What current practices assist in the ongoing loss in the community?
	How are families supported in bereavement?
	How are children supported in bereavement?
	What has been available to assist the Stolen Generation peoples?
	How are people re-integrated back into the community after absences such as incarceration, illness, or foster care?
	What current community or cultural practices enhance a sense of connection?
	How is life celebrated including new births in the community?
	How are women supported to connect together?
	How are men supported to connect together?
	How are children connected and supported in their development?
	How is attachment in infancy supported?
	How are Elders supported?
	How are family conflicts resolved?
Reconnection and Community Life	
Pathways to recovery	Bringing them home and Link-up services
	Family re-unification programs
	Grief counselling individual and family
	Community grief programs and ceremonies
	Recording of oral histories
	Community cultural celebrations
	Strong men's groups/ Strong women's groups
	Elders' groups
	Cultural renaissance programs, for example, language nests, dance groups, art forums
	Family support programs
	Mothers' and infants' support programs
	Continued . . . .

Table 24.1: Programs Development Summary (continued)

	THEME 3
	Trauma and Helplessness
Questions to be asked	What were the old ways people coped with stress?
	What happens now?
	What cultural and community mechanisms supported people to recover?
	How did the family and community protect children and keep people safe?
	What were the sanctions for those who did harm to others?
	What are the common behaviours people display when under stress or when something bad happens?
	What are the strengths in the community?
	What are the problems in the community?
	Are there cultural ceremonies/practices for healing from trauma?
	Are there cultural ceremonies for restoring the spirit?
	Are there places in the community where bad things happened that need a healing process?
	Are there places for healing in the community?
	Are there places for sanctuary, where you can be quiet, calm and peaceful?
	Are there safe places in the community?
	How do people show respect for these places?
	Are there community counsellors?
	How does the community intervene if families are not safe for children?
	How does parenting work in the families and community?
	How are morals and responsible behaviour taught (right way)?
	How is joy and happiness experienced in the community?
	What are the community's cultural values or principles?
	How are these upheld in the community?
	What are the ways to restore justice in the community?
	What are the barriers to changing bad behaviours?
	Restoration and community resilience
Pathways to recovery	Restoring the cultural narrative and promoting strengths in the community
	Mental health first aid education
	Child emotional development programs
	Community protocols promoting cultural values
	Drug and alcohol programs
	Counselling programs
	Mental health programs including individual and family intervention
	Continued . . . .

Table 24.1: Programs Development Summary (continued)

THEME 3 (continued)	
Restoration and community resilience *(continued)*	
Pathways to recovery *(continued)*	Recovery-focussed rehabilitation
	Offender programs
	Support groups
	Family violence programs
	Child protection programs
	Safe houses
	Restorative justice programs
	Relaxation, sport and recreational programs
	Healing Centres
	Cultural Healing Programs

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Enhancing Wellbeing, Empowerment, Healing and Leadership

Pat Dudgeon, Roz Walker, Clair Scrine, Kathleen Cox, Divina D'Anna, Cheryl Dunkley, Kerrie Kelly and Katherine Hams

OVERVIEW

This chapter explores the relevance of Aboriginal perspectives of empowerment, healing and leadership, as strategies to address the social inequality and relative powerlessness of Aboriginal people in contemporary society. These Aboriginal-led strategies are key social determinants that influence Aboriginal health, mental health and social and emotional wellbeing. Programs that facilitate Aboriginal understandings of healing, empowerment, and leadership can redress much of the grief, loss, and trauma experienced by Aboriginal families and communities. The chapter highlights the need for Aboriginal people to have ownership over the issues and the solutions to the devastation brought about from a history of social injustices and disadvantage. Based on the findings from Aboriginal community consultations in the Kimberley, this chapter outlines community-identified strategies to take charge of their lives, strengthen their families and address the unacceptable and devastating rates of suicide in their communities. Importantly, the community proposed solutions are confirmed by the extensive literature and program review undertaken as part of the *Hear Our Voices* project led by Dudgeon.[1]

BACKGROUND

There is an extensive body of research and evidence that shows the array of environmental, social, economic, cultural and historical factors influencing and determining Aboriginal SEWB. See, for example, Chapter 1 (Dudgeon and colleagues) and Chapter 6 (Zubrick and colleagues). The damage and trauma inflicted on Aboriginal people by colonisation, including the forcible removal of children from their families and cultural heritage (often into situations of cultural, physical and sexual abuse) and forcible removal of lands and the break-up of societies and families, has had a devastating and lasting impact. The various elements of this have been documented in several chapters in this book—for example, in Chapter 1, Dudgeon and colleagues detail the family breakdown, cultural dislocation, racism, discrimination, social disadvantage and physical health problems; in Chapter 17, Atkinson and colleagues describe the high levels of unresolved grief and loss, trauma and abuse; in Chapter 23, Kripps and Adams examine community and domestic violence; in Chapter 8, Wilkes and colleagues outline the harmful substance use; and in Chapter 10, Heffernan and colleagues describe identity issues and incarceration. Each of the chapters identify strategies to address the respective issues.

The extraordinarily high rates of suicide and other social and emotional wellbeing (SEWB) problems in Aboriginal communities are commonly attributed to a complex set of risk factors and disadvantage shared by other Australians, as well as a broader set of social, economic, historic and cultural determinants that impact on Aboriginal SEWB and mental health—see, for example, Chapter 4 (Gee and colleagues). Serious psychological distress among Aboriginal and

Torres Strait Islander peoples also tends to be correlated with higher exposure to stressful life events including death of family members, serious illness, accidents, incarceration of family members and poor family and community functioning.

Addressing Aboriginal SEWB and mental health is often beyond the capacity of the mainstream health and mental health systems. Even if general practitioners and mental health care providers were geographically accessible to Aboriginal communities (which often they are not), the lack of cultural competence of most service providers creates an additional barrier to effective service provision within a SEWB framework. The *Hear Our Voices* project confirms that, to be effective, programs and services need to be culturally-based and incorporate cultural elements.[1]

THE POLICY AND PROGRAM CONTEXT

Much of the Aboriginal mental health plans and suicide prevention policies to date have not implemented strategies to restore SEWB at a community level. Being identified as an 'at-risk' group within the wider population has resulted in a number of culturally-specific strategies and programs where only the most vulnerable groups receive short-term support. Multiple short-term projects that reach small numbers will not achieve the critical balance required to restore SEWB across the Aboriginal population. Furthermore, these programs and strategies are often not appropriate or effective for Aboriginal people and communities. The new *Roadmap for National Mental Health Reform 2012–2023* includes a *Taking Action to Tackle Suicide* component and a National Partnership Agreement on Mental Health with the States and Territories. The development of a *Fifth National Mental Health Plan 2014–2019* is being guided by the *Roadmap* and is expected to provide extensive opportunities for Aboriginal input through state and national advisory groups including Aboriginal and Torres Strait Islander Mental Health Advisory Group (ATSIMHAG) which is going combine with suicide prevention. See also Chapter 5 (Zubrick and colleagues) for further discussion on the evolving policy context.

There are many programs and services that address substance misuse, domestic and child abuse and family violence, and other manifestations of people's disadvantage and distress. However, the consultations with Kimberley communities and, more recently, those undertaken in nine sites across Australia (as part of the *National Empowerment Program*, both led by Dudgeon (2012, 2013 respectively),[2] confirm that more programs are required that empower Aboriginal people to heal themselves and take charge. It is evident that communities consulted want to take charge to change their lives and those of their families and communities, by addressing the specific issues impacting on their health—on their own terms and through an Aboriginal understanding of healing and wellbeing.[1] Several chapters in this book confirm that there is substantial evidence to show that lasting trauma suffered collectively by Aboriginal people needs acknowledgement, recognition and healing. At the same time, evidence suggests that it is critical to enable people to move from a 'victim mentality' to a strong sense of positive self-esteem and empowerment in order to change their circumstances.

Evidence also shows that an effective way of enhancing Aboriginal peoples' SEWB is through programs that focus on restoring and building on Aboriginal strengths. Programs need to foster good SEWB by working 'upstream', to enable Aboriginal people to enhance and build on their unique sources of strength and resilience linked to their social cohesion and connections to family and kin, country and cultural identities as outlined by Gee and colleagues (Chapter 4). Furthermore, services need to engage with the diversity of cultures and language groups and develop programs to meet local needs rather than simply adapting and delivering models designed for mainstream Australians, or assuming that for Aboriginal people 'one size fits all'.

The Importance of Hearing Aboriginal Voices

Listening to what Aboriginal people are saying they need is critically important. The *Hear Our Voices* project involved an extensive community consultation process led by a team of highly qualified and experienced researchers and practitioners in Aboriginal community SEWB. The community consultations identified existing gaps in services and supports and the need for programs to address empowerment and wellbeing and build individual and community resilience. The results of this project highlighted the importance of listening to Aboriginal people who themselves identified healing, empowerment and leadership as three critical elements in meeting their needs and aspirations. This was confirmed by the literature, which showed that addressing each of these elements provides some of the most effective and appropriate ways of enhancing the SEWB and 'suicide proofing' of Aboriginal individuals, families and communities.[3]

Identifying the protective factors that enhance the SEWB of Aboriginal communities, as well as those factors that contribute to community distress and suicide, is paramount. It requires an in-depth knowledge of the historic, social, cultural and economic risk factors at play in each community, which are best known and understood by community residents themselves. While external change agents might catalyse action or help create spaces for people to undertake a change process, healing and empowerment can occur only when/if communities create their own momentum, gain their own skills, and advocate for their own changes. To be effective, each language group/nation and/or community needs to be supported to achieve the goal of restoring SEWB at individual, family and community levels through a process of healing and empowerment. There are several examples of positive community change occurring in communities with very promising outcomes and cumulative benefits. See, for example, Chapter 20 (Hayes, D'Antoine and Carter) where communities are working to address harmful alcohol use in pregnancy.

Empowerment

The term empowerment has its roots in the civil rights and women's movements of the 'social action ideology' of the 1960s and the 'self-help' ideology of the 1970s.[4(p7)] In the early use of the term, psychologist Julian Rappaport described the aim of empowerment as 'to enhance the possibility for people to control their own lives'.[5(p15)] During the 1980s, empowerment became popularised in community psychology and community development where it was described as a means of effecting change through people, organisations and communities gaining control over their lives.[6(p380)] Furthermore, empowerment was understood as operating at the level of the individual, the family and the community. The Centre for Aboriginal Studies developed a Bachelor of Applied Science in Community Management and Development on the basis of the theory empowerment, as critical for Aboriginal self-determination and individual, family and community and broader social transformation.[7]

Individual Empowerment

Some of the literature on individual empowerment describes it in terms of a range of essential elements or set of beliefs and attitudes identified with becoming or being empowered. These elements include self-worth, hope, choice, autonomy, identity and efficacy, improved perceptions of self-worth, empathy and perceived ability to help others, the ability to analyse problems, a belief in one's ability to exert control over life circumstances, and a sense of coherence about one's place in the world.[8-10] Authors also talk of particular skills and knowledge required for people to act 'empowered', including emotional control, and reflective, analytic, communication and decision-making skills.[11, 12] Where studies talk of empowerment outcomes having been achieved, the focus is on some element of change or transformation having taken place. Often it is where people have a sense of greater choice in their decision-making and behaviour.[9, 13, 14]

Group/Community Empowerment

Group empowerment can include stronger social networks and community participation in organisational decision-making, perceptions of support, community connectedness and the ability to reach consensus on goal-oriented strategies. Community empowerment has also been described as a process that progresses along a dynamic continuum: individual empowerment; small groups; community organisation; partnerships; and political action.[9]

From a community development perspective, empowerment strategies are understood as a means for disadvantaged communities to challenge social injustice by uncovering the mechanisms of control, the institutional or structural barriers, the cultural norms and social biases. In doing so, people are able to challenge internalised oppression and develop new representations of reality.[4] It is these understandings that suggest why the concept of empowerment is seen by Aboriginal people and others as an effective and appropriate healing strategy, specifically as a means of redressing the damage and trauma experienced from a history of social injustices.

ABORIGINAL PERSPECTIVES ON EMPOWERMENT, HEALING AND LEADERSHIP

Discussions about Aboriginal healing and empowerment are relatively recent in the literature. Yet some important research suggests that they are an effective and appropriate means for Aboriginal people to redress the damage and trauma experienced from a history of social injustices. While there are many definitions of health and healing, there is a general acceptance that the concept of healing for Aboriginal people is itself specific to the experiences of Aboriginal people and differs considerably from many Western worldviews of healing as individual treatment modes.

National consultations undertaken by the Aboriginal and Torres Strait Islander Healing Foundation in *Voices from the Campfires* (2009), found that Aboriginal participants saw healing as a spiritual journey that requires initiatives to assist in the recovery from trauma and addiction, and reconnection to the family, community and culture.[10] Similarly, in the consultations for *Hear Our Voices,* people spoke of healing as:

> *A spiritual understanding of self, identity, love, belonging, family, security, hurt, heartache, good times, laughter and our connection to land. Having hope and finding acceptance based on love and respect, of understanding ourselves, our supports and being able to tell "our" stories. Becoming empowered is how we can start to deal with the pain and grief and then help others and our community.[1(p69)]*

Of importance to this concept of healing is the way it is understood—as both an individual's personal journey and that of the collective, and one involving regaining agency and control.

Linking Individual and Collective Empowerment

The links between the individual and the collective cannot be easily separated within Aboriginal healing programs. In fact, we suggest that one of the main reasons why so many mainstream programs fail, stems from a lack of understanding about the interdependence of individual and collective goals for Aboriginal people and individual change and healing as concerned with simultaneously healing one's self and community.[15] Hunter et al.,[16] concluded from their study of the *Yarrabah Family Life Promotion Program* in the Yarrabah community, Queensland, that the focus on healing the community as opposed to the individual was the key to the success of the program in addressing high rates of suicide.

The authors suggested that mainstream responses to suicide, which focused on the individual, were largely ineffective and the Yarrabah community eventually came to focus more strongly on interventions that addressed community level risk factors.[16(p65)] They noted that the two main advantages of focusing on the community, rather than the individual, were that it:

- acknowledges and addresses the true underlying causes of self-harming behaviour in Aboriginal communities; and

- provides a conceptual and practical framework that accommodates the involvement of ordinary community members in a way that the individual risk focused approach does not.[16(p64)]

The Family Wellbeing Program

Other authors and programs consider the role of the family as central to the individual's healing journey and the basis for healthy and empowered communities. Research on the *Family Wellbeing Program* in the *Empowerment Research Program* (ERP), at James Cook University in Queensland, identifies the focus on individual and family and their community as essential, but not necessarily operating in unison.[17] The program's original architects acknowledged the central role kinship and family plays in Aboriginal people's lives, and designed a program that facilitated stronger family relationships with a focus on improved communication and less conflict. The ERP involved a two-staged process focusing:

- firstly, on an individual's personal empowerment and growth; and

- secondly, on community development processes to assist groups to collectively address community issues and bring about change together.

Program participants support each other to collectively address problems they face, with the problem-solving skills individuals acquire, then having a ripple effect, as people start working together to affect change at the level of the family and the community.[17]

Holistic approaches are another important aspect of Aboriginal perspectives on healing. McEwan and Tsey (2009) state that the essence of holism as it is used in Aboriginal Australian health discourse, refers to 'the interconnectedness of life's dimensions'.[18(p14)] The interconnectedness of cultural domains and their relationship to health and SEWB is further developed by Gee and colleagues in Chapter 4. This sense of interconnectedness also describes Aboriginal conceptions of healing, empowerment and leadership understood as part of one continuum. Programs designed to foster empowerment are increasingly recognised as an effective way that Aboriginal people can begin the healing journey and, by becoming empowered, are then able to lead and assist others in their own healing.

Strengths-based Approaches

One important aspect to the effectiveness of healing, empowerment and leadership as a strategy, is its fit with a strengths-based approach to addressing health and mental health issues. This approach focuses on Aboriginal peoples' inherent strengths; it involves working in partnership with Aboriginal people rather than using a 'top down' approach; and assumes that Aboriginal people are best placed to identify the issues in their community and the ways to address them.[1, 19] In the literature, many authors describe empowerment as a process of healing that involves Aboriginal people coming to terms with past and present situations and dealing with the pain. They describe healing through empowerment as a process of 'decolonisation' and redressing the ongoing inequality experienced by Aboriginal people and communities (see Wanganeen, Chapter 28).[13, 20-22]

Those who promote the concept of empowerment are especially critical of programs and strategies that assume Aboriginal people and communities lack the tools or ability to address their own issues. Many are critical that health professionals and policy makers continue to assume that best practice health interventions with Aboriginal people depend entirely on 'the ingenuity, expertise and generosity of the outsider'.[19] This has led to repeated mistakes in 'fixing up' problems for Aboriginal peoples rather than 'harnessing and supporting those strengths from within'.[19]

Empowerment Research Program

The extensive research findings from the ERP have identified a range of outcomes for Aboriginal people participating in dedicated healing and empowerment programs (such as the Family Wellbeing Programs), including:

- improved communication skills with loved ones, including family, particularly with children;

- empathy, especially thinking about how other members of the family or community might feel;

- establishing a vision for the future and recognising personal potential—for example, formulating career or educational goals;

- thinking more about fundamental values such as trust, courage, hope and honesty and their influence in our lives;

- seeing ways of connecting with the past and tradition, finding new forms for expressing spirituality and new pathways for healing; and

- an ability to critically reflect on oneself and one's life journey.[23(p2)]

The research identified that the most critically important aspect to empowerment is individual change. This change starts with individuals clarifying and/or redefining their values and norms regarding right and wrong behaviour. This enables them to create boundaries and to be able to say 'no' to people, an ability which was identified as critically important in facilitating the process of changes for oneself. According to Tsey, as participants went through this process of personal transformation, they built up their self-esteem and self-confidence, and were able to create safer and happier home environments for themselves and their families.[24(p17)]

EMPOWERMENT TO ADDRESS RISK FACTORS FOR COMMUNITY DISTRESS AND SUICIDE

As discussed earlier, the high rates and increased risks of suicide among Aboriginal people are largely due to historical factors that have removed or actively suppressed people's self-determination and resiliency leading to chronic feelings of helplessness and hopelessness at an individual and community level.[16, 24] Empowerment and healing strategies enable Aboriginal people to:

- establish more equitable power relations;

- have greater control over their life;

- take responsibility for their situation;

- become strong culturally and spiritually; and

- become connected to their culture and community.

Several chapters in this book confirm that such empowerment and healing strategies are effective in addressing suicide risk factors, Silburn and colleagues (Chapter 9), including harmful substance use, Casey (Chapter 26).

The International Literature on Importance of Cultural Continuity and Suicide Prevention

The importance of a strong sense of self and cultural renewal to a person's SEWB is the central tenet of the extensive research of Canadian psychologists Michael Chandler and Christopher Lalonde on the devastating effects of Aboriginal people's cultural loss and disempowerment.[25] Using community level data from over 10 years, they examined why some Aboriginal communities had suicide rates 800 times the national average, while others experienced little or no suicide.[3] They developed measures of 'cultural stability' that took into account communities' efforts to self-govern and preserve and regenerate their cultures by pursuing land claims, managing social services, and investing in cultural activities.[25]

The authors compared suicide rates in communities defined as more culturally stable or enacting more to preserve and regenerate their cultures, with rates in communities where there was less cultural stability, if any. They found a range of poor outcomes including high rates of suicide, especially among Aboriginal youth, in communities where there was a lack of cultural preservation, stability and, in effect, empowerment. One of the key findings was the importance of fostering a secure sense of personal and cultural identity as a necessary protective factor against the threat of self-harm. As the authors state 'without some sense of personal (not to mention cultural) continuity, it would appear, life is easily cheapened, and the possibility of suicide becomes a live option'.[3(p70)]

Links Between Family Relationships and Youth Suicide

Others have found that family relationships and the quality of those relationships, especially between parents and young people, are a critical aspect to the role of empowerment strategies in addressing suicide, particularly youth suicide. The ERP identified a close correlation between quality parenting and young people's SEWB, which is a major factor in youth suicide.[24] The quality of the relationships children and adolescents had with those people who were in positions of influence in their lives was found to be an important factor determining their resilience and coping capabilities. Thus, programs such as the *Family Wellbeing Program* that focus on improving people's parenting skills and enhancing the family's ability to support and nurture young people, are increasingly recognised as an effective suicide prevention strategy.[26(p511)]

COMMUNITY LEADERSHIP AND GOVERNANCE

Good community leadership and governance is also well recognised as a primary element in successful communities, while failures in community governance have been associated with catastrophic social dysfunction. For all Aboriginal peoples, including women, empowerment and leadership is critical in the development of positive SEWB for individuals and the community.

The Aboriginal concept of leadership encompasses traditional cultural values and experiences, and cultural knowledge, laws, kinship systems, and extended family relations. The literature shows that the qualities of strong Aboriginal leaders mirror those listed as arising from an effective empowerment and healing program. These include: respect for culture, self-awareness and confidence, integrity and wisdom, good negotiation skills, enthusiasm and inspiration, good communication skills and a sense of humour and adaptability.[27] The ability to cultivate leadership skills is a central aspect to Aboriginal people's empowerment and healing journey because it means they are able to positively influence their families and communities. In doing so, they can provide supportive networks to each other to maintain and strengthen their empowerment and contribute to community wellbeing and shared values. This is especially critical in terms of the role of women.

THE IMPORTANCE OF HEARING ABORIGINAL PERSPECTIVES

In the community consultations for the *Hear Our Voices* project, there was an overwhelming consensus that Aboriginal people want the necessary and appropriate tools and support to change their lives. The findings were echoed in the program and literature review.

Across the three communities in the Kimberley (Halls Creek, Beagle Bay, Broome), people spoke of needing to 'build self first', 'make ourselves strong' and to focus on 'rebuilding family'. Participants said that they 'wanted to learn how to talk to one another again', 'to share and care for one another' and to 'praise those who do good things for themselves and their communities.'

There was a high level of concern and sense of urgency regarding the need to focus on young people who 'have lost their sense of connection to, and respect for, their culture, their family and themselves.' The consultations also confirmed the need to ensure individual and community readiness in order to commence any type of healing and empowerment program. It was frequently stated by community participants that those in most need of such a course, especially young people, would, for a range of reasons including lack of sense of self-esteem, shame, poor literacy and other barriers, be unable or unwilling to participate.

The consultations and literature also confirmed that no single developmental approach or healing, empowerment and leadership program will be relevant across all communities. Rather, people wanted flexible, visual and hands-on courses or programs that are able to support:

- different levels of capacity;
- stages of readiness for healing and change;
- different individual needs;
- different priorities of the local community;
- culturally based programs that go back to country and use the knowledge of the Elders; and
- employment and training for local people, including a mentorship program.

The project findings recommended that to be effective any empowerment, healing and leadership program needed to include the following components:

- Goal setting;
- Self development (self-esteem, confidence building, positive attitudes, motivation);
- Anger and conflict management skills;
- Communication and relationships skills;
- Addressing the use of alcohol and drugs;
- Building resilience;
- Support and mentorship training; and
- Building cultural identity.

The importance accorded flexibility, community support, the use of local settings, and recognition of the importance of local knowledge, align with the key findings from the international and Australian literature around the effectiveness of empowerment, healing and leadership programs. Other factors identified within much of this literature include:

- community members owning and defining their problems and designing the solutions;
- ensuring the role of Elders;
- program structures ensuring sustainability and ongoing support;
- trusting, respectful partnerships between Aboriginal community members and external resource people, agencies and providers;
- adequate resources within and outside the community;
- a holistic approach and a focus on the individual and the broader social environment—the family, community, workplace and broader society;
- the use of the Aboriginal survival experiences of course facilitators and students as the main learning resource; and
- a focus on teaching analytical skills (to assess elements or domains of life).

Aboriginal Healing, Empowerment and Leadership Programs

Similarly, analysis of some significant Aboriginal healing, empowerment and leadership programs confirms that no single approach or program can be made applicable across all communities. See Chapter 27 for an in-depth discussion of one such program—*Red Dust Healing*.

The support and engagement of community throughout the design, implementation and evaluation of programs, and the development of any related materials, is another critical factor in the effectiveness of programs. People need to have a sense of ownership over the issues and the solutions and, ultimately, to be both effective and empowering. One of the critical elements to an effective program is the readiness of individuals and communities to take on such a journey. People need to be given options and pathways that meet both where they are in the healing journey and their own preferences and capacity. Thus, programs need to be flexible and suitable for people with poor health, drug or alcohol addiction, a history of suffering or perpetrating abuse, and at varying levels of denial, grief and poverty.

CONCLUSION

It is widely acknowledged that factors leading to high rates of psychological distress and Aboriginal suicide are largely outside the capacity of the mainstream mental health system to address. Prevention strategies, which promote strong, resilient communities and focus on restoring SEWB, are lacking in many Aboriginal communities. Yet it is precisely these strategies which Aboriginal people have continually identified as what they need and want in order to heal themselves and their communities. Such strategies are in accord with *Ways Forward* principles of practice (page xxiv) that inform the programs and practices within this book.

Through an extensive literature and program review and community consultation process, the *Hear Our Voices* project identifies that programs that seek to facilitate healing, empowerment, and leadership are critical to improve Aboriginal SEWB. Such programs can be instrumental in resourcing Aboriginal people to further develop their understanding of the underlying causes of their poor SEWB and to determine what needs to happen to tackle those issues. The project found that the holistic approach to the role of the individual, family and community in these programs, along with the use of mentoring and a focus on redressing grief and loss, restoring family relationships, enhancing parenting roles and communication and leadership skills, offer real potential for restoring a community's SEWB and addressing rates of suicide, especially youth suicide.[1]

As such, these programs offer an effective, strengths-based approach to addressing the alarming rates of suicide in many Aboriginal communities. They are also a means of supporting people to be in a position where they are capable of taking on further training leading to employment and leadership positions; and facilitating community empowerment and responsibility leading to better governance, safety and leadership within these communities.

The main aim of this Consultation Project was to develop a dedicated new Aboriginal-led empowerment, healing and leadership program in the Kimberley that could be flexible enough to meet local circumstances while upholding some of the best practices understood in research. Knowledge was gained through extensive community consultations in Broome, Halls Creek and Beagle Bay in the Kimberley, as well as a national review of literature and programs concerning empowerment, leadership and healing. The findings from the consultations, and the program and literature review were reported in a publication *Hear Our Voices*.[1]

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26

Strong Spirit Strong Mind Model – Informing Policy and Practice

Wendy Casey

OVERVIEW

This chapter explores the *Strong Spirit Strong Mind* model specifically in terms of its application for practitioners and policy makers, and those seeking to use a highly regarded, culturally appropriate and holistic way of working with Aboriginal clients to deal with emotional, spiritual and social problems. *Strong Spirit Strong Mind* articulates the importance of strengthening the Inner Spirit to enhance good decision making and support behavioural change, not only at an individual level, but also with family and community.

This chapter is based on the Ngarlu model outlined in detail in Chapter 17 in the first edition of *Working Together*; and the *Strong Spirit Strong Mind Aboriginal Drug and Alcohol Framework for Western Australia 2011–2015*[1] and the *Strong Spirit Strong Future: Promoting Healthy Women and Pregnancies*[2] resources, which both advocate the *Strong Spirit Strong Mind* approach.

ACKNOWLEDGEMENT

Several people have contributed to the development of the Government of Western Australia's Drug and Alcohol Office (DAO) *Strong Spirit Strong Mind* suite of resources outlined in this chapter. The author wishes to acknowledge their contribution, in particular that of Jennifer Keen. Special thanks to the DAO who have granted permission for the replication of the images and some of the content used in this chapter.

BACKGROUND

Strong Spirit Strong Mind is based on, and inspired by, the Aboriginal Inner Spirit (Ngarlu) Assessment Model developed by the late Joseph 'Nipper' Roe, who belonged to the Karajarri and Yawuru people. The Ngarlu model is based on cultural beliefs and customs and concepts of emotional, spiritual and social wellbeing that have sustained Aboriginal and Torres Strait Islander peoples for centuries. Ngarlu is the Karajarri word for defining the place of the Inner Spirit. This place is understood to be in one's stomach which is the centre of people's emotions and wellbeing. When a group makes a decision, there is a sense of group Ngarlu; their feeling and thinking is the same. This is known as Waraja Ngarlu, which is to agree to be of one stomach and to be of one mind. Roe's work advocates how our Inner Spirit is linked to our mind and the way this influences one's thinking, feelings, behaviour and decision making. Figure 26.1 highlights the links between Inner Spirit, cultural beliefs, connection to country and social and emotional wellbeing.

The concept of *Strong Spirit Strong Mind* is one that recognises the importance of a sense of connectedness to the Inner Spirit to Aboriginal peoples' health. The Inner Spirit is the centre of Aboriginal peoples' being and emotions and when it is strong, the mind feels strong. When Aboriginal peoples' spirit is strong their mind feels strong and they make good decisions. Strong Inner Spirit is what keeps people healthy and connects them together. Strong Inner Spirit keeps the community strong and our country alive. Strengthening the Inner Spirit is a step towards a healed future.

Figure 26.1: Aboriginal Inner Spirit Model
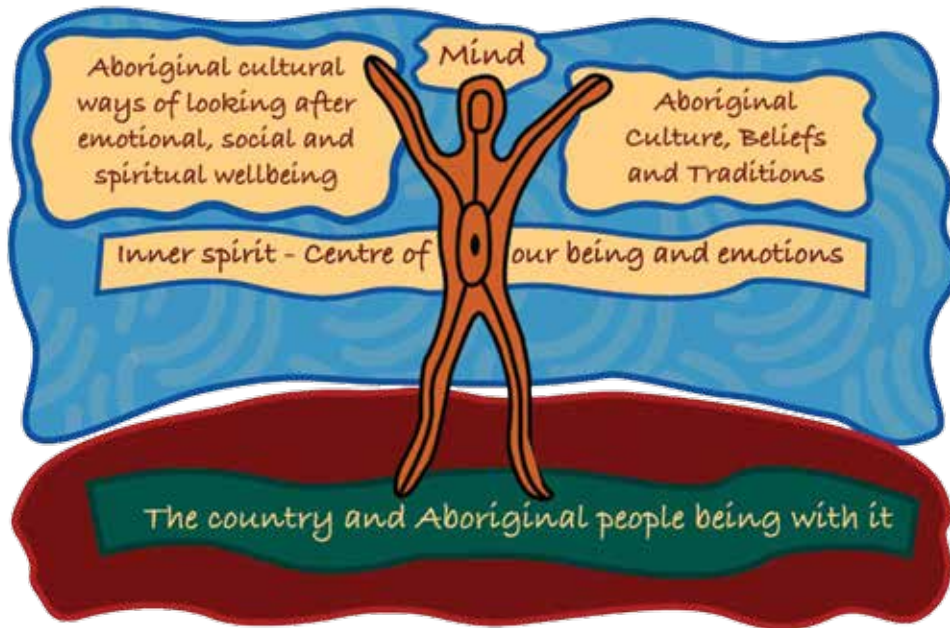
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STRONG SPIRIT STRONG MIND STORY

The concept of working with spirit is not a new one. For example, the 'Brain Story' and 'Story Telling Board' developed by Petrol Link Up and Living with Alcohol Program in the Northern Territory (NT) during the early 1990s were innovative and culturally secure initiatives.[3] These resources emphasised the importance of maintaining connection to culture, family and country to keep the spirit strong.

To extend the usefulness of these resources, it was important to further develop them to include a comprehensive theoretical explanation of how spirit is defined and the different contexts and multiple dimensions of spirit in Aboriginal culture. The development of the *Aboriginal Inner Spirit Assessment* model by Joseph Nipper Roe[4] inspired and strongly shaped the development of the *Strong Spirit Strong Mind* Alcohol and Other Drugs (AOD)[5] resources developed in WA.

The theory of Inner Spirit being linked to the mind and influencing people's feelings, behaviour and decision making has enabled working with Inner Spirit to be applied in a therapeutic context and incorporates culturally secure Cognitive Behavioural Therapy (CBT) approaches, a key skill required when counselling in the AOD field. This approach has been recognised as the way forward in addressing AOD-related harm for Aboriginal people and has been formally adopted by the Government of Western Australia's DAO and underpins all their programs and resources.[1]

Previously, mainstream models of practice in the AOD field have overwhelmingly been developed within western systems of knowledge and may ignore an Aboriginal worldview. As a consequence, application of these models can have disadvantages and limitations when working with Aboriginal people. Even worse, some mainstream approaches directly cut across and sever Aboriginal cultural ways of working. These result in Aboriginal people feeling disempowered, as their cultural beliefs/values and family systems are ignored, misunderstood or disrespected. As a result, Aboriginal people disengage from seeking support and treatment. Furthermore, in the past, there has been a push to impose other Indigenous people's cultural approaches from other countries on Aboriginal Australians. This can have devastating outcomes as it weakens our culture (Australian Aboriginal culture) and often these approaches are embedded in western disease ideology which is very different to an Aboriginal concept of holistic health and wellbeing. Therefore it has been essential to develop AOD evidence-based approaches that are central to Aboriginal ways of working.

PRINCIPLES UNDERPINNING *STRONG SPIRIT STRONG MIND*

Cultural Security

Cultural security is the guiding principle of *Strong Spirit Strong Mind*. It aims to respect the cultural rights, values, beliefs and expectations of Aboriginal people. This approach is central in the development of programs, services, policies and strategies that impact Aboriginal people.

Aboriginal leadership, community consultation, direction, negotiation and involvement form an essential part of this process, as does working in partnership with Aboriginal communities.

> **A Culturally Secure Approach**
>
> This involves:
>
> - Identifying the cultural needs of Aboriginal people in the design and delivery of programs and services;
>
> - Reviewing programs and services to ensure they meet the needs of Aboriginal people;
>
> - Utilising and supporting culturally secure ways of working with community, such as outreach;
>
> - Enhancing and modifying program design and service delivery processes where necessary;
>
> - Monitoring and evaluating services to ensure they are culturally safe;
>
> - Ensuring services work from a family sensitive approach and respect Aboriginal family values and systems.

Holistic Concept of Health and Wellbeing

A holistic view of health is one that focuses on the physical, spiritual, cultural, emotional and social wellbeing of the individual, family and community. A holistic approach emphasises the importance of strengthening cultural systems of care, control and responsibility.

Aboriginal ways of being healthy are to look after ourselves by making good choices, and to care for our family, community and culture. Alcohol and other drugs can tangle and weaken our spirit and mind. This can affect our emotional, social, spiritual and physical wellbeing and weaken our connection to family, community, culture and country.

People who don't use alcohol and other drugs or use a little bit, generally maintain a strong Inner Spirit. Their connections to family, community and country remain strong.

Impact of Alcohol Use

People who use a lot of alcohol and other drugs on a regular basis start to weaken their Inner Spirit. This starts to weaken their connections and their responsibilities towards their family, community and country.

An important part of healing is understanding how using alcohol and other drugs at harmful levels impact on our spirit, our people, our culture and our country. We need to understand this and use this knowledge to make better choices. As Joe Roe explained:

> *When people's emotional, spiritual, physical and social needs are met, then their Inner Spirit feels strong because they are in a good state of health. When one or more of these needs are not met, people's health deteriorates. This will affect your Inner Spirit and make you feel weak or no good (Roe, 2000).*

STRONG SPIRIT STRONG MIND MODEL – INFLUENCING POLICY

Strong Spirit Strong Mind—Aboriginal Drug and Alcohol Framework for Western Australia 2011–2015

Strong Spirit Strong Mind underpins the Drug and Alcohol Interagency Strategic Framework for Western Australia 2011–2015 and its supporting documents.[1] The framework was developed to provide guidance to key stakeholders in the alcohol and other drug sector and other government and non-government agencies, for delivering culturally secure programs that address many of the social determinants of Aboriginal health, mental health and social and emotional wellbeing—see also Chapter 4 (Gee and colleagues). This is reflected in the key action areas of the framework[1].

Key Action Areas

There are four key action areas to address alcohol and other drugs:

Key Action Areas to Address Alcohol and Other Drugs
1. Capacity Building   Building the skills and capabilities of individuals, families, communities, employers and the non-government and government sectors to better tackle alcohol and other drug issues and make positive changes.
2. Working Together   Working in partnership, making the best use of resources and knowledge.
3. Access to Services and Information   Providing accessible, culturally secure information and services to Aboriginal people and communities.
4. Workforce Development   Developing and maintaining a skilled and supported workforce.

Key Aims

A key aim of the framework is to support Aboriginal ways of working to manage and reduce alcohol and other drug-related harm in Aboriginal communities. The *Strong Spirit Strong Mind* model underpins the framework in the following key strategic areas:

Framework Key Strategic Areas
Focusing on prevention
Educating and encouraging individuals, families and communities to develop the knowledge, attitudes and skills to choose healthy lifestyles and promote healthy environments.
Intervening before problems become entrenched
Implementing a range of programs and services that identify individuals, families and communities at risk and intervening before problems become entrenched.
Effective law enforcement approaches
Reducing and controlling the availability of alcohol and other drugs and implementing strategies that aim to prevent or break the cycle of offending.
Effective treatment and support services
Providing integrated, evidence based treatment and support services that promote positive and healthy lifestyle changes by effectively responding to an individual's use and those affected by someone else's use.
Strategic coordination and capacity building
Providing improved and targeted responses to alcohol and other drug related problems through capacity building, workforce development, collaboration, evidence based practice, monitoring and information dissemination.

The implementation of *Strong Spirit Strong Mind* is a self-sustaining model that, once embedded and integrated into government planning, encourages a holistic approach across government and community organisations to make sure that Aboriginal AOD policy, programs and service responses are culturally secure and make the best use of available resources and partnerships.[1(p5)]

STRONG SPIRIT STRONG MIND MODEL IN PRACTICE

The *Strong Spirit Strong Mind* model allows clients to assess how their alcohol and other drug use affects their Inner Spirit and their connections to family, community and country. Figure 26.2 shows the breakdown of the connection between Inner Spirit and mind as it becomes increasingly broken or tangled up by the effects of alcohol and other drugs. As the person uses more and more AOD, their Inner Spirit weakens, the connection becomes broken, their thinking gets tangled and finally the spirit leaves. All of this impacts on their family, community and country.

Figure 26.2: Inner Spirit Assessment Model

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Clients can be introduced to the concept of Inner Spirit and shown the model as a way of getting them to identify where on the chart their Inner Spirit is. Clients can be asked to reflect on a time when their Inner Spirit was strong and to remember what that was like. Clients can be asked about who in their family or community has a strong Inner Spirit and who can support them to restore their own Inner Spirit. This model demonstrates that people can move through the stages, and that reducing use of alcohol or other drugs can strengthen their Inner Spirit and connections to family, community and country.

UNDERSTANDING AND ADDRESSING THE IMPACT OF ALCOHOL AND DRUG USE: THE SEVEN AREAS

The Seven Areas refers to part of the *Strong Spirit Strong Mind* Model and aims to address the problems associated with AOD use. It involves assessing the types of problems people may be having with AOD which can affect a person's life in many different ways and that of their family and community.

People with AOD problems will generally have one or more problems in the following areas:

Figure 26.3: *Strong Spirit Strong Mind*: The Seven Areas

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Strong Spirit Strong Mind: The Seven Areas

Health

Your body is getting sick, your Inner Spirit is feeling tangled, you may be feeling confused, stressed, worried, sad or depressed, angry or fearful.

Family and Community Relationships

Putting pressure on your family, fighting with your partner, Elders and your children. Your family are worried and angry about your behaviour. Not observing your family and community responsibilities.

Aboriginal Law and Culture and Country

Not keeping your social and cultural obligations; breaking Aboriginal law when drunk or out of it on drugs; not respecting, passing on or learning your culture,.

Land/Country

Being lonely for country; not looking after and respecting your country.

Grief and Loss

You use alcohol and/or other drugs to cope with issues of: family and friends passing away; loss of family connections due to stolen generations issues; family members being in jail; experiencing painful events within your family and community.

Livelihood/Money and Work

Spending too much money on alcohol and/or other drugs—not buying food for the family, not paying the bills. Humbugging your family for money. Lose your job or can't be bothered looking for work. Can't be bothered with finishing school or getting a career.

Legal

You've been busted for drugs. You've been charged with assaults, breaking and entering, homicides, manslaughter, drinking and driving, or other crimes while you were drunk or out of it. You have been to jail or have a criminal record.

Impacts of Colonisation and Alcohol Use

For many Aboriginal people, the history of colonisation and their marginalisation in Australian society means that sometimes their problems are very complex. As a mental health worker (MHW) or counsellor you will find that when clients present with multiple issues, you need to separate the issues out and address their alcohol and other drug use. Sometimes when people start to get more control back in their lives from their problematic or harmful alcohol and other drug use, they will find that other areas of their life also start to heal. The Seven Areas assist in gathering the information required to understand and support the client. They help guide the questions and provide a framework for the answers.

Addressing the Determinants of Social and Emotional Wellbeing

By using the Seven Areas you can explore the risks, pressures and problems a person is experiencing in their life and ask about problems relating to those issues including:

- physical and psychological health;
- relationships with family, children, friends and community members;
- socio-economic status—including housing, money, accommodation, jobs, lifestyle;
- engagement with the criminal justice system and police;

- disengagement from school;
- access to country and caring for country; and
- social and cultural obligations, breaking cultural rules and not passing on culture.

Using a storytelling board can help clients to map out the issues, and visualisation of their story can help increase awareness. These are important issues that are often associated with peoples reasons for AOD use at harmful levels. For further discussion of the social and cultural determinants of Aboriginal social and emotional wellbeing, please refer to Chapter 4 (Gee and colleagues); Chapter 6 (Zubrick and colleagues); and Chapter 8 (Wilkes and colleagues).

STRONG SPIRIT STRONG MIND PROGRAMS

Use of the *Strong Spirit Strong Mind* model in mainstream resources and programs for applying in the AOD field, has resulted in the development of culturally secure evidence-based, best practice interventions, informed and developed by Aboriginal people to address AOD use in the Aboriginal community.

Strong Spirit Strong Future: Promoting Healthy Women and Pregnancies, Resource for Professionals

This resource kit is part of a suite of resources developed by the Western Australian Drug and Alcohol Office as part of the *Strong Spirit Strong Future* resources and training. It is designed to assist practitioners to conduct brief interventions with Aboriginal women to reduce alcohol related harm through using the Inner Spirit model and Stages of Change.[6] The culturally secure resource promotes a clear message that the safest thing to do when pregnant, planning a pregnancy or breastfeeding, is not to drink alcohol.[7] It also highlights that partners, family and community all have a role in supporting women to have a healthy pregnancy. (For further discussion of Aboriginal–led initiatives, see Chapter 20 (Hayes and colleagues).

CONCLUSION

Strong Spirit Strong Mind underpins a range of important policies, programs and practices. It is a model and a way of working which highlights the importance of practitioners adopting an Aboriginal perspective of social and emotional wellbeing and culturally secure, strengths-based approaches to Aboriginal healing. These approaches are essential to address some of the many issues impacting on the health, mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples.

RESOURCES

Strong Spirit Strong Mind—Culturally secure resources

A range of culturally secure resources can be found on the Drug and Alcohol Office (DAO) website:

http://www.dao.health.wa.gov.au/Informationandresources/Publicationsandresources/CulturallysecureresourcesforAboriginalpeople.aspx

Strong Spirit Strong Future: Promoting Healthy Women and Pregnancies

Information about the *Strong Spirit Strong Future: Promoting Healthy Women and Pregnancies* project is available from the DAO website:

http://www.dao.health.wa.gov.au/Informationandresources/Engagingthecommunity/CommunityPrograms/StrongSpiritStrongFuture.aspx

FASD Consultation Forum 2010 Report: http://www.dao.health.wa.gov.au/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=621&PortalId=0&TabId=211

REFLECTIVE EXERCISES

1. How might the concept of Inner Spirit be useful in working with clients to address their alcohol and other drug use?

2. How do the Seven Areas allow you to assess the types of problems people may be having?

3. As a practitioner, in what ways might you apply the *Strong Spirit Strong Mind* model to address Aboriginal clients' social and emotional issues?

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27

Red Dust Healing: Acknowledging the Past, Changing the Future

Tom Powell, Randal Ross, Darryl Kickett and James F. Donnelly

> *We may not be responsible for the past 200 years but we can choose to be responsible for what happens now.*
>
> Barry Toohey, personal communication, 2012

OVERVIEW

This chapter provides a view from a new angle. It briefly describes a critical perspective on how a history of dispossession, rejection and powerlessness negatively affected Aboriginal and Torres Strait Islander family structures and individual development and behaviour, and gave rise to the intergenerational transmission of trauma.

However, it is important to note that conveying the events of history and the impacts of colonisation is not about pointing the finger and blame. It is about giving an understanding about the impact it all has had on our families, especially our men. All of this history has removed a key ingredient for a strong family—resulting in the taking away of the man as a source of love to family and the critical role and responsibility of that man. This chapter describes *Red Dust Healing*, an innovative and highly effective approach to assisting men and women in their efforts to heal and make better choices for themselves and in their relationships.

A primary experience of those who have suffered trauma and grief, is rejection. Like an infectious disease, rejection has reached epidemic proportions in many communities, not just Aboriginal communities but wherever a person's capacity to lead a meaningful life has been crippled by the feeling of being unloved or unwanted. *Red Dust Healing* examines the nature of rejection, the causes of rejection, the results of rejection and most importantly the remedies for rejection. We conclude our discussion with some outcome data and anecdotal reports on the life-changing and sometimes life-saving effects of this program.

INTRODUCTION

Two Aboriginal and Torres Strait Islander men (authors Powell and Ross) decided that they had had enough. For many years they worked in the area of Aboriginal and Torres Strait Islander juvenile justice and came to the conclusion that locking people up was not changing anything. So from their own family and work experiences they worked to piece together the *Red Dust Healing* program, to help their own people, and to, also increase non-Aboriginal understanding of the issues. *Red Dust Healing* has demonstrated that it can light up the healing fire in the heart of the most trauma and grief affected individual to become a healthy, culturally strong person who can build a strong, loving family. This healing benefit is for anyone across the world and so the program's potential is universal.

The *Red Dust Healing* program is targeted at the heart, not the head. It promotes healing of the persistent effects of rejection and grief and loss common in the Aboriginal community but also

throughout modern society. Key features are the methods for engaging participants, the *Red Dust Healing* tools, experiential components that foster deep exploration of one's own history of rejection and loss, and the support offered after training. *Red Dust Healing* is not just another Aboriginal program, but a powerful healing tool that should be made available to everyone no matter what race, religion, class or gender. While the tools are described below, in practice it is essential that they are presented in an individualised and personalised manner so how they relate to solutions in one's own life is apparent.

Finding effective solutions to the pervasive and persistent negative effects of Australian colonisation on Aboriginal peoples has plagued communities, Elders, governments, scholars and healthcare providers for decades. Hundreds of millions of dollars have been spent on a wide range of interventions, programs and services with and without guidance or direction from those supposedly being helped.

CONTEXT

Colonisation changed our world. The horrific history of how Aboriginal people were treated by those colonising this country and how government-sanctioned and church-sanctioned systems perpetuated the trauma into the 20th century is described in several chapters in this book. The goal here is not to reiterate these facts but rather to offer a thesis on the psychological and social mechanisms by which they changed the mind-sets and behaviours of Aboriginal men and women for generations.

For too long now some Aboriginal men and women have survived in a state of oppression; whether by choice or circumstance is a matter of perspective and opinion. The authors and others[3] propose that those who colonised Australia purposely applied four main tactics—attacking four core values—that irreparably changed the culture and lifestyles of Aboriginal and Torres Strait Islander peoples by specifically targeting the role of men in their families and the community. These **four core values** are: *identity, responsibilities, relationships and spirituality.* Below we explain what we mean by these domains and how the *Red Dust Healing* program and prescribed tools help undo the effects of these tactics and promote healing.

Core Values Explained

Identity

By changing their names, and removing them from their role as the source of love and resources in the family, Aboriginal men and women lost their sense of identity. For example, as late as the 1960s, some people were given dehumanising names such as 'Diesel Engine' or 'Pox' when they were required to make their mark to receive rations or welfare support. Any identity related to their role in the community was also obliterated as many were removed from their homes and placed in missions, institutions and on secluded islands far from their families and communities.

Responsibility

Men were the protectors, teachers, Lore-makers and providers of the basic necessities for their families (food, safety, security, and affection), but these responsibilities were forcibly removed. Family-based responsibilities were shifted by external forces to governments that determined to whom and when resources were delivered. Men were stripped of their traditional roles as skilled hunters, keepers and sharers of cultural and traditional knowledge, toolmakers, builders of shelters and canoes, etc. Men and women had been responsible for educating the next generation but significant chasms in the communication network for transmitting traditional knowledge and social values were created.

Continued . . . .

Relationships

Fractured relationships led to lost opportunities to learn how to be a father, husband, son, etc. and lost opportunities to share that wisdom with their family and young people in the community. They lost the opportunity to observe and learn from Elders so they could pass on ways of conducting oneself in relationships that fostered meaningful connection rather than just control. Many of the men grew up not knowing how to show emotion and build relationships in their own families and with other men.

Spirituality

The centuries old connection to the land and the traditional spiritual sense that permeated Aboriginal life was attacked as part of the tactics noted above. Spirituality (the feeling felt within) was replaced by an imposed religion (an external, man-made interpretation) that was linked to accessing resources. This tactic is summarised by Powell as, 'Religion defined us, confined us and controlled us'. Many Aboriginal people had to possess an exemption certificate known as the 'dog tag'. They had to seek permission from the controlling mission or reserve superintendent if they wanted to leave the place of control, however, the exemption certificate still incorporated strict guidelines which one had to comply with if they were to reside amongst the general population. The new religion simply did not serve the same meaningful role in Aboriginal life. The Aboriginal spiritual sense provided continuity and an understanding of how to live in harmony. Religion did not provide appropriate tools to replace traditional ways of thinking or behaving.

Fathers Taken Away

Former Aboriginal Senator, Neville Bonner stated:

> 66 *As parents, uncles, cousins or brothers, we (Aboriginal males) must take responsibility for the future of our young people…emphasis is placed on sporting personalities, but the best role model a son can have is a patient caring father. The attitude towards life of the son will mirror that of the father, which is the way things used to be done before white settlement…I am convinced there is absolutely no reason why a system that worked so well in the past cannot work today.[5(p53)]* 99

Ross describes his own experiences that helped him understand how to possibly help others. He acknowledges that he while he had a father growing up, his father was unable to serve as a role model or a source of love. Ross says that he came to realise that his father's failure to properly, lovingly parent him was not his father's fault but maintains that as men we must still be accountable and responsible for our choices and actions. He acknowledges that others have sadly lost their sons, partners, brothers, cousins, uncles, grandfathers, husbands and fathers to tragic, frequently unpreventable circumstances. Ross and colleagues argue that in all these situations surviving adults and children raised in the aftermath of these losses would have felt a sense of abandonment or rejection from absent partners or husbands, and more importantly from those in the family who were fathers.

Ross speaks of the tradition in his family:

> 66 *One of our key roles as men is to link a child back to his past in order to shape his future. Many of my Elders said to me, if we do not know where we come from, we will not know where we are going (Grandfathers and Uncles).* 99

Men have had a crucial sustaining role within our families, which has maintained balance within our families and environment for thousands of years. Not only did we have men's business and women's business, but men have played crucial roles with responsibility within the family that positively affected the community and the nation. The importance of fathers and the detrimental effects of father's being absent, have been studied in the predominantly white culture in Australia and among urban and rural poor and minority groups elsewhere. Although a comprehensive review of this literature is beyond the scope of the current chapter, the results all seem to support the point made here: the role of the father can be critical and its loss has widespread negative effects on family and community.

Men's roles in the Australian Aboriginal community were to instruct, teach, train, nurture, shape character and culture, control, rule and, most importantly, to love. Today many of our men still struggle to serve some of these essential roles for their loved ones as their own experiences have left them unprepared as cultural practices and families were broken. The Noongar Men's Manual states:

> *The role of the man was held in high esteem. He performed ceremonial rites and guided the young boys through their initiation into manhood. We guided our young men to understand their world, to know their country, to make their tools, to dance and paint, to learn our stories, to know the spiritual world. Men were providers for their families…[8(p51)]*

Writing about a traditional custom practiced within the Kutjungka region, in the southeast of the Kimberley region of Western Australia, McCoy states:

> *When boys (marnti) become men (wati) the manner of kanyirninpa changes. No longer do young men seek to be held by their mothers and female relations. Instead, they seek to be held by older men: brothers, uncles and other males. [4(p4)]*

McCoy explains that '*holding*' has been a recognised tradition for thousands of years but also writes about how this practice is disappearing due to the lack of men to fulfil this sacred role for our next generation of men.

> *By holding them, older men induct younger men into the social meanings and behaviours of desert, male adulthood. A generative and generational male praxis is disclosed. [4(p4)]*

Law and Justice

This issue has been dealt with by applying a damaging, ineffective judicial or punishment model on a national level. Aboriginal and Torres Strait Islander males are imprisoned at an alarming rate (discussed in Chapter 10, Heffernan and colleagues), but worsening individual and social problems in the community indicate the severe negative impact of applying this *Law and Justice* approach to address longstanding complex social problems that have grown since the time of colonisation. Already Aboriginal adults are almost 14 times more likely to be incarcerated than other Australians. High arrest rates among Aboriginal males create challenges and high costs for all tiers of government and heartache and sorrow in the lives of many of our Aboriginal families. Sadly, Aboriginal women also have high arrest rates.

In a snapshot of the *Law and Justice* statistics concerning Aboriginal and Torres Strait Islander peoples,[6,7] four major life stressors are highlighted. Members of the community:

- are frequently witnesses to violence;
- are victims of abuse or violent crime;
- have trouble with the police; and
- have a member of their family who is at current risk of being sent to jail or is currently in jail.[7]

Life Cycles of Violence and Rejection

With regard to witnessing violence at home or in their community, younger generations are at increased risk of then practicing the same violence in their homes as adults and parents. This lifecycle is discussed by Hayes and colleagues (Chapter 20). This is particularly true for young males who will serve as the next generation of fathers. Understanding transgenerational patterns of violence begins with this experience of intergenerational violence at home.

The following statistics outline the common stressors and risk factors in the Aboriginal and Torres Strait Islander community including witnessing violence:

- In 2002, 16 per cent of Aboriginal people aged 15 years and over reported that they, a friend, or family member had witnessed violence in the 12 months prior to the survey;[7]

- Aboriginal people in remote areas were three times as likely as those in non-remote areas to have witnessed violence (30 per cent compared with 10 per cent);[7]

- Almost half (45 per cent) of Aboriginal people who had been a witness to violence also reported being a victim of physical or threatened violence.[7] Rates of hospitalisation, as the result of spousal assault are 35 times higher in the Aboriginal population;[6]

- Ninety-one per cent of the total Aboriginal population incarcerated are males.[1] Almost one-half of Aboriginal prisoners are under the age of 30. Nationally, one-in-fifteen Aboriginal males aged between 25 and 29 are in jail.[7] The most common offence by Aboriginal prisoners is *acts intended to cause injury* (32 per cent).[7]

Conversations with many previously violent offenders in the Aboriginal community (e.g. *Red Dust Healing* attendees) indicate that normalisation of violence when they were young was a major contributing factor to their current behaviour. If our next generation of Aboriginal young people have witnessed violence, whether it be at home, at a friend's place, within the community or in an institution, what are the chances of them becoming perpetrators in the future as opposed to accepting and fulfilling their important role as men? As children grow up with this underlying generational hurt referred to above, they see and feel the hurt in all its forms. Unconsciously their individual hurt may become suppressed, but comes out at some point in their lives and is directed at others.

In the authors' experience with young Aboriginal males, when the issues of violence and anger do surface, many are young fathers and they tend to release their suppressed hurt as anger directed at other family members, peers or others in the community. Aboriginal sons and fathers who have been exposed to these hurts through no fault of their own during their childhood may have no knowledge or understanding of how or why the hurt occurred. The effects of this deep-seated, powerful hurt appears to fuel family-based and community-based violence, drug and alcohol misuse, and subsequent homelessness, incarceration, family separation, multiple failed relationships and unemployment as discussed in detail in several of the chapters of this book. Many never learned what else to do with overwhelming thoughts and feelings about what has happened to them and those they know and care about. Unfortunately, this deep sense of rejection or hurt that many have carried in their hearts has been so detrimental that they do not realise as sons and now fathers that they are hurting the ones that are close to them or, if they do, feel helpless to do things differently.

If there is to be recovery, it is critical for governments to acknowledge or face the fact that future generations of families are growing up without fathers, and that decades of hurt are at the basis of many of today's social and personal difficulties. Families have been abandoned with the pain of the past, and future families are being left with absent fathers. It is this frightful underlying ignorance that poses a great threat to all families from all walks of life within Australia whether you are Aboriginal, Torres Strait Islander, Australian South Sea Islanders or other. How do we address this major threat of creating a fatherless nation?

Currently we have approximately 30 per cent of Aboriginal families in our population that are headed by single parent families.[2] In addition, anecdotal reports in workshops indicate that there is a growing sense of anxiety that many of our single parent families are headed by our women trying to manage the tasks of child-rearing alone. Ross suggests that this trend signals a silent death for cultures based on the essential role of the father that will negatively affect future generations. He further suggests that this trend will create a tsunami of blindness within this nation to the true needs of, and solutions for, Aboriginal communities.

The authors propose that a key cause of hurt among all Aboriginal people is a history of rejection that continues in their daily life. All of us may have experienced rejection and pain at one time or another. The rejection may have been minor or so crushing that it affected one's whole life, the many family and intimate relationships, and the capacity to show emotion with loved ones and in the community. As noted above, many of our men suppress the pain suffered at the hands of others but, most importantly, we believe that many of our men have suppressed the pain from rejection.

Today, in order to reverse the effects of rejection, we must turn the hearts of the fathers back to their sons and the hearts of the sons back to their fathers to restore a bond that had been practiced by over two thousand generations prior to colonisation. One such program called *Red Dust Healing* is allowing this process to begin so our men can stand as a man, husband and father.

Red Dust Healing identifies a model of oppression and how this oppression worked to remove the four core values (*identity, responsibilities, relationships and spirituality*) from man as the individual. The program addresses oppression in ways that reverse the colonisation process.

REVERSING OPPRESSION

The primary authors of this chapter (Powell and Ross) understood the model of oppression and the removal of the four core values (*identity, responsibilities, relationships and spirituality*) from man as the individual. They knew it was time to develop a model which would address oppression by reversing the oppressive colonising process represented in the schema below.

Figure 27.1: Reversing the Oppressive Colonising Process
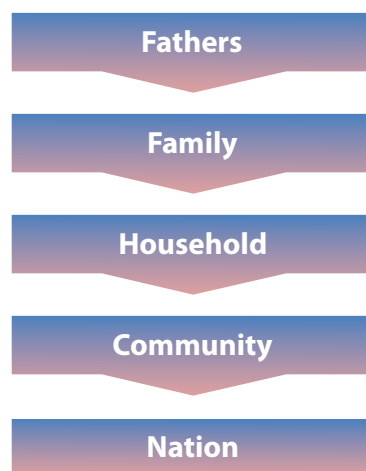
The first critical step is to start with the individual—each man. It is vital, more than ever, to heal Aboriginal men, and support them as they begin to remove the deep wound of rejection so they can reclaim their position in the family, community, culture and nation. The cultural program, *Red Dust Healing* has been achieving outstanding results healing men and also restoring families. We need our individuals to step up and see themselves as a man, then see themselves again as husbands for our wives, fathers and role models for our children, and leaders of our communities. They can make a nation proud again. We believe that if you fix a man you fix a family and all things that stem from this foundation.

RED DUST HEALING PHILOSOPHY

The *Red Dust Healing* program is based on six philosophical principles that guide the work by trained facilitators.

> **Philosophical Principles Guiding the *Red Dust Healing* Program**
>
> - Ancient traditional practices, morals and values should be understood as a way of addressing issues in today's society;
>
> - Exploration of one's personal history addresses the question: *If we do not acknowledge who we are and from where we came, how can we know where we are going*?;
>
> - Healing is defined as a spiritual understanding of self, identity, love, belonging, family, security, hurt, heartache, good times and laughter;
>
> - Healing is a renewed grasp for hope that grows from developing love, respect and understanding of ourselves and others who support us. Healing comes from telling your story in a place and with people that offer acceptance and tools for going forward;
>
> - Healing does not happen immediately. Time and personalised support are required to learn and practice the new tools, negotiate systems that may still feel foreign or threatening, and refine one's ability to trust the heart over the head; and
>
> - Helping men heal, in particular, will have a spreading positive effect on his relationships with his children, partner and family, as well as the community.

RED DUST HEALING PROGRAM

The *Red Dust Healing* program has already been delivered to over 5,300 attendees in 300 different communities in rural, remote, regional and urban Australia. It has been commissioned by various agencies and community groups to address a range of presenting issues including sexual assault, suicide prevention, grief and loss, family and domestic violence, harmful substance use, law and order concerns, mental health and social and emotional wellbeing, anger management, education, employment and housing issues, encouraging community contribution and more independent governance. It has proven valuable in the education sector, justice and juvenile justice, community mental health settings and the general community where the persistent effects of trauma exist. Although designed for Aboriginal Australians, it applies equally well to those from other cultural backgrounds who have themselves suffered loss and rejection in the context of their families and communities.

It is a challenge to engage those most hurt in their past to have another go at healing. The credibility and community recognition of the facilitators and the widespread success of the program play an important role in getting attendees to show up. Many attendees have a lengthy history of negative experiences or at least non-helpful exposure to standard social agency, psychological or other mental health interventions including psychotherapy, case management, psychoactive medication, job training, career counselling, and in their experience with the juvenile and adult justice systems. This is a tough crowd for delivering any kind of program. Most believe they have heard it all before. However, the key appears to be that the participants are quickly engaged as contributors and active members of a group trying to understand common themes in their lives and potential solutions that fit their individual concerns. They receive information about history and some important tools, but the personalised approach and the opportunity to come away with something that immediately applies to their daily troubles and deep personal unmet needs, reportedly drives the success.

Utilises Visual Holistic Learning Modules

The *Red Dust Healing* program encompasses visual holistic learning modules (see below) that engage the participants on an emotional level by having them create images and tell their story. Cultures are linked to personal stories to encourage participants to gain individual insights into their identity, belonging and self-belief. Pro-Social Modelling arises naturally as facilitators and attendees learn about their culture and apply new tools for resolving conflict and getting their basic personal and interpersonal needs met.

The program facilitates the understanding of *Rejection* and *Grief and Loss* as the possible foundation of all hurt. Although written from an Aboriginal perspective, *Red Dust Healing* also applies to other people. Rejection knows no bounds; it is the same for young and old, for male and female, and for black and white—it hurts us all.

Participants are supported as they examine their own personal hurt which allows them to heal from within by closely considering and sometimes discussing family and personal relationships. Many describe life-long patterns of violence, abuse and neglect. The *good* and *bad* nutrients that were part of their young life are examined and related to their present day behaviour.

The program facilitator places the participant both in the position of being hurt (victim) and then as the one doing the hurting (perpetrator). They identify the powerful, and in some cases crippling, emotions felt as the victim and then the hurt they cause as the perpetrator and perpetuator of intergenerational trauma. Participants are asked to examine the effects the rejection, abuse and neglect may have had on their lives while growing up, and question whether they are repeating the same tactics that may have hurt them.

Encouraging People to Heal

The program encourages participants to heal so they can build stronger family relationships. It promotes the philosophy that taking responsibility for making the best possible choices is essential and the way forward that allows for growth in personal self-respect and meaningful connections to others. Numerous topics are covered, depending in part on the purpose of the group and the needs of the attendees. They include: Religion (man-made interpretation) versus Spirituality (felt within), Aboriginal history and the impacts of colonialism on personal identity, family roles and structure, relationships, Elders, and men's business. These challenging topics are discussed openly—along with the wide range of symptoms and behaviour problems that stem from this history such as drug and alcohol issues, family violence, grievances and loss, stress and damaged mental health—with the goal of finding solutions rather than solely reliving the hurt and rage.

Promoting Ownership, Self-determination, Sustainability and Autonomy

The program promotes ownership, self-determination, sustainability and autonomy. Although many participants have participated in a clinical/controlled environment, *Red Dust Healing* attempts to empower people to retrace their childhood memories to address much of the hurt which they have encountered growing up. By allowing participants to share their stories, many of the participants are able to identify the specific hurt/s. Once they are able to 'lay the axe' to their root cause of their problem, they are then able to move forward with a number of strategies that empower positive lifestyle changes personally. Too many clinical settings don't address the heart issues which see many participants incarcerated in a mental health facility or jail. *Red Dust Healing* empowers the individual and communities to participate and contribute to solutions within the individual and their families, households and communities.

Developing Individual Case-Management Plans

Each person is supported in developing an individual case-management plan to meet their personal needs. *Red Dust Healing* promotes follow up by directly providing links and referrals to relevant services. The case-management plan can be supported by a buddy and mentor system that can assist and enhance completion of individual case plans.

Utilising Existing Mainstream Services

The program also utilises existing mainstream service providers, Aboriginal service providers and Aboriginal Elders to assist with the delivery of relevant service modules. For example, relevant Elders may assist with information on cultural and traditional ways; Aboriginal health workers may provide information on healthy lifestyle and diet; Sexual Health workers and Drug and Alcohol workers may assist with case-plans if required. In other words, this program recognises and adopts an interdisciplinary approach, as described in detail in Chapter 13 (Schultz, Walker and colleagues).

Modes of Delivery

Versions of the program can be delivered in one or three day formats with most requiring a second session within four to six weeks. Of note, however, is that the facilitators and buddies/mentors who come from the same community and have been trained with the tools of *Red Dust Healing* are available for individual support between sessions and after the program is complete. The program is delivered to groups of eight to ten participants, with more basic descriptive programs available to larger groups. Two trainers are typically present throughout the program. Trainers travel to communities to offer the program as most attendees are unable to travel elsewhere to seek resources. Providing support within a community beyond what is offered in the sessions is also frequently essential.

THE *RED DUST HEALING* TOOLS

The most innovative and powerful feature of the program is the description and personalisation of the tools and the support provided as attendees apply them in their own lives. Some *Red Dust Healing* tools may seem like common sense, some overlap with Buddhist or other cultural teachings regarding acceptance of our limits in life, and some stem from Aboriginal traditional culture. Together they arm attendees with strategies and ways of examining the challenges in their life and their relationships in a way that can be clarifying and simplifying. The program links personally defined values to what they *choose to do*. The tools give them a method for achieving their goals. Through these visual modules the participants acquire an understanding of who they are, where they come from and from where and whom they get their strength. The *Red Dust Healing* tools are depicted in Figure 27.2.
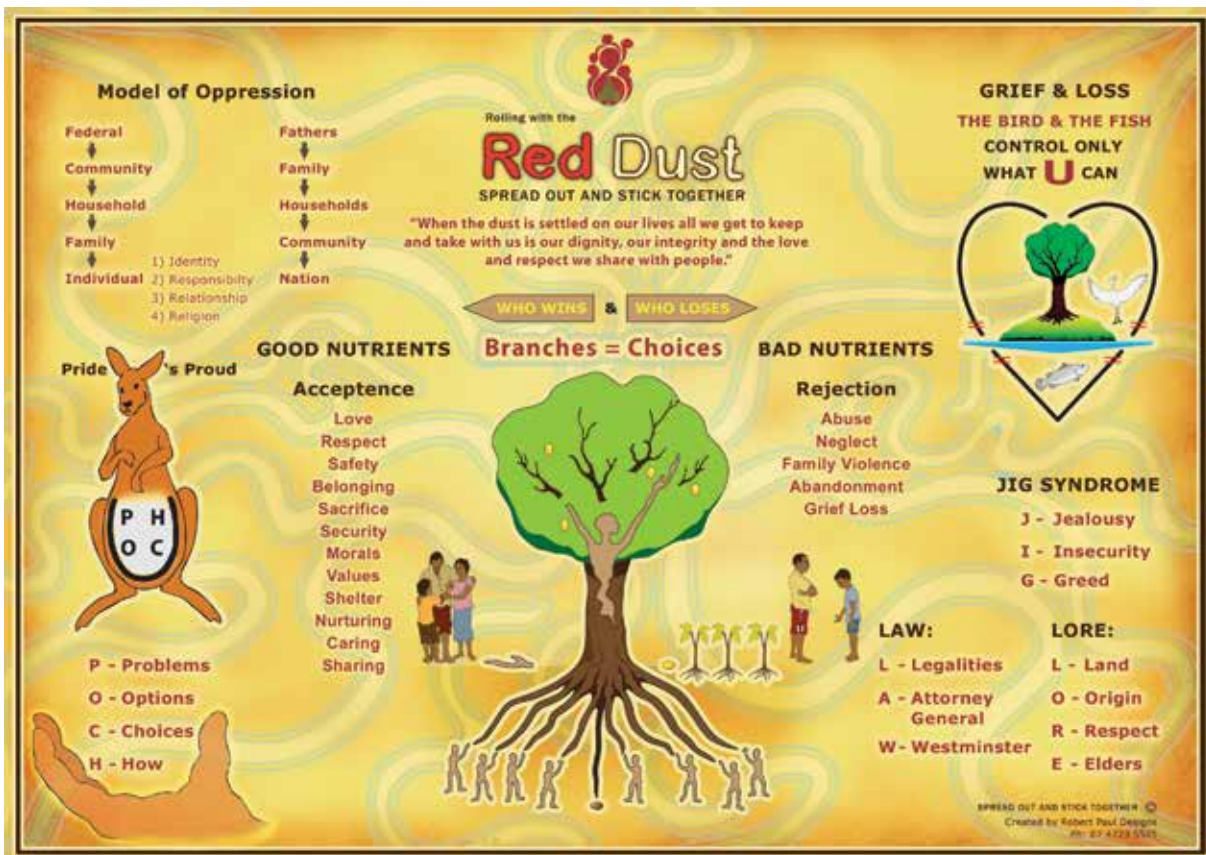
© Spread Out and Stick Together
Created by Robert Paul Designs

Understanding the Visual

The key visual learning modules: the 'Family Tree', 'the Bird and the Fish', 'Law versus Lore', 'the JIG Syndrome', 'Pride versus Proud' and 'POUCH' as depicted in the *Red Dust Healing* Tools Figure 27.2, are further described below.

Family Tree

The **Family Tree** gives participants an understanding of the people who were, and maybe still are, important to them in their lives. It also confirms from where they get their strength and also gives them an understanding of where some of their rejection may have come from. It outlines through the branches, the choices each person made and the consequences of these choices for themselves and others. The family tree also helps them understand grief and loss. It is explored initially as a group but then, importantly, each participant examines his/her Family Tree individually with the support of a skilled and compassionate facilitator.

Bird and the Fish

With **the Bird and the Fish**, participants come to further understanding how to deal with grief and loss. This concept and tool also imparts knowledge about the limits of their control and what they can and cannot control in the environment. For example, you cannot control other people, the forces of nature or life events not within your direct control. If you keep trying, welcome to stress! Participants frequently acknowledge that they have all been in the situation of trying to control things they cannot and how it has stressed them.

Law versus LORE

Law versus LORE demonstrated that as Indigenous people we may have to live and abide by two laws—the law imposed by society and cultural Lore (Figure 27.3). However, the authors of the program (Powell and Ross) propose that if you maintain your LORE, this being the foundation of your dignity, integrity, power and freedom, then it makes the other Law redundant and irrelevant. But if you give up your LORE to LAW then this law will make a judgement on how you live your life.

Figure 27.3: The Characteristics of Law and Lore

© *Powell and Ross*

JIG Syndrome

The *JIG Syndrome* stands for Jealousy, Insecurity and Greed. Participants recognise why and how these human feelings bring down families, relationships, agencies, organisations and communities and relate JIG to their own work, home and community environments.

Pride versus Proud

Pride versus Proud is an evaluation tool to deal with preoccupation with one's self (termed self-consciousness in the program). Letters are used to make the distinction between the destructive and isolating effects of *pride* as opposed to the more healthy and community-oriented sense of feeling *proud*. There is an 'I' in pride that makes it all about I, I, I. There is a 'U' in proud making it about US. *Red Dust Healing* is about US, not 'I' or 'me'.

POUCH

POUCH is a solution-based, problem solving concept that allows participants to deal with the issues and difficulties in their own lives. It stands for what **Problems** U have, what **Options** U have, what **Choices** U have and **How** are U going to deal with them. Discussing this tool encourages participants to look at solving some of the concerns that they may have and helps put the responsibility back on the person without being in their face or pointing the finger.

PARTICIPANTS COMMENTS

We have attempted to understand how both male and female attendees of the *Red Dust Healing* program view its value and the personal effects on their life. We used a few different approaches, each with its own limitations and strengths.

We have filmed conversations with those who attended in various locations for various reasons around Australia. We wanted to get their story in a culturally sensitive manner about how

things were for them before, and how things might have changed after attending the Red Dust program. We wanted to determine if what we offered was meaningful or helpful but also to gauge what follow-up support might be required as they attempted to apply the tools. We have included some quotes from attendees below:

> " *I have had a lot of pain and hurt due to life's circumstances, which has seen me attending all sorts of counselling over the years, none which seemed to help me see my way through to inner peace. I felt I did not deserve a happy life because my mum did not have one. I did not know my dad. Mum passed, I did not get to ask for her forgiveness. It is from this point my life spiralled into darkness. My children did not see me as their mum anymore, the alcoholic shame. Then today...you gave me hope to heal the wounds of my past and change direction with confidence. To accept all that has happened as it is. To cry, whether they be tears of joy or sadness. Today I can say for the first time in 35 years I feel I can choose and believe with conviction, I deserve love and happiness as much as anyone else. I deserve the love of my family. I can be all that I want to be.* "

> " *I have learnt what a man really is (through the Red Dust program). I thought a man's role was dominating. I now realise that a real man is someone that cares and loves his family and is also a good role model.* "

> " *I grew up with my mother's people most of my life and never had much to do with my father's side and that was playing on my mind for a very long time. My mother past away, I was nineteen the baby of mum's children. At this stage in my life I was going through some very difficult stages being diagnosed with bipolar and very bad case of manic depression. I used to smoke Yandi day in day out, as a result of my habit for this drug I lost my job and was starting to lose pride and dignity and became a man that scarred my family a lot. I landed at a mental health clinic for three, one month visits over two years. Attending this Red Dust Healing program gave the very thing I was missing all my life, two men that I never met before listening to my pain and sorrow. I sounded like a baby bird crying out for my father to come and save me. Red Dust Healing opened my eyes to a world of different approach methods on decision making right through to respecting Lore to defeat law. They cleared my thought process and helped me understand simple things from a different angle. Leaving Nambucca was a good feeling, a lot of unhappy feelings were left behind and I felt free again and a chance to redeem myself. Today, I live on the Gold Coast and my new life is deadly and my father and family is very proud of me and I love them very much so.* "

> " *I did not realise that my pain had a name called rejection, I am glad that I understand how rejection works, so now I can move forward with my life.* "

In addition we have asked attendees to complete questionnaires after the program to rate its usefulness, the presentation style and methods, and also each of the program components. Some preliminary data on 118 attendees regarding the tools is included in Table 27.1 and Figure 27.4 below:

Table 27.1: Attendees Endorsing the Use of Each Red Dust Healing Tool

Will you use in the future?	Family Tree (%)	Bird and Fish (%)	Law versus Lore (%)	JIG (%)	POUCH (%)	Understanding past rejection (%)
Yes	71	66	52	49	55	45

Table 27.1 shows the high percentage of respondents who reported that at least one of the tools was helpful and likely to be used in the future. Given that many of the attendees had experiences in mental health and social services that reportedly gave them no useful information or strategies, the finding that *Red Dust Healing* is providing useful tools that attendees are willing to apply is notable. Future work is required to understand who is endorsing the usefulness of which tool and for what issues they thought that tool was appropriate in their own lives. This may allow for programs to be customised for those presenting with specific issues however, in the opinion of the program developers, the entire tool kit may be necessary as life and challenges unfold in the future. It is therefore probably better to arm them with the full complement of tools and skills, along with the capacity to reflect on the contents of their own head and heart.

Figure 27.4 depicts the proportion of respondents who ranked the program and its presentation at various levels. The overwhelming majority ranked both very positively.

Figure 27.4: Proportion of Responses to the *Red Dust Healing* Program and Presentations
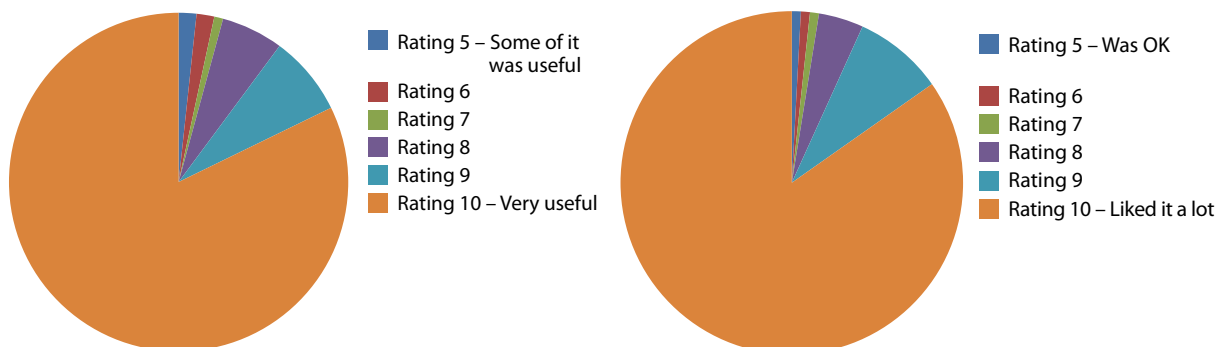
The authors have also developed a questionnaire (Donnelly, Powell, Ross and Kickett, Red Dust Evaluation Form, unpublished, 2012) for assessing how attendees think and feel *before* the program and then again after the program. The idea was to assess whether ways of thinking and social and emotional wellbeing change as a result of the Red Dust content and experiences. Piloting of this questionnaire has demonstrated that asking attendees to report on very personal feelings *before* they have developed rapport and trust with the presenters over the days of the seminars may be unreasonable. Many required some sense of what the program was about and who the presenters were before they would share what were personal and possibly painful details. Even discussing these issues with other men also seemed inappropriate for many at first as it was inconsistent with whom they believed they needed to be. For example, reporting on their perceived level of choice in their life or how they would rate their level of social and emotional wellbeing seemed premature in the relationship that needed the development of the trust that formed as part of the program. The openness and sincerity of post-program videos indicated that a willingness to discuss their past and the effects of the program was established. A questionnaire that asks attendees to rate themselves on items relative to how they felt or thought before the program compared to how they would rank themselves afterwards, all completed after the seminars, is now being implemented.

WHEN THE DUST SETTLES

For over two hundred years, all tiers of Australian government have been trying to create solutions for Aboriginal and Torres Islander Australians. As founders and promoters of the *Red Dust Healing* program, we believe that governments have not got it right. However, we would like to work with governments to supplement many of their existing solutions to restore a vital balance between 'head and heart', for all Australians. There has also been an underlying current of alienation, with many other Australians thinking that First Nation Australians always receive benefits whether they are financial or through services. The *Red Dust Healing* program focuses on changing ways of thinking and behaving that moves people toward a more powerful, self-sufficient role in their lives. It helps them make better choices that are in line with their values and culture.

This new approach has been a long time coming. In the past we have shared resources, had numerous consultations, held conferences and gatherings to exchange information and ideas, and have even been researched over and beyond as individuals, families, communities and as a nation. There have been numerous recommendations from individuals, communities, agencies, professions and government bodies for Aboriginal people to develop programs for Aboriginal and Torres Strait Islanders in our Nation. Many Aboriginal and Torres Strait Islanders have also heeded the call and responded with the development of a number of programs appropriate for the needs of many of our people.

Red Dust Healing is just one such program that has been developed by two Aboriginal and Torres Strait Islander men who have had extensive experience working with juveniles and their families in New South Wales and Queensland. However, in developing the *Red Dust Healing,* there are some basic philosophies that make this program unique in supporting individuals and their families, households and communities, and a range of agencies both non-government organisations and governments at the state and federal levels. Chapter 5 (Zubrick and colleagues) outlines the various commissions and enquiries that have been carried out to address the wide ranging impacts of colonisation and the nine principles of practice required to move forward that are echoed in *Red Dust Healing.*

Some of the aspects of *Red Dust Healing* that have helped it become a huge success were the cultural tools that First Nation Australians could understand and relate to. Most importantly, those that complete the program can utilise the tools and knowledge in their lives as they may for the first time feel empowered to make life style changes for the better. *Red Dust Healing* is about life. Living can be simple but sometimes we are prone to complicate our lives when we stress or worry about things that we cannot control. Both of the founders believe in people and their ability to fix the problems in their own lives, if given the right tools. The *Red Dust Healing* challenges people to think with their hearts and to look at history and problems from different angles. It allows First Nation Australians to tell their own stories, and caters to the young and old of both genders. It is adaptable, so it can complement any service or existing alternative program. However, a key principle of *Red Dust Healing* is that the program must be facilitated by a properly trained, First Nation Australian.

The Red Dust program is not just about healing but also incorporates law and justice, health, mental health, education, drug and alcohol, unemployment and employment, social and emotional wellbeing, family violence, cross cultural issues, disability, trauma, grief and loss and rejection. Even amongst First Nation Australians there is a mentality that we must compete to develop the best program for our First Nation peoples instead of being complementary with one another's programs and be grateful that a broader spectrum of programs can only enhance and improve the lives of many of our people. The surprise impact that *Red Dust Healing* offers is that it is also appropriate for all Australians. *Red Dust Healing* provides an understanding of how rejection, 'the sense of being unloved or unwanted', can negatively affect all individuals and families.

Red Dust Healing has now been operating for six years and has had over five thousand participants complete the three, two or one day program. The participants have ranged in age from eight years through to Elders over seventy years of age. Participants have varied in terms of ethnic or cultural background (Aboriginal, non-Aboriginal, multicultural); both genders; from urban, regional and rural communities; and from different socioeconomic backgrounds.

The *Red Dust Healing* founders have been fortunate. As a part of their own personal journey, as one door closed, others have opened with the assistance and persistence of people and their communities. They want others and communities to experience real lifestyle changes. The time is now to heal our Nation so we can support those who have been lost, due to the hurt of the past, to regain direction and purpose. The future vision of the *Red Dust Healing* founders is to establish *Red Dust Healing* centres to cater for the whole family and develop appropriate individual case plans which will then support the family unit.

> ❝ *We must turn the hearts of the fathers back to our children and the hearts of our children back to their fathers' so we can see each other right as a nation.* ❞
> **Randal Ross, 2006**

The *Red Dust Healing* motto encapsulates what this program is about,

> ❝ *When the dust is settled on our life, all we get to keep and take with us is our dignity, our integrity and the love and respect that we share with people.* ❞
> **Tom Powell, 2006**

RESOURCES

The *Red Dust Healing* Program

If you require further information pertaining to *Red Dust Healing,* simply log on to the following website: www.thereddust.com

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28

Seven Phases to Integrating Loss and Grief
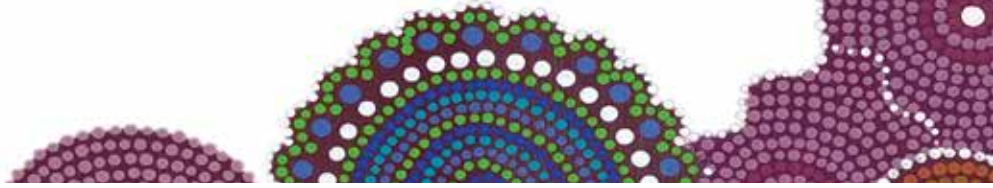
Rosemary Wanganeen

> *It's a long road we have come and it's a long road we can go. We have to walk together and talk together. If you never listen to me, I will never listen to you. I will not follow you. Walk side by side and let's get there.*
>
> Conrad Ratara, at a handing back ancestral lands to Aboriginal people ceremony

OVERVIEW

This chapter describes an innovative and unique loss and grief model—the 'Seven Phases to Integrating Loss and Grief'—to 'work with' major challenges impacting on the social and emotional wellbeing and mental health in Aboriginal communities. Incorporating 25 years of personal and professional experiences, the Seven Phases model comprises a comprehensive process addressing many of the contemporary major social and emotional and health challenges being experienced within Aboriginal communities in the 21st century. As a process, the Seven Phases has two major applications: as a counselling model and a teaching tool, both of which have been evaluated as culturally appropriate and sensitive to the needs of Aboriginal people.

INTRODUCTION

Mental health problems and distress are prevalent and of concern among Aboriginal and Torres Strait Islander peoples. A study by McKendrick et al., reported that over 50 per cent of 112 randomly selected Aboriginal participants could be described as having a mental disorder, with a further 16 per cent reporting at least 10 non-specific psychiatric symptoms, including depression and harmful substance use.[1] Within the sample, 49 per cent had been separated from both parents by the age of 14 years and a further 19 per cent from one parent. Those who grew up in their Aboriginal families learned their Aboriginal identity early in life and regularly visited their traditional country. These people were significantly less distressed.

Similarly, in Clayer's study, based on a sample of 530 Aboriginal people in South Australia (SA), 31 per cent had been separated from parents before age 14.[2] The absence of a father and of traditional Aboriginal teachings was found to be significantly linked with attempted suicide and mental disorder. Hunter also found that childhood separation from parents was strongly correlated with subsequent problems, including high levels of depression in Aboriginal people seeking primary health services.[3] Hunter comments particularly on the effects on males, whose histories are influenced by the loss of fathers. In these cases, models for, and initiations into, mature manhood are often lacking.[3]

Raphael and Swan argued that high levels of loss, traumatic and premature mortality and family break-up contribute to the present high levels of stress experienced in Aboriginal and Torres Strait Islander populations.[4] The extended family structures of Aboriginal peoples mean that individuals have more exposure to bereavements, trauma and loss than other people. It has

been argued that these experiences are likely to lead to higher levels of mental health problems, in particular depression and symptoms of post-traumatic stress disorder.[4] Recent work has focused on both intergenerational and chronic personal experiences of traumatisation that may cause anxiety disorders.[5] Problems include a wide range of general psychological and somatic symptoms, impact on personality and identity, vulnerability to self-harm, suicide, revictimisation and further abuse.[4] Given findings such as these, it is not surprising that Indigenous Australians experience high levels of mental illness. In this respect, Sansbury noted that 25 per cent of Aboriginal people living in the inner city or in large towns have mental health problems associated with stressful life situations; that Aboriginal males are 80 per cent more likely to commit suicide than non-Aboriginal males; and that more than 63 per cent of Aboriginal people presenting to Aboriginal medical services have a significant level of distress, principally depression.[6] However, although there are many medical centres focussing on the physical body, we also need to heal our spirit from all of our past pains, traumas and tragedies. We have to look at healing in a holistic manner.

BACKGROUND TO THE SEVEN PHASES HEALING MODEL

The program of healing was designed in response to my personal acknowledgement of my own loss and grief and the impact it was having on my life. The program has been implemented and developing over the past 20 years in response to my own life experiences as a person of the Stolen Generation.

The Seven Phases application as a holistic and constructive grieving process will be demonstrated. The ultimate purpose to grieving for ancestral and contemporary losses is to evolve spiritually in the physical world and to realign our Seven Humanities.

The Seven Humanities

The humanities comprise:

Mental	The ability to have and process beliefs, concepts and understandings using our five senses—see, feel, hear, touch and taste;
Emotional	Have the ability to feel sadness, anger, guilt, love and compassion;
Physical	Body moves into action or becomes debilitated;
Spiritual	Intuition;
Sexual	Procreation;
Social	Survival; and
Cultural	Identity.

These Seven Humanities must be maintained and aligned. How individuals maintain their Seven Humanities is to participate in the Seven Phases to Integrating Loss and Grief. Once the losses and unresolved grief have been integrated, the individual has a higher probability to transcend into their intuitive intelligence to retrieve their unique and innovative life's purpose!

DEFINITIONS AND SCOPE OF LOSS AND GRIEF

What is Loss?

Losses are a prerequisite for being a human being. Planet Earth gives and takes life, creating space for the next phenomenon. People can experience the different types of loss many times throughout their life. Loss can be categorised as:

- Recognised loss i.e. loss that is evident (can be seen) and tangible;
- Unrecognised loss i.e. loss that is not evident (cannot be seen) and not tangible yet may be perceived/felt by an individual;
- Ancestral loss;
- Contemporary loss;
- Anticipatory/expected loss (such as when you are aware someone has an illness and may pass away soon; a child is leaving home);
- Sudden/unexpected loss (i.e. when someone dies suddenly).

What is Grief?

Grief and grieving is a prerequisite to being a human being and it is also a basic human right to honour, respect and express it according to an individual's needs and cultural needs. The depth of grief is determined by the category of loss or losses.

Grief is 'Live Energy'

Grief is 'live energy' needing expression to get it out of the physical body.

If 'live energy' is **suppressed long term**, it stimulates the physical body to become pressurised and if there's no outlet for this 'live energy'—like a pressure cooker with its spout sealed up—the cooker will eventually explode. Suppressed long term, it is then conceivable to imagine the physical body under such extreme pressure that it can begin to weaken and destroy healthy body cells, making the body susceptible to diseases as well as experience major social and emotional and other health challenges.

Categories of Grief

There are two categories of grief:

- *healthy grief* expression is when someone is reasonably conscious as to why one must express grief and participate;
- *toxic grief* is when an individual is unreasonably unconscious as to why one must express grief and they can't, don't or won't participate.

Grief is experienced firstly as a shock reaction (immediate reaction to the loss/es), and then in mourning (journey towards processing grief or emptying the grief energy out of the physical body.)

Experiencing Grief Through Storytelling

Not all stories told by adults to their children promote a state of wellbeing. Grief is seen, felt and heard by the next generation usually through storytelling. Many parents tell stories to their children about their experiences which can be shaped by toxic grief; in this way ancestral grief stories are told across and then down the generations, eventually compounding and complicating their contemporary descendants' grief.

Shock	Disbelief, denial, numbness;
Anger	Conflict in relationships, ill health, sudden violence;
Panic	May have panic attacks;
Apathy	*'I don't care anymore...'*;
Depression	Suicidal thoughts are common;
Guilt	'*If only …'* stage;
Physical Illnesses	Grieving people often neglect themselves nutritionally
Crying/Wailing	Suppressing tears can cause ill-health

THE CHARACTERISTICS OF THE SEVEN PHASES

Plato conceptualised that 'grieving is a weakness' and 'therefore, the well-educated need not grieve'. Such a concept is a myth—it seems to have become intergenerational worldwide. Such a myth needs '*bulldozing'* and rebuilt with contemporary beliefs, concepts, understandings and practices.[8]

The System of The Seven Phases

- The Seven Phases reveal that there is much more to loss and grief than death and dying;

- Loss and grief within the system of the Seven Phases addresses many social and emotional and health challenges experienced within many Aboriginal communities;

- It is holistic in its approaches as it realigns all seven humanities, solidifying the reconnection to intuitive intelligence for long term health and wellbeing, creating inter-generational wellbeing;

- It does not shame or blame but rather assists in accountability and responsibility for self-healing;

- It acknowledges that loss and grief is a human experience, therefore it does not discriminate;

- It does not seek 'closure' as this gives the impression that one's loss and grief cannot, or won't, be seen, felt or heard of ever again. Woven into 'closure' is fear of real grieving resulting in weakness; therefore 'closure' seeks to really avoid the deeper and more meaningful grieving process;

- The Seven Phases seeks to integrate all ancestral and contemporary losses to 'locate' suppressed and unresolved grief.

Table 28.1 describes how many belief systems within western culture still operate on the assumption that the only way to 'heal' people is to dissect them in life as in death. For example:

Column 1 demonstrates the alignment of the Seven Humanities, as a 'well balanced' human being who could be someone living in traditional Aboriginal culture before the 'arrival' in 1788 or a 'well balanced' individual in the 21st century; or an ancestral individual human being and their descendent who now lives with a highly evolved Intuitive Intelligence creating a healthy lifestyle!

Column 2   demonstrates someone whose Seven Humanities have fractured showing them to now be out of alignment with each other. Since the 'arrival' in 1788, this person's Seven Humanities are fractured disconnecting them from their Intuitive Intelligence!

Column 3   demonstrates the categories of western systems studied in universities, set up to work in isolation of each other—maintaining 'silos'. This has led to each 'silo' believing they are experts in their field and are above the other modalities.

Column 4   outlines the study of each modality set up in western universities.

Table 28.1: Dissecting the 'Living' Human Being

Western Culture Dissects the 'Living' Human Being			
1. Seven Humanities	*2. Grief Stricken Fear*	*3. Western Systems*	*4. Study of Systems*
Mental	Mental	Psychiatry	The study of medicine which deals with the diagnosis and treatment of mental disorders
Emotional	Emotional	Medicine	The study of diseases and ways of maintaining and restoring health
Physical	Physical	Psychology	The branch of science which studies consciousness and behaviours
Spiritual	Spiritual	Theology	The study of divinity or religious doctrines, such as the characteristics of a god or gods in relation to man the universe
Sexual	Sexual	Psychiatry Psychology Medicine	As above
Cultural	Cultural	Anthropology	The study of origins and developments of mankind
Social	Social	Sociology	The study of social behaviour especially in relation to the development or changing of societies and social institutions
Seven Humanities aligned	Seven Humanities out of alignment	Western systems designed as 'silos'	

SEVEN PHASES TO INTEGRATING LOSS AND GRIEF MODEL

The Seven Phases system of grief recovery was developed from my personal lived experiences.

In 1994, I completed a loss and grief personal development course that enabled me to finally put a name to all my confusing emotions.[7] It was loss and suppressed unresolved grief. My grieving processes saw me grow out of being a childish frightened adult victim, to an accountable and responsible adult. The course awakened my consciousness to seeing, feeling and hearing that there is so much more to loss and grief than death and dying. It was several months before I began conceptualising that the model needed an extensive overhaul to include the loss of one's culture and spirituality and much more.

In order to validate the Seven Phases holistic approach, I draw on my own personal experiences. While it is important to see the Seven Phases as my own personal and intimate experience—real, uncomfortable and confronting—it is also a compelling loss and grief system with processes that can 'work with' intergenerational suppressed unresolved grief. Similarly, it can also 'work with' contemporary suppressed unresolved grief which has become compounded and complicated for individuals and their families and communities, a race of people, a nation and their continents.

The *Seven Phases to Integrating Loss and Grief* emphasises the Past, Present and Future. When reflecting on, and considering, each of the phases, I asked myself the following questions which compelled me to research each phase, enabling me to move on to the next phase.

Table 28.2: Seven Phases to Integrating Loss and Grief

Parts	Phases	
The Past	**Phase Five:**	Identifying ancient Aboriginal and European grieving ceremonies/activities creating and maintaining Intuitive Intelligence in the highest degree. (What they had!)
	Phase Four:	Identifying ancient Aboriginal and European grieving ceremonies/activities using the physical body for its expression. (What they lost!)
	Phase Three:	Ancestral losses and suppressed unresolved grief being 'converted' into intergenerational suppressed unresolved grief
	Phase Two:	Identifying childhood and adolescent multiple losses and suppressed unresolved grief
The Present	**Phase One:**	Contemporary adult major grief reaction
The Future	**Phase Six:**	Recreating Aboriginal grieving ceremonies/activities using the physical body for its expression
	Phase Seven:	Maintaining Aboriginal grieving ceremonies/activities to maintain Intuitive Intelligence in the highest degree

PHASE ONE: CONTEMPORARY ADULT MAJOR GRIEF REACTION

My Personal Reflection

> " *It all began in 1987 when I had my contemporary adult major grief reaction, commonly referred to as a nervous breakdown by the medical profession.*
>
> *I ended up in a women's shelter, 'pretty busted up, yet again'—it was not a new experience but the women's shelter was. I was at 'rock bottom' and needed to climb up and out to confront the numerous and really difficult questions. I needed to investigate where I came from, in the hope it could explain why I was so angry and sometimes full of rage and at times volatile. At this time I also experienced deep sadness and occasional suicidal thoughts.*
>
> *Similarly, I needed to know how I became an adult victim of domestic violence. I remembered being a child victim of family violence. I questioned whether there some sort of 'kinship' relationship between the both? Likewise in the women's shelter, I had a shocking realisation, that I might perpetrate varying degrees of domestic violence in some way and if so, where did that come from? How is it that I could be both a victim and a perpetrator of domestic violence?* "
>
> *Continued . . .*

> ❝ *While still in the shelter I had a major spiritually-based experience. I recall lacking an enormous amount of faith and trust in myself and my abilities, in fact this was what I felt my whole life, where did this come from? I found myself intuitively drifting toward an only mirror in the small and dingy room at about 3 a.m. in the morning.*
>
> *Tears streaming down my face, I looked into the mirror and heard myself say:*
>
> > 'How the hell did I end up a victim of family violence, again?'
>
> *I recall, I was not horrified when an old traditional Aboriginal woman's face superimposed herself over mine and it is here she 'instilled' into me faith and trust in myself and others. Once I left the women's shelter, unbeknown to me, my 'Intuitive Intelligence' switched on and it has never switched off.*
>
> *I am a wife, a mother, a woman, a daughter, a colleague and yet on leaving the women's shelter, I am so traumatised because I realise I do not even know who the hell I really am and where I am going in life!*
>
> *While I knew intellectually that I was an Aboriginal woman, I didn't feel Aboriginal. I realised then that my lack of Aboriginal identity had me experiencing my life with a lot of deep-seated shame. It took some months for me to realise that I could not find—or begin to understand—my future without looking into my past.*
>
> *In retrospect this period was the most fearful experience I have ever had to endure in adulthood. The fear derived from being psychologically conditioned, certainly all my adult life, to*
>
> > 'stay away from your past, what's happened has happened, you can't change it, so just move on!'
>
> *Assuming I was just going back into my childhood I 'felt the fear and went back into it anyway'.* ❞

Phase One: A Victim of Family Violence

Question:

How the hell did I end up a victim of family violence, again?'

My Mental Thought Processes

Throughout this phase, my mental thought processes were seemingly out of control:

- What happened? Where did it happen? When did it happen? How did it happen? Why did it happen? Who did it?

My Grief Emotions

In and out of:

- anger and rage, sadness, depression;
- suicidal thoughts.

Summary of Phase 1

As a health practitioner/counsellor, or even other family member, it is worthwhile noting:

1. Individuals need to love, honour and respect and also need a strong set of rules, boundaries and limitations so as not to encourage them to 'use and abuse' family, friends and professions.

2. The individual needs to reach what they consider to be their rock bottom and not yours.

3. They will feel disorientated and will have times when they are frantic.

4. When the timing is right for them and with the right support, they'll pose their own initial question that will be their motivating factor to begin healing their grief.

5. Once they begin they'll perceive what is the right support and assistance for them to 'unpack' their childhood/teenage loss experiences and where their grief has been suppressed when they revisit those years.

PHASE TWO: CONTEMPORARY CHILD/TEENAGE LOSSES

At the time I 'entered into' this second phase, neither I nor my family had any idea that I would be fluctuating between adulthood and childhood to recall experiences. I recall asking some questions only to be told: '*What are you worrying about that stuff for, get on with your life!*'

Unpacking my significant major *Loss Experiences* are outlined in Table 28.3:

Column 1 identifies the *major recognised loss experiences* in childhood/adolescent.

Column 2 identifies which of the *seven humanities* have been abused in this particular loss experience.

Column 3 names the *innate emotion or emotions* that I was born with but were being eroded in my childhood. Depending on the individual's life experiences, these innate emotions have the potential to become either affirmed or extinguished incrementally—these are losses that cannot be seen.

Column 4 includes the *emotional legacies* which are cultivated as a direct consequence of experiencing columns 1 and 2; they are 'unrecognised' as they can't be seen as a loss. This column became crucial in the grieving process.

Column 5 is the *age* when columns 1 and 2 occurred throughout childhood/adolescence. The age that these experiences occurred 'supported' my childhood grief reactions in an adult body.

Table 28.3: Childhood/Adolescent Loss of Innate Emotions Model

1. Major Recognised Loss	2. Form of Abuse	3. Innate Emotion (What I had)	4. Emotional Legacies (Unrecognised)	5. Age
Teacher told me and classmates that I was a dummy. I felt her wrath and public humiliation	Mental and emotional abuse	Sense of safety; Sense of trust for teacher My sense of intelligence was intact	Don't set myself up to trust people in authority; to feel safe I believe I'm a dummy	8
Witnessed my father physically abuse my mother	Mental, emotional and spiritual abuse	In the home safe and feeling trust; Trusting parents	Don't set myself up to truly love; to trust people I love	7
My mother died when I was ten years old. I was removed from family and taken into the welfare for two and a half years		Love for family; Love for mother and father Life in control; Dreams, hopes and expectations of parents/family will remain intact	Don't set myself up to truly love my children. Family equals death Don't set myself up to be controlled by marriage/ relationships (sabotage)	10
First foster home—I experienced a beating with a copper stick naked below my waist	Physical, mental and emotional abuse	Went in with a degree of trust and safety	Don't set myself up to trust certain white people; similarly they aren't really safe to be around	11
Second foster home—teacher states that 'When Captain Cook landed Aboriginal people were savages'. I felt her wrath again	Mental, emotional, spiritual, cultural and social abuse	Sense of pride for Nunga identity but was waning by this time but still intact	Ashamed of my ancestors' Aboriginality and that of myself	12
Second foster home—I experienced sexual abuse	Mental, emotional and sexual abuse	Minimal sense of trust, safety and power was still waning but still intact	Don't set myself up to trust certain white people; similarly they aren't really safe to be around. Sexual abuse is a new experience. Saying no is worthless; compliments mean abuse will follow	12
The day I left the second foster home I witnessed the woman attempting to commit suicide in her kitchen by using their gas oven	Mental, emotional, and socially abused	Sense of trust, safety and was still waning but still intact	Don't set myself up to trust certain white people; similarly they aren't really safe to be around	12.5
A non-Aboriginal woman pulls a pair of scissors out on me in a shop	Mental and emotional abuse	Safe and trusting shop keeper on entering her shop	Don't set myself up to trust certain white people; similarly they aren't really safe to be around	16

Understanding and Theorising My Reality

The collection of my individual children and adolescent loss and grief experiences became my 'children's' memories frozen in time according to my age; hence why I call them multiple 'inner children'.

As a child and adolescent, my physical body grew into adulthood, but my multiple children remained 'stunted' at the ages that grief events occurred as outlined in Table 28.3. This is because these multiple 'stunted' children in me had suppressed and unresolved childhood grief as a direct consequence of experiencing multiple recognised and unrecognised losses.

In my adulthood, these 'children' frequently had their immature childish major grief reactions when they sensed they could, or would, be exposed to similar recognised and/or unrecognised loss experiences that resembled what had happened to them in their childhood and adolescent years. These childish major grief reactions inadvertently continued to affirm the emotional legacies and the beliefs, concepts, understandings and practices that accompanied them. Finally, they facilitated equally numerous misinterpretations of some adult experiences that should have been experienced as adult-to-adult but, instead, they became an adult/child relationship.

So, from 18 to 38 years of age, these multiple suppressed and unresolved experiences constantly reminded me, the now adult Rosemary, of what happened to all of 'us'(stunted children) in our childhood/adolescent years.

The Second Phase

Question:

Who had the right to take me away from my family?

My Mental Thought Processes

Throughout this phase, my mental thought processes continued to be out of control (couldn't shut them up):

- Still in a state of questioning significant memories, day or night; or questioning why do I do or say what I do or say?

- What happened? Where did it happen? When did it happen? How did it happen? Why did it happen? Who did it?

My Grief Emotions

In and out of:

- anger and rage, sadness, depression;

- suicidal thoughts.

Summary of Phase 2

As a health practitioner/counsellor, or even other family member, be aware that:

1. For an adult individual to begin and maintain their grieving processes, it's imperative that society supports them with encouragement.

2. Once the grieving individual understands the impact of losses and suppressed unresolved grief in childhood/adolescence, and they still have numerous grieving inner children, they can participate in healing their grief rather than rejecting them. In so doing, this person has a greater potential to reach adult maturity.

3. It takes the adult person to really heal all their inner children's suppressed unresolved grief emotions that collectively develop into grief emotions and grief fears in adulthood.

4. The purpose for processing suppressed unresolved grief is to reclaim back some or all innate emotions that were intact before the losses.

PHASE THREE: INVASIONS/COLONISATIONS

We know we cannot live in the past but the past lives with us.
Charles Perkins

What Happened to Aboriginal Ancestors after the 1788 'Arrival'?

The arrival of the first fleet was not a 'settlement' but an invasion. Aboriginal people were subjected to systematic genocide using the following three warfares:

- *Outright warfare:* To kill as many people as quickly as possible using weaponry;

- *Germ warfare:* Sexually transmitted diseases, smallpox, measles, contagious germs put into blankets, waterholes poisoned;

- *Psychological warfare:* Survivors had come under written policies, practices and procedures. For example, Aboriginal people were forcibly removed into missions and reserves away from non-Aboriginal people; Assimilation Policy; Exemption Certificates; etc.

These '*genocide*' policies, practices and procedures could not be documented as all other formal policies. The arrival of European migrants maintained the racially motivated comments and behaviours.

As a health practitioner/counsellor, or even other family member, be aware of the following:

1. **Racism:** Historical and contemporary racism is the basis of grief, fear of personal and ancestral loss. People who engage in racism harbour a strong sense of obligation to their ancestors to maintain racism. Just as suppressing grief is learned behaviour, racism is learned behaviour and is passed down from generation to generation.

2. **Victims into Perpetrators:** Suppressed unresolved grief in victims of historical and contemporary recognised and unrecognised losses are more likely to convert their grief into behaviours associated with anger, rage and violence thereby becoming perpetrators in their own right as an individual, a family, a community, and as a race or a nation.

3. **Intergenerational:** A perpetrator's suppressed unresolved grief is learned behaviour based on their childhood environment. They are therefore more likely to pass this unresolved grief on to their own children by telling them stories embroiled in grief-related emotions—such as anger, rage, violence; sadness or depression—about what happened during and after 1788.

4. The English could **commit invasions called colonisations** because of their personal intergenerational suppressed unresolved grief emotion called grief anger, escalating to rage, escalating to violence. Ultimately they are disconnected from their Intuitive Intelligence.

5. **Migrant groups:** Migrants arrived with a deep seated emotion called 'gratefulness' for Australia and would do all they could to avoid being seen as ungrateful if they supported Aboriginal peoples and their cause. Migrant racism is also delivered with a strong sense of obligation to their ancestors—both types of racism are learned behaviours.

6. **Both groups**: The deep seated grief in English and migrant groups enables them to 'shame and blame' the victim for their social and emotional predicament.

7. My research found that Aboriginal people did not do anything erroneous—the invasion was extremely disproportionate to what our ancestors 'didn't do' to the first fleet and thereafter.

One of the previous questions catapulted me even further into my past to research the following question:

If my ancestors weren't the 'savages' what sort of people were they?

PHASES FOUR AND FIVE: TRADITIONAL CULTURE

Throughout my research I found that traditional Aboriginal culture had developed and implemented their own governing systems, guiding them through life and in death. These systems had been developed and maintained for over 60,000 years.

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Traditional Aboriginal Culture

Musicians	Health	Social order
Law and justice	Trade/commerce	Funerals
Spiritual Lore	Geography	Grieving
Aquaculture	Governing system	Births/deaths/marriage
Science	Women's/Men's business	Parenting
Education	Technology	Astrology
Sport	Food hunting/gathering	Geology
		Art (rock painting)

</div>

A Spiritual Journey – Being Found by our Ancestors

I was fortunate to have a very spiritual experience to demonstrate that traditional Aboriginal Dreaming totems can and will find us, not by us going out and finding them—we have to experience them to know the difference.

Our ancestors will see, feel and hear our commitment to healing our intergenerational unresolved grief that has been compounded and complicated by contemporary unresolved grief in the 21st century. Not being afraid to reclaim our totem when it arrives is a cultural belief, concept, understanding and practice of traditional culture that has contributed to maintaining strong kinship relationships to all living things.

Before, during and after this experience and within this phase, I began the grieving processes of returning the intense shame of my Aboriginality back to my teacher who, unbeknown to her, took it from me publicly and viciously.

I gave the shame back by first of all giving myself permission to express my deep-seated grief anger and rage towards her, even though she might be dead. I carried shame not just for my cultural identity, but for my ancestors as well. I recall feeling intense anger for them because they did not fight for their rights to keep their culture. It took researching phase four and five to learn that my ancestors were not warlike, therefore not an out-of-control violent race of people.

It was not until I unpacked this part of my history and had such a powerful experience that I reclaimed my Nunga (South Australian Aboriginal word for Aboriginal people) identity without any more shame or blame. I reclaimed my ancestors' love, honour and respect for me and, equally, for what I had for them!

Throughout researching this phase, I discovered many things about traditional culture that I have never lived or studied. My research understanding is abstract, other than what I personally experienced spiritually.

When I moved back to Adelaide I met grandfather Crow and my mother, and the concept of setting up a centre that could help Aboriginal women experiencing family/domestic violence was conceived. The 'Sacred Site within Healing Centre' was established in December 1993.

The Fourth Phase exploration

Traditional 'Aboriginal' and 'English' cultures had structured practical grieving ceremonies and activities.

The Fifth Phase exploration

Traditional 'Aboriginal' and 'English' cultures had structured grieving ceremonies and activities that heightened their Intuitive Intelligence.

My Mental Thought Processes

Throughout this phase, my mental thought processes became calmer although still questioning:

- What was traditional culture?

- What happened? Where did it happen? When did it happen? How did it happen? Why did it happen? Who did it?

My Emotions

In and out of:

- happy, inspired, proud;

- identity solid.

Summary of Phases 4 and 5

As a health practitioner/counsellor, or even other family member, be aware that:

1. Expressing grief using a healthy model left me with the choice of forgiving contemporary and ancestral losses and consequently forgiving my ancestors for not fighting back to maintain their traditional ways.

2. The choice to forgive derives from fully understanding their circumstances. My ancestors surrendered to warlike strategies centuries ago; they were not warlike because they knew how dangerous it was for them all. Also, they did not have the numbers, let alone resources, to keep our culture intact.

3. Aboriginal Australians were spiritually evolved in the highest order.

4. Many contemporary Aboriginal Australians can reclaim the ability to become spiritually evolved again using contemporary grieving activities/ceremonies.

5. Aboriginal Australians had developed social networks and strategies that were structured to maintain relationships with each other, animals and Mother Earth.

PHASES SIX AND SEVEN: THE FUTURE

Phases Six and Seven are about the future. The Healing Centre evolved into the Australian Institute (2005) where I implement the Seven Phases to Integrating Loss and Grief as a counselling model and training program. Coming to the realisation that loss and grief is a human experience, the counselling is designed to 'work with' *all* people; and the training programs are for Aboriginal and non-Aboriginal people who work with Aboriginal people.

As an example, my counselling client case study 'John' and I found one of his 'inner children' ('Inner children', are discussed in Phase Two).

Case Study   **John**

Background

First session was August 2012; last session January 2013—sessions totalled 29 hours. John presented as a 59 year-old Caucasian male. He was one of three siblings of a migrant family. Originally John was looking for a Men's Group. He eventually spoke to a male who heard John's 'loss and grief' and referred him to the Australian Institute. John perused the Institute on the Internet and contacted me. After a discussion, I informed John that, though I was Aboriginal, I worked with all peoples and had a non-academic background. We were both satisfied that I had the potential to help him. John's requirements were to be helped to identify and 'unpack' his adult losses and unresolved suppressed grief from an eight year relationship breakdown.

When John presented he was on anti-depressant medication due to preoccupation with suicidal ideation—on the Internet seeking out weaponry as preferred method. John's eight-year relationship unexpectedly dissolved fairly rapidly due to him raising his voice for the first and only time in the relationship at her 'injustice' of not supporting him and his adult child to take a fun interstate trip.

Throughout the sessions, John seemed unhealthily besotted by his now ex-partner—she was placed very high on a pedestal where her faults were unattainable. According to him 'the break up was his entire fault'. This enabled him to acquire 'false' readings of their relationship unravelling sooner rather than later.

Knowing the 'inner children' concept, and unbeknown to John, it was about the third session that I was able to identify John's 10 year-old often 'speaking up' in the session. He had a high level of responsibility before and after school for a very sick mother who later died 'in his care'. His father had no concept of caring for his 10 year-old son, and so John experienced childhood suppressed unresolved grief for the next 50 years. As a consequence, he accumulated his teenage and adult losses and his ominous grief remained unresolved.

With time, understanding and compassion, he embraces his 10 year-old. My approach is to help 59 year-old John determine on a day-to-day basis who is having the conversation when it relates to seeking out medium- to long-term female relationships. Is it 10 year-old John seeking out a women who does not know how to discriminate against any of her flaws, because he 'just' needs someone that reminds him of his dead mother to, in effect, make up for not keeping her alive. Fifty-nine year-old John becomes the 'medium' to make it happen because 10 year-old John's urge 'to make it up to his mother' is like an addiction that must be quenched. Ten year-old John's suppressed unresolved grief has inadvertently facilitated 59 year-old John to develop a pattern of feeling a deep sense of responsibility for his 'partners' happiness at the risk of minimising his own.

This long term approach encouraged 59 year-old John to embrace his 10 year-old and help him grieve for his mother and subsequently reconcile the shame and blame for not 'saving' his mother by showing forgiveness and acceptance—he was just a child! The pathway to this reconciliation was to apply suitable grief activities, namely: talking grief through (counselling); working it through (walking); writing it through without any censoring (writing to his ex-partner and forwarding it on to me). The approach also helped him grieve for a father who was not taught anything about loss and grief. The father could not help his 10 year-old son process grief emotions at the loss of his mother and so help prevent the son from maintaining his childlike interpretation of the death of this mother that lead to being controlled and manipulated into adult practices that contributed to precarious intimate relationships.

Client Feedback

On 18 March 2013, 'John' wrote:

> *Life is still a struggle but I`m trying to adapt to my new situation. As you know I sought help from many avenues but only you truly understood who I was, what I have lost and where I am at for which I am really grateful. I hope to keep striving to return to a peaceful and more happy existence. No problem using my inner children example provided I remain anonymous as you have suggested. If these stories somehow help others understand the impact of traumas in their lives and allow them a means of resolution, then that would be great.*

EVALUATION OF WORKSHOPS

More recently participants have been evaluating the training program. The table below indicates overall ratings of the one, two, three and five day workshops. We acknowledge the evaluation did not rate responses to each question, so we allocated responses to a rating from 1 to 5, the highest rating being 5. Information has been collated from a total of 369 responses.

Table 28.4: Workshops Evaluation

Course		Rating					
		1 – Poor	2 – Fair	3 – Good	4 – Excellent	5 – Outstanding	Total
1 Day Course	No.	0	2	3	15	32	52
	%	0.0	3.8	5.8	28.8	61.5	100.0
1 Day Course (2)	No.	0	0	3	22	11	36
	%	0.0	0.0	8.3	61.1	30.6	100.0
2 Day Course	No.	0	0	8	28	104	140
	%	0.0	0.0	5.7	20.0	74.3	100.0
3 Day Course	No.	0	0	10	13	44	67
	%	0.0	0.0	14.9	19.4	65.7	100.0
5 Day Course	No.	0	0	1	1	6	8
	%	0.0	0.0	12.5	12.5	75.0	100.0
5 Day Course (2)	No.	0	2	5	21	38	66
	%	0.0	3.0	7.6	31.8	57.6	100.0
Total	**No.**	**0**	**4**	**30**	**100**	**235**	**369**
	%	**0.0**	**1.1**	**8.1**	**27.1**	**63.7**	**100.0**

The table shows that the highest number of participants attended the two day workshop, the rating for which was higher over the 'Excellent/Outstanding' categories than for the other workshops.

In addition to demographic information, we obtained qualitative responses from participants regarding whether they:

- had learnt about past and contemporary issues facing Aboriginal people today that they were not aware of prior to attending the workshop;

- think some aspect/s of their current work practices could change as a result of what they had gained from this workshop and, if so, briefly what could that be?

The following are some of the participant's responses:

> 66 *Absolutely, we have a lot of Aboriginal clients and staff on/in our program. I hope I can be more sensitive but also more encouraging to get to know each other without fear of getting it wrong all the time? Also never assume.* 99

> 66 *Indeed too easy to make assumption of self and others. This workshop enabled me to look beyond and understand not only the spiritual connection to land but also the grief of not having connection to land, causing a sense of loss of identity.* 99

> 66 *Making an effort to physically connect to the Aboriginal community and letting them know we have training that is culturally appropriate. We have not done this to date.* 99

> 66 *Absolutely, more people need to be educated to better work with Aboriginal people, to get a better understanding of their situation.* 99

> 66 *Absolutely, this training is accessible to non-Aboriginal staff in a non-blaming but deeply effective way.* 99

CONCLUSION

This chapter has discussed the importance of recognising and acknowledging the transgenerational and pervasive effects of individual and collective loss and grief, and the extent to which this has impacted at so many levels on individual, family and community mental health and social and emotional wellbeing. The chapter aims to inspire practitioners, service providers and students to consider that, by participating in the seven phases of healing process, there is potential to address major social and emotional and mental health challenges facing Aboriginal and Torres Strait Islander peoples.

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The Marumali Program:
Healing for Stolen Generations

Lorraine Peeters, Shaan Hamann and Kerrie Kelly

OVERVIEW

There are an estimated 10,625 people who directly experienced the trauma generated by forcible removal, an estimated 25,844 children (second generation) who have been living with parents affected by forcible removal, and an estimated 40,612 grandchildren who continue to experience the effects of their grandparents' removal.[1] Two models developed by Aboriginal people have been evaluated and consistently identified as 'best practice' to assist those who have been forcibly removed—Link-Up family tracing and reunion services, and the *Marumali Journey of Healing*. Both seek to restore what the children lost when they were removed. This chapter provides insight into the *Marumali Journey of Healing* which works in harmony with Link-Up family tracing and reunion services to restore connections to Aboriginal identity and social, emotional and spiritual wellbeing. The *Marumali Journey of Healing* is grounded in Aboriginal knowledge systems, and restoring connections to spirit and spirituality is key to recovery. Counsellors are encouraged to work in collaboration with other agencies, and a number of workshops have been developed to support this. As well as training Aboriginal and Torres Strait Islander counsellors, workshops have been developed to train other mental health practitioners to work in partnership with Aboriginal counsellors.

THE TRAUMA OF FORCIBLE REMOVAL OF ABORIGINAL CHILDREN

Aboriginal children have been forcibly separated from their families and cultures since European occupation of Australia.[2] The term 'Stolen Generations' refers specifically to the Aboriginal children who were deliberately and systematically removed from their families using laws, policies and practices which relied on compulsion, duress or undue influence 'forcible removal' during the years 1910 to 1972.[2] In contrast to children removed following the adoption of the Aboriginal and Torres Strait Islander Child Placement Principle from the late 1980s, children removed during these years were raised in non-Aboriginal institutions and families and required to adopt their cultural values and ways of life.

> *One principal effect of the forcible removal policies was the destruction of cultural links. This was of course their declared aim. Culture, language, land and identity were to be stripped from the children in the hope that the traditional law and culture would die by losing their claim on them and sustenance on them.*[2(p202)]

The trauma generated by these policies was experienced by thousands of children over a 62-year period up until 1972. However, the source of this trauma was not acknowledged until the *Royal Commission Into Aboriginal Deaths In Custody* (RCIADIC) drew attention to policies and practices of forcible removal in 1991. The Royal Commission reported:

> *The horror of a regime that took young Aboriginal children, sought to cut them off suddenly from all contact with their families and communities, instil in them a repugnance of all things Aboriginal, and prepare them harshly for a life as the lowest level of worker in a prejudiced white community .*[3(p30)]

While these policies and practices were a 'history that few Australians know', they were 'a living legacy amongst many Aboriginals today'.[3]

Following removal, children were placed in non-Aboriginal institutions and foster and adoptive families and many were assigned new names and birth dates to prevent their families from locating them. The children were told either that their families had rejected them or that they were dead.[2(p154)] The systematic programs of racial denigration implemented in institutions established to create a 'servant class' of domestics and labourers were not brought to light until the *National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* exposed them in 1997:

> *The assimilation policy seemed to demand that the children reject their families. The tactics used to ensure this ranged from continual denigration of Aboriginal people and values to lies about the attitudes of families to the children themselves.*[2(p200)]

To prevent the children from returning to Aboriginal Australia as adults, programs of racial denigration were targeted toward their parents, their families and Aboriginal people in general:

> *Nothing could have prepared me for the days I spent with my co-Commissioners listening as people spoke the truth of their lives for the first time. They recalled being told that their parents had given them away because they did not love them. And they told me what it was like to be taught to hate Aborigines and then turn that hate against your own history, your own mother and yourself .*[2(p1)]

The National Inquiry heard harrowing first person testimonies from more than 500 adult survivors about the human rights abuses they experienced, and the burden of trauma and the impact it had on their lives. Although the National Inquiry recommended 'the development and implementation of a program of research and consultations to identify *the range and extent of emotional and wellbeing effects* of the forcible removal polices,'[2(p341)] this recommendation has yet to be implemented. In 2007, almost a decade after the National Inquiry, an evaluation of the Bringing Them Home Counselling and Indigenous Mental Health Programs reported:

> *It became apparent that there is, in fact, very little published literature specifically relating to best practice strategies for meeting the social and emotional wellbeing (SEWB) needs of Stolen Generations groups. Although there is an emerging body of literature on SEWB approaches, and also on mental health approaches for Aboriginal Australians, this literature has tended to focus on the Aboriginal population as a whole, rather than specifically on the Stolen Generations.*[3(p126)]

The National Inquiry stated 'principles for responding to the effects of forcible removals must be developed from an understanding of Australian history as having included 'gross violations of human rights' and the response provided within a human rights framework.[2(p274)] However, the Commonwealth Government rejected the human rights basis of the *Bringing Them Home* (BTH) report, and until the National Apology in 2008, remained firm in its resolve that Aboriginal children were only forcibly removed if there was 'good reason' to do so, and the 'treatment of separated Aboriginal children was essentially lawful and benign in intent.'[4] The establishment of a stand-alone Bringing Them Home Counselling program in response to tabling of the *Bringing Them Home* report reflected the Commonwealth Government's understanding of what had happened, rather than what the *Bringing Them Home* report recommended. It is not surprising therefore that these programs have been found to be largely inadequate and/or culturally inappropriate.[5]

The United Nations Special Rapporteur, Theo van Boven, quoted in the *Bringing Them Home* report, made the following points:

> *It is well-established that for many victims of gross violations of human rights, the passage of time has no attenuating effect; on the contrary, there is an increase in post-traumatic stress, requiring all necessary material, medical, psychological and social assistance and support over a long period of time.*[6(para135)]

Many who experience gross violations of human rights object to the use of the term post-traumatic stress disorder (PTSD), because their reactions are normal and understandable, given what they have experienced. Professionals experienced in working with those who have experienced human rights violations support such an approach:

> *PTSD participates in a process that converts a social and political problem into psychopathology. 'D' stands for disorder. There is probably nothing less helpful for a victim of human rights violations than to classify his or her suffering as a mental illness. Furthermore, PTSD pretends that the trauma is over, that we are dealing with the consequences of a past event. It thus cannot grasp long-lasting chronic traumatic situations, nor can it understand why symptoms might appear only many years after the original traumatic situation. Last but not least we have to state that PTSD is an individual diagnosis, incapable of understanding the destruction of family structures in trauma, and also that the list of symptoms PTSD lists is absolutely incomplete.*[7(p3)]

The on-going traumatic effect of forcible removal should include the impact on survivors when they learned:

- what they had been told as children was untrue;
- that they and their families had been targeted for forcible removal for the purpose of assimilation;
- that forcible removal was lawful at the time and deliberately done; and
- of their situation in the national and historical context of the Stolen Generations.

The long-term psychological effects of programs of racial denigration targeted toward Aboriginal children have yet to be understood by anyone other than those who experienced it.

In order to avoid causing further harm, services targeted to address long-standing trauma in any population need to be 'trauma-informed' services. Trauma-informed services are based on an understanding of the vulnerabilities or triggers that service delivery might exacerbate in the client group, so they avoid re-traumatising those they seek to serve.[8] The reluctance to fund research in this area has hindered the development of the specialised support services the Stolen Generations require. This leaves survivors relying on mental health service providers recognising that they have experienced 'gross violations of human rights' (as defined by the United Nations) requiring a response within a human rights framework (preferably using a 'reparations' approach). Many members of the Stolen Generations were removed in *the absence of* neglect or abuse, and their parents were *prevented* from protecting them. If survivors are counselled to accept that their removal was purely a protective measure, then human rights abuses will continue to be perpetuated.

If 'trauma-informed' services are to be provided, practitioners must be adequately prepared to work with the ethical principle of 'do no harm' as central to service provision. To enable this, it is critical that Aboriginal mental health practitioners are supported and are able to define the burden of trauma attributed to policies and practices of forcible removal, and to identify best practice responses to address this. Profiles of trauma also need to be developed which document the core features defined as traumatic in forcible removal placements in non-Aboriginal institutions and foster and adoptive families. Common strategies used to 'assimilate' children in

each type of placement, and common triggers which contain the potential to reactivate trauma, also require understanding and documentation.

Any risks posed to Stolen Generations through counselling delivered by non-Aboriginal mental health practitioners in the current environment need to be identified and strategies developed to manage these. Aside from dealing with the trauma arising from human rights abuses, there is a need to take account of the impact of forcible removal in the context of Aboriginal concepts of social and emotional wellbeing (SEWB). The inability of mainstream concepts of psychological trauma to articulate with, or accommodate, Aboriginal concepts of SEWB has long been recognised.[9]

THE BURDEN OF TRAUMA ASSOCIATED WITH FORCIBLE REMOVAL

The cause of the specific type of trauma seen in the Stolen Generations ceased 40 years ago with the end of Aboriginal-specific forcible removal policies in 1972, and this was further strengthened with the introduction of the Aboriginal Child Placement Principle from 1987.

The *primary burden of trauma* associated with forcible removal has been borne by those who directly experienced forcible removal during the years from 1910 to 1972. Nationally, an estimated 10,625 (or one-in-ten) people aged 45 years or older report being forcibly removed.[1]

The *secondary burden of trauma* associated with forcible removal lies with those other than the individuals forcibly removed, such as their families and communities. Nationally 43 per cent, or an estimated 92,300 of those aged 15 years or older, report a relative was removed.[10] The children (second generation) constitute 28 per cent of the 43 per cent who reported their relatives were removed (estimated to be 25,844 people, most of whom would be aged 30 years or older). The third generation (grandchildren) constitute 44 per cent of the 43 per cent who reported their relatives were removed (estimated to be 40,612 people aged 15 years or older).[10]

The *future burden* is the ongoing legacy of not adequately addressing the burden of trauma in the population of people who directly experienced it, and the transgenerational transmission of social, emotional and spiritual wellbeing problems as a result of connections that were severed or attenuated by past government policies.

In total there are an estimated 10,625 people who directly experienced the trauma generated by forcible removal, an estimated 25,844 children (second generation) who have been living with parents affected by forcible removal, and an estimated 40,612 grandchildren who continue to experience the effects of their grandparents' removal.

TRAUMA GENERATED BY HUMAN RIGHTS VIOLATIONS

Forcible removal of Aboriginal children and subjecting them to systematic programs of race-based denigration, fall within United Nations classifications of 'systematic discrimination': 'persecution on social, political, racial, religious or cultural grounds in a systematic manner or on a mass scale' and meet international definitions of 'gross violations of human rights'.[11]

The policy response to the *Bringing Them Home* report was crucial to preventing the burden of trauma from being carried into the future. Unfortunately the investments in the *Bringing Them Home* Counselling and Aboriginal Mental Health programs between the years 1998 to 2009 failed to reach or benefit members of the Stolen Generations.[5, 12, 13] As a result, these programs have not functioned as 'rehabilitation' services for the Stolen Generations.

Until the full set of recommendations from the *Bringing Them Home* report are implemented and some remedy is provided for the harms suffered by survivors, present day 'triggers' or reminders will continue to evoke the painful re-experiencing of the trauma associated with forcible removal. Each time this trauma is reactivated, it continues to be transmitted to subsequent generations.

RESTITUTION AND REACTIVATED TRAUMA

The National Inquiry found that a key objective of forcible removals was to sever the link between the child and his or her family, community and culture.[2(p260)] Family reunion was identified as 'the most significant and urgent need of separated families' and 'the beginning of the unravelling of the damage done to Aboriginal families and communities by the forcible removal policies':[2]

> *Going home is fundamental to healing the effects of separation. Going home means finding out who you are as an Aboriginal: where you come from, who your people are, where your belonging place is, what your identity is. Going home is fundamental to the healing processes of those who were taken away as well as those who were left behind.[2(p318)]*

However, the systematic programs that accompanied the 'assimilation' of Aboriginal children often resulted in survivors recovering their identity against a background of denial and denigration of Aboriginality:

> *... it might be that the person who's trying to go back to their community really struggles with how to deal with that return and really needs quite a lot of help in adjusting to the old identity that they believe they were brought up with and this new sense of identity which they feel is much more their real identity, and that's a very complex issue to come to terms with in any individual person as well as within a family.[2(p311)]*

As a result, the process of restoring Aboriginal identity can be a complex process which involves re-connecting with family, land, culture, ancestors, spirituality and community, while managing and overcoming traumatic stress reactions activated or re-activated by confronting the government sanctioned human rights abuses they and their family experienced, the derogatory and racist comments found in their 'files', and their fears they will be rejected by their families and communities, and finding what they had been told as children about their removal, their parents, and other Aboriginal people were true. These processes are interconnected and interdependent, and cannot be understood in isolation from each other.

While traumatic stress reactions may underlie the experiences and responses of the Stolen Generations, the consequences of forcible removal on health and wellbeing are far-reaching as a consequence of being disconnected from sources of Aboriginal identity and social, emotional and spiritual wellbeing.

> *Our identity as human beings remains tied to our land, to our cultural practices, our systems of authority and social control, our intellectual traditions, our concepts of spirituality, and to our systems of resource ownership and exchange. Destroy this relationship and you damage—sometimes irrevocably—individual human beings and their health.[14(p15)]*

Therefore, strategies which restore connections to social, emotional and spiritual wellbeing are likely to ease traumatic stress reactions and contribute to healing and recovery over time, irrespective of whether clinical interventions for long-standing untreated post-traumatic stress disorder are available or not.

ABORIGINAL MODELS OF RESTITUTION

The *Bringing Them Home* report recommended that 'services to redress these effects had to be designed, provided and controlled by Aboriginal people themselves'.[2(p277)] Aboriginal models work within Aboriginal concepts of SEWB to restore Aboriginal identity and social, emotional and spiritual wellbeing—see Chapter 4 (Gee and colleagues).

Two models developed by Aboriginal people to assist those who have been forcibly removed have been evaluated and consistently identified as 'best practice'[2, 3]: *Link-Up* family tracing and reunion services and the *Marumali Journey Of Healing*.[5, 15, 16] Both models seek to restore what the children lost when they were removed and are 'trauma informed'. Both programs have been operating continuously for 32 years and 15 years respectively, with both models working in harmony with each other. Both support family tracing and reunion in conjunction with a variety of strategies to manage reactivated trauma.

The evaluation of the *Bringing Them Home* Counselling and Aboriginal Mental Health programs reported:

> *There is a lack of documented material concerning mental health approaches specifically for Stolen Generations members, and the key program identified in the review was the Marumali Program. Many BTH and Link-Up staff consulted had undertaken this program, and all spoke extremely highly about how useful this training was'.*[5(p37)]

In the face of a poorly directed government response, 'first generation' survivors of Cootamundra Domestic Training Home For Aboriginal Girls were forced to rely on each other to deal with the aftermath of forcible removal policies. The remainder of this chapter will focus on the *Marumali Journey of Healing* developed by Aunty Lorraine (a Cootamundra survivor) to support the family tracing and reunion process.

THE MARUMALI JOURNEY OF HEALING PROGRAM

Marumali is a Kamilaroi word meaning 'put back together'. The aim of the Marumali Program is to increase the quality of support available for survivors of forcible removal undertaking their healing journeys. The Marumali model offers an effective framework, structure and process which supports the healing of survivors of forcible removal, whether removed to institutional care, foster care or adoptive families. The pathway to recovery involves mind, body and spirit and is holistic in that culture, identity and reconnecting with family, community and country are central to the healing journey.

The *Marumali Journey of Healing* model offers a comprehensive, coordinated and risk-managed approach which cuts through the pain and confusion and allows survivors to find a safe path home to themselves, their families and their communities. Reconnecting with spirit and spirituality is seen to be a core healing tool to overcome the grief and loss experienced by those who were forcibly removed.[17] While the program was developed specifically to support the members of the Stolen Generations to heal, all Aboriginal people have been affected by removal policies to some degree and may draw meaning and strength from the program.

In the words of Aunty Lorraine:

> 66 *Ten years ago, as a Wailwan/Bidgera woman removed and institutionalised at age four, it was frustrating to find a lack of appropriate support to heal from my experiences. It was fortunate that the mental health professional I consulted at the time had some knowledge of removal policies, and reassured me that I was having normal human reactions to extremely traumatic circumstances. Reassured I was experiencing normal human distress, I felt empowered to observe, study and seek to understand my own journey of healing in order to help others. The Marumali Journey of Healing model was developed by documenting my own healing journey over five years, from 1994 to 1999. My first publication about this journey was titled 'The Years that Never Were'[18] and my second publication identified 'what helped and what hurt' as I 'reclaimed my identity through the pain' (Peeters and Kelly, 1999).[17]*
>
> *The Marumali Journey of Healing was presented for the first time as a keynote address at the NSW Aboriginal Mental Health Conference held in Sydney in 1999. At the conference, it was recommended the body of work I had developed and the Marumali Journey of Healing model be 'copyrighted, published and circulated within Aboriginal communities, Link-up organisations and Aboriginal Community Controlled Health Organisations (ACCHOs), to enhance the healing process for Aboriginal people'.[17(p139)]*
>
> *In response, assisted by Shaan Hamann who has a degree in Adult Education, I developed a five day training workshop for Aboriginal counsellors to provide them with the understanding they needed to support us on our healing journeys.* 99

The Australian Government Department of Health and Ageing (now Department of Health) (DoHA) funded a pilot *Marumali Journey of Healing* workshop in Sydney with experienced Link-Up NSW case workers and counsellors. An external evaluator, Professor Gail Garvey, was contracted by the Department to evaluate the pilot workshop. The evaluation was very positive and the Department agreed to support the delivery of the *Marumali Journey Of Healing* workshops to train Aboriginal and Torres Strait Islander counsellors and case workers employed in Link-Up services and ACCHOs from 2000.

The *Marumali Journey of Healing* model and workshop was endorsed by co-author of the Ways Forward report, Professor Beverly Raphael (Letter of Support, 2000) and Aboriginal organisations Link-Up NSW (2001) and the National Aboriginal Community Controlled Health Organisation (NACCHO) (2002) as being a safe, effective and culturally appropriate model to use with survivors of forcible removal.

The *Marumali Journey of Healing* has been variously identified as a 'good practice,' 'promising practice' and 'best practice' Aboriginal model of healing for those who have been forcibly removed, by the Moving Forward Conference (2002), the evaluation of the *Bringing Them Home* and Indigenous Mental Health Programs.[5, 16]

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004–2009 identified the *Marumali Journey of Healing* as an initiative that achieved the key result area of 'recognising and promoting Aboriginal and Torres Strait Islander philosophies on holistic health and healing'.[15]

HEALING THE STOLEN GENERATIONS

The *Bringing Them Home* Report highlighted that 'only Indigenous people themselves are able to comprehend the full extent of the effects of the removal policies' and recommended that 'services to redress these effects must be designed, provided and controlled by Indigenous people themselves'.[2(p312)]

The trauma of policies and practices of forcible removal has been compounded by the widespread denial about what actually happened to us, and this has included denial by mental health practitioners. Survivors of forcible removal carry heavy burdens of trauma and this can frighten practitioners who do not understand it, where it comes from, or how to heal it. A core belief of the Marumali Program is that, when survivors of forcible removal embark on a healing journey, they are experiencing normal human distress and suffering in response to what they went through, rather than showing symptoms of mental illnesses or disorders.

For many years, those of us who tried to get assistance to heal were misdiagnosed, left to flounder in our distress, or met with blank stares from non-Aboriginal mental health practitioners that left us feeling that our pain had no meaning and made no sense.

While many who were forcibly removed may be afraid to undertake a healing journey because of the pain it will reawaken, there is no need to be afraid—with support from others we are able to confront this pain and heal from its effects. Our journey of healing is one of recovering our culture and identity as Aboriginal people even though this reactivates our trauma. For many reasons, we are a unique group with unique healing needs, and out of necessity have had to become the experts of our own trauma and healing. We have learnt a lot about the long-term and transgenerational effects of removal by observing our own healing journeys, and assisting each other to heal.

As survivors, we have clear views about what needs to happen to support other survivors to heal. We ask that our views are heard and our knowledge respected, since no other group has experienced what we did at the hands of governments and their agencies. For us, healing involves mind, body, spirit, spirituality, family, culture and sometimes (if we are lucky) country. It is about finding our 'belonging place', whatever that might mean to each of us. How we were removed, and the diverse experiences we had following removal, have created unique individuals, and the 'belonging place' we find for ourselves will reflect this diversity. A lot has been learnt from facilitating more than 200 five day workshops throughout Australia for the past 13 years with nearly 2000 Aboriginal and Torres Strait Islander workers from all walks of life, groups of survivors themselves, and inmates in jail about the effects of forcible removal.

THE EFFECTS OF REMOVAL: DISCONNECTION

Although the means of removal may have varied, most of us shared some common experiences. We were deliberately and systematically cut off from our families, our culture and our Aboriginality. We had our heads filled with negative stereotypes about Aboriginal people; we were told our mothers and families did not want us, and were forced to act and speak like non-Aboriginal people. We were punished if we acted 'naturally'—that is, if we spoke, felt and thought like Aboriginal people. I would like you to take a moment to stop and think about this. What if this had happened to you or your children? How would you feel now?

Many of us were also subjected to a range of abuses: physical, emotional and sexual. As kids, in order to survive, many of us had to detach ourselves from what we really felt and thought, and try not to feel anything at all. We were powerless. To be fully present during those times might have destroyed us. It was as if we had to play dead, emotionally and spiritually, in order to survive. Our spirits had to hide.

As a result, many of us left important parts of ourselves behind, and have paid, and continue to pay, a high price in our everyday lives. Disconnection of mind from body, thinking from feeling, and spirit from mind and body are core issues that many removed people struggle with inside themselves, as well as the more obvious disconnections from family, country, language, history, culture and spiritual heritage.

Many of us have lived lives of fear, and have been running from ourselves—and sometimes our Aboriginality—ever since. Some of us don't trust anyone, including ourselves. Many of us who grew up in institutions feel most comfortable with each other. Others have become good at putting their feelings on hold and withdrawing when life gets difficult. Some use alcohol and other substances to drown the pain and anger inside. Feeling like an outsider is common to all of us. Many still don't know who they are, where they have come from, and where, if anywhere, they 'belong'. Many say they feel 'empty' inside.

Despite this, those of us who survived have developed an incredible strength. When the chips are down, we know we can do whatever we need to do, to survive. Although we have this strength, many of us also have special vulnerabilities. Every removed person has their own set of triggers, shaped by their experience of removal, and these can tap into the pain buried deep inside and unleash strong reactions. At certain points in our lives, usually in response to certain events, these triggers can lift the lid on our pain and destabilise us. Whether a trigger will set off a healing journey will depend on what else is happening in the person's life. If they are not safe enough or strong enough to face the pain of healing, they can just close down and keep going. It is very dangerous to push someone to heal before they are ready to do so. No one has a right to set another person's healing agenda. Nor is it possible for one person to 'heal' another. Each of us needs to be recognised as the expert of our own healing, and it is crucial that we are able to control the speed, direction and outcomes of our own healing journey. This includes the right to refuse to look at any removal issues at all until we feel ready to do so.

Today we have a better understanding of what happens when you isolate Aboriginal children from their families and forcibly remove their Aboriginal identity from them and replace it with another. No one warned us what we might go through as adults, that something might trigger our trauma and set off a volcano of feelings and memories that would shatter the identities that were imposed on us as children. For many of us, our healing journey will be triggered by an event in our lives. This may take us by surprise. We might have thought we were okay and did not have any Stolen Generations issues to deal with. Some might not even identify as Aboriginal people. But once our memories start to resurface, our healing journey has usually begun.

Once a healing journey begins, it cannot be stopped. Memories that had to be 'disremembered' in order to survive come flooding in, accompanied by a volcano of emotions. We see this as the spirit coming back to life to reconnect with mind and body.

The first stage of our journey can be a stage of crisis. For example, I started crying and couldn't stop—I cried for days on end. We might be full of anxiety, fear, grief and loss, and think we are losing our minds.

It is important that good quality support is available to help us through this stage of crisis, to reassure us that many other survivors have successfully used this time to begin a healing journey, and to offer us some guidance about what to expect. Often there are spiritual dimensions to this part of the journey that only other Aboriginal people can understand. It is important that Aboriginal counsellors are available to explain these things to us, and to non-Aboriginal mental health practitioners if they are involved, so that we are not misdiagnosed early on.

DISCONNECTION IS THE DISEASE: RECONNECTION IS THE CURE

Reconnecting with and healing our spirit can be a painful and difficult path to follow—all those memories of things we wanted to forget, layers of pain and bottomless grief and loss to deal with, before we can even start to think about reconnecting or reclaiming anything. Without guidance and support on our journey, many survivors could become overwhelmed or even give themselves over to mental illness, suicide or substance abuse as a way out. Others might be at risk of 'acting out' their distress in violence or other self-destructive behaviours.

The Marumali Program provides an overview of the healing journey and how it might unfold. It identifies the core issues that need to be addressed at each stage of the journey, the risks associated with these issues and how to anticipate and manage these risks to ensure a safe passage for the survivor. It aims to help people who were removed to face the pain, and to work through it in manageable steps so that they can reclaim their identity and eventually arrive at a place of peace and strength.

The Healing Journey

The healing journey may include:

- learning about removal policies
- making sense of memories as they come up
- taking stock of what has been lost
- accessing files and reports written about us
- putting all the pieces together to find out what really happened to us and why
- finding out who our family is and where we are from
- facing our demons
- reconnecting mind, body and spirit
- reclaiming our spiritual heritage
- working through issues of blame
- retracing our steps
- looking at what has been taken, left behind or unlearned, and
- replacing some of the mainstream values implanted by others with relearned Aboriginal values.

Some may choose to reject their Aboriginality altogether, and that is okay too. The journey is about finding out who we were and who we are now, in light of all that has happened to us. We want to heal from our past, so that our future belongs to us.

The Marumali model is only a guide and each journey will be as different as the experiences of removal were. For some it will be a long journey, for others it will be short. It depends on what actually happened as part of removal process. For many of us, the journey will be lifelong. The healing journey is a circle, and many of us will go around the circle many times as we deepen our healing each time our memories and experiences are triggered. The importance of recognising the removed person as the specialist of their own healing cannot be overstated— they need to be able to control what happens, and when, as well as what does not happen.

THE IMPORTANCE OF ABORIGINAL COUNSELLORS

We invite non-Aboriginal mental health practitioners to assist us to do this healing work, but in a way that allows us to determine what is done and in what way.

The overview of the healing journey provided above should help to explain why we need Aboriginal counsellors as guides to our healing. It can be a barrier to effective healing if a non-Aboriginal counsellor dabbles in core issues for reclaiming our Aboriginal identity and spiritual heritage. For this, we need authentic Aboriginal input, which reflects the diversity in Aboriginal cultures, not 'mainstream' interpretations of what it is to be Aboriginal.

The Marumali Program recommends that if non-Aboriginal counsellors become involved during our stage of crisis, they should look for removal in our history, and if they find this, to refer us as soon as possible to Aboriginal counsellors in Link-Up services.

Link-Up case workers and counsellors are highly skilled in cultural and spiritual matters and the delicate consultations required to reconnect us with our Aboriginal families and communities. For this reason, it is recommended that no journey of healing should be embarked upon without the involvement of Link-Up case workers at key stages of the journey.

THE NEED TO CONSIDER THE SECOND AND THIRD GENERATIONS

The pain of forcible removal has been shared by the children and grandchildren of the Stolen Generations. The National Inquiry recommended that reparations programs should also be directed to descendents. Within a human rights framework, the descendants of the Stolen Generations are classified as 'victims' of forcible removal with legitimate rights, since they too have been 'deprived of community ties, cultural and language and entitlements to traditional land'.[2(p342)] The government's refusal to address forcible removal within a human rights framework has resulted in a lack of recognition of the unique set of harms suffered by the descendents of the Stolen Generations.

Aside from living with deeply traumatised parents who require support when their trauma is reactivated, the toll taken on the social, emotional and spiritual wellbeing of descendants is likely to include living in isolation from other Aboriginal people, experiencing higher levels of disadvantage, a family reluctance to engage with government agencies or Aboriginal-specific services, and an inability to obtain the three parts required for proof of Aboriginality. The absence of protective factors such as connection to kinship and family is likely to have affected resilience, particularly in relation to mitigating the racism experienced in wider Australia.

Population health outcomes for the Stolen Generations suggest that around one-in-ten of those who were forcibly removed were likely to be diagnosed with a mental illness, an alcohol-related problem, to experience discrimination, or to be incarcerated.[10] While these events would have impacted on children in the family, the effects of living with one or more parents affected by human rights abuses and dealing with the periodic reactivation of unaddressed trauma are not captured by these statistics.

The lack of any recognition that forcible removal had even occurred until 1997 left many survivors and their children without a framework to understand themselves or the burden of trauma carried by their family. Many who were forcibly removed tried to protect their children from this knowledge, and others have been unable to speak of their experiences. Learning their parents had been targeted for human rights abuses is likely to have had a sudden, direct and traumatic impact on many descendents.

Yet, the impact of forcible removal on the second and third generations has yet to receive any attention or recognition. There is an urgent need to support the second generation in particular to begin the process of describing and documenting the transgenerational burden of trauma they have carried and the impact this has had on their social, emotional and spiritual wellbeing.

DELIVERY OF MARUMALI JOURNEY OF HEALING WORKSHOPS

Since 2000, the first author 'Aunty Lorraine' has personally delivered more than 220 *Marumali Journey of Healing* workshops to 2,500 participants.

Workshops for the Social And Emotional Wellbeing Workforce

Participants are required to have had previous training as counsellors. The program provides a basis for identifying and understanding common indicators of long-standing trauma associated with forcible removal and an overview of the healing journey and how it may unfold. It offers clear guidelines about what type of support is required at each stage of the journey. It identifies core issues to be addressed and some of the risks associated with each stage (including misdiagnosis), suggests appropriate strategies to minimise the risks, and offers indicators of when the individual is ready to move on to the next stage of their healing journey. Trauma is managed using protective factors drawn from Aboriginal concepts of SEWB. Reconnecting with spirit and spirituality is seen as a core healing strategy to overcome the trauma associated with forcible removal.

An important aspect of the training is the need to respect the rights of the survivors of the removal policies to control the pace, direction and outcome of their own healing journey.

The workshops consist of:

- a five day *Marumali Journey of Healing* workshop for Aboriginal and Torres Strait Islander people who work with Stolen Generations. 160 workshops have been delivered since 2000.

- a two day *Marumali Journey of Healing* workshop for non-Aboriginal collaborators/counsellors. 30 workshops have been delivered to 450 non-Aboriginal counsellors since 2000.

- a two day Risk Management workshop for Aboriginal and non-Aboriginal workers. 15 workshops have been delivered since 2009.

Participants who successfully complete the five day workshop and two day risk management workshop gain competency against the national competency unit Assess and Support Client's Social and Emotional Wellbeing, which forms part of the Health Training Package-HLT07.

The overwhelming majority of workshop participants (94 per cent) have rated the Marumali training as 'excellent'. Many have identified it as a 'life-changing' experience.

A one day workshop has been developed to support non-Aboriginal practitioners working in a range of settings, including the health sector, corrective services and child protection services, to recognise and respond to the burden of trauma for families with a history of forcible removal.

Workshops for Survivors of Removal Policies

A number of *Marumali Journey of Healing* workshops have been delivered for survivors of forcible removal policies, including groups who grew up together in institutions.

Twenty-seven workshops have been delivered in correctional facilities in Victoria.

In 2011, the Healing Foundation supported the Marumali program to develop and successfully pilot workshops for Aboriginal children in Out-of-Home Care; parents of children in Out-of-Home Care; and young people who are descendants of the Stolen Generations.

Tips for Practitioners

Before an Aboriginal client presents, Aboriginal and other service providers need to:

- Recognise that many Aboriginal people who were forcibly removed are survivors of gross violations of human rights and require a response within a human rights framework—this cannot be delivered by providing counselling as a stand-alone response;

- Establish connections to the nearest Link-Up service in advance of accepting Aboriginal clients;

- Ensure access to cultural mentors to inform their own practice and to refer Aboriginal clients to.

When an Aboriginal client presents:

- If an Aboriginal client presents in crisis, recognise the crisis may relate to 'extreme trauma' generated by *gross* violations of human rights. Ask yourself the question: 'Am I competent to provide the services this person requires?

- Take a detailed history—look for evidence of forcible removal;

- If there is a history of removal, discuss referral to Link-Up services.

Non-Aboriginal practitioners need to:

- Avoid providing cultural input to Aboriginal clients who have been forcibly removed—refer to a cultural mentor;

- Work in collaboration with Link-Up case workers and counsellors and cultural mentors.

Remember: Link-Up case workers are highly skilled in the delicate consultations required to reconnect us with our Aboriginal families and communities. Cultural protocols for families as well as communities need to be followed and no journey of healing for members of the Stolen Generations should be embarked upon without the involvement of Link-Up case workers at key stages of the journey.

REFLECTIVE EXERCISES

Throughout this text, and particularly in Chapter 12 (Walker and colleagues), readers are asked to reflect on their own cultures and values. Sometimes this requires reflecting on our common humanity. This chapter describes how many of us were deliberately and systematically cut off from our families, our culture and our Aboriginality. We had our heads filled with negative stereotypes about Aboriginal people, were told our mothers and families did not want us, and were forced to act and speak like non-Aboriginal people. We were punished if we acted 'naturally'—that is, if we spoke, felt and thought like Aboriginal people.

Take a moment to stop and think about this and consider the following questions/discussion:

1. What if this had happened to you or your children?

2. How would you have felt then? How would you feel now?

3. This chapter provides a particular perspective on the impact of forcible removal on Aboriginal and Torres Strait Islander social, emotional and spiritual wellbeing. Discuss these perspectives and your thoughts on this issue.

CONTRIBUTIONS

Aunty Lorraine Peeters developed the *Marumali Journey of Healing* program and delivers all workshops (2000 to the present). Shaan Hamann is a second generation member of the Stolen Generations and assists in the delivery of many Marumali workshops. Kerrie Kelly co-facilitates Marumali Risk Management workshops with Aunty Lorraine. They have assisted Aunty Lorraine to publish articles and develop education resources for workshops.

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Aboriginal Offender Rehabilitation Programs

Victoria Hovane, Tania Dalton (Jones) and Peter Smith

OVERVIEW

This chapter highlights the ongoing over-representation of Aboriginal and Torres Strait Islander peoples in the criminal justice system and emphasises an urgent need for the development of appropriate responses to this problem. A key response to this issue is through the provision of culturally secure, relevant and effective rehabilitation programs for Aboriginal people within the criminal justice system. This chapter proposes an Aboriginal psychological approach to the development, implementation and delivery of culture-specific rehabilitation programs to reduce re-offending and Aboriginal people's contact with the criminal justice system. It will outline how such an approach, that is grounded in Aboriginal Law and culture, can also accommodate standard therapeutic techniques and approaches based on the 'what works' literature and the key principles for effective intervention outlined in the Risk, Needs and Responsivity Model.

INTRODUCTION

Since the landmark inquiry, the Royal Commission into Aboriginal Deaths in Custody (RCIADIC),[1] which provided the first comprehensive national audit of Aboriginal people's over-representation in the justice system, Aboriginal people have continued to experience disproportionately high levels of contact with the criminal justice system throughout Australia.[1] This is largely due to the impact of several key factors in influencing community and social and emotional wellbeing (SEWB) outcomes. These include factors such as:

- colonisation and ongoing oppression – Chapter 1 (Dudgeon and colleagues);

- the pervasive role of transgenerational trauma – Chapter 17 (Atkinson and colleagues) and socioeconomic circumstances – Chapter 6 (Zubrick and colleagues); and

- the impact of substance misuse on health and wellbeing in Aboriginal communities – Chapter 8 (Wilkes and colleagues).

These factors interact in complex ways and contribute to the over-representation of Aboriginal people in the criminal justice system.[1] Consequently, addressing over-representation requires systemic, community, family and individually focused responses.

Over-representation varies between each state and territory, with numbers ranging in some states from just under 40 per cent (Department of Corrective Services (DCS) 2012)[2] to 84 per cent (ABS, 2012).[3] We intend to focus on the development of culture-specific offender rehabilitation programs which have been relatively neglected, largely due to a lack of recognition of Aboriginal knowledge bases as legitimate and valuable sources of information in this area, and a lack of commensurate resource allocation aimed at improving these circumstances.

RECOGNISING ABORIGINAL LAW AND CULTURE

Aboriginal people as Australia's First Nations Peoples have lived, experimented with different ways of living, made amendments based on the findings of these experiments, survived and thrived in this country for tens of thousands of years. As a result, they have developed sophisticated systems of community, family and kinship, Law[i] and relational systems. Aboriginal cultures already have a comprehensive and legitimate evidence-base of knowledge that may be used to inform prevention, early intervention, diversion and programmatic intervention with those who come into contact with the criminal justice system.

Unfortunately, there is a lack of recognition by the broader society of the value of Aboriginal Law and culture, and the critical importance of working within this framework in order to respond effectively to the rehabilitation needs of Aboriginal people within the criminal justice system. This oversight has led to a failure to appreciate the power of such an approach to support positive transformations within families and communities that reflects an Aboriginal way of life in which pro-social behaviour and being a contributing member of society is a fundamental part. Creating such pro-social and culturally strong environments is essential for supporting and reinforcing not only positive gains made by Aboriginal people through engaging in offender rehabilitation programs once they return to the families and communities, but also for changing the environments which have given rise to offending behaviour in the first instance—for reducing recidivism.

Secondly, we recognise that Aboriginal Law and culture has faced considerable pressures as a result of the processes of colonisation and ongoing oppression, and from rapid social and technological changes in contemporary society. These pressures have adversely impacted on the observance of Law and culture in a number of communities and families. Consequently, there is an urgent need for a re-statement and reinforcement of the important values, principles and guidelines for living that are a fundamental part of Aboriginal Law and culture. Adopting this approach provides cultural permission for Aboriginal people to challenge the status quo of chronic disadvantage and ongoing over-representation with the criminal justice system. It provides cultural permission for Aboriginal people to be all that they can be, and for the creation of culturally strong and secure families and communities.

Finally, we recognise that the existing criminal justice systems reflect the prevailing dominant western ideology and perspectives on crime, justice and community safety; it is not designed to meet the needs of Aboriginal Australians thereby reinforcing systemic inequalities within such systems.[4] Addressing such systemic inequities remains a priority because, as noted previously, Aboriginal Australians continue to experience high and disproportionate rates of contact with criminal justice systems throughout Australia.[5, 6] This publication provides a comprehensive description of the over-representation of Aboriginal Australians in the criminal justice system and particularly those experiencing mental health issues, as further outlined in Chapter 10 (Heffernan and colleagues).

As a result, this chapter proposes that an Aboriginal psychological perspective which is grounded in Aboriginal and Torres Strait Islander Law and culture, and which incorporates an understanding of the processes of colonisation and oppression, and how these processes have impacted on observance of Law and culture, is critical for responding effectively to the rehabilitation needs of Aboriginal and Torres Strait Islander peoples within the criminal justice system.

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i   Law as opposed to Lore is in accord with the recommendations of Law Men and Women during the WA Customary Law Project; asserting the legitimacy and equivalence of Aboriginal Law.

COLONISATION, OPPRESSION AND OVER-REPRESENTATION

There are a number of key mechanisms involved in the process of colonisation that have been identified as having a negative impact on Aboriginal and Torres Strait Islander peoples.

> **Colonising Processes**
>
> Key mechanisms involved in the colonisation process:
>
> - violence involving force, conquest invasion and occupation of territory;
> - political exclusion;
> - economic exploitation, sexual exploitation ;
> - control of culture, including language, art, stereotyping, othering and denial of voice; and
> - fragmentation of community and division.[7]

Arguably, a number of these mechanisms have continued into contemporary times and continue to characterise the ongoing relationship between Aboriginal and other Australians. It is only recently that governments and other controlling agents such as universities have begun to include Aboriginal voices in developing policies and programs and to incorporate culturally responsive initiatives in programs as outlined in Chapter 25 (Dudgeon and colleagues).

The pervasive legacy of colonisation and oppression characterised by the significant efforts to put pressure on Aboriginal people and their cultures, reinforces the critical need for self-determination within psychology and other governing disciplines that have key roles in addressing offending behaviour. This is critical in the establishment of culture-specific rehabilitation programs for Aboriginal Australians who have been incarcerated. Indeed, as noted by the RCIADIC and described in Chapter 1(Dudgeon and colleagues) and Chapter 6 (Zubrick and colleagues):

> *Racism permeates and operates through expectations, through everyday behaviour and practices which, while they may not be intentionally racist, are racist in their effects.[1(p156)]*

Further, whilst significant resources continue to be invested in identifying what is going wrong in Aboriginal and Torres Strait Islander families and communities, little is being done to identify what is going right and why some individuals, families and communities are resilient in the face of ongoing oppression.[8, 9]

Indeed, Homel and colleagues noted that it was important to improve existing knowledge and understanding of risk in Aboriginal communities beyond identification of static risk or protective factors.[9] Key elements which resonate with an Aboriginal perspective include developing an understanding of the importance of:

- time and timing, points of transition and change, and the ongoing interactions between individuals and their environments;
- the cumulative total and timing of adverse factors, their interactions (over time) with each other and with positive features of the environment and the life phases involved[9(p5-6)]

This reflects the multiple, cumulative and intergenerational effects of Aboriginal people's negative historical experiences with the dominant culture, whilst also acknowledging that some individuals are more resilient than others despite those negative experiences. Many of these elements are discussed in Chapter 6 (Zubrick and colleagues). Identification of existing risks, strengths and resiliencies has a key role to play in the prevention of offending and rehabilitation in the criminal justice system.

CURRENT APPROACHES IN PSYCHOLOGICALLY-BASED OFFENDER REHABILITATION PROGRAMS

Criminal justice and correctional systems in Australia are based on the priority of ensuring community safety through the rehabilitation of offenders. A key focus is on helping people convicted of crimes to stop offending behaviours, to reduce the resultant harm caused within communities. In relation to offender rehabilitation programs, the principal approach is based on:

- western psychological explanations of offending;[10, 11] and

- the '*what works*' literature (e.g. Geandreau,[12] Lipsey,[13] Losel[14]) that developed in response to Martinson's[15] controversial articles that *nothing works* and resulted in common principles for effective intervention identified and captured in the Risks Needs Responsivity (RNR) Model.[16]

Notably, there have been early attempts at investigating the applicability of such approaches for use with Indigenous populations.[17, 18] Research in Australia highlights some key issues for practitioners around offending and re-offending amongst Aboriginal and Torres Strait Islander peoples in the criminal justice system[19-21]. These are risk assessment,[22] needs assessment,[23] and establishing Aboriginal specific norms.[24]

Aboriginal Offender Programs

The unacceptably high over-representation of Aboriginal and Torres Strait Islander peoples in the criminal justice system suggests that there is an urgent need to review current approaches to psychologically-based offender rehabilitation programs based on Aboriginalising mainstream approaches and programs. Such ongoing over-representation raises pressing questions about the efficacy and cultural transferability of such approaches and programs based on the *what works* literature and the RNR Model.[25] This is because existing psychological theories '… are inherently linked to the cultural context in which they are developed'.[26(p64)] Indigenous peoples around the world have challenged the western psychological evidence-base as being ethnocentric, raising questions about its applicability to Indigenous peoples.

What is required is the development of culture-specific psychological theories and theories of offending, to inform the development of suitable, culturally relevant offender rehabilitation programs. Hodgetts and colleagues have noted that the effectiveness of responses to the needs of Aboriginal Australians:

> *… has been limited, in part, because we have assumed certain things, such as a common understanding of the self, and that this common understanding is shared between psychologists and the people with whom we work. Sometimes it is, but more often than not understandings diverge across our own interpretive communities … (d)ifferent cultures have different perspectives on the nature of individuals and groups and on the extent to which people and environments influence us. In fact, the very notion of a separation of individuals and environments is a particularly Western and historically recent one.[7(p115)]*

SOME PRELIMINARY ISSUES IN WORKING WITH ABORIGINAL OFFENDERS

It is important for those working with Aboriginal people within the criminal justice system to refrain from making judgements about the cultural identity of individuals by applying labels such as traditional or non-traditional to them. Such labelling serves to undermine the identity of individuals to whom the labels are applied and promotes making a number of assumptions about the cultural authenticity of those individuals. As a result, there is a significant risk of misunderstandings developing which may affect a worker's ability to appropriately meet the needs of Aboriginal offenders in order to reduce their offending behaviour.

It is more appropriate and instructive to adopt a more holistic/ecological approach to support offender rehabilitation. This involves exploring the different areas of an individual's life and functioning such as where they grew up; what was their early life experiences; what is their level of literacy; what are their strengths and abilities; is there anything preventing them from participating in programs; and what is important to them culturally (key cultural learnings, obligations and responsibilities, values and principles).

Such an approach may assist mental health practitioners and others working within the criminal justice system to make an informed assessment about the criminogenic/non-criminogenic needs of the person, as well as their cultural strengths. Identification of the cultural strengths of a person may be used therapeutically in supporting a reduction in offending behaviour whilst also promoting the positive elements of Law and culture that promote ongoing desistance from such behaviour. These are just some of the areas of functioning that may need to be assessed. Further research will also assist in developing and validating a comprehensive culturally appropriate assessment package.

Aboriginal Psychology: Some Introductory Ideas

Aboriginal psychology is an emerging field in psychology which has grown considerably over the past 30 years.[27] There are possible lessons from this early work for the Aboriginal psychology field.[28] It is suggested that psychological knowledge should:

- be derived from within the culture;

- reflect local behaviours;

- be interpreted within a local frame of reference; and

- yield results that are locally relevant.[29]

The need for such reorienting of psychology is something that is recognised amongst Aboriginal psychologists in Australia in the context of the experiences of colonisation and the imposition of a foreign culture and way of life on Aboriginal peoples.

Adopting an Aboriginal psychological approach to offender rehabilitation programs is a means of legitimising Aboriginal cultural knowledge so that new culturally grounded perspectives, concepts, theories and ideas may be included in this space.[7]

Indigenous psychologies may be described as an approach to psychology that emphasises content (i.e. meaning, values, and beliefs) and contexts (i.e. family, social, cultural, and ecological).[30] Importantly, culturally-based resources such as content and contexts ought to be explicitly incorporated into psychological research design, to improve the relevance of research findings with Aboriginal and Torres Strait Islander populations.[27, 30]

Similarly, in Australia, there is a common call amongst Aboriginal and Torres Strait Islander peoples and practitioners for the use of cultural resources and frames of reference which includes:

- the evidence-base of knowledge developed over thousands of years of existence;

- the story of colonisation and oppression and its impact on observance of Law and culture; and

- Aboriginal theories and ways of knowing and understanding people's behaviour, so that more effective responses may be developed to address issues such as over-representation within the criminal justice system.[31]

Moreover, such an approach shifts the emphasis from identification of psychological deficits which are typically framed within western psychological perspectives, to emphasising cultural strengths and positive cultural perspectives.

A final issue is that problems such as offending behaviour within families and communities, is often linked to perceptions of breakdowns in observance of Law and culture.[32, 33] In order to address such offending behaviour, it is critical to identify where such perceived breakdowns are thought to occur so that these may be addressed. In other words, as we engage with the dominant society, in addressing Aboriginal contact with the criminal justice system, it is important to make explicit the implicit cultural knowledge held by Aboriginal and Torres Strait Islander peoples and practitioners. In her doctoral research on child sexual abuse (CSA) in Aboriginal communities, Hovane used an approach of peeling back the layers of the outward expressions of culture (e.g. customs, practices and traditions), to identify core cultural values and a set of principles that support the retention of those values that may be used in developing primary prevention, early intervention and tertiary responses to a range of issues in communities[34]. This has important significant implications for what should be included in the development and implementation of offender rehabilitation.

Some Concepts: Culture, Practices, Customs and Traditions

The concept of culture broadly refers to the system of information that must be learnt by members, which sets out the way in which individuals within a particular group, society or country, interact with their social, physical and spiritual environment, using a particular frame of reference that is comprised of rules, regulations, mores and customs.[35] It involves core values, beliefs, assumptions and norms in defining a group's culture which are mutually interactive and *... constitute the directional force behind human behaviour.*[36(p89)] Importantly, the core values of a culture underpin the ideological system of a group.[29]

The rehabilitation of Aboriginal offenders must begin from a sound understanding of Aboriginal and Torres Strait Islander Law and cultures and how they work (i.e. the dynamics within families and communities). In this context, communities may be described as being characterised by sets of shared values, practices and emotional ties or schemas. Such schemas have evolved over thousands of years of Aboriginal and Torres Strait Islander experimentation and despite the various pressures they have faced in the context of colonisation and oppression, core elements of these schemas remain today.[31] There have however been some changes that are referred to in terms of the breakdowns in observance of Law and culture noted previously, and workers must possess a sound understanding of what these are and how they may be responded to in a culturally relevant and culturally safe way in correctional settings.

Practitioners need to have a clear understanding of terms such as practices, customs and traditions which are often used interchangeably. We separate practices and customs, from traditions for the purposes of clarity. Practices are described as '... the customary, habitual, or expected procedure or way of doing something'.[37] Customs are practices common to many or to a particular place or group of people.[35] Thus, practices and customs are conceptualised as reflecting everyday mundane activities, such as Aboriginal and Torres Strait Islander forms of greeting that seek to establish who a person is by asking questions such as: *Where are you from* (your country)? *Who's your mob* (your family)? Another key example is observance of family and kinship obligations to care for family/kin members.

A tradition is '... an inherited, established or customary pattern of thought, action or behaviour, such as a religious practice or a social custom ... which are usually representative of a person's culture'[37] ... which '... may be widely practiced and is usually passed down through generations'.[35] An Aboriginal tradition is conceptualised as operating at a higher-order from everyday practices. A key example is observance of and adherence to Aboriginal Law and ceremony.

A key reason for seeking such clarity is to address the problem of engaging inadequate and superficial or *cosmetic* attempts to *indigenise* western psychological theories and offender rehabilitation programs.[29] The development of Australian psychologies provides an appropriate space in which to address issues associated with the rehabilitation of Aboriginal offenders in a comprehensive, culturally secure, culturally relevant and effective manner.

An Aboriginal Psychological Approach

An Aboriginal psychological approach to the rehabilitation of Aboriginal offenders is grounded in Law and culture which provides the foundations on which to build offence-specific modules. In this context, Aboriginal Law was and continues to be viewed as providing the overarching guidelines for living in Aboriginal societies.[38] Aboriginal Law sets out the standards for behaviour that are expected of Aboriginal people and outlines how these may be expressed and regulated.

From this perspective, communities, families and individuals may be considered to have cultural schemas which provide localised frameworks or guidelines for living, and for undertaking other tasks such as interpreting various situations, and for solving problems. Such schemas have developed over time as a result of people's experiences and interpretations of those experiences. They are based on a set of shared values and beliefs, which provide legitimacy to cultural activities such as ceremonies, the behaviour of Law men and Law women, and patterns of functioning within the community that are consistent with those values. Over time they become self-imposed, stable and enduring.[39] These schemas are described below.

Community, Family and Individual Cultural Schemas (adapted from Hovane, 2011)[31]

1. Community cultural schemas may be viewed as being underpinned by a set of values and associated principles and practices. Some of the values that underpin Aboriginal community cultural schemas included a value for land, language, Law, Spirituality, community, and family and kinship. In Chapter 4, Gee and colleagues have emphasised similar values in terms of connectedness to land, culture, spirituality and ancestors, community, family, and physical and mental health and social and emotional wellbeing.

   Key beliefs are associated with:

   - spirituality and the presence of a higher power;
   - that the ancestors are all-seeing and one has to be accountable for one's behaviour;
   - that maintaining a balanced and harmonious life is important; and
   - that if family, community and cultural obligations are fulfilled, then it is possible for one to live a good life and enjoy a sense of social and emotional wellbeing.

   Associated with such values and beliefs are a set of core principles that assist in reinforcing and maintaining them. These are described in the 4Rs Cultural Principles Model of Respect, Reciprocity, Relationships and Responsibilities, and underpinning practices of work, rules, learning and training. In this model, the principles include being respectful, observing reciprocal obligations and responsibilities, observing and maintaining important relationships to land, culture family, kin and community, and being accountable and taking responsibility for one's behaviour.

   Continued . . . .

The reinforcing practices are that:

- everyone works and helps out;

- everyone follows the rules and behaves themselves;

- everyone learns the lessons; and

- everyone is open to receiving the training that they need in order to survive and thrive physically, culturally and spiritually.

2. Family cultural schemas include a value for:

- family and kinship structures;

- observance of roles, obligations, responsibilities and relationships;

- for preserving the standing or reputation of the family within the community;

- respect; reciprocity; and

- for Elders and children.

Key beliefs are that each person has a role to play within the family and kinship system, for observing reciprocal obligations and responsibilities which are essential for preserving the health of the family and kinship system, and that family and kinships systems provide not only an enduring and fundamental source of support, nurturance and sites for learning, but they also provide a setting that is important for the regulation of the behaviour of family/kin members. The key principles outlined in the 4Rs Model and reinforcing practices help support the healthy functioning of the family schema.

In this approach, it is suggested that there are some fundamental universals in understanding human behaviour that translate across cultures, including that Aboriginal people have cognitions, emotions, behaviours, and are capable of personal agency. For instance, one has to be sufficiently motivated to engage with behavioural change strategies; and that building distress tolerance skills are a useful treatment target with Aboriginal offenders to support them to better deal with daily challenges, including high levels of stress, unresolved trauma, and loss and grief, which are common experiences in this population.[40] In other words, there are some useful points of connection between Aboriginal and non-Aboriginal psychologies. Similarly to standard offender treatment programs, treatment targets for rehabilitating Aboriginal offenders should include promoting:

- motivation to change offending behaviour and ability to tolerate strong uncomfortable feelings (distress tolerance) as noted above;

- emotional management skills;

- cognitive skills;

- communication skills;

- responsibility-taking;

- victim empathy;

- an understanding of individual pathways into offending;

- an understanding of offence-specific factors such as general violence, family violence, sexual violence, and CSA; and

- an understanding of the role of substance use in offending where appropriate.

This is not an exhaustive list and it is likely that additional treatment targets will be identified by others. Cultural and psychological knowledge, concepts, and strategies have been successfully incorporated into an *Aboriginal Men's Family Violence Program* developed by Hovane[31] and offered to the WA Department of Corrective Services.

Care needs to be exercised in relation to including sessions on colonisation in rehabilitation programs. Rather, application of our understanding of these issues should inform what needs to be included in such programs, such as inclusion of a foundational cultural maintenance module; this should inform about how to work in a way that promotes self-determination—for example, where inmates are offered the opportunity to make pro-social choices about their behaviour.[31]

AN ABORIGINAL OFFENDER REHABILITATION MODEL

The following describes a model for the rehabilitation of Aboriginal offenders. It is based on a holistic worldview that recognises the interconnectedness of all living and inanimate things; and that each level is dynamically related which may involve interactions across a number of levels at the same time. This dynamic space of interactional potential is captured at the common point where all circles connect in the model.

This model has at its core Aboriginal Law and culture and the values, principles, practices and schemas outlined previously. This provides the space for a re-statement and reinforcement of appropriate standards of behaviour against which current offending behaviours may be examined, and through which opportunities for pro-social, culturally relevant behavioural change strategies may be identified.

In other words, this model is based on a broad set of Aboriginal cultural foundations which may be contextualised to suit specific local cultures, but importantly, it also makes explicit the behavioural standards expected under Aboriginal Law and culture. The re-orienting of offender rehabilitation programs necessitates identifying culturally appropriate ways of using standard therapeutic such as:

- art projects such as painting

- music, song, poetry

- storytelling and narrative approaches

- talking circles

- drama projects

- dance and movement

- traditional rituals and ceremonies

- meditation, prayer and other spiritual elements

- use of native language.[41]

Figure 30.1: Aboriginal Offender Rehabilitation: A Preliminary Model

Employment/Work

Training/Learning Skills

Education / Learning Knowledge

Offence-specific
Rehabilitation Programs

Aboriginal and Torres Strait
Islander Law and Culture:
Cultural Maintenance
and Identity
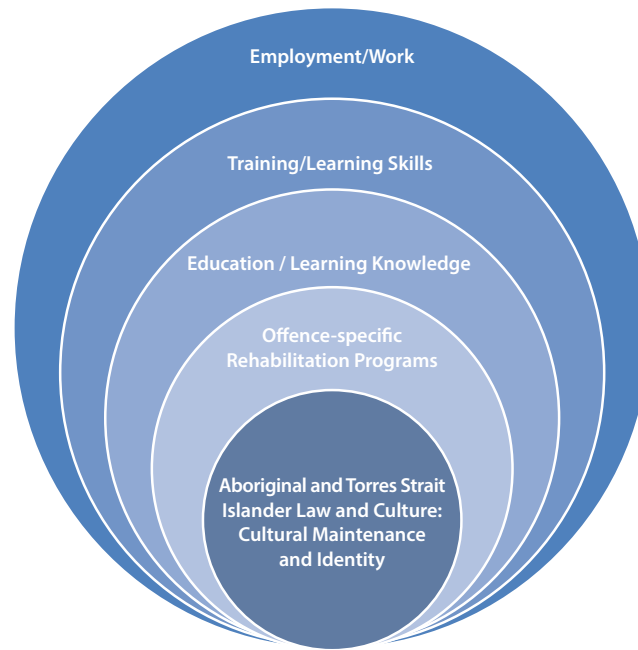
© V. Hovane

Caution needs to be exercised when using some techniques such as ritual and ceremony in a culturally appropriate way, to ensure this use is not breaching the cultural protocols of participants. For example, meditation used for promoting distress tolerance via techniques such as progressive muscle relaxation needs to be re-framed into a cultural context, which assists with engagement, rapport-building, retention in rehabilitation, and arguably, the efficacy of programs. Hovane[31] has reframed a number of standard treatment techniques, which are culturally and experientially relevant to Aboriginal offenders. This approach is strengths-based and promotes cultural appropriateness of such techniques.

In addition, the reframed standard treatment techniques are an intrinsic part of Aboriginal psychologies crucial to the rehabilitation of offenders. In this regard, it is critical that other practitioners have appropriate training in order to appropriately and effectively apply this model to Aboriginal offender rehabilitation and associated therapeutic techniques.

REFLECTIVE EXERCISES

1. Please discuss how the lived experience of Aboriginal people may impact on their contact with the criminal justice system?

2. What ways do you currently apply your knowledge and understanding of these relationships, as in question 1, to your everyday practice and, if applicable, to policy and program development?

3. Do you feel confident in applying this knowledge in your practice? How can you improve your confidence, if need be?

4. What can you do in your workplace to improve the cultural appropriateness and efficacy of the programs and services that are provided to Aboriginal and Torres Strait Islander peoples?

CONCLUSION

This chapter has suggested some preliminary ideas to support an Aboriginal psychological approach to the development of diversionary and rehabilitation programs for Aboriginal people. The model outlines how Aboriginal Law and culture and psychological concepts and techniques can be incorporated to more effectively respond to the rehabilitation needs of Aboriginal Australians within correctional settings. Importantly, it articulates a legitimate place for existing Aboriginal-led approaches to be included in the offender rehabilitation space. These include the Getting Back on Track: Aboriginal Men's Family Violence Program[31] which has provided the foundations for this chapter, and other models showcased in this book such as the *Strong Spirit Strong Mind* Model by Casey (Chapter 26); the *Red Dust Healing* Program by Powell and colleagues (Chapter 27); and the Marumali Program by Peeters and colleagues (Chapter 29). Importantly these existing programs reflect many of the concepts outlined in this chapter relating to Aboriginal Law and culture, its principles articulated through the 4Rs model, and associated reinforcing practices. Adopting such an approach has the capacity to significantly reduce offending in the first instance by supporting pro-social transformations in families and communities, and subsequent rates of re-offending amongst Aboriginal people.

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The Djirruwang Program: Cultural Affirmation for Effective Mental Health

Tom Brideson, Jane Havelka, Faye McMillan and Len Kanowski

OVERVIEW

This chapter outlines the growth and development of the *Djirruwang Aboriginal and Torres Strait Islander Mental Health Worker Education and Training Program* (The *Djirruwang Program)* in Australia. The chapter describes what can be achieved when individuals, organisations, health disciplines and Aboriginal communities work in close partnership and learn from each other. We emphasise the importance of recognising Aboriginal cultural experiences and knowledge within the mental health curriculum, and providing a culturally safe environment to facilitate effective outcomes. Importantly, it stakes a claim for Aboriginal Mental Health Workers (AMHWs) as equally significant as the professions and disciplines of psychiatry, psychology, social work, nursing and occupational therapy in addressing the social and emotional wellbeing and mental health needs of Aboriginal and Torres Strait Islander peoples.

BACKGROUND

The year 2013 will be the 20th successive year in the life of the *Djirruwang Program*. It is an achievement worthy of celebration and reflection and an opportunity to review and share what we have learnt. The landscape of mental health services, Aboriginal health and mental health has transformed markedly over the past 20 years.

Over the past years, much has changed—the emergence of an Aboriginal mental health workforce onto the national mental health landscape is now firmly on the agenda. Aboriginal and Torres Strait Islander mental health is now one of the four priority areas of the National Mental Health Commission's '*A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Preventio*n'.

The burden of mental ill health and distress in Aboriginal communities is well known. The negative impacts on Aboriginal social and emotional wellbeing (SEWB) can be understood through the historical issues confronting Australia and the current health and social circumstances (see Chapter 1, Dudgeon and colleagues and Chapter 2, Parker and Milroy for further information). The *Djirruwang Program* adopted a mainstream understanding of clinical mental health care by design. The aim is to address the over-representation of Aboriginal people in the 'hard' end of mental health care. The need for a skilled Aboriginal workforce within the mental health care system is central to responding to the levels of depression, psychotic disorders and high numbers of suicides in communities. Insisting that mainstream clinical care is inappropriate further exacerbates the stress levels for MHWs and services, and is likely to result in increased complications for clients and their families or, at the extreme end, becomes a matter for coronial investigations.

Aboriginal people are not accessing mental health services at a rate equal to the levels of distress. Access for this population often occurs during various states of crisis, and representation within acute care is approximately three times what the population distribution suggests it should be across many health services whereas, for the same population, access into community based mental health care is significantly under-represented—see Chapter 2 (Parker and Milroy). Throughout this entire 20-year period there have been repeated calls for, and reports highlighting, the need to build an effective Aboriginal and Torres Strait Islander SEWB and mental health workforce.

IMPROVING ACCESS TO MAINSTREAM MENTAL HEALTH CARE

The first way to improve access to mainstream mental health care is to increase the Aboriginal mental health workforce. While Aboriginal people from communities are far more likely to understand the needs of local families, networks and relationships, they often lack opportunities to obtain the skills to understand the care arrangements and systems in which mental health care occurs. Combined with this, the lack of genuine service relationships and partnerships with Aboriginal communities contributes to poor mental health service provision for this population. The rhetoric and paternalistic approaches are often a barrier to effective relationships with Aboriginal people.[1]

The second way to improve access to services is to:

- employ local Aboriginal people; and

- provide training in mental health care.

By doing this, Aboriginal people are provided with the skills to deliver a more culturally, responsive, safe and accessible mental health service (MHS). The flow on effects to the remainder of the mental health workforce will then follow.[2]

The third way to improve access is the development of a more culturally responsive workplace within local MHSs. The relationship between the MHS and Aboriginal communities is critical for this to succeed. The MHS has a responsibility to be informed through effective local working relationships and partnerships at all levels. These relationships need to be respectful and based on equity and equality and promote cultural safety. If the emerging workforce is supported well, development grounded in culture, local community and an informed base of clinical mental health care will occur.[3] The recipe is relatively simple: build and support the Aboriginal workforce, strengthen the formal service relationships with Aboriginal Medical Services (AMSs) and everything else will fall into place.

OVERCOMING THE CHALLENGES

The need to nurture this emerging professional Aboriginal mental health workforce is still very real. The challenges still exist. These challenges were identified in two published papers almost 10 years ago claiming that Aboriginal professionals were treated as 'seasonal workers'[3] and the system needed to support this Aboriginal mental health workforce.[3, 4] Brideson argued for:

> ..the support of the mental health industry and professional organisations to move towards systematic adulthood with respect to 1) the professional recognition of students and graduates of the program, and 2) the need for professional organisations, and service management and staff to take responsibility in their responses to Aboriginal mental health issues.[4(p1)]

These papers expressed concerns of the Aboriginal mental health workforce being undervalued by the professions and the services in which they work. Some of the early historical accounts

of developments of Aboriginal mental health worker education and training highlight both the need for recognition and the lack of support within the main stream.[5-11] Several papers have now been written about the establishment of the *Djirruwang Program*.[6,7,2] A systematic review of the literature in this area would add to the knowledge of what works, what has been learned and the role of cultural affirmation within this context.

Leaders of Aboriginal Mental Health Training in Australia

Despite little being written in this area, there have been many significant contributors to Aboriginal mental health training in Australia. Examples in the early to mid-1990s include:

- the *Marr Mooditj Program*, Western Australia (WA), developed by Dr Joan Winch;

- the Aboriginal Counsellors Course, Centre for Aboriginal Studies (CAS), Curtin University, WA, developed by Darren Garvey and Harry Pickett;

- the *Bachelor of Applied Science and Diploma in Aboriginal Community Health* at the CAS, Curtin University, WA, developed by Glenys Grogan; and

- the Cape York Aboriginal and Torres Strait Islander Mental Health Worker Program, developed by Dr Ernest Hunter in Queensland.

Throughout the 2000s there were a number of developments through the AMS networks, the NSW Aboriginal Health College—including the work undertaken by Trish Nagel through the Australian Integrated Mental Health Initiative (AIMhi) and many others. Key drivers and advocates for developing a critical mass of professional mental health workers in Australia include: Professors Pat Dudgeon, Beverly Raphael and Helen Milroy, Dr Tony Williams, Darren Garvey and many others. Early Aboriginal leaders and advocates for mental health training include Cyril Hennessey, Dr Robyn Shields and Pat Swan-Delaney.

THE DJIRRUWANG PROGRAM DEVELOPMENT AND DELIVERY

The *Djirruwang Program* emerged from the Koori Mental Health Outreach Workers Training Program which commenced in November 1993. The program was originally based in Queanbeyan, NSW. It was funded by the Commonwealth Department of Health Rural Health Support Education and Training (RHSET) Program. A number of Aboriginal and non-Aboriginal staff have worked in the program. Professional disciplines included Aboriginal mental health and drug and alcohol workers, psychiatrists, psychologists, social workers, academics, policy makers, sociologists and sexual assault counsellors. Input from Aboriginal Elders and Aboriginal leaders has been significant and central to program success.

The *Djirruwang Program* was a pioneer in the establishment of a clinical-based tertiary level mental health course in Australia designed for Aboriginal and Torres Strait Islander peoples. The program was the first course within Australia to incorporate the *National Practice Standards for the Mental Health Workforce* (The Practice Standards) within the course curriculum. The program was also the first course in Australia to embed the Aboriginal and Torres Strait Islander Mental Health First Aid Certificate within its curriculum structure.[8]

The *Djirruwang Program* has restricted entry, and is designed for Aboriginal and Torres Strait Islander peoples to gain high quality knowledge, skills and attitudes in the field of mental health. This is achieved by building on people's knowledge and combining mental health theory with clinical practice. The program maintains the opportunity for people to gain formal mental health qualifications at certificate, diploma and degree levels.[9]

Program Aims

The aims of the *Djirruwang Program* are to:

- Educate and train Aboriginal trainees to develop the appropriate knowledge, skills and attitudes to work as an Aboriginal Mental Health Worker (AMHW);

- Develop the skills needed to work effectively in a community mental health setting; and

- Develop skills to assist communities to identify mental health needs and initiate primary prevention and early intervention programs.[6]

Curriculum Content

The initial curriculum for the *Djirruwang Program* was developed by Kanowski and Morgan (mental health nurses) with input from an Aboriginal Education Committee. The curriculum was broadly based and included units on counselling, mental health assessment and treatment, drug and alcohol and sexual assault studies, Aboriginal history and culture, suicide prevention, assessment and intervention, and a range of related subjects. Clinical skills were developed during which Aboriginal trainees worked in close contact with non-Aboriginal clinicians. The trainees were required to meet a range of competencies in order to pass the course.

The initial intention was to provide trainees with a Health Service Certificate provided by the NSW South Eastern Health Region. In 1995, negotiations between Charles Sturt University (CSU), the Health Service and the Aboriginal Steering Committee resulted in upgrading the qualification to an associate diploma and later to a diploma and degree status. Students had the option to graduate with a certificate after one year, a diploma after two years and a degree after three years of academic study and on-the-job training.

In 2002, the curriculum and course structure were revised under the guidance of a National Reference Group. Significantly, the new curriculum was underpinned by the Practice Standards to ensure that *Djirruwang Program* graduates had the skills, knowledge, values and attitudes of like-minded health professionals, whilst maintaining a deep sense of cultural integrity.

The program developed a Clinical Handbook and Course Competencies document to assist students to gain meaningful, practical experience in the clinical environment. The Clinical Handbook is an important historical development that remains in the course structure of the program. The current Clinical Handbook is still underpinned by the Practice Standards, 2002. The *Djirruwang Program* has continued to ensure that the curricula aligns with the Practice Standards as well as incorporating best practice models from complementary health programs, such as community health and nursing. The program has continued with this approach to assert and encourage professional recognition and professional status in the mental health field.[10]

Ongoing Evaluation and Review

The program has continually been evaluated by the university with input from the mental health professional sector. Ongoing evaluations of the program have recorded the direction and continual build of evidence. Each evaluation has found the program to be unique, valuable and meeting the needs of health services by developing a well qualified Aboriginal mental health workforce.[6, 11]

The last external evaluation of the *Djirruwang Program* was undertaken in 2010. This review identified new opportunities to enhance the skills, knowledge and attributes of the students, with far reaching implications for the professionalism of graduates. The review highlighted key areas for engagement with industry partners, the university and the student cohort which

has led to informed curricula development and change. This has seen the development of new curricula in 2013, which include a greater emphasis on dual diagnosis, pharmacology and understanding of the diversity within the Australian demographics.[12] Whilst the establishment of new curricula is a positive move forward, the *Djirruwang Program* has, and maintains, a fluidity that embraces industry contributions and inclusion of current practices into the teaching within the program.

The program has undergone a number of changes since it first began in 1993. With the growing interest in the area of Aboriginal mental health, the program was offered as an undergraduate degree program—Bachelor of Health Science (Mental Health). The program continues to recognise the importance of having Aboriginal lecturers as an integral part of the success of the program.[13]

Course Delivery

The program was, from its inception, a 'block release' model of work-based training coupled with academic study. The degree course is conducted over a three-year period with two semesters each year. The course is delivered by a mixed mode—a combination of face-to-face residential schools and study within the home/community/work environment. This external component is supplemented by online teaching materials (modules) and compulsory workplace experience. Each semester, students undertake four subjects as a full-time equivalent student.[12] CSU have a number of support services for students that complement the delivery of the *Djirruwang Program*. These are provided through Ngungilanna Indigenous Student Support at the Wagga Wagga Campus.

Recognition for Excellence

The program has had significant impact across the mental health sector and has won and has been strongly associated with a number of Mental Health Services awards including:

1996	The MHS Award
2003	College of Psychiatrist Award – Tom Brideson
2005	In partnership with the former Far West Area Health Service won a NSW Health Aboriginal Health Award in workforce development
2005	In partnership with the former Far West Area Health Service won a Silver Award at the 2005 Premier's Awards
2008	Australian Learning and Teaching Council Award
2010	Premier's Award for Excellence, Greater Western Area Health Service

CURRENT PROGRAM

The program is currently headed by an Aboriginal Director, Faye McMillan. It is still actively supported by several program founders and early students of the original program. The program is now fully supported, staffed and funded by Charles Sturt University (CSU), Wagga Wagga NSW. The issue was always about generating sufficient student numbers for the program to become self-sustaining within tertiary and health service environments.

Through the *Djirruwang Program*, CSU has played an extremely important role as the preferred education provider for trainees in NSW Mental Health Services. This model of education and workplace training provided significant results for employment opportunities and service provision to members of the Aboriginal community in many Health Services of NSW.[14] The

Djirruwang Program has extended across five states with NSW and WA having equal numbers of students. WA has modelled significant parts of their development of Aboriginal mental health professionals on the NSW Health Service's trainee program.[15] Many of the graduates employed in mental health positions are providing care to Aboriginal people experiencing mental health problems.

Program Outcomes

Since the *Djirruwang Program* commenced there have been 137 graduates who have attained relevant mental health qualifications and are making positive contributions to the lives of individuals, families and communities in various ways. The program is now seeing two generations obtaining qualifications through the program. There are currently 105 students enrolled in the program which promotes collegial networks of like-minded people with mental health skills and qualifications.

Graduates of the program have gained employment in senior and influential roles in a number of areas. This reflects that the skills and knowledge gained from their qualifications are portable and transferable across a range of settings in Human Services (e.g. Social Work or Psychology and related disciplines). These program outcomes are likened to an 'Aboriginal mental health superannuation scheme' that contributes to longer term human capacity through investment into human resources within communities. The continued investment in such programs will reap sustainable long term benefits for communities, services and people.

WHAT ARE THE SUCCESS FACTORS?

Some significant developments that have contributed to the program's success include:

- Periodic external evaluations to improve and build the evidence base;

- Ongoing program review as an ongoing quality performance issue;

- Embedding the *National Practice Standards for the Mental Health Workforce, 2002;* and

- Achieving professional recognition of the qualification of the Bachelor of Health Science (Mental Health) by the Indigenous Allied Health Australia (IAHA) 2012.

The Role of Cultural Affirmation in Program Development and Delivery

The single point of difference between the development of the *Djirruwang Program* and the major mental health professions is that cultural affirmation is central to the design and embedded throughout the program. Cultural affirmation along with the development of skilled Aboriginal mental health professionals, in accord with the mental health profession's own practice standards, is central to the identity of the program. This is conducted in culturally respectful ways which sets this program apart from other disciplines as an emerging independent profession in its own right and within the matrix of multidisciplinary mental health care. Cultural affirmation:

- is the most important foundation of the program and the major contributor to its growth and development over 20 years;

- informs the structural arrangements, curriculum and implementation strategies that are meaningful to Aboriginal and Torres Strait Islander peoples.

Notions of cultural affirmation need to be implemented by those who want genuine change and show genuine leadership.

The Role of Partnerships for Effective Implementation

The *Djirruwang Program* would not be the success it is today without the establishment of effective partnerships between Aboriginal organisations, Elders and Aboriginal community leaders, local health services, academic bodies and student and family groups. The program is a positive example of people, organisations and cultures working together to achieve set goals. The partnerships were based on mutual respect and a both-ways learning model. Aboriginal people taught non-Aboriginal people about Aboriginal issues, culture and cultural respect and non-Aboriginal mental health staff provided education and training in western approaches to mental health and wellbeing treatment and care.

FUTURE DIRECTIONS

Since 2012, graduates and students from the Bachelor of Health Science (Mental Health) across the country have national representation through IAHA. This is a significant step in supporting the Aboriginal mental health workforce and the allied health workforce and Aboriginal Australians.[16] Essentially, for the first time Aboriginal and Torres Strait Islander mental health practitioners belong to a professional body that will advocate on their behalf, alongside other allied health professionals at the national level, for vital changes across the sector including a national awards structure.

There have been historical struggles to formalise these arrangements into a recognised professional association—it has been a long journey going back to the mid-1990s. This decision will ensure Aboriginal mental health remains high on the agenda. It is an opportunity for collective responses to issues affecting this workforce through active participation, choice and control of educational processes that are empowering to Aboriginal and Torres Strait Islander peoples. But most importantly it validates the belief, hard work and persistence of the many graduates of the *Djirruwang Program* into a valuable professional association.[16] The *Djirruwang Program* provides compounding benefits through longer term gains for graduates and workplaces across a range of human services and communities.

Challenging the Mental Health Disciplines

The emergence of programs such as *Djirruwang* creates challenges for the mental health system to recognise and acknowledge the qualifications and the role of Aboriginal mental health practitioners. The *Djirruwang Program* is about Aboriginal people determining and responding to a set of needs in culturally appropriate ways rather than the disciplines determining what we should be aspiring towards. If those of us seeking genuine transformation in Aboriginal mental health only ever focus on the five disciplines—Psychiatry, Psychology, Nursing, Occupational Therapy and Social Work—we risk overlooking the relevance and appropriateness of value of culture being incorporated as a key principle of mental health education and training. The failure (until recently) of these disciplines to acknowledge and affirm culture may help to explain why Aboriginal Australians are underrepresented in almost all health-related occupations, including psychology, and why Aboriginal students are underrepresented in graduate courses in health.[17, 18] Unless we challenge these disciplinary fortresses, we risk supporting the power imbalance that still exists within services, professions and disciplines that diminishes the real potential and value that an Aboriginal mental health workforce brings.

Positive Examples of Structural and Curriculum Reform

However, there is movement across the mental health professions. For example, the Australian Psychological Society (APS) has recently developed a Reconciliation Action Plan and the Australian Association of Social Work has a position statement relating to Aboriginal people. There is a substantial increase in Aboriginal enrolments in courses in medicine due to a process

of cultural affirmation in the formal structural and curriculum arrangements supported by the Australian Indigenous Doctors' Association (AIDA) and the Australian Medical Association (AMA). For the last two years, Aboriginal student enrolments have reached 2.5 per cent of the student population (compared with 0.8 per cent in 2004); in doing so, they have broken the barrier in terms of Aboriginal student numbers. This outcome provides both a formula and further challenge for all other disciplines in mental health care to improve Aboriginal student numbers in a supported structure. Some of these challenges and solutions are outlined in the *National Medical Education Review: 2012*,[19] which emphasises that:

> To achieve this requires sustained and accelerated support from governments, education and health sectors to increase the recruitment, retention and completion rates of students, as well as work environments that encourage medical graduates to practice and specialise in their chosen field.[20]

> The implementation of the curriculum framework has not only resulted in the development of more relevant Indigenous health content, but has also stimulated a number of highly effective and more culturally appropriate pedagogical approaches in some schools.[21(p1)]

The approach by AIDA focuses on real and sustainable structural reform to the entire base of medical training with the support from Deans of Medical Faculties and the AMA.

Embedding Culture in the Curriculum

There is also some interesting work emerging from the Vocational and Education and Training (VET) sector that highlights the value of embedding culture and affirming processes:

> Where it is viable for curricula and models of delivery of education and training to incorporate elements that affirm and accommodate Aboriginal people's culture, it follows that such practices are also likely to realise improved outcomes for Aboriginal Australians.[22(p8)]

> If a strong sense of continuity of self-identity safeguards young people against taking their own lives, it may also have positive impacts in other domains in which people 'invest' in their futures, such as education, health, a career and relationships with family and community.[22(p10)]

> To promote a positive sense of cultural identity for Aboriginal students in education settings requires respect for and affirmation of Aboriginal students' culture. Coupled with evidence that a positive sense of identity is important for wellbeing more generally, the case can be made that material and activities to support this should be incorporated into curricula wherever possible.[22(p43)]

CONCLUSION

This chapter has tracked the 20 years of history of the *Djirruwang Program*. The contribution to the mental health and wellbeing workforce through the Bachelor of Health Science (Mental Health) is impressive and far beyond its humble beginnings of five trainees in a pilot program at Queanbeyan, NSW in 1993. It has highlighted that their commitment to making meaningful improvements to the lives of Aboriginal Australians experiencing mental health issues is evident. The flow-on effects of supported education and training of students demonstrates that programs that positively validate and affirm cultural difference are both critical and central to their success. The *Djirruwang Program* can be proud of its foundations and its ongoing contribution beyond the mental health area. The program values Aboriginal people's experiences, and affirms all aspects of culture within the curriculum, structural arrangements and implementation. It is a story that is broadly based into the sphere of human services professions and one that values Aboriginal people at the core of all developments. This is the success story that is worthy of celebration and cultural affirmation in action.

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Maps of Australian Aboriginal language groups and population

Map One: Aboriginal Australia

Using published resources available between 1988–1994, this map attempts to represent all the language, social or nation groups of the Indigenous people of Australia. It indicates only the general location of larger groupings of people which may include smaller groups such as clans, dialects or individual languages in a group. Boundaries are not intended to be exact. This map is just one representation of many other map sources that are available for Aboriginal Australia.

Map Two: Aboriginal and Torres Strait Islanders' population distribution

This map shows the distribution of the Aboriginal and Torres Strait Islander population across Australia. It reflects the diversity and complex network of Aboriginal communities across areas of geographic remoteness in all States and Territories.

Map One: Aboriginal Australia
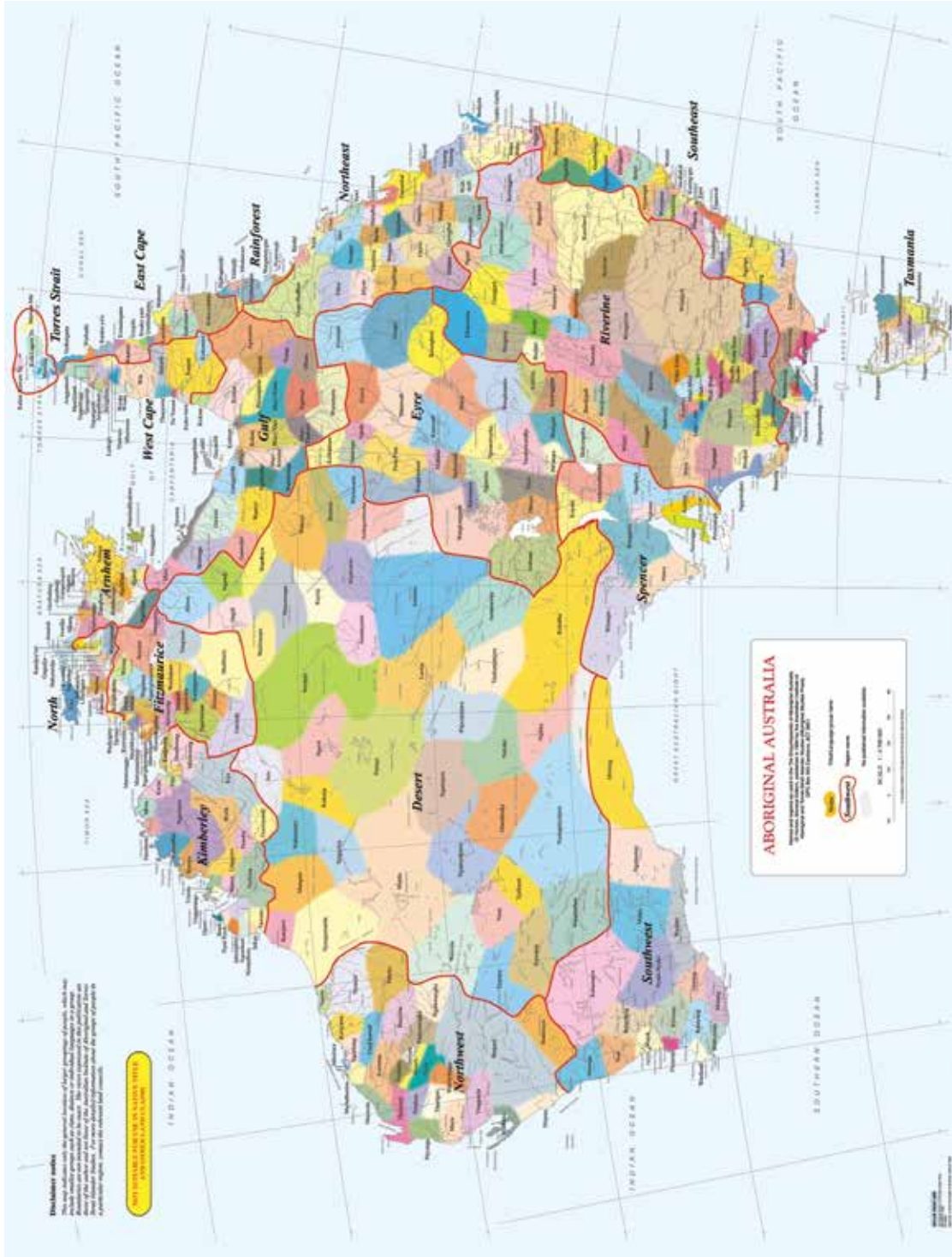
Map Two: Aboriginal and Torres Strait Islanders' population distribution - 2006(a)

1 Dot = 100 Indigenous persons

Remoteness Areas

- Major Cities
- Regional Areas
- Remote Areas
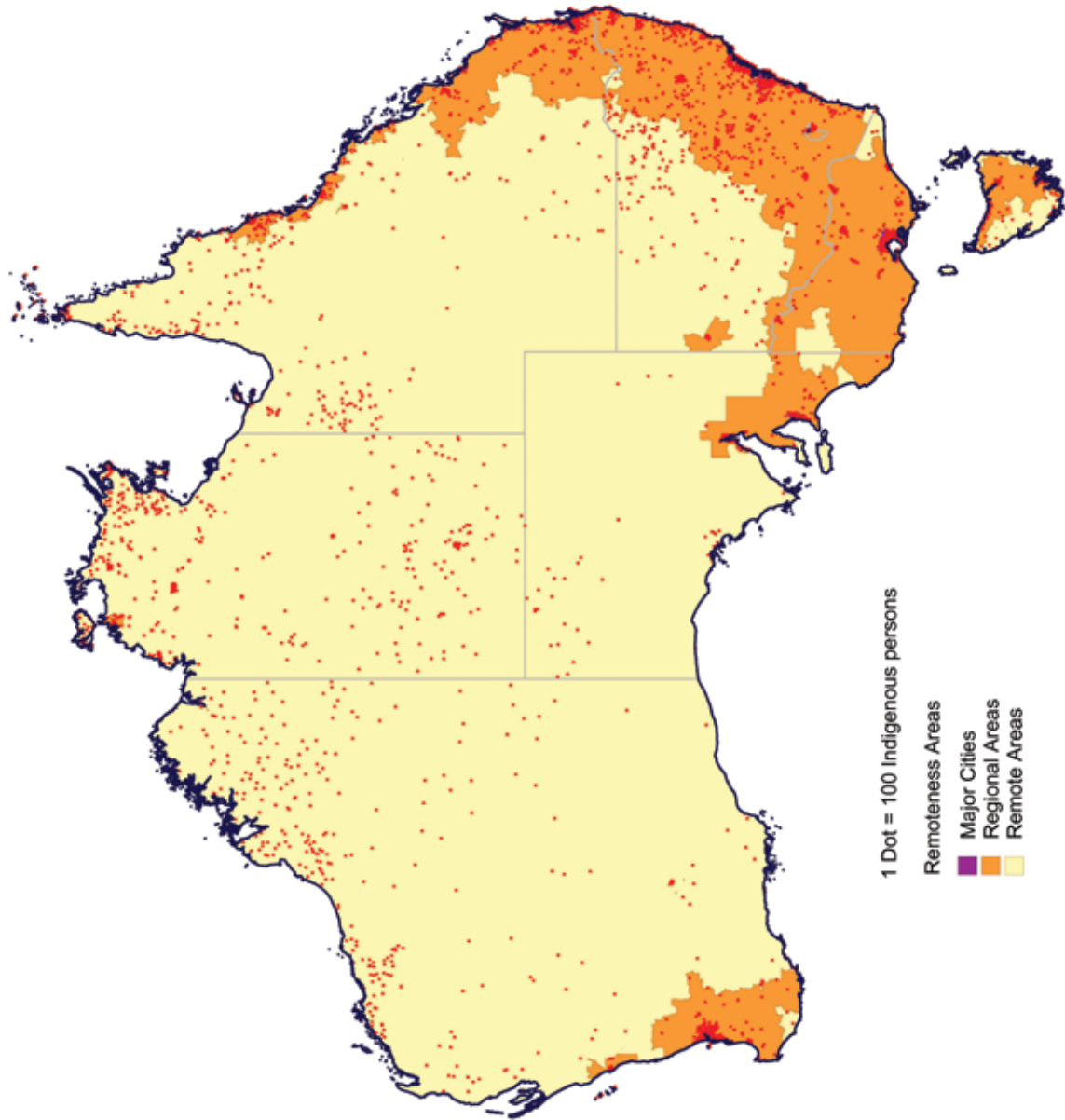
(a) Final estimate based on the 2006 Census of Population and Housing. Source: ABS data available on request, Australian Demographic Statistics (cat. no. 3101.0)

Abbreviations

AAVHTQ	Australian Aboriginal Version of the Harvard Trauma Questionnaire
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service
ACER	Australian Council for Educational Research
ACSSA	Australian Centre for the Study of Sexual Assault
ACYHC	Apunipima Cape York Health Council
AD	Adjustment Disorder
ADAPT	Adaptation After Prosecution and Trauma
ADHD	Attention Deficit Hyperactivity Disorder
AEDI	Australian Early Development Index
AeJAMH	Australian e-Journal for the Advancement of Mental Health
AFL	Australian Football League
AGPS	Australian Government Publishing Services
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AHMRC	Aboriginal Health and Medical Research Council
AHP	Aboriginal Health Practitioner
AHW	Aboriginal Health Worker
AIATSIS	Australian Institute of Aboriginal Torres Strait Islander Studies
AIDA	Australian Indigenous Doctors' Association
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AIMhi	Australian Integrated Mental Health Initiative
AIPA	Australian Indigenous Psychologists Association
AIRRFI	Awareness, Identify, Reclaim, Reconcile, Forgive, Inspire
AMA	Australian Medical Association
AMHW	Aboriginal Mental Health Worker
AMS	Aboriginal Medical Service
AMSANT	Aboriginal Medical Services Alliance of the Northern Territory
ANCD	Australian National Council on Drugs
ANPPEIMH	Australian Network for Promotion, Prevention and Early Intervention for Mental Health
ANU	Australian National University
ANZAME	The Australian and New Zealand Association for Medical Educators
APA	American Psychiatric Association
APA	Australian Physiotherapy Association
APHA	Australian Private Hospitals Association
APS	Australian Psychological Society
Arafmi	Association of Relatives and Friends of the Mentally Ill
ARACY	Australian Research Alliance for Children and Youth
ARBD	Alcohol Related Birth Defect
ARND	Alcohol Related Neurodevelopment Disorder

ASCA	Adults Surviving Child Abuse
ASD	Acute Stress Disorder
ASD	Autism Spectrum Disorder
ATAPS	Access to Allied Psychological Services
ATOD	Alcohol, Tobacco and Other Drug
ATR	Aboriginal Terms of Reference
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSIHF	Aboriginal and Torres Strait Islander Healing Foundation
ATSIMHSPAG	Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group
ATSIPHCS	Aboriginal and Torres Strait Islander Primary Health Care Services
ATSIPP	Aboriginal and Torres Strait Islander Peoples and Psychology Group
AUDIT	Alcohol Use Disorders Identification Test
AUSIENET	Australian Network for Promotion, Prevention and Early Intervention for Mental Health
BI	Brief Interviews
BPSS	Biopsychosocial–spiritual
BTH	*Bringing Them Home*
BTHC	Bringing Them Home Counselling
CAEPR	Centre for Aboriginal Economic Policy Research, ANU
CAMH	Child and Adolescent Mental Health
CAP	Complementary Action Plan
CARPA	Central Australian Rural Practitioners Association
CAS	Centre for Aboriginal Studies
CBT	Cognitive Behaviour Therapy
CFI	Cultural Formulation Interview
CHPPE	Centre for Health Policy, Programs and Economics
CIDI	Composite International Diagnostic Interview
COAG	Council of Australian Governments
CRCAH	Cooperative Research Centre for Aboriginal Health
CRUfAD	Clinical Research Unit for Anxiety and Depression
CSA	Child Sex Abuse
CSIRO	Commonwealth Scientific and Industrial Research Organisation
CSU	Charles Sturt University
DAO	Drug and Alcohol Office
DCS	Department of Corrective Services
DE(E)TYA	Department of Employment, (Education,) Training and Youth Affairs
DHS	Department of Human Services
DoHA	Australian Government Department of Health and Ageing (now Department of Health)
DRUID	Darwin Region Urban Indigenous Diabetes
DSM III R	*Psychiatry Diagnostic and Statistical Manual of Mental Disorders*, Third Edition Revisited
DSM IV-TR	*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision
DSM-5	*Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition
EPDS	Edinburgh Postnatal Depression Scale
ERP	Empowerment Research Program
FAE	Fetal Alcohol Effects
FaFT	Families as First Teachers
FAHCSIA	Families and Housing, Community Services and Indigenous Affairs
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorder
FAST	Families and Schools Together
FCAATSI	Federal Council for the Advancement of Aboriginal and Torres Strait Islanders
FSS	Foetal solvent syndrome

FVPLS	Family Violence Prevention Legal Services
GEM	Growth Empowerment Measure
HIPPY	Home Interaction Program for Parents and Youngsters
HPF	Health Performance Framework
HREOC	Human Rights and Equal Opportunity Commission
HRSCEET	House of Representatives Standing Committee on Employment, Education and Training
IAHA	Indigenous Allied Health Australia
ICD-10	*International Statistical Classification of Diseases and Related Health Problems* 10th Revision
ICMD	Indigenous Community Management and Development
IPS	Indigenous Psychological Services
IQ	Intelligence Quotient
IV	Informant Version
IVAWS	International Violence Against Women Survey
KAMSC	Kimberley Aboriginal Medical Services Council
KICA	Kimberley Indigenous Cognitive Assessment
KMMS	Kimberley Mum's Mood Scale
KRAs	Key Result Areas
LEAD	Localities Embracing and Accepting Diversity
MCDS	Ministerial Council on Drug Strategy
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MHFA	mental health first aid
MHCC	Mental Health Coordinating Council
MHS	Mental Health Service
MHSC	Mental Health Standing Committee
MHSW	Mental Health Social Worker
MI	Motivational Interviewing
MSE	mental state examination
NACCHO	National Aboriginal Community Controlled Health Organisation
NADA	Network of Alcohol and other Drug Agencies
NAHS	National Aboriginal Health Strategy
NAHSWP	National Aboriginal Health Strategic Working Party
NAPLAN	National Assessment Program for Learning and Numeracy
NATSIHC	National Aboriginal and Torres Strait Islander Health Council
NATSIHEC	National Aboriginal and Torres Strait Islander Health Equality Council
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NCAFP	National Congress of Australia's First Peoples
NCIS	National Centre for Indigenous Studies
NCIS	National Coronial Information System
NDARC	National Drug and Alcohol Research Centre
NDIS	National Disability Insurance Scheme
NDSHS	National Drug Strategy Household Survey
NDS	National Drug Strategy
NHLF	National Health Leadership Forum
NHMRC	National Health and Medical Research Council
NHPA	National Health Performance Authority
NHS	National Health Survey
NIDAC	National Indigenous Drug and Alcohol Committee
NIRA	National Indigenous Reform Agreement
NMHC	National Mental Health Commission
NMHCCF	National Mental Health Consumer and Carer Forum
NMHS	National Mental Health Strategy

NMHS	North Metropolitan Health Service
NPA	Northern Peninsula Area
NPDI	National Perinatal Depression Initiative
NPHIC	National Prisoner Health Information Committee
NPSMHW	National Practice Standards for the Mental Health Workforce
NSDC	National Sorry Day Committee
NSFATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health
NSGA	National Stolen Generations Alliance
NSP	needle and syringe program
NSPS	National Suicide Prevention Strategy (formerly National Youth Suicide Prevention Strategy, NYSPS)
OID	Overcoming Indigenous Disadvantage
OT	Occupational Therapist
OVAHS	Ord Valley Aboriginal Health Service
PACE	Participation and Community Engagement
PFAS	Partial Fetal Alcohol Syndrome
PHAA	Public Health Association of Australia
PHCC	Public Health Collaborating Centre
PND	Postnatal Depression
PTA	Post-Traumatic Amnesia
PTSD	Post-Traumatic Stress Disorder
RACGP	Royal Australian College of General Practitioners
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RAP	Reconciliation Action Plan
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
RHSET	Rural Health Support Education and Training
RNR	Risks Needs Responsivity
RTO	Registered Training Organisations
SAMHSA	Substance Abuse and Mental Health Services Administration
SCRGSP	Steering Committee for the Review of Government Service Provision
SEWB	Social and Emotional Wellbeing
SHRG	Social Health Reference Group
SUG	suppressed unresolved grief
TSRA	Torres Strait Regional Authority
VET	Vocational Education and Training
VSM	Volatile Substance Misuse
WAACHS	West Australian Aboriginal Child Health Survey
WAIS	Wechsler Adult Intelligence Scale
WAPMHU	WA Perinatal Mental Health Unit
WASC-Y	Westerman Aboriginal Symptom Checklist—Youth
WGIR	Working Group on Indigenous Reform
WHO CSDH	World Health Organisation Commission on Social Determinants of Health
WISC	Wechsler Intelligence Scale for Children
WSU	Workforce Support Unit

Glossary

1967 Commonwealth Referendum – Often thought of as the beginning of national reconciliation. This referendum changed the Commonwealth Constitution to recognise Indigenous people in Commonwealth laws and in the national census.

Aboriginal – A person of Aboriginal descent who identified as an Aboriginal and is accepted as such by the community in which he or she lives.

Aboriginal Culture – The culture of Indigenous Australians is the oldest continuing culture in the world thought to have gone back approximately 40,000–50,000 years.

Aboriginal family systems – Aboriginal and Torres Strait Islander peoples have a complex system of family relations, where each person knows their kin and their land.

Accessibility – Ability of people to obtain health care at the right place and right time irrespective of income, physical location and cultural background.

Antenatal depression – Depression experienced during pregnancy. Australian research indicates that antenatal depression is experienced by up to one-in-ten women (9 per cent) (*beyondblue,* 2011).

Anxiety disorders in the perinatal period – There are a number of different types of anxiety disorders:
Panic disorder - frequent attacks of intense feelings of anxiety that seem like they cannot be brought under control;
Social phobia - intense fear of criticism, being embarrassed or humiliated;
Generalised anxiety disorder - feeling anxious about a wide variety of things on most days over a long period of time;
Specific phobia - fearful feelings about a particular object or situation;
Obsessive compulsive disorder - ongoing unwanted/intrusive thoughts and fears that cause anxiety (obsessions) and a need to carry out certain rituals in order to feel less anxious (compulsions);
Post-traumatic stress disorder (beyondblue, 2011).

Appropriateness – Care, intervention or action provided is relevant to the client's needs and based on established standards.

Arnhem Land – Located in the Northern Territory.

Assimilation – Cultural assimilation is the process by which a minority group's language and culture are lost under pressure to adopt those of a dominant cultural group.

Attachment Theory – An explanatory conceptual framework of human development that prioritises the developmental imperative of an infant forming an enduring emotional tie to a special person, characterised by a tendency to seek and maintain closeness with that person.

AUDIT-C – A three question screening test for problem drinking which can be used in a doctor's office. It was derived from the Alcohol Use Disorders Identification Test' (AUDIT) which is a simple 10 question test developed by the World Health Organisation to determine if a person's alcohol consumption may be harmful.

Baby blues – Develops within 3–10 days after birth. It affects an estimated 80 per cent of postnatal women. Women feel emotional and teary, anxious, tense and exhausted. They may have difficulty sleeping. It is a self-limiting condition that resolves within 1–2 weeks especially when support and understanding are given (*beyondblue*, 2011).

Bereavement overload – Refers to circumstances in which a grieving individual confronts multiple losses simultaneously or in rapid succession, such that one loss cannot be accommodated before another occurs.

Biopsychological – An approach that focuses on, and prioritises, the biological foundations of behaviour, emotions and mental processes.

Biotechnology – The use of micro-organisms or biological substances to manufacture a product or run a process, including the use of biotechnical methods to modify the genetic material of living cells so they will produce new substances or perform new functions.

Bringing Them Home Report – National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families, 1997.

Buddy system – An arrangement in which persons are paired, as for mutual safety or assistance.

Capability – An individual's or service's capacity to provide a health service based on skills and knowledge.

Carer – A carer/caregiver is generally 'a person' who provides unpaid care for another who requires help with everyday tasks because of disability, frailty, chronic illness including mental health.

Central Australian Rural Practitioners' Association (CARPA) Manual – Developed to support medical practice in remote and rural communities in Central Australia by providing protocols for the management of commonly encountered conditions.

Central Australia – Geographical area in Australia, comprised of desert land and incorporating various states.

Close the Gap Campaign – The campaign to achieve Aboriginal health equity by 2030, to close the health and life expectancy gap between Aboriginal and Torres Strait Islander peoples and non-Aboriginal Australians within a generation.

Colonisation – Happens when one nation establishes a colony in another land, and then extends its political, economic, and cultural control over that land and the people living in it.

Community – In Aboriginal culture, a community is first and foremost about country, (extended) family ties, and shared experience. Community is about inter-relatedness and belongingness, and is central to Aboriginality. An Aboriginal person may belong to more than one community – for example, where they come from, where their family is, and where they live or work.

Community control – Is the local community having control of issues that directly affect their community. Implicit in this definition is the clear statement that Aboriginal people must determine and control the pace, shape, and manner of change and decision making at [all] levels.

Community obligations – Responsibilities and obligations to attend funerals, to participate in community meetings, functions and various committees. Individual family members and group members are expected to participate at various levels in order to ensure that family representation, roles and responsibilities are being met and carried out. These obligations range from limited contact (such as for family members who have just met or who have been recently introduced to the community) through to intense everyday contact.

Comorbidity – The co-occurrence of more than one disease or disorder in an individual.

Continuity – Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.

Council of Australian Governments (COAG) – The peak intergovernmental forum in Australia. Members consist of the Prime Minister, State and Territory Premiers and Chief Ministers and the President of the Australian Local Government Association. COAG is currently pursuing a reform agenda aimed at improving economic and social participation, strengthening the national economy, creating a more sustainable and liveable Australia, delivering better health services and closing the gap in Indigenous disadvantage.

Country – Signifies the strong connection and ongoing life responsibilities to the land where a person is born or where their ancestors were born. The connection is spiritual and physical: spiritual recognition from the land (ancestors) and spiritual recognition from the person including physical safeguarding of the land.

Craniometrists, anthropometrists and psychometrists –
Craniometrics is the comparative study of skull measurements to determine its characteristics as related to sex, race, or body type;
Anthropometrics is the comparative study of human body measurements for anthropological classification and comparison;
Psychometrics is the comparative measurement or assessment of individual differences in abilities, aptitudes, attitudes, behaviour, intelligence, and other attributes.

Critical Reflective Framework for Analysis – A guided process to aid analysis and increase the potential for positive outcomes.

Critically reflexive approach – Paying critical attention to the values, norms and conventions that inform practice and action, so as to engage in a process of continuous learning.

Culture – Refers to social patterns of acting and thinking and feeling. Culture is the total way of life of a people.

Cultural adaptation – Refers to the shift of one group's culture to align with another, such as when Indigenous cultures change to become co-opted into the dominant non-Indigenous culture.

Cultural competence – A commitment to engage respectfully with people from other cultures. Encompasses and extends elements of cultural respect, cultural awareness, cultural security and cultural safety. A set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations. The ability to identify and challenge one's own cultural assumptions, one's values and beliefs.

Cultural dislocation – Refers to the removal, loss or inability of an individual to connect with their traditional culture or heritage.

Cultural equivalence of a tool of assessment – A psychological assessment tool's performance with people who belong to a different cultural group from those with whom the tool was originally assessed (Esler et al 2008).

Cultural practice – Generally refers to the manifestation of a culture or sub-culture, initially in regard to the traditional and customary practices of a particular ethnic or other cultural group.

Cultural resistance – The tactical opposition by one group of the dominant culture in society.

Cultural respect – The recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal people.

Cultural safety – An environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need.

Cultural security – Is a commitment from mainstream culture and services to respect the cultural rights and heritage of Aboriginal people.

Culturally appropriate – An approach to policy, intervention, service-delivery, and intergroup interaction that is based on the positive acceptance of the cultural values and expectations of Aboriginal people.

Culturally responsive – Refers to the ability to take a person's culture and help that person infuse it into another culture, making it uniquely one.

Culture – Refers both to patterns of acting and behaviour, and patterns of thought and feeling. Put simply, culture is the total way of life of a people.

Culture bound syndromes – Are generally limited to specific societies or culture area and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations.

Darwinism – A theory of biological evolution claiming that new species arise and develop through the natural selection of those with characteristics that make them most fit to survive particular environmental conditions.

De facto – A Latin expression that means 'concerning fact.'

De jure – An expression that means 'concerning law.'

Decolonisation – The undoing of colonialism, the unequal relation of polities, whereby one people or nation establishes and maintains dependent Territory over another.

Denigrating – Attacking the character or reputation of, or denying the importance of, someone or something.

Deconstructivist – A person who deconstructs the values, assumptions and theories of each discipline. This allows them to gatekeep their power and authority and lock others out.

Discourse – Written or spoken communication or accepted language used in a given field or culture, such as legal discourse, religious discourse, etc. Discourse is closely linked to the power and authority to define reality itself, so we speak of dominant and non-dominant discourses.

Disease Model – Prioritises biological, neurological and genetic causes as explanatory factors of health and ill-health.

Dissociative Fugue – A rare psychiatric disorder characterised by reversible amnesia for personal identity, including the memories, personality and other identifying characteristics of individuality.

Dreaming – A set of beliefs of spirituality that relate to an individual or group. It is a complex network of knowledge, faith and practices that informs all spiritual and physical aspects of life. These ancestral spirits created the earth and distinctive natural features of the country.

Dreamtime – The creation time when the Ancestral Beings moved across the land and created life: animals, plants, the landscape and all that we know now. They also created the mystical bond between humans, the environment and spirituality: the relationships between groups and individuals to the land, the animals and other people. At the end of their journeys, they became part of the landscape.

DSM-IV-TR – The standard classification of mental disorders used by mental health professionals in the United States. TR relates to a 'text revision' done on the manual in the year 2000.

DSM-5 – (Formerly known as DSM-V.) The fifth edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders. It supersedes DSM IV.

Dysfunctional community syndrome – Comprises categories to describe more complex and larger scale forms of family violence.

Eastern Arnhem Land – Eastern area of Arnhem Land located in the Northern Territory.

Edinburgh Postnatal Depression Scale (EPDS) – A symptom-based screening measure utilising a self-report questionnaire with ten questions pertaining to feelings of wellbeing in the preceding seven days. It is a useful screening tool in the antenatal and postnatal detection and monitoring of depression and anxiety.

Educaring Model – An educaring approach to healing generational trauma in Aboriginal Australia. Where there is hurt there has to be a healing. In healing, people's trauma stories become the centerpiece for social action, where the storyteller is the teacher and the listener is the student (or learner).

Effectiveness – Care, intervention or action achieves desired outcome in an appropriate time frame.

Efficiency – Achieving desired results with the most cost-effective use of resources.

Emotional and social wellbeing – The holistic concept of mental health recognised by Aboriginal and Torres Strait Islander peoples. 'Health does not just mean the physical wellbeing of the individual but refers to the social, emotional and cultural wellbeing of the whole community. This is a whole-of-life view and includes the cyclical concept of life–death–life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total wellbeing of their communities.'

Empowerment – Refers to increasing the spiritual, political, social, educational, gender, or economic strength of individuals and communities.

Ethnocentric – Belief in the inherent superiority or taken-for-granted normality of one's own ethnic group or culture.

Ethnography – A qualitative research method aimed to learn and understand cultural phenomena which reflects the knowledge and system of meaning guiding the life of a cultural group.

Extreme traumatic stressor – Under the American Psychiatric Association classification, a stressor must be assessed as extreme to qualify an individual for a diagnosis of Post-Traumatic Stress Disorder (PTSD) or Acute Stress Disorder (ASD), but can be of lesser severity for a diagnosis of Adjustment Disorder (AD).

Forced removal – From 1909 to 1969, Australian government authorities assumed legal guardianship of all Indigenous children and removed large numbers of children from their families in order to 'assimilate' the children into European society and culture.

Genomics – The study of gene sequences and their structural and regulatory functions.

Genotypical – The genetic makeup of a cell, an organism, or an individual (i.e. the specific allele makeup of the individual) usually with reference to a specific character under consideration.

Health – A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

Hegemony – The domination of society by one group through the subtle and indirect control of patterns of social values and behaviours rather than through the use of overt force.

Homeland – Tracts of traditional land where Aboriginal clans lived before they were moved off and forced to live in white-controlled missions.

Indigenous Community Management and Development (ICMD) – Provides the skills and knowledge to make a positive impact in communities. Explore ways to implement effective, culturally appropriate change in Indigenous service organisations and communities.

Indigenous disadvantage – Specific to the areas of health, housing, employment, justice and remote communities.

Institutionalised – Established as a value, convention or norm within the operations of social institutions.

Institutionalised racism – Refers to the ways in which racist beliefs or values have been built into the operations of social institutions in such a way as to discriminate against, control and oppress various minority groups.

Julalikari Council – An Aboriginal community service organisation governed by Julalikari Council, an elected body representing the whole Aboriginal community of Tennant Creek.

Kessler-10 Scale (K10) – Widely recommended as a simple measure of psychological distress and as a means to monitor progress following treatment for common mental health disorders such as anxiety and depression.

Kimberley English – Modified English that incorporates a mix of local Aboriginal languages and English.

Kimberley Mum's Mood Scale (KMMS) – An alternative to the Edinburgh Postnatal Depression Scale (EPDS) and screens for depression and anxiety. It has been collaboratively developed by health care providers and over 100 Aboriginal women from eight language groups throughout the Kimberley.

Kinship – The system of law governing social interaction, particularly marriage, in traditional Aboriginal culture. It is an integral part of the culture for Aboriginal groups across Australia.

Leadership – Advancing the interests of Aboriginal communities through ACCHOs and their collective knowledge of the communities they are accountable to in order to ensure their involvement in decision making and public debate.

Life Skills Profile – Assessment tool for measuring life skills.

Life stressors – Situations that are experienced as a perceived threat to one's wellbeing or position in life.

Mabo and others vs. the state of Queensland – A significant court case decided in the High Court of Australia on 8 December 1988. It found that the Queensland Coast Islands Declaratory Act, which attempted to retrospectively abolish native title rights, was not valid according to the Racial Discrimination Act 1975.

Malignant grief – A process of irresolvable, collective and cumulative grief that affects Indigenous individuals and communities.

Mental health – A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Mental illness – Refers to anxiety-related disorders, depression, personality disorders, and psychosis.

National Health Survey – Conducted by, and results available at, the Australian Bureau of Statistics. Indicates the health status of the nation.

National Practice Standards for the Mental Health Workforce (2013) – Contains the twelve practice standards for those who work in mental health services within the professions of psychiatry, nursing, social work, psychology and occupational therapy.

Native title – The rights and interests that are possessed under the traditional laws and customs of Aboriginal and Torres Strait Islander peoples and that are recognised by common law.

Northern Territory Intervention – A consequence of the *Northern Territory National Emergency Response Act 2007*, a legislative response from the Federal Government to the Northern Territory Government's Inquiry into the Protection of Aboriginal Children from Sexual Abuse, or *Little Children are Sacred* report. The legislation received bipartisan support in the Commonwealth parliament.

Oppression – (O)ppression is maintained and propagated through overt or material violence (i.e. physical coercion and terror, denial of rights and resources, restriction of mobility, etc.) and by subtle or ideological violence (i.e. institutionally codified racism, sexism, classism, heterosexism, and related practices). Physical and ideological violence act in mutually reinforcing patterns such that physical violence establishes social domination and ideological violence legitimises and normalizes oppressive social relationships and material inequity.

Otitis media – Inflammation of the middle ear, or middle ear infection, is very uncommon in First World countries and is best regarded as a disease of poverty. The associated hearing loss has a life-long impact, as it occurs during speech and language development and the early school years.

Partnership – Cooperation to ensure that the expertise and experience of the ACCHS sector is brought to health care processes. This expertise comprises knowledge of Aboriginal culture and health care, and clinical service provision of the AHMRC's constituent services.

Paternal perinatal depression – Fathers are not immune. Paternal depression rate is estimated at 6 per cent, the rate being higher if the mother is depressed. A non-depressed father has a protective effect on the children of a depressed mother.

Perinatal mental health – Encompassing the emotional wellbeing of parents and infants, the Western Australian State Perinatal Reference Group (2003) defines perinatal mental health as 'the emotional and psychological wellbeing of women, encompassing the influence on infant, partner and family, and commencing from preconception through pregnancy and up to 36 months post-partum'.

Perinatal period – From conception to the end of the first year after the baby is born.

Personality Disorder – Refers to a class of maladaptive personality traits, that is, enduring patterns of behaviour, cognitions and inner experience that are exhibited across many contexts and deviate markedly from those accepted by the individual's culture.

Phenotypical – The composite of an organism's observable characteristics or traits: such as its morphology, development, biochemical or physiological properties, phenology, behaviour and the products of behaviour.

Piagetian – Of, relating to, or dealing with Jean Piaget or his writings, theories, or methods especially with respect to child development.

Positive wellbeing – Is about being calm and peaceful, happy, full of life and having a lot of energy.

Postnatal Depression – Defined as five or more symptoms occurring during pregnancy or during the postnatal period (from birth of infant and up to one year afterwards). Symptoms of depression include: persistent low mood, loss of interest or pleasure in activities, significant change in weight or appetite, markedly increased or decreased sleep, psychomotor agitation or retardation, fatigue or loss of energy, feeling worthless or guilty, loss of concentration, recurrent thoughts of death, self-harm or suicide (KAMSC, 2010).

Postnatal Psychosis – Manifesting as hallucinations, thought disturbances, paranoia and delusions, it affects 1 in 500 postnatal women within the first week of childbirth. It is a medical emergency.

Post-Traumatic Stress Disorder – A severe condition that may develop after a person is exposed to one or more traumatic events, such as sexual assault, serious injury or the threat of death.

Prejudice – A preconceived judgment or opinion formed without knowledge or reason; generally unfavourable.

Primal health – The basic state of health built at the time when the baby is closely dependent on its mother, first in the uterus, then during childbirth, and then during the period of breastfeeding (the primal period). Everything that happens during this primal period, or period of dependence on the mother, has an influence on the basic state of health of the infant (Odent, 2002).

Prime Minister Kevin Rudd's 2008 apology – A speech on behalf of the Australian people apologising to Aboriginals.

Principle – A principle is defined as a general, basic maxim; a fundamental truth; a generally accepted rule or procedure or ... a rule or belief governing one's behaviour.

Protective factors – Factors in a person's life that promote mental health and wellbeing.

Psychological determinism – A conceptual view that events are fundamentally caused by explanatory factors that are psychological in nature.

Queensland test (Q Test) – Developed by McElwain and Kearney (1971). This is a test of general cognitive ability. It relies heavily on non-verbal communication skills with specific non-verbal instructions that require test-takers to use problem-solving skills by manipulating physical objects.

Racism – Refers to pervasive and systematic assumptions of the inherent superiority of certain groups, and inferiority of others based on cultural differences in values, norms and behaviours. Those who are assumed to be inferior are treated differently and less favourably in multiple ways. Racism reflects and is perpetuated by deeply rooted historical, social, cultural and power or authority inequalities in society. Racism is oppressive because it involves the systematic use of power or authority to treat others unjustly. It creates an atmosphere in which a group finds itself in a devalued position.

Recidivism – The act of a person repeating an undesirable behaviour after they have either experienced negative consequences of that behaviour, or have been treated or trained to extinguish that behaviour.

Reconciliation – The bringing together of Aboriginal and Torres Strait Islander and non-Aboriginal Australians through unity and respect, and valuing justice and equity for all Australians.

Responsiveness – The service provides respect for all persons and is client orientated. It includes respect for dignity, cultural diversity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks, and choice of provider.

Risk factors – Factors in an individual's life that, either directly or indirectly, affect their social and emotional wellbeing.

Rural and remote communities – Based on population numbers and an index of remoteness.

Safety – The avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered.

Second generation clients – The children of Aboriginal and Torres Strait Islander peoples who had been separated from their families as a child, as a result of past governments' removal policies and practices, including institutionalisation and adoption or foster care.

Self-determination – The ability of Aboriginal peoples to freely determine their own political, economic, social and cultural development as an essential approach to overcoming Indigenous disadvantage.

Sensory deprivation – The deliberate reduction or removal of stimuli from one or more of the senses.

Shame – A feeling of embarrassment, frustration and helplessness that Aboriginal people cannot do anything about, or which makes them feel 'small' in the eyes of others, or experienced when other Aboriginal people make them aware that they are wrong in their attitudes, actions or treatment of others.

Six-generation traumagram – The presence of unacknowledged or unresolved trauma in previous generations was linked to dysfunction in later generations of an extended family.

Social and economic disadvantage – Generally speaking, an individual suffers from 'disadvantage' when, for whatever reason, he or she is not able to access the range of social services/institutions that can be accessed by the majority of the population.

Social and emotional wellbeing (SEWB) – Recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual.

Social and emotional wellbeing counsellor – A counsellor, funded by DoHA, that provides counselling, health promotion and early intervention services to promote social and emotional wellbeing amongst Aboriginal Australians, prioritising people from the Stolen Generations.

Social contagion – Information, ideas and behaviours that spread through networks of people, similar to an infectious disease.

Social Darwinism – A popular school of thought in the early part of the 19th century which misapplies principles of Darwinian evolutionary biology to social groups to suggest that dominant groups in society are dominant because of the 'survival of the fittest'.

Social determinants – Conditions in which people are born, grow, live, work and age, including the health system.

Social determinants of health – Those factors such as education, employment, income and housing which contribute to an individual's health and wellbeing status.

Social exclusion – Refers to processes in which individuals and entire communities of people are systematically blocked from rights, opportunities and resources (e.g. housing, employment, health care, civic engagement, democratic participation and due process) that are normally available to members of society and which are key to social integration.

Social health team – Team of people working together to provide best practice.

Social inclusion agenda – An approach for addressing social disadvantage and alleviating poverty in Australia.

Social indicator – Forms of evidence that help assessment of present position and future directions.

Social inequality – Refers to a situation in which individual groups in a society do not have equal social status, including voting rights, freedom of speech and access to education, health care, quality housing, transport and other social goods and services.

Social learning theory – Theory, developed by Albert Bandura, of how people learn new behaviour through observational learning and through modelling processes.

Somatic effects – Effects of radiation that are limited to the exposed person, as distinguished from genetic effects, which may also affect subsequent generations.

Somatic symptoms – Physical symptoms.

Sorcery – Secret and sacred practices.

Sorry – A most important word as it has great meaning in Aboriginal and Torres Strait Islander communities. It means having empathy and compassion and understanding.

Sorry business – Similar to bereavement, it is a very important part of Aboriginal culture. Funerals can involve entire communities, and the expression of grief can include self-injury.

Sorry Day – An Australia-wide observance held on May 26 each year. This day gives people the chance to come together and share the steps towards healing for the Stolen Generations, their families and communities.

Sorry Time – The time it takes for everyone to arrive to pay their respects when someone has passed away. Communities 'cry together' for the lost loved one.

Spiritual Sickness – Symptoms of mental illness understood within Aboriginal communities as part of a person's spirit or personality, and not conceptualised as a form of treatable mental illness.

Stolen Generation – An Aboriginal and Torres Strait Islander person who was forcibly removed from the family as a child as a result of past governments' removal policies and practices, including institutionalisation, adoption and foster care—and their direct descendants.

Story Telling Project – Works on the concept of improving mental health through strength in spiritual, physical, family, work, social, mental and emotional components of the life of the person affected.

Sustainability – System or organisational capacity to provide infrastructure such as workforce, facilities, and equipment, and be innovative and respond to emerging needs.

Systemic discrimination – Patterns of behaviour, policies or practices that are part of the structures of an organisation and governments which create or perpetuate disadvantage for persons.

Terra nullius – Literally meaning 'land belonging to no-one'. This is a legal principle resorted to by British colonialists to justify taking Aboriginal land without recognition or recompense. The fiction of terra nullius was overturned by the High Court's Mabo judgement in 1992.

Third generation clients – The grandchildren of Aboriginal and Torres Strait Islander peoples who had been separated from their families as a child, as a result of past governments' removal policies and practices, including institutionalisation and adoption or foster care.

Top End – The Top End of Northern Australia covers roughly 400,000 square kilometres south of the northern coast, from the Northern Territory capital of Darwin across to Arnhem Land and the Gulf of Carpentaria to the east, and to the Indian Ocean to the west.

Torres Strait Islander – A Torres Strait Islander or a Torres Strait Islander person is a person/descendant from the Torres Strait Islands which are located to the north of mainland Australia.

Transgenerational loss and trauma – The impacts of loss and trauma on generations after generations in families, often referred to when describing the long term effects of colonisation.

Traumatic stressor – A commonly used term describing reactive anxiety and depression.

Validity – The extent to which a test or assessment measures what it was designed to measure.

Whiteness studies – An interdisciplinary arena of academic inquiry focused on the cultural, historical, and sociological aspects of people identified as white, and the social construction of whiteness as an ideology tied to social status.

Wholistic health – Aboriginal health is not just the physical well-being of an individual but the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being.

Aboriginal and Torres Strait Islander Terminology

Balardung (Baladon) – People from York, Beverley and along the Avon River, north to the Wongan hills, Western Australia.

Bardi – People from north of Broome and parts of the Dampier Peninsular in the Kimberley region of Western Australia.

Benelong's Haven – Benelong's Haven Family Rehabilitation Centre was established in 1974 and offers a residential treatment service for Aboriginal and Torres Strait Islander peoples with a dependence on alcohol or other drugs.

Bepo – Time.

Bibbulmun – People from Dwellingup, Collie, Balingup, Donnelly River Village, Pemberton, Northcliffe, Walpole, Peaceful Bay and Denmark in Western Australia.

Bilyurr – Our spirit from within.

BTH services – Bringing Them Home services and support.

Dadaway – Traditional meeting grounds.

Goreng – Aboriginal people from Jerramungup, Gnowerangerup and Katanning areas of Western Australia.

Gurindji People – A group of Indigenous Australians living in northern Australia, 460 km southwest of Katherine in the Northern Territory's Victoria River region.

Hermannsburg people – Refers to the Western Arrernte People of Central Australia who were exposed to a western style of education through the mission established by Pastor Carl Strehlow in 1877.

Ilan Pasin – This is our way.

Kamilaroi – 'to heal' or 'put back together'.

Karajarri – People and their traditional tountry located in the area around Bidyadanga Community, which used to be called La Grange Mission, Western Australia.

Kaurna – People whose traditional lands include the area around the Adelaide Plains of South Australia.

Koori Kids – Support programs in Victoria and NSW.

Kutjungka region – Comprise the communities of Balgo, Billiluna and Mulan in Western Australia.

Liyarn – Heart or spirit.

Lore – A body of traditions and knowledge on a subject or held by a particular group.

Lore time – Time to gain knowledge through tradition.

Mabarn (or 'clever' men) – Men who have great knowledge of healing both mentally and physically. They also deal with the metaphysical and spiritual world.

Mai – The Mourning. Immediate and extended families mourn deceased.

Mantha – Water from the Dreamtime.

Maralinga Tjarutja – People who traditionally inhabit the remote western areas of South Australia. They are a Southern Pitjantiatjara people.

Maralinga Workshop – First activity of its kind designed for psychologists to highlight first hand the issues of social (in)justice and their effects on Aboriginal people. The meeting was held in 1990 with Elders of the Maralinga Tjarutja community in the South Australian desert.

Mari Gethal – Mari Gethal means "Hand of the Spirit" where the "Law of the Deceased" defines specific cultural practices and issues that must be addressed when informing relatives of a death and when making funeral arrangements. Dressing of the body also has special significance in healing.

Men's business – An Aboriginal ritual open only to initiated males.

Minang – People from Mount Barker, Denmark, Albany and Cape Vancouver areas in Western Australia.

Murama Theodan – The Burial. Burial Site selected and decorated. Male Mari Gethal has a significant role.

Murr Merr or Uthia Tharan – Reports of sorcery affecting or being performed by a person suffering from depression as well as delusions of jealousy, including a preoccupation with the alleged perpetrator's footprints.

Ngarlu – The Karajarri word for defining the place of the Inner Spirit. The Inner Spirit model is based on cultural beliefs and customs and concepts of emotional, spiritual and social wellbeing that have sustained Aboriginal and Torres Strait Islander peoples for centuries.

Nyungar (Noonygar) – Aboriginal people from the southwest corner of Western Australia, from Geraldton on the west coast to Esperance on the south coast. Traditionally, they inhabited the region from Jurien Bay to the southern coast of Western Australia and east to what is now Ravensthorpe and Southern Cross.

Oombulgurri – Community in the East Kimberley region of Western Australia.

Pintubi – People from the Central Western Desert.

Pitjantjaratjara – People from the Central Western Desert.

Rai – Our spirit from the country.

Tai or Markai tombstone opening – Ceremony to signify that the deceased is "housed". Official grieving ceases. There is a feast and gifts are given to people who cared for the family of the deceased.

Thoerabau Ai – The Burial Feast. Originally a feast for Mari Gethal, but now the whole community is involved. Time for debriefing. Also an opportunity for Mari Gethal to assess the level of grief and intervention strategies.

Uman Goega – The Day of the Death. Tidings of the deceased taken to the community by Mari Gethal.

Wadjuk – Aboriginal people acknowledged as the traditional custodians of much of the area where the city of Perth stands.

Walpiri – People from the Central Australian desert.

Waraja Ngarlu – To agree to be of one stomach and to be of one mind.

We Al-li – Train-the-trainer model approach to achieve and support community change over time.

Werra Werra – Name of a group of women in the Eastern Kimberley region of Western Australian.

Wongi – Aboriginal people from the Western Desert and Goldfields of Western Australia.

Yadungal – Group dwelling place.

Yamatji – People from the Gascoyne-Murchison region of Western Australia.

Yolgnu Tribe – People from East Arnhem Land in the Northern Territory.

Programs and Services

beyondblue – An Australian non-profit organisation which aims to increase awareness and improve the treatment of depression, bioplar disorders and anxiety disorders and related mental disorders.

Cool Kids – A structured, skills-based program that teaches children (including teenagers) and their parents how to better manage the child's anxiety. It involves the participation of both children and their parents, and focuses on teaching clear and practical skills.

Family Wellbeing Program – Focuses on the empowerment and personal development of Aboriginal people through people sharing their stories, discussing relationships, and identifying goals for the future.

FRIENDS – A program helping children and teenagers cope with feelings of fear, worry, and depression by building resilience and self-esteem and teaching cognitive and emotional skills in a simple, well-structured format.

Gelganyem Trust – Established in April 2005 as a charitable trust. The formation of the Gelganyem Trust marked the end of three years of negotiations and heralded a new era of self determination for Traditional Owners from the Argyle Diamond Mine area.

Link-Up – Provides services to reunite Aboriginal people with their families.

ORYGEN – Research Centre in Melbourne.

Stolen Generation Australia National Library Oral History Project – This important oral history project was funded by the Commonwealth Government in 1997 in response to the first recommendation of *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families*. The aim of the project has been to collect and preserve the stories of affected Aboriginal people and others, such as police, missionaries and administrators.

We Al-li Indigenous Therapies – The We Al-li program provides the foundation for Certificate Level 4 of Indigenous Therapies, the undergraduate degree in Trauma and Healing and a masters degree in Indigenous Studies (Wellbeing) offered at Gnibi College.

Contributing Authors

Tom Calma

Dr Tom Calma is an Aboriginal elder from the Kungarakan tribal group and a member of the Iwaidja tribal group in the Northern Territory. He has been involved in Aboriginal affairs at a local, community, state, national and international level focusing on rural and remote Australia, health, education and economic development. Dr Calma was appointed National Coordinator, Tackling Indigenous Smoking in March 2010 to lead the fight against tobacco use in Aboriginal and Torres Strait Islander communities. Past positions include Aboriginal and Torres Strait Islander Social Justice Commissioner and Race Discrimination Commissioner at the Australian Human Rights Commission, and senior Australian diplomat in India and Vietnam. Through his 2005 Social Justice Report, Dr Calma called for the life expectancy gap between Indigenous and non-Indigenous people to be closed within a generation and laid the groundwork for the *Close the Gap* campaign. He chaired the *Close the Gap* Campaign Steering Committee for Indigenous Health Equality since its inception in March 2006 that has effectively brought national attention to achieving health equality for Indigenous peoples by 2030. He is a strong advocate for Indigenous rights and empowerment, and has spearheaded initiatives including the National Congress of Australia's First Peoples, development of the inaugural Indigenous suicide prevention strategy and justice reinvestment. In 2007, Dr Calma was named by the Bulletin Magazine as the Most Influential Indigenous Person in Australia and in 2008 was named GQ Magazine's 2008 Man of Inspiration for his work in Indigenous Affairs. In 2010, he was awarded an honorary doctor of letters from Charles Darwin University and named by Australian Doctor Magazine as one of the 50 Most Influential People in medicine in Australia. In 2011 he was awarded an honorary doctor of science from Curtin University and, in 2012, was awarded an Order of Australia: Officer (AO) in the General Division and is the ACT Australian of the Year 2013.

Dr Michael Adams

Dr Michael Adams is a respected Elder within the Aboriginal and Torres Strait Islander communities. He is an Adjunct Professor with the School of Public Health, Queensland University of Technology working as the National Indigenous Coordinator with the Institute of Health and Biomedical Innovation. His PhD examines the prevalence and correlates of sexual dysfunction among Aboriginal and Torres Strait Islander males, the first and largest study of its kind. His extensive involvement in key policy and program developments has enabled him to translate research into action. His efforts at knowledge translation have directly impacted on health system responses and led to better informed approaches to address the needs of Indigenous peoples who are socially excluded and often have poor access to services.

Yolonda Adams

Yolonda Adams is an Aboriginal psychologist and a Larrakia woman based in Darwin, Northern Territory. She graduated from Charles Darwin University in 1999 and is a member of the Australian Indigenous Psychologists Association (AIPA). She is undertaking PhD studies and has extensive experience working in the public and private sectors. She has worked with the Department of Justice and in mental health, providing a service to clients with mental illness and complex needs in a community setting. She has worked in management, overseeing programs and service delivery, and has significant experience working with Aboriginal clients from urban, rural and remote communities. She has been a consultant with Indigenous Psychological Services (Dr Tracy Westerman) for several years.

Jenny Adermann

Jenny Adermann has worked for Education Queensland for 25 years as a teacher, teacher–librarian, media production officer and guidance officer with Year 1 to Year 12 students in a range of urban, rural and remote settings. Spanning a 20-year period, she has returned several times to work in Cape York and Torres Strait communities and has more than 10 years' experience working with Indigenous students and their families. Jenny holds a Graduate Diploma in Education and a Master of Education degree. She is currently a Guidance Officer based at Trinity Beach near Cairns and is undertaking PhD studies at Queensland University of Technology, focusing on anxiety and Indigenous youth.

Kimina Andersen

Kimina Andersen is Aboriginal (Cowburn) and Torres Strait Islander (Guivarra). Her maternal heritage is Wuthathi from Cape York and Darnley Island and her paternal heritage is Wakka Wakka outside Brisbane. She is a social worker with over 20 years' experience in Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health. She has worked in community controlled and public sectors and is the State-wide coordinator for Indigenous Forensic Mental Health Queensland. She was a co-investigator on Australia's largest study of the mental health of Aboriginal and Torres Strait Islander Peoples in Custody, *Inside Out*. She has a social justice focus and is keen to ensure that community members who come into contact with mental health and criminal justice systems receive appropriate and culturally sensitive care.

Dr Caroline Atkinson

Dr Caroline Atkinson is of Jiman—Bundjalung heritage and currently lives in New Guinea, undertaking community development work with a focus on trauma and violence. She achieved first class honours from the University of South Australia with a thesis focusing on violence against Aboriginal women. Her PhD in Community Psychology examined Aboriginal male violence and its relationship to generational post-traumatic stress disorder underpinned by a research framework that honours Aboriginal knowledge, epistemology and philosophy. She formed a consultancy service, specialising in mixed-method research. She has a background in teaching Master level Indigenous Studies (Wellbeing) and Community Recovery. She is currently focusing on curriculum development within We Al-li. Caroline sits on the Research Advisory Committee for the National Healing Foundation and is involved in a reference group embedding Aboriginal content within social work degrees nationally.

Professor Judy Atkinson

Professor Judy Atkinson is a Jiman and Bundjalung woman, whose academic work focused on understanding and responding to trauma issues stemming from the violence of colonisation and working towards healing and recovery. Judy is a member of the Harvard Global Mental Health Scientific Research Alliance; serves on the Australian Institute of Health and Welfare Scientific Advisory Committee; the Board of Directors of the Aboriginal and Torres Strait Islander Healing Foundation and is the Patron of the We Al-li Trust. Her academic contributions around trauma and healing of Aboriginal peoples has won her the Carrick Neville Bonner Award in 2006 and the Fritz Redlick Memorial Award for Human Rights and Mental Health from Harvard University 2011. Her book *'Trauma Trails - Recreating Songlines: The transgenerational effects of trauma in Indigenous Australia',* provides context to the life stories of Indigenous people who have been moved from their country.

Dr Sivasankaran Balaratnasingam

Dr Siva Bala undertook his post graduate degree in medicine at UWA. He undertook psychiatric training in Western Australia, half of which was completed in the North West of Australia. He has been the regional psychiatrist in the Kimberley since 2007, working mainly with Aboriginal people and as a consultant psychiatrist at *Headspace* in Broome, providing assessment and treatment of adolescents and youths. He is an adjunct Associate Professor with the School of Psychiatry and Clinical Neurosciences, UWA. Since September 2011, he has been an advisor to the Federal Mental Health Minister, Hon. Mark Butler, as a member of the Australian Suicide Prevention Advisory Council. His clinical and research interests include Aboriginal Mental Health, Intellectual Disability, Telepsychiatry, Safety and Quality in Health Care and Medico-legal Psychiatry.

Associate Professor Dawn Bessarab

Associate Professor Dawn Bessarab is of Bardi and Yindjabarndi descent. She lived and worked in remote, regional and urban settings before settling in Perth. She has extensive experience in Aboriginal child protection, family violence, drug and alcohol misuse, justice and health. Dawn supports the role of social work in the interdisciplinary field to ensure the values, ethics and focus on advocacy and self-empowerment enhance the health sector. Dawn leads the Aboriginal Health Education and Research Unit at the Curtin University Health Innovation Research Institute and is a Chief Investigator on the Centre for Research Excellence in Aboriginal Health and Wellbeing in collaboration with the Telethon Institute, applying a psycho-social/social determinants model in understanding the complex needs of Aboriginal people and developing de-colonising strategies and approaches to improving health outcomes for Aboriginal people and their communities.

Tom Brideson

Tom Brideson is an Aboriginal man who has been actively involved in Aboriginal mental health since 1993 and has published a number of journal articles on issues facing the Aboriginal mental health workforce. He chairs the Aboriginal Advisory Committee of the NSW Centre for Rural and Remote Mental Health and is currently the Chair of the Management Committee of The Mental Health Services Conference (TheMHS). Tom has had a number of appointments to state and national Mental Health and Suicide Prevention Committee's. In 2012, he was appointed to the Board of Indigenous Allied Health Australia and in 2013 he was appointed to the Community Advisory Council of the NSW Mental Health Commission.

Dr Robert Brooks

Dr Robert Brooks was Research Director of the Aboriginal and Torres Strait Islander Healing Foundation conducting research into healing approaches to facilitate Aboriginal and Torres Strait Islander peoples' wellbeing and empowerment. The research focussed on traumatised populations including Aboriginal people, postconflict and refugee populations. Strong statistical skills, including psychometric skills and structural equation modelling, support his work in collaborative research teams. His applied work history developed skills in psychological counselling and group work with a variety of populations, adult education and University teaching. He has developed a program of research based on community level approaches to suicide prevention in Aboriginal and Torres Strait Islander peoples.

Dr Marilyn Campbell

Dr Marilyn Campbell is a Professor in the school of Learning and Professional Studies, Faculty of Education at Queensland University of Technology. She lectures in the Masters of Education and Educational and Developmental Psychology programs preparing teachers for school counselling and psychologists to work in a range of educational and developmental positions. Marilyn has worked as a teacher and psychologist in early childhood, primary and secondary schools. She has also been a teacher–librarian, school counsellor and supervisor of school counsellors. Her research interests are in behavioural and emotional problems in children and adolescents. Her recent work has included research into anxiety prevention and intervention as well as the effects of bullying and especially cyber-bullying in schools. She is the author of the Worrybusters series of books for anxious children.

Maureen Carter

Maureen is a Chief Investigator on the Lililwan Project and Chief Executive Officer of Nindilingarri Cultural Health Services, an Aboriginal community-controlled health organisation in Fitzroy Crossing. She is a Kija and Gooniandi woman from the Kimberley region of Western Australia. Maureen is a founding member of the 'Marulu' Strategy Leadership Team of the Fitzroy Valley. This strategy was developed to address the need for diagnosis and prevention of FASD and to support the parents and carers of affected children. Maureen is Chair of the Fitzroy Valley Futures Forum Health sub-committee and sits on the WA Government's Northern and Remote Health Governing Council. She leads a team of health professionals responsible for delivering health promotion and education throughout remote communities of the Fitzroy Valley.

Wendy Casey

Wendy Casey belongs to the Karajarri and Yawuru people and her extended family reside in the West Kimberley region of Western Australia. She is the Manager of the Aboriginal Alcohol and other Drug Program of the WA Drug and Alcohol Office. For the last 20 years she has specialised in the drug and alcohol field. She has worked within the community-controlled and government sectors, in metropolitan and remote area regions and in a variety of roles that include managing clinical services, policy, workforce development, resource development, community development and research. Wendy is a member of the National Indigenous Drug and Alcohol Committee.

Adele Cox

Adele Cox is a Bunuba and Gija woman from the Kimberley region of Western Australia. She spent her early life in the Kimberley working in media and in suicide prevention. She has worked at the Telethon Institute on Indigenous Suicide Prevention and Maternal and Child Health Research, the WA Aboriginal Child Health Survey and the Centre for Aboriginal Medical and Dental Health at UWA. She is a private consultant in the areas of Aboriginal mental health and medical education. She is a member of the: WA Ministerial Council for Suicide Prevention, Australian Suicide Prevention Advisory Council, Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group, and provides strategic and policy support for the Department of Health and Ageing's (now Department of Health) Aboriginal and Torres Strait Islander Mental Health Advisory Group.

Kathleen Cox

Kathleen Cox is a local business woman whose ancestry connects her to the East and West Kimberley regions of Western Australia. She is a Bard, Gija, Nygkina, Nimanburr and Baiol woman who is passionate about cultural tourism and advocates strongly for the homelands movement of her people (going back to country). She is passionate about working with her people specifically with women and youth. She is always looking for new opportunities on ways her people can become empowered to take control of their own destiny, lead their people towards their own autonomy and develop viable and sustainable communities in which they live. She contributed to *hear our voices* Community Consultations for the Development of an Empowerment, Healing and Leadership Program for Aboriginal people living in the Kimberley, Western Australia.

Dr Kylie Cripps

Dr Kylie Cripps is a senior lecturer at the Indigenous Law Centre, Faculty of Law, University of New South Wales, researching Aboriginal family violence, sexual assault and child abuse including policy development and program/service delivery. She is leading an ARC project called 'Building and supporting community led partnerships to respond to Indigenous family violence in Victoria'. Her PhD thesis was entitled 'Enough Family Fighting: Indigenous Community Responses to Addressing Family Violence in Australia and the United States'. She has taught Aboriginal Health to nursing students and regularly provides policy advice to the Australian and state governments and training and support to professional bodies and organisations dealing with the aftermath of violence.

Tania Dalton (Jones)

Tania Dalton (Jones) is a registered psychologist with a Masters in Health Science and Behavioural Science from Victoria. She has led the development and implementation of the AIPA's Cultural Competence workshop. She works with Aboriginal Communities in the Barwon Southwest region as an Indigenous Family Violence Regional Coordinator. She adapted James MacGuires Cognitive Skills program for Koorie male and female offenders in prison and further adapted it for Koorie community corrections offenders.

Dr Lawrence Dadd

Dr Lawrence Dadd studied medicine at Sydney University and had training experiences with Aboriginal communities on Groote Eylandt, the Royal Darwin Hospital and in northwestern NSW. He trained as a psychiatrist in the Northern Territory and New South Wales, including a role as senior registrar and staff specialist with the 'Remote Team', covering Aboriginal communities of the 'Top End'. From 2010, he worked in a specialised Dual Diagnosis Service. In the Hunter region, he trains doctors in Aboriginal mental health, works on a mentor program for Aboriginal medical students and consults with the Awabakal Aboriginal Medical Service. He is the current Chair of the RANZCP Aboriginal and Torres Strait Islander Mental Health Committee.

Divina D'Anna

Divina D'Anna is a community consultant, born and raised in Broome and has always lived in the Kimberley and worked with Kimberley Aboriginal people at Notre Dame, Broome and Kimberley Land Council. She is passionate about her people feeling empowered to enrich their own lives in their own ways. She was a consultant and contributed to *hear our voices* Community Consultations for the Development of an Empowerment, Healing and Leadership Program for Aboriginal people living in the Kimberley, Western Australia.

Heather D'Antoine

Heather D'Antoine is a Bardi woman from the West Kimberley. She is Associate Director of Indigenous Programs for the Menzies School of Health Research and has over 35 years of experience in the health sector. Her research interest is in maternal and child health with a focus on fetal alcohol spectrum disorders (FASD) and other birth defects. Heather has worked on a number of projects, including describing what health professionals and women know and do about alcohol and pregnancy and FASD. She has been involved with developing and evaluating resources for health professionals and developing a model of care for FASD in WA. In 2007, Heather received the 'Award for Excellence and Commitment in Research' and the Public Health Association of Western Australia Branch Indigenous Health Award in 2009.

Dr James F. Donnelly

Dr James Donnelly trained in the US as a clinical and neuropsychologist assessing and treating people who were coping with mental illness, brain injuries or the stress associated with being from disadvantaged environments. He moved to Armidale, NSW in 2001and worked in the university and community setting with Aboriginal families and children. He was Head of Psychology and Neuropsychology at Sydney Children's Hospital. He is a Lecturer in the School of Health and Human Sciences at Southern Cross University teaching psychology. He presents information about the existence of the *Red Dust Healing* program in his teachings and promotes the delivery of the program in the university setting.

Professor Neil Drew

Professor Neil Drew is Deputy Head of the University of Notre Dame, Broome. He is a social psychologist with over 25 years' experience working with a diverse range of communities. He has worked with Aboriginal communities since beginning his career as a volunteer at the Aboriginal and Torres Strait Islander Medical Service in North Queensland. He was psychologist for the Department of Family Services in Queensland working in far northern and remote Cape York communities. He was Director of the UWA Institute for Regional Development. He is the program head and co-founder of the Aboriginal Youth and Community Wellbeing Program in the East Kimberley, promoting wellness and suicide prevention with young people in communities. The program has received national awards for excellence. He is co-author of *Social Psychology and Everyday Life*.

Cheryl Dunkley

Cheryl Dunkley is a Program Development and Delivery Consultant for the Kimberley Aboriginal Medical Services Council in Broome. Cheryl has been involved with the empowerment of Aboriginal people since the first research consultation back in 2011 where the findings were published in the *hear our voices* report. She then went on to develop the Empowerment, Healing and Leadership program with a number of expert developers across Australia. Since then she has been delivering the empowerment program to Aboriginal communities in the Kimberley since 2012. She contributed to *hear our voices* Community Consultations for the Development of an Empowerment, Healing and Leadership Program for Aboriginal people living in the Kimberley, Western Australia.

Sue Ferguson-Hill

Sue Ferguson-Hill is currently an Educator with One21seventy (Menzies School of Health Research, Brisbane) training health care workers in the application of researched and evidence-based processes for auditing and service development for care given in Aboriginal and Torres Strait Islander Primary Health Care settings. Sue has been a trainer in the use of the Edinburgh Postnatal Depression Scale and has extensive experience in the field of perinatal mental health. Specialising in the management of postnatal stress and depression has been a component of Sue's work in management roles and clinical practice including community-based roles, nursing and midwifery education programs, and health-related programs for Aboriginal Health Workers in communities in New South Wales and Queensland.

Darren Garvey

Darren Garvey was born and raised in Cairns, North Queensland, and his heritage extends to, and reflects, the diversity of the Torres Strait. Darren has a degree in Psychology from James Cook University and postgraduate qualifications in Health Promotion and Education from Curtin University. He is currently enrolled in a PhD in psychology, examining the contested arena of Aboriginal mental health. Darren has spoken both domestically and internationally, and written about 'the need to consider the mental health of Aboriginal health workers', 'Aboriginal youth suicide', 'the role of psychology with Aboriginal people' and 'ethics in psychological research'. In 2000 he contributed to a handbook for psychologists working with Indigenous Australians, and recently published the book *Indigenous identity in contemporary psychology: Dilemmas, developments, directions* (2007) which was shortlisted for the AIATSIS Stanner Award.

Graham Gee

Graham Gee is an Aboriginal man, also with Celtic heritage. His father's family is originally from the Barkly Tablelands, however Graham was born and raised in Darwin. He trained as a school teacher in 1993, teaching in primary and secondary schools before working as a remote community lecturer with the Batchelor Institute of Indigenous Education. In 2002 he began studies in psychology at Melbourne University while also working at Native Title Services Victoria. Since 2008 he has worked as a counsellor at theVictorian Aboriginal Health Services and is undertaking a Masters/PhD in clinical psychology at Melbourne University. The focus of his PhD research is resilience and trauma recovery in urban Koori communities.

Professor Dennis Gray

Professor Dennis Gray is a Deputy Director at the National Drug Research Institute at Curtin University, and a leader of the Aboriginal Research Program. He is an eminent researcher and has a long history of conducting collaborative research with Aboriginal community-controlled organisations. He has published extensively and presented at national and international forums on substance misuse. His recent work focuses on the provision of services and on enhancing options for the management of alcohol and cannabis-related problems. He is a member of the National Indigenous Drug and Alcohol Committee, his research team was awarded the 2006 National Alcohol and Drug Award for Excellence in Research, and in 2010—in recognition of his significant contribution to the alcohol and other drugs field—he was named on the National Drug and Alcohol Honour Roll.

Heather Gridley

Heather Gridley specialises in community, counselling and feminist psychology, professional ethics, and critical history of psychology. Her engagement with community psychology followed her awareness of the limitations of interventions directed solely at individuals. In her 20 years at Victoria University in Melbourne, Heather coordinated one of Australia's two postgraduate programs in community psychology. She held national positions in the APS College of Community Psychologists and Women and Psychology Interest Group, and was a founding member of the Aboriginal and Torres Strait Islander Peoples and Psychology Interest Group. She is currently APS Manager of Public Interest, where she has oversight of psychology's contribution to public debate and policy in the interests of community wellbeing and social justice, including carriage of the APS Reconciliation Action Plan.

Shaan Hamann

Shaan Hamann is a Weilwan and Bidjera woman and her involvement in Aboriginal affairs spans more than two decades. She has worked in government, private and community-controlled sectors in the areas of Native Title, tertiary and community education, and social and emotional wellbeing. Shaan has been involved in the development and implementation of the Marumali Program since it began in 2000. Shaan has a degree in Adult Education and her involvement has included co-facilitation of many Marumali workshops. Shaan is a second generation survivor of forcible removal policies and is currently undertaking an evaluation of the Marumali Program.

Katherine Hams

Katherine Hams is an Aboriginal mental health professional and has worked as a teacher, counsellor and trainer. With more than eight years of management experience in mental health services, she has extensive clinical experience, particularly in Aboriginal communities. Her interests include developing strong recognition and positive promotion of mental health, establishing a stronger link to holistic health, advising on providing culturally specific mental health service and supporting stronger linkages between state mental health services and community based and primary health care providers.

Amanda Hart

Amanda Hart is a Bagala woman from the Jawoyn people of the Katherine region in the Northern Territory. Amanda has an honours degree in psychology and is a registered psychologist. Amanda has extensive experience in working with remote and regional communities across the Northern Territory and South Australia, and has been a School Counsellor with the Northern Territory Department of Education and Children's Services since 2006. Amanda is also a founding member of the AIPA and served as a Steering Committee Member from 2008 to 2012. From 2011 to 2013, Amanda has overseen the development and delivery of AIPA's Cultural Competence workshops.

Jane Havelka

Jane Havelka is a Wiradjuri woman. She is the Clinical Coordinator/Lecturer for the Djirruwang (Mental Health) Program in the School of Nursing, Midwifery and Indigenous Health at Charles Sturt University. She holds Certificates in Aboriginal Teaching and Learning and Wirrudirri Language (TAFE), a Diploma in Aboriginal Health and Community Development (University of Sydney), a Bachelor in Community and Public Health (Charles Sturt University), a Post graduate Certificate in Indigenous Health (University of Wollongong), and a Master of Health Science (Charles Sturt University). In addition, she is a qualified Aboriginal and Torres Strait Islander Mental Health First Aid Instructor and is studying for her Doctor of Health Science and is a newly appointed Director on the Board of Indigenous Allied Health of Australia.

Lorian Hayes

Lorian Hayes is a descendant of the Bidjerra and Wadja peoples of central Western Queensland. Lorian holds degrees in Applied Health Science from the University of Queensland and a Masters in Epidemiology from the Australian National University. Her doctoral research focuses on FASD, Aboriginal family violence, substance misuse, and, being an exponent of Friere's theories, the transfer of knowledge to the underprivileged. Lorian has been actively researching and initiating community-based education programs about FASD in Queensland's Cape York Peninsula and nationally has created an awareness of the plight of children exposed to alcohol in the womb. Lorian co-ordinated a Federal Government initiative, Stronger Families and Community strategy, and is working on developing resources for Rio Tinto's Aboriginal Child Health Partnership Project to address FASD.

Dr Edward Heffernan

Dr Ed Heffernan is the Director of Queensland Forensic Mental Health Services and a Senior Lecturer in Psychiatry at the University of Queensland. He has been involved in the provision of mental health care for people in contact with the criminal justice system for over a decade. He was the founding Director of Queensland's Prison Mental Health Service and helped establish a mental health court liaison service and major watch houses across the state of Queensland. He was the Principal Investigator for Australia's largest study focusing specifically on the mental health status of Aboriginal and Torres Strait Islander peoples in custody. He has helped ensure Forensic Mental Health Services in Queensland assume responsibility for providing culturally sensitive services to individuals, their families and community members.

Darrell Henry

Darrell Henry has worked for 20 years as a psychologist working with Aboriginal people involved in harmful drug and alcohol use, family violence and child sexual abuse. He works with Aboriginal men, women and children in their families and communities, with a focus on healing. Darrell was co-founder of the Yorgum Aboriginal Family Counselling Service in Perth and was one of three panel members tasked with the 2002 Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities. He was an inaugural member of Western Australia's first Child Death Review committee. He continues to train lay Aboriginal community people in working clinically with chronic trauma and in old and modern ways of healing.

Chris Holland

Chris Holland worked for three years as a dedicated solicitor on Trevorrow v South Australia, the first successful claim for damages by a member of the Stolen Generations. From 2002, under the direction of the Aboriginal and Torres Strait Islander Social Justice Commissioner, he worked to develop the human rights framework that underpins the *Close the Gap* Campaign for Aboriginal Health Equality, and managed the Campaign Secretariat from 2006 to 2012 and the Secretariat for the National Health Leadership Forum of the National Congress for Australia's First Peoples in its first year of operation. He now works as a consultant and has written extensively on health and mental health policy.

Victoria Hovane

Vickie Hovane has family links to the Yinjibarndi in the Pilbara and the Kitja and Goondiyandi in the Kimberley. She holds a First Class Honours Degree in Psychology and is completing a PhD (Forensic Psychology) to develop an Aboriginal psychological theory of child sexual abuse. She is a member of the Advisory Panel to the WA FDV Death Review Committee, the Australian Centre for the Study of Sexual Assault (ACSSA) Reference Group, and the APIA. She provides lectures to post-graduate psychology students on Aboriginal cultural values, principles and working effectively with people in relation to mental health issues. She has conducted training on suicide prevention in Aboriginal communities and training for non-Aboriginal mental health professionals on working respectfully with Aboriginal people.

Dr James Huntley

Dr James Huntley is Senior Psychologist at the Southern Area Brain Injury Service based in Goulburn, NSW. James undertook studies in Canada and postgraduate work at University of New England, NSW. He completed his PhD through The Bouverie Centre, La Trobe University, focusing on rural and remote families contending with the challenges of brain trauma. He is Clinical Lecturer, the Research School of Psychology, at the ANU in Canberra teaching the postgraduate course *Introduction to Clinical Neuropsychology* and lectures at the NSW Police Academy. This work is referred to and published in the text *Policing Vulnerability*, in the chapter *Acquired Brain Injury and Vulnerability to the Criminal Justice System*. He is visiting Psychologist to the Rehabilitation Department at Royal Darwin Hospital, with an interest in assessment of cognitive abilities and rehabilitation needs for Aboriginal people.

Len Kanowski

Len Kanowski is a Registered Nurse with qualifications in rural and international mental health. Len was a Harvard University/University of Melbourne International Mental Health Leadership Fellow and a Rowan Nicks Russell Drysdale Fellow. He is currently a Senior Advisor with the NSW Centre for Rural and Remote Mental Health and a Visiting Fellow at the Australian National University National Centre for Indigenous Studies. Len has many years of experience in Aboriginal and Torres Strait Islander mental health and wellbeing as a clinician, educator and health service coordinator. He worked with Aboriginal educators and community leaders to develop the Djirruwang Aboriginal Mental Health Worker Education and Training Program and the National Aboriginal and Torres Strait Islander Mental Health First Aid Training and Research Program.

Kerrie Kelly

Kerrie Kelly has worked with Aboriginal and Torres Strait Islander colleagues in the area of social and emotional wellbeing (SEWB) for nearly 20 years. Projects include documenting an Aboriginal SEWB counselling process and developing and delivering accredited training. She coordinated the Bush Crisis Line and developed a telephone co-counselling model and resources to support remote Aboriginal health practitioners with job-related stress and trauma. She coordinated a national project to encourage help-seeking in Aboriginal communities, including developing a national database of SEWB services. Kerrie supported the Steering Committee to establish the AIPA and to develop and roll out cultural competence training for the mental health workforce. She worked with the Marumali *Journey of Healing* program to improve the quality of support to survivors of forcible removal policies—the Stolen Generations.

Darryl Kickett

Darryl Kickett was an advisor to the Minister for Aboriginal Affairs, Canberra. He worked in policy positions in the National Aboriginal Conference (NAC), the Royal Commission into Aboriginal Deaths in Custody and Foster Care Strategy, and led the Kimberley Land Council in Derby, Centre for Aboriginal Studies at Curtin University and the WA Aboriginal Health Council, was the CEO of Aboriginal Medical Services and a Council Member of the WA Ministerial Council for Suicide Prevention. Currently he is a consultant with Anglicare WA, implementing their Reconciliation Action Plan and assisting to roll out the *Red Dust Healing* Program, as a trained facilitator. He is on the Board of the Gnalla Marmun Moort Boodja Mens Association bringing cultural healing opportunities to men in Nyungar country, aiming to reduce imprisonment rates and the incidence of single parent families. He is Chairperson of the Halo Leadership Development Agency, coaching young Aboriginal men using cultural leadership as a tool for building capacity.

Associate Professor Stuart Kinner

Associate Professor Stuart Kinner is the Principal Research Fellow for Justice Health in the Centre for Health Policy, Programs and Economics (CHPPE), School of Population Health, University of Melbourne. He holds honorary positions at University of Queensland, Monash University and Murdoch Children's Research Institute. He has a PhD in forensic psychology, his research having focused on the health of prisoners and ex-prisoners. He is currently Chief Investigator for NHMRC studies of justice-involved populations in Australia, and for a study of HIV risk among prisoners and ex-prisoners in Fiji. He is lead author of a global systematic review of health-related re-entry programs for prisoners; Co-Convenor of the Justice Health Special Interest Group in the Public Health Association of Australia (PHAA) and serves on the National Prisoner Health Information Committee (NPHIC), guiding development of a world-first national minimum dataset for prisoner health.

Bernard Leckning

Bernard Leckning is the Coordinator of the Suicide Prevention Research Program at the Centre for Child Development and Education in Darwin. He has a background in sociological research. He has worked on a child and youth suicide study in the NT and on the development of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. He is currently involved in a study of deliberate self-harm hospitalisations in the NT which focuses specifically on remote Indigenous populations and on the design, development and piloting of an Indigenous life skills intervention for remote Indigenous communities.

Dr Jane MacLeod

Dr Jane MacLeod is a general practitioner who has worked in Aboriginal communities in Arnhem Land, Central Australia and Gulf Queensland and in rural and urban Aboriginal and Torres Strait Islander health services in NT and QLD. She has worked as an academic for Griffith University School of Medicine assisting with Aboriginal health curriculums. She is passionate about working alongside Aboriginal and Torres Strait Islander health care providers, academics, Elders and community members to provide culturally appropriate and culturally safe health care. She is completing her Masters of Health Professional Education with her thesis exploring use of simulated patients for cultural competency education for health students.

Annette Mageean

Annette Mageean is a maternal descendant of the Pitta Pitta people from Cloncurry region. After serving 22 years in the Australian Defence Force, she commenced study in 2002, graduating at Charles Darwin University with a Bachelor of Social Work (BSW) in 2007 and was awarded "The Centacare NT Award" for Highest Academic Achievement for the BSW program. Her role for the past five years at Amity Community Services Inc., a not for profit Alcohol and Drug Organisation, has been coordinator for a Department and Health and Substance Misuse Delivery Grants funded project 'the Aboriginal and Indigenous Communities Project'. Thr project applies a harm minimisation approach to develop strategies with the community and stakeholders to reduce harms associated with inhalants, alcohol and other drugs in nominated Aboriginal town communities in Darwin.

Professor Rhonda Marriott

Winthrop Research Professor Rhonda Marriott is a senior researcher with expertise in Aboriginal maternal and child health in the Centre for Child Health Research, UWA. As an Aboriginal woman, registered nurse and midwife, Rhonda is proud to be a member of the Congress of Aboriginal and Torres Strait Islander Nurses and to have been awarded Indigenous Nurse/Midwife of the Year at the 2008 Western Australian Nursing and Midwifery Excellence Awards. Rhonda is Patron of a named postgraduate award, sponsored by the Nursing and Midwifery Office, which recognises the achievements and contributions of Aboriginal nurses and midwives and the crucial role that they play in WA Health. Her research and academic interests are in building the capacity of Aboriginal people and communities and increasing their representation in higher education as students, academic staff and researchers.

Elizabeth McEntyre

Elizabeth McEntyre is a Goori woman from the Worimi and Wanaruah Peoples of NSW. An accredited Social Worker and Mental Health Social Worker, she is presently undertaking a PhD in Social Work with the University of NSW, under the supervision of Dr Eileen Baldry, Professor of Criminology. Elizabeth is involved in a national study 'Indigenous Australians with Mental Health Disorders and Cognitive Disabilities in the Criminal Justice System.' This research is directed towards addressing the imprisonment rates of Aboriginal and /or Torres Strait Islander Peoples with mental health disorders and intellectual and other cognitive disability enmeshed in the criminal justice system. Elizabeth's own research, undertaken by, with and for Aboriginal women, focuses on Aboriginal women who are at even greater risk of incarceration due to their vulnerability and lived experiences.

Faye McMillan

Faye McMillan is a Wiradjuri woman from Trangie, NSW. She is the Chairperson of IAHA (Indigenous Allied Health Australia) and Director of the Djirrawang Program (Bachelor of Health Science—Mental Health Program) at Charles Sturt University. Prior to this she worked at University of Wollongong as course coordinator of the Postgraduate Indigenous Health Program. Faye has a Master of Indigenous Health Studies and a Bachelor of Pharmacy. She was the first Aboriginal pharmacist in Australia, graduating in 2001. Her passion is the recruitment and retention of Aboriginal and Torres Strait Islander peoples into health professions and improved teaching of Aboriginal and Torres Strait Islander health in tertiary health courses. Faye has an in depth knowledge of the health and participation needs of Aboriginal and Torres Strait Islander peoples, particularly in relation to mental health and community pharmacy.

Dr Jeff Nelson

Dr Jeff Nelson is the Director of Research and Research Training at Southern Cross University's Gnibi College of Indigenous Australian Peoples. Jeff works as a Research Fellow at James Cook University's School of Indigenous Australian Studies. He gained his undergraduate and postgraduate qualifications from the School of Psychology at UWA. Before commencing his current role, he worked in the health, education and justice sectors in research and community development roles.

Associate Professor Yin Paradies

Associate Professor Yin Paradies is an Aboriginal-Anglo-Asian Australian, raised in Darwin and has lived in Melbourne since 2007. He is a Principal Research Fellow and Co-deputy Director at the Centre for Citizenship and Globalisation, Faculty of Arts and Education, Deakin University. He has qualifications in mathematics and computing (BSc), medical statistics (MMedStats), public health (MPH) and social epidemiology (PhD). His research focusses on the health, social and economic effects of racism as well as anti-racism theory, policy and practice. He has received awards including a 2003-4 Fullbright scholarship at the University of California, Berkeley, the Australia Day Council's 2002 Young Achiever of the Year award for the Northern Territory, Scholar of the Year in the 2007 National NAIDOC Awards and Victorian Young Tall Poppy Science Award in 2011.

Associate Professor Robert Parker

Associate Professor Robert Parker is an Adjunct Associate Professor of Psychiatry at James Cook University and the Northern Territory Clinical School. He initially completed an Arts degree, majoring in Anthropology and Prehistoric Archaeology before working on the Tiwi Islands in the Northern Territory for three years as an Aboriginal art and craft adviser. He then studied medicine and specialised in psychiatry. He has extensive clinical experience of Aboriginal and Torres Strait Islander health and mental health issues. He is past Chair of the Aboriginal and Torres Strait Islander mental health committee for the RANZCP and was also the previous Chair of the Board of Professional and Community Relations for the College. He is the Director of Psychiatry for Top End Mental Health Services in the Northern Territory and is the Consultation-Liaison Psychiatrist for Royal Darwin Hospital.

Lorraine Peeters

Lorraine Peeters (Auntie Lorraine), forcibly removed from family at the age of four is committed to helping others understand the unique experiences of Stolen Generations. She developed and has facilitated the Marumali Program, to support the healing of Stolen Generations since 2000. She was key in the lead-up to the National Apology and presented Kevin Rudd with a glass coolamon, a traditional vessel for carrying children, containing a message thanking the Parliament for the Apology. She was NSW Senior Australian of the Year in 2009, and in 2011 was co-winner of the World Council for Psychotherapy – Sigmund Freud Award and in 2012 won the Deadly Award for Lifetime Contribution Achievement Award for Healing the Stolen Generations.

Tom Powell

Tom Powell is a proud Warramunga Man from within the Wiradjuri Nation. Tom finished school after year 10 and worked in the family earthmoving/road construction business established by his father in 1973. In 1994, he enrolled in a community welfare course at Dubbo TAFE. He spent 14 years with the NSW Department of Juvenile Justice as an Aboriginal Programs Officer. After leaving the Department, he designed and facilitated *Red Dust Healing*, which was further developed in partnership with Randal Ross whom he met while working with Juvenile Justice. *Red Dust Healing* is a cultural healing program derived from an Aboriginal perspective that gives people tools to deal with the rejection in their lives. The program has now been delivered nationally to over 5,300 people.

Professor Debra Rickwood

Professor Debra Rickwood is Professor of Psychology at the University of Canberra where she teaches research methods, developmental and social psychology. She researches factors affecting youth mental health and promotion, prevention and early intervention for mental health. Debra is currently seconded to *Headspace* National Youth Mental Health Foundation as the Head of Research and Evaluation. She is a Fellow of the Australian Psychological Society and member of the APS College of Community Psychologists. She has been involved in mental health and health policy for the Australian Government for over 15 years, and is a member of NHMRC principal committees—the Australian Health Ethics and Health Care Committees. She has a strong commitment to ensuring that research, policy and practice better support the social, emotional, spiritual and cultural wellbeing of Aboriginal and Torres Strait Islander Australians.

Associate Professor Gary Robinson

Associate Professor Gary Robinson is the Deputy Director of the Centre for Child Health and Education at Menzies in Darwin. He is an anthropologist who studied Aboriginal suicide when working on the Tiwi Islands in the 1980s. He has been Program Leader, Social-Emotional Wellbeing in the Cooperative Research Centre for Aboriginal Health; has participated in a number of national advisory forums on Aboriginal health and wellbeing; and been published on suicide and social-emotional wellbeing. He leads the Let's Start Parent-Child Program which has been successfully implemented in the Top End of the Northern Territory. With Sven Silburn, he led a team undertaking national consultations to inform the development of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy on behalf of the Australian Government.

Dr Monique Robinson

Dr Monique Robinson completed her PhD and MPsych (Clinical) degrees at UWA in 2010. Monique is currently Associate Principal Investigator and NHMRC Early Career Fellow at the Telethon Institute and a registered psychologist working in the field of perinatal, child and adolescent mental health. Monique's primary research focus has been on the maternal lifestyle factors during pregnancy that influence mental health throughout childhood and adolescence, including stress, maternal obesity, vitamin D, hypertension, alcohol and cigarette smoking. She has over 30 publications in this area, including peer-reviewed journal articles, book chapters and government reports and has received 21 early career researcher grants and awards to date. She is passionate about early intervention in mental health and is active in translation as an Ambassador for the Telethon Institute.

Randal Ross

Randal Ross has three traditional descendant backgrounds. His Aboriginality is the Bindol and Juru from the Burdekin region, his Torres Strait Island family is from Erub (Darnley Island) and is an Australian South Sea Islander with connections in the communities from Ayr and Bowen. Randal has had a strong background working with government at local, state and federal levels in both Queensland and New South Wales. Much of his work has been related to working with Aboriginal youth and families. He further developed *Red Dust Healing* with Tom Powell and his vision is to restore a vital cultural connection within the family by continuing to work with men such as with the *Red Dust Healing* program.

Dr Meera Roy

Dr Meera Roy lives in the UK and is a consultant psychiatrist for people with intellectual disabilities at Birmingham Community Healthcare, where one–third of the population are from minority communities. She is a Clinical Senior Lecturer in Psychiatry at the University of Birmingham. Her interest in providing culturally sensitive psychiatric services led her on sabbatical to work at Kimberley Mental Health Services in Broome. She became interested in the diagnosis and management of intellectual disability and comorbid conditions in Aboriginal people and has since collaborated with Dr Bala to write papers in Australian and International psychiatry journals on this issue. She has also worked on the impact of Developmental Disorders—Autism and Attention Deficit Hyperactivity and the reproductive rights of women with an intellectual disability.

Kelleigh Ryan

Kelleigh Ryan is a descendant of the Kabi Kabi people of southeast Queensland and the South Sea and Loyalty Islands. She is a registered psychologist, a member of the AIPA, sits on the AIPA steering committee, co-chairs the Australian Psychological Society Aboriginal and Torres Strait Islander Peoples and Psychology Interest Group, is a director on the Indigenous Allied Health Australia Board and holds a position as a Project Officer in the Research team of the Aboriginal and Torres Strait Islander Healing Foundation, focusing on the Intergenerational Trauma projects, the Stolen Generations and the complex evaluation of Healing Programs. Her clinical work involves providing counselling, therapeutic intervention, critical response work and psychoeducation delivery in response to trauma, crisis and mental health. She also currently runs a Social Consultancy practice in Queensland providing supervision for Indigenous workers.

Clinton Schultz

Clinton Schultz is a Gamilaroi man and a registered psychologist, currently employed by Griffith University School of Public Health as Lecturer of Aboriginal and Torres Strait Islander Health. His PhD focusses on researching the risk and protective factors of SEWB for the Aboriginal health workforce. He is a member of the AIPA Steering Committee and director of Marumali Consultations, providing cultural competence auditing and training, cross cultural psychological and business management services and mentoring and supervision. He is author and facilitator of Forming Culturally Responsive Practice, a RACGP accredited cultural competence training package and a lead facilitator and developer of AIPA's cultural competence training for mental health practitioners. His areas of research include SEWB, institutional discrimination, and cultural and interdisciplinary education in tertiary settings.

Dr Clair Scrine

Dr Clair Scrine is a Senior Research Officer at the Telethon Institute, working on a number of project teams involving research and evaluation with Aboriginal communities, including the WA Aboriginal Child Health Survey, Rio Tinto Child Health Partnership, BHP-sponsored Substance Use Reduction project in Hedland and Newman areas of the Pilbara, reviews of the St John of God Health Care *Strong Women, Strong Babies, Strong Culture* program in the Pilbara, the Michael Leslie Pilbara Performing Arts Program, and the Wheatbelt Aboriginal Health Service. She is a member of the research team of '*hear our voices*: Community Consultations for the development of an Empowerment, Healing and Leadership Program for Aboriginal people living in the Kimberley in Western Australia' and '*Kicked to the Curb*: An examination of the critical factors in Aboriginal non-smoking'.

Dr Carrington Shepherd

Dr Carrington Shepherd is a senior analyst at the Telethon Institute, with qualifications in economics and statistics (BEc) and health sciences (PhD). His research focuses on the wellbeing of Aboriginal and Torres Strait Islander Australians, and the use of population-level datasets to examine the social determinants of child and youth health. His research interests include Indigenous identification in linked administrative datasets, and the use of these data to investigate intergenerational determinants of health. He was previously the manager of the National Children and Youth Statistics Unit at the Australian Bureau of Statistics (ABS) and has undertaken a range of statistical consultancy projects prior to commencing a role in research.

Professor Sven Silburn

Professor Sven Silburn leads the program of developmental health, education and wellbeing research at the Menzies School of Health Research in Darwin. He co-directed Curtin University's Centre for Developmental Health at Telethon Institute. He practiced as a clinical psychologist for 15 years with the WA Child and Adolescent Mental Health Service and became involved in Aboriginal mental health when he chaired the WA Ministerial Council for Suicide Prevention's working group on Aboriginal suicide prevention. He was a chief investigator on the WA Aboriginal Child Health Survey, a report on the measurement of mental health problems in Aboriginal children and young people and the first independently verified population data documenting the nature and extent of the intergenerational effects of forced separation in WA. During 2012, he co-led the national consultation process undertaken jointly by Menzies and the National Aboriginal Community Controlled Health Organisations (NACCHO) for the drafting of the 2013–2018 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

Peter Smith

Peter Smith is a registered psychologist and member of AIPA who has worked within forensic settings for the past 13 years. For 14 years he worked in child protection. Most recently he worked within the New South Wales Department of Juvenile Justice as clinical supervisor of the Newcastle Multisystemic Therapy team, which was responsible for an in-home family therapy program designed to support and empower the parents and primary carers of serious repeat young offenders. At the present time he lives in the northwest of New South Wales—Kamilaroi country—from where he traces his cultural origins, and works in private practice in Gunnedah.

Associate Professor Christopher Sonn

Associate Professor Christopher Sonn teaches community and intercultural psychology and qualitative methodologies at the College of Arts at Victoria University, Melbourne. His work aims to contribute to theory, research and practice that make visible practices of racialisation and other forms of exclusion as well as identifying resistant and resilient community responses, central to promoting social change. He explores the sense of community and social identity negotiation from the perspectives of immigrant and Aboriginal people, examines the dynamics of oppression and liberation in the context of intergroup relations and develops critical pedagogy for anti-racism. His work has been published in the *Journal of Community Psychology, Race, Ethnicity and Education* and the *American Journal of Community Psychology*. He co-edited the books *Psychological sense of community: Research, applications and implications* and *Psychology and Liberation: Theory and applications*.

Annalee Stearne

Anna Stearne is a Nyungar woman from Western Australia with a background in education and public health, and has been involved in researching Aboriginal substance misuse since 2001. She has been involved in a number of projects at national, state and local level, the evaluation of local community-based interventions and conducting national studies—such as the identification of the areas of greatest need in Aboriginal substance misuse (2010). In Alice Springs, she worked closely with Tangentyere Council's Research Hub and was a member of the research team that won the National Drug and Alcohol Award for Excellence in Research, and a Curtin University Vice-Chancellor's Award for Excellence. She sits on the board of Palmerston Association. She was awarded the 2012 First People's Award for Excellence in Science and Research by the Australasian Professional Society on Alcohol and other Drugs.

Karen Ugle

Karen Ugle is an Aboriginal psychologist from southwest Western Australia (Balladong and Bibbulmun). Karen moved to Perth to study psychology as a mature-age student and graduated with a Bachelor of Psychology. Karen gained full registration as a psychologist in 2007. She is an Associate Member of the Australian Psychological Society and a member of the AIPA. She has a passion for psychology and counselling for Aboriginal and underpriviledged people. Karen has worked in various departments and organisations as a therapist and cultural consultant. She currently delivers psychological counselling, both in full-time employment and in private practice.

Professor Iain Walker

Professor Iain Walker is a senior scientist with the Commonwealth Scientific and Industrial Research Organisation (CSIRO), where he leads a group of social and behavioural scientists working on sustainability issues. Prior to joining CSIRO, he was a professor of psychology at Murdoch University where he worked since coming to Perth in 1986. He has been researching prejudice and intergroup relations for nearly three decades. He is co-author of *Social Cognition: An integrated introduction* (a third edition of which will soon be available) and co-editor of *Social representations and Identity: Content, process and power and of Relative Deprivation Theory: Specification, development and integration.*

Rosemary Wanganeen

Rosemary Wanganeen describes herself as a Griefologist—one who studies and applies holistic approaches to loss and grief counselling and educational models. Rosemary has been an educator and counsellor for 16 years in addition to the five years she endured healing her own personal suppressed unresolved grief. Her study and research in weaving holistic approaches into a standard mainstream loss and grief model has led to the School of Psychology at University of South Australia awarding her the title of Adjunct Research Fellow. Her passion and commitment to lessen the pain of loss and grief had her involved in a number of research projects. She has presented her work to a range of audiences, both nationally and internationally.

Associate Professor Edward Wilkes

Associate Professor Edward Wilkes is working for the National Drug Research Institute at Curtin University. He has a wide and extensive knowledge of aboriginal health. He was a member of the Working Party that produced the National Aboriginal Health Strategy 1989 and he chaired the working group that produced the Complementary Action Plan for the National Drug Strategy 2003–2009. His work with the Derbarl Yerrigan Health Service (1986–2002) as Director allowed him to advocate for change to bring about necessary gains in health and quality of life for Aboriginal Australians. Ted continues to advocate as an Aboriginal health leader and is particularly focused on alcohol and other drugs and research. He is a member of the Australian National Council on Drugs (ANCD) and Chairperson of the National Indigenous Drug and Alcohol Committee (NIDAC).

Dr Michael Wright

Dr Michael Wright is a Yuat Nyoongar man from Western Australia. He has extensive experience in the area of Aboriginal health and mental health. He has worked as a social worker in an inner-city hospital and was the manager of the first Aboriginal community-controlled service to provide a psycho-social and emotional inreach service to Aboriginal families living with a serious mental illness in the Perth area. His PhD thesis explored the experiences of caregiving for Aboriginal people living with a serious mental illness. He is a Post-Doctoral Research Fellow at Telethon Institute where he is leading the *Looking Forward* Aboriginal Mental Health project, which aims to improve the access and responsiveness of mental health services provided to Nyoongar Aboriginal people.

Professor Stephen Zubrick

Professor Stephen Zubrick is a Winthrop Professor in the Centre for Child Health Research at UWA. He was trained in the USA at the University of Michigan where he completed Masters degrees in speech pathology and audiology, followed by doctoral and postdoctoral work in psychology. Steve worked in Western Australian hospital and outpatient health and mental health settings for many years before commencing his career in research. His research interests include the study of the social determinants of health and mental health in children, language growth and development in infants and young children, and large-scale psychosocial survey work in non-Aboriginal and Aboriginal populations. He chairs the Consortium Advisory Group implementing the Longitudinal Study of Australian Children and is a member of the Steering Committee for the Longitudinal Study of Indigenous Children. He is interested in the translation of psychological and social research findings into relevant and timely policies and actions on the part of governments and private agencies.

The Boatshed Racism Roundtable Declaration

University of Western Australia Boatshed, Nedlands, Perth. 1st and 2nd June 2009

Background

On the 1st and 2nd June 2009, over 40 leading researchers and academics from across Australia met at the University of Western Australia Boatshed in Perth, to discuss research concerning racism towards Aboriginal and Torres Strait Islander Australians.

This Roundtable brought together Aboriginal and Torres Strait Islander and fellow Australian leaders and racism researchers, with the recognition that *high quality research and evidence must be at the heart of our endeavours to inform public policy and everyday practice* in order to understand and combat racism in all its forms. The two-day meeting significantly advanced the themes of social justice and reconciliation in Australian society and has culminated in the production of a detailed statement against racism. The statement is presented as a declaration on racism towards Aboriginal and Torres Strait Islander Australians that is intended to have a significant impact on the social change agenda within our society.

Declaration

We, the undersigned, make this declaration to reassert the rights of Australian Aboriginal and Torres Strait Islander peoples:

- to be acknowledged as the First Nations peoples of Australia; and,
- to be recognised as the legitimate people to take real responsibility for their education, health and wellbeing, with the respectful support of Australian governments.

We believe that for Australia to fulfil its considerable potential for future generations, it must acknowledge the terrible injustice done to Aboriginal and Torres Strait Islander peoples – an injustice that continues to disadvantage all our futures.

We believe that this recognition will be the basis for re-strengthening the Australian national identity to the benefit of all and future Australians.

We believe that a strong and confident national identity is one that begins with its First Nations peoples, their knowledge, heritage, and spiritual connection to the land and seas.

We propose four areas for action:

Constitutional – That there be a preamble to the Constitution that recognises the rights of First Nations peoples, followed immediately by the establishment of a treaty that details a formal agreement between the Australian Government and Aboriginal and Torres Strait Islander peoples, and a framework for national action.

Policy – That policies that affect and impact on Australian Aboriginal and Torres Strait Islander peoples must be based on their full involvement and engagement to ensure appropriate agendas and appropriate levels of resourcing are applied.

Practice – That effective and genuine partnerships with governments and capacity building agendas be recognised as essential pathways to improving the outcomes for Aboriginal and Torres Strait Islander peoples' education, health and wellbeing.

Standards – That all actions must be based on, and be an expression of, the articles in the UN Declaration of the Rights of Indigenous Peoples – particularly Article 3 (the Right to Self Determination) and Article 42 (calling on the states and agencies of the United Nations to implement the Declaration).

The Roundtable, in reviewing research data and evidence, identified some key factors and issues that act as barriers to the progress of Australian Aboriginal and Torres Strait Islander peoples towards improved futures:

- Racism against Aboriginal and Torres Strait Islander peoples exists in various forms and in all systems in Australia today.

- Racism has a destructive impact on Aboriginal and Torres Strait Islander peoples' education, health and wellbeing, well beyond its immediate impact.

- Racism works strongly against all agendas which aim to close the gaps in health and other outcomes between Aboriginal and Torres Strait Islander peoples and other Australians.

We call upon the Prime Minister and the First Ministers of Australia to initiate a new national plan of action beginning with:

1. Constitutional protection against racial discrimination;

2. The reconsideration of the methods of the Northern Territory intervention to better reflect the aspirations for and of Aboriginal and Torres Strait Islander peoples, while maintaining any gains that have been made; and,

3. The formal recognition of the capacity and the right of Aboriginal and Torres Strait Islander peoples to self-determine their futures.

Our key principle for a plan of action is simple: We believe that the future happiness and wellbeing of *all Australians* and their future generations will be enhanced by valuing and taking pride in Australian Aboriginal and Torres Strait Islander peoples—the oldest living cultures of humanity.

A print version of the Boatshed Declaration, including the names of participants who were signatories to the Declaration, is available from: http://www.aida.org.au/pdf/statements/NationalRoundtableDeclaration.pdf.

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'It will surely mark another watershed in this ever-growing field, and it is my hope that it not only continues to inform mental health policy and practice in Australia to the benefit of Aboriginal and Torres Strait Islander peoples, but that all Australians benefit from the understanding of Aboriginal and Torres Strait Islander peoples that it provides.'

Dr Tom Calma AO
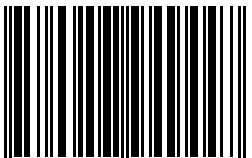*Chair, Reconciliation Australia; Chancellor, University of Canberra*

'The expansion of this new edition to include a greater focus on children and young people, the significant impacts of mental health in the justice system and the cultural determinants of social and emotional wellbeing is welcomed. The knowledge contained in this book directly supports the Government's efforts to address the underlying causes of the disadvantages many Aboriginal and Torres Strait Islander people face.'

Senator the Honourable Nigel Scullion
Minister for Indigenous Affairs