

Working Together:

Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice



Editors: Nola Purdie, Pat Dudgeon and Roz Walker
Foreword by Tom Calma

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

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Australian Government
Department of Health and Ageing



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The views expressed in this publication are those of the individual authors and do not necessarily represent 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.

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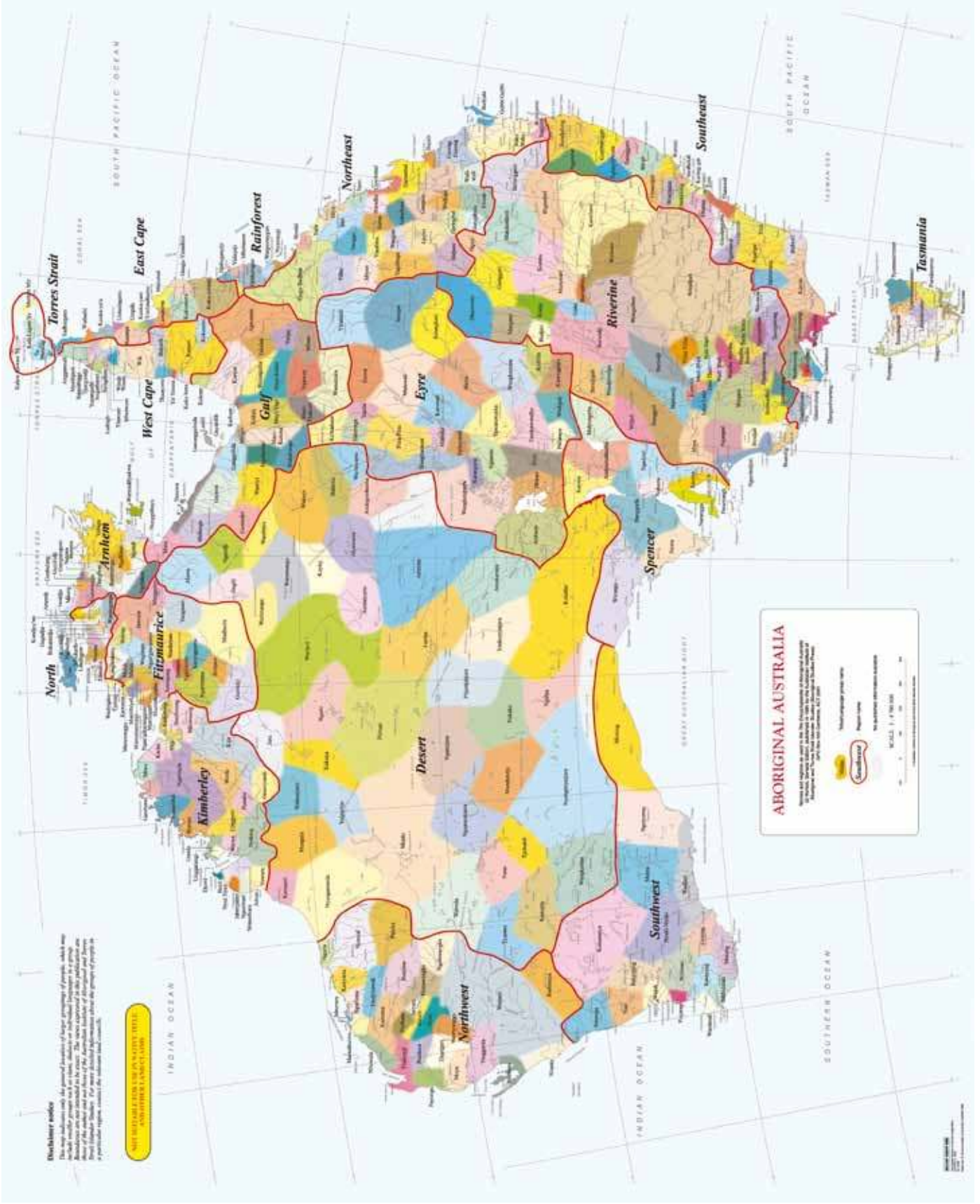
"Throughout life we go through many life changing events and experiences. Sometimes, these are so we can learn lessons, other times during great adversity these experiences can really test our strength. At these times, we must ask our Spirits to guide and support us – for they are always there, just within reach to give us strength and clarity. We must trust the spirits for they have travelled their journeys before us and are wise to the ways of the world – we have much to learn and gain from them, to allow ourselves strength of spirit also."

Jonelle (Nellie) Green was born in Morawa, Western Australia. Nellie's people are the Badimaya people (Yamatji mob) who were traditionally located east of Geraldton. She is the fourth eldest in her family with two brothers and three sisters. Nellie has worked in Indigenous Higher Education for over 15 years and is Manager of Indigenous Student Services at La Trobe University, Melbourne. She is a graduate of Curtin University, Perth, and undertook her Honours year in 2009. She is also an Aboriginal artist and is a keen activist involved with Indigenous social justice and human rights issues.

Other artwork is reprinted with permission of Women's Health Goulburn North East. The six paintings are from the Making Two Worlds Work Project developed by Mungabareena Aboriginal Corporation and Women's Health Goulburn North East, 2008. They depict aspects of Aboriginal health and wellbeing. The themes are: spiritual and mental health, kinship and family, culture and identity, physical health, practical support and understanding, and partnerships with health and community agencies.

http://www.whealth.com.au/ourwork/mtww/mtww_posters.html

Map of Aboriginal Australia



Contents



Foreword	vii
Message from the Minister	ix
Acknowledgments	x
Contributors	xii
Abbreviations	xxiv
Introduction	xxvi
Part 1: History and Contexts	1
1 Australian Aboriginal and Torres Strait Islander Mental Health: An Overview	3
<i>Robert Parker</i>	
2 A History of Psychology in Aboriginal and Torres Strait Islander Mental Health	13
<i>Debra Rickwood, Pat Dudgeon and Heather Gridley</i>	
3 The Social, Cultural and Historical Context of Aboriginal and Torres Strait Islander Australians	25
<i>Pat Dudgeon, Michael Wright, Yin Paradies, Darren Garvey and Iain Walker</i>	
4 The Policy Context of Aboriginal and Torres Strait Islander Mental Health	43
<i>Stephen R. Zubrick, Kerrie Kelly and Roz Walker</i>	
Part 2: Issues of Aboriginal and Torres Strait Islander Mental Health and Wellbeing	63
5 Mental Illness in Aboriginal and Torres Strait Islander Peoples	65
<i>Robert Parker</i>	
6 Social Determinants of Aboriginal and Torres Strait Islander Social and Emotional Wellbeing	75
<i>Stephen R. Zubrick, Pat Dudgeon, Graham Gee, Belle Glaskin, Kerrie Kelly, Yin Paradies, Clair Scrine, and Roz Walker</i>	
7 Preventing Suicide among Indigenous Australians	91
<i>Sven Silburn, Belle Glaskin, Darrell Henry and Neil Drew</i>	
8 Anxiety and Aboriginal and Torres Strait Islander Young People	105
<i>Jenny Adermann and Marilyn A. Campbell</i>	
9 Substance Misuse and Mental Health among Aboriginal Australians	117
<i>Edward Wilkes, Dennis Gray, Sherry Sagers, Wendy Casey and Anna Stearne</i>	

10	Trauma, Transgenerational Transfer and Effects on Community Wellbeing <i>Judy Atkinson, Jeff Nelson and Caroline Atkinson</i>	135
11	Indigenous Family Violence: Pathways Forward <i>Kyllie Cripps</i>	145
Part 3: Mental Health Practice		155
12	Working as a Culturally Competent Mental Health Practitioner <i>Roz Walker and Christopher Sonn</i>	157
13	Communication and Engagement: Urban Diversity <i>Pat Dudgeon and Karen Ugle</i>	181
14	Issues in Mental Health Assessment with Indigenous Australians <i>Neil Drew, Yolonda Adams and Roz Walker</i>	191
15	Reviewing Psychiatric Assessment in Remote Aboriginal Communities <i>Mark Sheldon</i>	211
16	Promoting Perinatal Mental Health Wellness in Aboriginal and Torres Strait Islander Communities <i>Sue Ferguson-Hill</i>	223
Part 4: Working with Specific Groups: Models, Programs and Services		243
17	Ngarlu: A Cultural and Spiritual Strengthening Model <i>Joe Roe</i>	245
18	Principled Engagement: Gelganyem Youth and Community Well Being Program <i>Maria Morgan and Neil Drew</i>	253
19	Dealing with Loss, Grief and Trauma: Seven Phases to Healing <i>Rosemary Wanganeen</i>	267
20	The Marumali Program: An Aboriginal Model of Healing <i>Lorraine Peeters</i>	285
21	Mental Health Programs and Services <i>Gina Milgate</i>	293



Foreword

I welcome the publication of *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* as an important contribution to the ongoing struggle for the achievement of health equality between Indigenous and non-Indigenous Australians, and I thank the Australian Government for funding and initiating the project under the 2006 \$1.9 billion COAG Mental Health Initiative.

This book stands to make an enormous contribution to the mental health of Indigenous Australians, for so long a subject bedevilled by the inappropriate application of non-Indigenous models of mental health, models that so often failed to account for our unique experiences and the significantly higher burden of poor mental health found in our communities.

Indeed, for many years there have been calls for new approaches to Indigenous mental health that identify and acknowledge what makes us different from non-Indigenous Australians—the resilience that our cultures give us on one hand, and, on the other, the collective experience of racism, the disempowerment of colonisation and its terrible legacy, and the assimilationist policies that separated us from our families, our culture, our language and our land. This book is to be welcomed for meeting this long overdue need.

I am particularly pleased that the editors— Nola Purdie, the Australian Council for Education Research and Pat Dudgeon and Roz Walker, the Telethon Institute for Child Health Research—ensured that Indigenous mental health experts led the development of each chapter to ensure that Indigenous voices are heard, loud and clear, in its pages.

Designed for practitioners and mental health workers, as well as students training to be mental health workers, I am confident that the publication of *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* marks a watershed in the treatment of Indigenous mental health issues.

I urge all students of health and education to read this book to gain a real appreciation of the issues that may confront you when working with Indigenous people wherever they live in Australia.

This publication stands to make a substantial contribution to the achievement of Indigenous health equality in Australia as we move into the 21st century. I commend it to you.

Tom Calma

*Former Aboriginal and Torres Strait Islander Social Justice Commissioner
2010*



Message from the Minister



I am pleased to show my support for this pioneering book '*Working Together - Aboriginal and Torres Strait Islander Mental Health and Wellbeing, Principles and Practices*'.

This exciting new resource will prepare students and practitioners across a range of allied health professions to meet Indigenous mental health needs when working in mainstream and Aboriginal Medical Services.

Embracing the principles and practices in this book will help the health workforce play its part in achieving the commitment by all Australian governments to closing the life expectancy gap between Indigenous and non-Indigenous Australians within a generation.

The chapters within this book provide compelling evidence to show that just as addressing the health gap requires simultaneous effort in housing, education and employment; improving Indigenous wellbeing means tackling more than just physical illness.

Around 70 per cent of Indigenous deaths occur before the age of 65, compared with 21 per cent among non-Indigenous Australians, and so many early deaths tear at the fabric of a community and have lasting impacts on the mental, social and cultural health of a family.

Initiatives to grow and support the Indigenous health workforce and improve the social and emotional wellbeing and mental health of Indigenous communities are vital to efforts to reduce Indigenous disadvantage.

The book provides the reader with exposure to strong views relating to social and emotional wellbeing and mental health. I hope it will stimulate interesting discussion amongst students and practitioners of Indigenous mental health and wellbeing.

I commend the mental health experts who have contributed their invaluable knowledge and experience within these pages and I look forward to working with future health practitioners and mental health workers as they take up their careers improving the health of Aboriginal and Torres Strait Islander people.

The Hon Warren Snowdon MP

Member for Lingiari

Minister for Indigenous Health, Rural and Regional Health & Regional Services Delivery

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Contributors



Yolonda Adams

Yolonda Adams is an Aboriginal psychologist and a Larrakia woman. She is from Darwin in the Northern Territory and comes from a very large extended Indigenous family. Yolonda graduated from Charles Darwin University in 1999 and became a fully registered psychologist in 2002. She is a member (and a steering committee member) of the Australian Indigenous Psychologists Association.

Yolonda has worked in the public and private sector and has most recently worked with Mental Health Services where she provided a service to clients in a community setting who have serious mental illness and complex needs, including assessments of risks and needs to assist in developing care plans. She has many years of clinical experience with a diversity of clients, with significant experience working with Indigenous clients from urban, rural and remote communities in various employment positions. Yolonda is particularly committed to providing culturally appropriate practice in assessment and intervention of Indigenous people's wellbeing, especially in the area of mental health.

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.

Dr Caroline Atkinson

Caroline Atkinson currently lives in Papua New Guinea, undertaking community development work with a focus on trauma and violence. Her Bachelor of Social Work at the University of South Australia achieved first class honours, with a thesis focusing on violence against Aboriginal women. She then completed a placement in Tamil Nadu, India, researching the specific issues and needs of adolescent girls. Following this she headed a small team at a drug and alcohol rehabilitation centre in Katherine, NT, before completing her PhD in Community Psychology focusing on Aboriginal male violence and its relationship to generational post-traumatic stress disorder. While completing her PhD, Dr Atkinson formed Caroline Atkinson Consultancy Services, specialising in multi-method research approaches with a focus on violence and trauma issues. In the course of her career Dr Atkinson has written numerous papers for various organisations and publications and her PhD is due to be published in book form in 2010. Caroline is the daughter of Professor Judy Atkinson, renowned for her work in trauma and family violence in Aboriginal Australia. She is married to David and has a daughter and son who are twins.

Professor Judy Atkinson

Professor Judy Atkinson identifies as a Jiman/Bundjalung woman who also has Anglo-Celtic and German heritage. With a PhD from Queensland University of Technology, her primary academic and research focus is in the area of violence and relational trauma, and healing for Indigenous and indeed all peoples. Having developed a Diploma in Community Recovery, an undergraduate degree in Trauma and Healing, a Masters in Indigenous Studies (wellbeing), and a Professional Doctorate in Indigenous Philosophies, she is presently focused in her role as Director of the Healing Circle (Collaborative Indigenous Research Centre for Learning and Educare). The centre links community and university, building pathways between teaching and research, with a belief that the science of teaching must have a research base, that research can result in a practice based on evidence, and hence influence evidence-based policy for better outcomes for Indigenous and indeed all Australians. Judy is a member of the Indigenous Clearinghouse Secretariat of the Scientific Reference Group of the Australian Institute of Health and Welfare.

Dr Marilyn Campbell

Dr Marilyn Campbell is an associate professor in the school of Learning and Professional Studies, Faculty of Education at Queensland University of Technology. She currently lectures in the Masters of Education program preparing teachers for school counselling and in the Masters of Educational and Developmental Psychology preparing 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.

Wendy Casey

Mrs Casey belongs to the Karajarri and Yawuru people and her extended family reside in the West Kimberley region of Western Australia. She is currently 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. Mrs Casey is a member of the National Indigenous Drug and Alcohol Committee.

Dr Kyllie Cripps

At the time of writing this chapter Kyllie Cripps was an Indigenous research fellow with the Onemda Vic Health Koori Health Unit, Centre for Health and Society at the University of Melbourne. She has since accepted a senior lectureship at the Indigenous Law Centre, Faculty of Law, University of New South Wales. Dr Cripps's research interests include issues relating to Indigenous family violence, sexual assault and child abuse including policy development and program/service delivery. She is currently 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'. In addition to her research Kyllie has taught Aboriginal Health to nursing students and regularly provides policy advice to the Australian and state governments. She also provides training and support to professional bodies and organisations dealing with the aftermath of violence.

Professor Neil Drew

Neil Drew is Head of Behavioural Science and Dean of Arts and Sciences at the University of Notre Dame Australia (UNDA). He is a social psychologist with over 25 years' experience working with a diverse range of communities and groups. He has worked with Aboriginal and Torres Strait Islander communities since beginning his career as a volunteer at the Aboriginal and Torres Strait Islander Medical Service in far North Queensland. He was psychologist for the Department of Family Services in Queensland. Before joining UNDA Professor Drew was Director of the University of Western Australia Institute for Regional Development. At UNDA he is the program head and co-founder of the *Aboriginal Youth and Community Wellbeing Program* in the East Kimberley, established in 2006. The Program is funded by the Gelganyem Aboriginal Trust and promotes wellness and suicide prevention for young people in East Kimberley Aboriginal communities.

Associate Professor Pat Dudgeon (author and editor)

Dr Pat Dudgeon is from Bardi and Gija people of the Kimberley. She went to Perth to study psychology and afterwards joined the Centre for Aboriginal Studies at Curtin University of Technology. She was appointed as the Head of the Centre for Aboriginal Studies at Curtin and provided leadership in Indigenous higher education for some 19 years. Dr Dudgeon has also had significant involvement for many years in psychology and Indigenous issues. She was the first convenor of the Australian Psychological Society Interest Group, Aboriginal Issues and Aboriginal People and Psychology, and has been instrumental in convening many conferences and discussion groups at national levels to ensure that Indigenous issues are part of the agenda in the discipline. She has many publications in this area and is considered one of the 'founding' people in Indigenous psychology. She was the chief editor and major contributor of *Working With Indigenous Australians: A Handbook for Psychologists* (2000, Gunada Press). She is the current Chair of the Australian Indigenous Psychologists Association and advisory member on the Public Interest Advisory Group of the Australian Psychological Society (APS). She was also awarded the grade of Fellow in the APS in 2008. Pat Dudgeon is actively involved with the Aboriginal community and social justice issues for Indigenous people. She has participated in numerous community service activities of significance, was a member of the Parole Board of Western Australia for several years, and was a psychologist in the defence forces. She recently completed her PhD in psychology. She was appointed as an adjunct associate professor with the School for Indigenous Studies at the University of Western Australia and worked as a consultant. In 2009 she was awarded a three-year post-doctoral fellowship to undertake research with Aboriginal and Torres Strait Islander women on women's leadership.

Sue Ferguson-Hill

Sue Ferguson-Hill is currently the Western Australian Project Manager and Senior Research Officer for the Australian Early Development Index (AEDI) Indigenous Adaptation Study based at the Telethon Institute for Child Health Research in Perth. Sue is also a trainer in the use of the Edinburgh Depression Scale and has extensive experience in the field of perinatal mental health, as well as being a long-term member of the Australian Association for Infant Mental Health. During the course of a diverse midwifery and nursing career Sue completed a Masters in Midwifery, pursuing an interest in postnatal depression through research, health subjects, and as a component of a final thesis.

Management roles and clinical practice in a community-based Family Care Centre in Sydney saw a specialisation in the management of postnatal stress and depression in a community setting. As a Nurse Educator at the College of Nursing in Sydney, Sue managed education programs in Child and Family Health Nursing and Midwifery and participated in training programs for Aboriginal Health Workers in communities in New South Wales and

Queensland. Sue moved to the Kimberley in Western Australia in 2000 to undertake clinical practice in Child and Family Health Nursing based in community health, providing the service to Aboriginal communities in the West Kimberley over a period of six years.

Further study through a Masters in Public Health and Tropical Medicine continued a special interest in the identification and management of perinatal stress and depression in Aboriginal and non-Aboriginal women living in remote settings, viewed from the perspective of a public health issue, and noting the significant effects of perinatal stress and depression on families and communities.

Darren Garvey

Darren Garvey was born and raised in Cairns in northern Queensland, and his heritage extends to and reflects the diversity of the Torres Strait. Darren has a degree in Psychology from James Cook University of North Queensland and postgraduate qualifications in Health Promotions and Tertiary Education from Curtin University of Technology. For the past 15 years he has worked at the Centre for Aboriginal Studies at Curtin, now lecturing in the Indigenous Australian Cultural Studies Program. He is presently pursuing his PhD on how mental health professionals, students and Indigenous people construct the arena of Indigenous mental health and negotiate their participation in it. In 2000 he helped edit and contribute to a handbook for psychologists working with Indigenous Australians, and recently published *Indigenous identity in contemporary psychology: Dilemmas, developments, directions* (2007, Thomson), which was shortlisted for the AIATSIS Stanner Award. Darren is a devoted family man and the proud father of Oliver and Elliot.

Graham Gee

Graham Gee is a descendant of the Garawa nation and grew up in Darwin. Originally trained as a schoolteacher in 1993, Graham taught Physical Education internationally in the United Kingdom before working with Indigenous students in northern New South Wales and with the Batchelor Institute of Indigenous Education as a remote community lecturer in the Northern Territory.

In 2000 he realised that he was most passionate about trying to understand how people navigated their own healing processes, and he was inspired to learn more about the similarities and differences in the way Aboriginal Australians experienced and overcame adversity compared to other cultures. Graham began his studies in Psychology at Melbourne University in 2002, while also working part-time at Native Title Services Victoria. His role there involved coordinating native title meetings for Victorian Traditional Owner groups, and he gained particularly valuable experience while assisting the Victorian Traditional Owner Land Justice Group to engage in (ultimately successful) negotiations with the Victorian Government to jointly develop a Statewide Native Title Settlement Framework.

In 2008, Graham began working as a counsellor at the Victorian Aboriginal Health Services, while also undertaking a combined Masters/PhD in Clinical Psychology at Melbourne University. His work at the Victorian Aboriginal Health Services primarily involves counselling clients who have experienced trauma, grief and loss. The focus of his PhD research is on trauma and resilience in urban Koori communities. Currently Graham sits on the steering committee of the Australian Indigenous Psychologists Association, and on Stolen Generation Victoria's Partnerships in Healing advisory committee.

Belle Glaskin

Belle Glaskin is a Nyungar-Bibbulmun woman from the south-west of Western Australia, and she is also a clinical psychologist (Registrar).

Belle completed a Bachelor of Arts with Honours in Psychology at the University of Western Australia in 2006. During her undergraduate years she was heavily involved in the

Western Australian Student Aboriginal Corporation, and was the Aboriginal and Torres Strait Islander Representative on the UWA Guild Council in 2004. In 2007, Belle was awarded the inaugural Bendi Lango Foundation Bursary, which was established by the Australian Psychological Society to support Aboriginal students in the completion of postgraduate studies in psychology. She completed her Master of Psychology (Clinical) at Curtin University of Technology in 2009. Her Masters thesis explored the role of social and emotional wellbeing in Aboriginal students' school success in a Western Australian school-based resiliency program.

Belle has worked with Aboriginal people and the Aboriginal community in a range of areas including the government and private sectors, not-for-profit organisations, and voluntary work. Her areas of professional interests include Aboriginal mental health, social and emotional wellbeing, resiliency, trauma and healing, grief and loss, suicide prevention and post-vention.

Professor Dennis Gray

Dennis Gray is Professor and Deputy Director of the National Drug Research Institute at Curtin University of Technology, where he heads the Institute's Indigenous Australian Research Program. He has conducted research projects on Indigenous health in general and Indigenous substance misuse in particular and is author of numerous publications in those areas. He is particularly concerned with collaborative research and building Indigenous research capacity. Professor Gray's research has had practical outcomes for Indigenous people at the local, state and territory, and national levels; and he is a member of the National Indigenous Drug and Alcohol Committee - a committee of the Australian National Council on Drugs and the peak advisory body on Indigenous substance misuse. In 2006, his research team won the National Drug and Alcohol Award for Excellence in Research and a Curtin University Vice-Chancellor's Award for Excellence.

Heather Gridley

The middle of three sisters in a predominantly Irish-Australian family, Heather Gridley's upbringing in an inner northern suburb of Melbourne revolved around her family, the parish church and her neighbourhood. Her sociopolitical consciousness gathered momentum during the 1970s and since the 1980s has explicitly encompassed feminism and anti-racism. Heather's areas of specialist knowledge include community and feminist psychology, professional ethics, critical history of psychology, psychology and social justice. Her interest in community psychology stemmed from her work in community health, where she became aware of the limitations of interventions directed solely at individuals.

Heather coordinates one of Australia's two postgraduate programs in Community Psychology, at Victoria University, Melbourne. She has held national positions in both the APS College of Community Psychologists and Women and Psychology Interest Group, and she was a founding member of the Aboriginal and Torres Strait Islander Peoples and Psychology Interest Group. She has served two terms on the APS Board of Directors, and is currently also working at the APS as Manager, Public Interest, where she has oversight of psychology's contribution to public debate and policy in the interests of community wellbeing and social justice.

Darrell Henry

Darrell Henry has worked 20 years as a psychologist, predominantly in the areas of drug and alcohol abuse, Aboriginal 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's Aboriginal grandmother country is with the Wunmulla people from the Canning Stock route in desert Western Australia. Darrell was co-founder of the Yorgum Aboriginal Family Counselling Service (established 1994, in Perth) with a small group of senior Aboriginal grandmothers, and served for periods as Manager and Clinical Director. Darrell 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, and a member of the advisory committee for the 2007 Structural Review of the WA government department responsible for child protection. He was an inaugural member of Western Australia's first Child Death Review committee. He is a former Deputy Chair of the WA Ministerial Advisory Council on Child Protection. Darrell has worked throughout regional Western Australia and currently works as a clinician in Warmun and Narrogin. He continues to train lay Aboriginal community people in working clinically with chronic trauma and in old and modern ways of healing.

Kerrie Kelly

Kerrie Kelly is a non-Indigenous psychologist who has worked for more than a decade with Aboriginal and Torres Strait Islander colleagues in the area of social and emotional wellbeing, which exists in a context of collective and transgenerational trauma. To develop cultural competence in this area, Kerrie entered into mentoring relationships with Aboriginal elders which continue today. Projects have included documenting an Indigenous counselling process and developing accredited counsellor training to reflect this; developing cross-cultural training for mental health practitioners and a co-counselling model to support remote Indigenous health practitioners to cope with job-related trauma. Kerrie has worked with the Marumali Journey of Healing program for many years, which aims to improve the quality of support available to survivors of Stolen Generation policies. More recently, Kerrie coordinated a national project to identify mental health services which encouraged help-seeking in urban, regional and remote Indigenous communities. Kerrie is currently working to support the steering committee of Indigenous psychologists to establish and develop the Australian Indigenous Psychologists Association.

Gina Milgate

Gina Milgate is an Aboriginal woman from the Kamilaroi and Wiradjuri clans of New South Wales. Gina has an undergraduate and postgraduate degree in marketing and management and a teaching degree in higher education. She is currently working at the Australian Council for Educational Research in the area of Indigenous education. Gina's background in education, marketing and management has helped her contribute widely to the community, in particular through projects that create awareness, educate and inform key stakeholders, empower Indigenous students, and promote social awareness. In her role at ACER and through her participation in Indigenous affairs, Gina contributes to programs and policies at local, state and national levels that contribute to making a difference and improving outcomes for Indigenous people. Before her appointment at ACER, Gina was an academic at the University of New England for six years where she was teaching and researching in the subject areas of Indigenous organisational management, marketing, strategic planning and management, organisational behaviour and principles of management. She has also facilitated workshops with students in the areas of motivation, building confidence, goal-setting, career-planning, health and wellbeing, and has consulted with organisations. Gina is also working with *Mindmatters* in delivering their social and emotional wellbeing professional development workshops for schools and community groups and stakeholders that have a focus on Indigenous people and culture.

Maria Morgan

Maria Morgan was born in Broome, of Yawuru (Karajarri/Bunuba) heritage, and was raised in Wyndham. She was a Kimberley Development Commission Board member from 1996 to 2002 and was a founding member of the Wyndham Aboriginal Medical Service. Maria was also part of the Argyle Agreement negotiations and is currently Co-Chair of the Gelganyem Trustee Board. In addition she has served for many years on numerous community boards and committees including Ngnowar Aerwah, Joorook Ngnarni and Garduwar. With her husband Colin, she is proprietor of Wundargoodie Aboriginal Safaris and an inaugural member of the WA Indigenous Tourism Operators Committee State Board. In 2006 she founded the Youth and Community Wellbeing Program as a partnership with the University of Notre Dame Australia.

Dr Jeff Nelson

Jeff Nelson is the Director of Research and Research Training at Southern Cross University's Gnibi College of Indigenous Australian Peoples. Jeff gained his undergraduate and postgraduate qualifications from the School of Psychology at the University of Western Australia before working in various locations in various roles in rural and remote communities. Before commencing his current role, Jeff worked in the health, education and justice sectors in research and community development roles. He is primarily focused on developing and using cognitive assessment tools to inform programs that achieve sustained health and educational benefits for Aboriginal and Torres Strait Islander people. Dr Nelson is also working with Gnibi and its partnering communities to develop a model of community engagement that empowers and supports the positive changes that come from the upskilling of local people.

Dr Yin Paradies

Dr Paradies is an Aboriginal-Anglo-Asian, born in Darwin, who has lived in Melbourne since 2007. He is a Research Fellow jointly at the Menzies School of Health Research and the University of Melbourne. He has qualifications in mathematics and computing (BSc), medical statistics (MMedStats), public health (MPH), and social epidemiology (PhD). Yin's research focuses on the health, social and economic effects of racism together with anti-racism theory, policy and practice for Indigenous Australians as well as migrants/refugees and their descendants. He also teaches short courses in anti-racism and diversity to researchers and professionals in Indigenous and multicultural affairs. Dr Paradies has received a range of awards including a Fulbright scholarship to study at the University of California, Berkeley, the Australia Day Council's 2002 Young Achiever of the Year award, and Scholar of the Year in the 2007 National NAIDOC Awards.

Associate Professor Robert Parker

Robert Parker is an Adjunct Associate Professor of Psychiatry at James Cook University and the Northern Territory Clinical School. Associate Professor Parker 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 went on to study medicine and specialise in psychiatry. In the course of his medical and psychiatric career he has had extensive clinical experience of Aboriginal and Torres Strait Islander health and mental health issues. Associate Professor Parker is past chair of the Aboriginal and Torres Strait Islander mental health committee for the Royal Australian and New Zealand College of Psychiatrists and was also the previous Chair of the Board of Professional and Community Relations for the College. He is married to Gregoriana, a Tiwi Aboriginal Health Worker, and they have three daughters.

Lorraine Peeters

Like many Aboriginal and Torres Strait Islander children of her generation, Auntie Lorraine Peeters was forcibly removed from her family at the age of four and placed in an institution. Through the healing journey necessitated by this traumatic event, she became involved with helping others from the Stolen Generation. She developed the Marumali model of healing and in response to great demand she established a healing program called Winangali Marumali in 2000, to support survivors of the Stolen Generation. Participants are empowered by the workshop and its model of healing. The program works in tandem with Link-Up, which allows Indigenous people to trace lost family members, and Bringing Them Home counsellors. Recognising that those removed from their families are twice as likely to have been arrested, she also established the Marumali program in Victorian prisons. Since 2002, more than 1000 participants have completed the program. Auntie Lorraine Peeters also played an important role in the National Apology given by the Prime Minister in 2008 to the Stolen Generations. Following the apology, she presented the Prime Minister with a glass coolamon, an Indigenous vessel for carrying

children, to thank him for offering the apology. Auntie Lorraine Peeters has had a profound impact on helping members of the Stolen Generation to heal.

Dr Nola Purdie (editor)

Nola Purdie is a Principal Research Fellow and Coordinator of Indigenous Education Research and Development at the Australian Council for Educational Research. She is an Adjunct Professor at the Queensland University of Technology where she was previously coordinator of research methods and educational psychology courses, and Director of the Centre for Cognitive Processes in Learning. Before commencing a career in educational research, Nola worked in state, Catholic, and independent schools in Western Australia in a variety of teaching and administrative capacities for over 20 years. She was the 2003 recipient of the Australian Association for Research in Education Award for Excellence in Indigenous Research. Nola's work in Indigenous education and related areas is guided by a social justice perspective, a valuing of diversity, and a desire to promote informed policy and practice.

Dr Debra Rickwood

Debra Rickwood is Professor of Psychology and Head of Department at the University of Canberra, where she teaches research methods, developmental and social psychology. She researches in the areas of youth mental health and help-seeking, and promotion, prevention and early intervention for mental health. Debra is a member of the APS College of Community Psychologists and is active in the society through membership of the Public Interest Advisory Group and the Climate Change Reference Group. She has been involved in developing mental health and health policy for the Australian Government, including being the consultant writer of the *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health* (2000) and the *National Chronic Disease Strategy* (2006). It is through these initiatives that Debra has developed a growing interest in the impact of policy on the health and social, emotional, spiritual and cultural wellbeing of Aboriginal and Torres Strait Islander Australians. Debra has also been involved in developing information and resources on mental health and mental illness for Aboriginal and Torres Strait Islander peoples.

Joe Roe

The late Mr Joseph Roe (Purungu by skin name) was a Karajarri/Yawru man. His people are also from the Broome and Bidadanga area. He completed a Bachelor of Applied Science in Indigenous Community Health (Mental Health Counselling specialisation) in 1996. Mr Roe worked in the area of Indigenous 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. His family has kindly given permission for Mr Roe's unique work to be reprinted so that his legacy can continue.

Professor Sherry Sagers

Sherry Sagers is Professor and Project Leader at the National Drug Research Institute, Curtin University of Technology, where she is establishing a research program on *Prevention, Early Intervention and Inequality* with an emphasis on child-focused, family and community-centred models to address disadvantage. She was formerly Foundation Professor of Applied Social Research and the Director of the Centre for Social Research at Edith Cowan University. An anthropologist, she has worked with and for Indigenous communities across Australia for almost 30 years. She is best known for her research and publications on Indigenous health and substance misuse, including the widely used textbooks *Aboriginal health and society* and *Dealing with Alcohol: Indigenous usage in Australia, New Zealand and Canada*, both co-authored with Dennis Gray. She has also published on children and young people; allied health and community services; and community development.

Dr Clair Scrine

Clair Scrine is currently a Senior Research Officer at the Telethon Institute for Child Health Research. She has been a member of a number of project teams involving research and evaluation with Aboriginal communities in Western Australia including the WA Aboriginal Child Health Survey, the Rio Tinto Child Health Partnership, the BHP-sponsored Substance Use Reduction project in the Hedland and Newman areas of the Pilbara, the review of the St John of God Health Care 'Strong Women, Strong Babies, Strong Culture' program in the Pilbara and the review of the Wheatbelt Health Service. Before moving to Perth in 2006, Dr Scrine worked as a senior officer at the Office of Indigenous Policy Coordination and was previously a policy officer with the Aboriginal and Torres Strait Islander Commission (ATSIC).

Dr Scrine received her doctorate from Macquarie University in Sydney in 2003. During the completion of her doctorate she undertook a student residency at the Wellcome Trust Centre for the History of Medicine (within the University College of London) and at the University of Victoria, British Columbia, Canada.

Dr Mark Sheldon

The late Dr Mark Sheldon was a pioneer psychiatrist with a mission to provide psychiatric services to remote Aboriginal communities. Mark died in Sydney, aged 33 years. In the vastness of Central Australia, Mark learnt to overcome cultural and language barriers in his dealings with Indigenous people and was honoured by having an Aboriginal name bestowed upon him. Working with the Ngungkari (local healer), he developed a flexible methodology of investigation, convinced that the best outcomes were often obtained when traditional methods and modern medicine were used together. Designing his own clinical strategies, he was able to confront the psychological and social problems endemic in many communities. Mark 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.

Professor Sven Silburn

Professor Silburn leads the program of developmental health and education research at the Menzies School of Health Research in Darwin where he is currently involved in the collaborative evaluation of the NT Department of Education and Training's Transforming Indigenous Education Strategy. Before his appointment at Menzies in 2009, he was Co-director of Curtin University's Centre for Developmental Health at the Telethon Institute for Child Health Research in Perth. Sven originally practised as a clinical psychologist with the WA Child and Adolescent Mental Health Service and became involved in Aboriginal mental health in the mid-1990s when he chaired the WA Ministerial Council for Suicide Prevention's working group on Aboriginal suicide prevention; this led to the WA Government instituting a \$2 million across-government state strategy to reduce Indigenous suicide and self-harm from 2001 to 2003. He was one of the chief investigators on the *Western Australian Aboriginal Child Health Survey*, whose findings are reported in four major monographs including a technical 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 Western Australia.

Dr Christopher Sonn

Dr Christopher Sonn is a senior lecturer in the School of Sciences and Psychology at Victoria University, Melbourne. He teaches in the areas of community and intercultural psychology and qualitative methodologies, at both undergraduate and postgraduate levels. 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, which are central to promoting social change. This has included exploring the sense of community and social identity negotiation from the perspectives of immigrant and Indigenous people, examining the dynamics of oppression and liberation in the context of intergroup relations, and developing critical pedagogy for anti-racism. This work draws on decolonising methodologies and critical whiteness studies. Papers based on this work have been published in refereed journals, including 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 Indigenous Australian substance misuse issues since 2001. She is the manager of the National Drug Research Institute's online resource, Indigenous Australian Alcohol and other Drugs Bibliographic Database, <www.db.ndri.curtin.edu.au>. In addition to this Ms Stearne has been involved in a number of research projects at national, state and local level. Research includes the identification of the elements of best practice in Indigenous substance misuse interventions (2003) and the areas of greatest need in Indigenous substance misuse (2009). Ms Stearne has also conducted a number of Indigenous-specific drug and alcohol program evaluations, including the evaluation of the effectiveness of the fuel substitution program COMGAS. From September 2005 until late 2008, Ms Stearne was based in Alice Springs. There she supported a local Aboriginal community organisation, enabling them to control and conduct their own research.

Karen Ugle-Strachan

Karen Ugle-Strachan is an Aboriginal psychologist from south-west Western Australia. Karen moved to Perth to study Psychology as a mature-aged 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 Australian Indigenous Psychological Association (AIPA). She has a passion for psychology and counselling for Aboriginal people. Karen has worked in various departments as a therapist and cultural consultant. She is now happily working for Yorgum Counselling Service in East Perth.

Professor Iain Walker

Iain Walker is a Scottish-born Wadjella living and working on Noongar land. He has recently started work as a Research Group Leader for Social Sciences and Sustainability at the CSIRO in Floreat, Perth. Previously, 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 the second edition of *Social cognition* and co-editor of *Social representations and identity: Content, process and power* and *Relative deprivation theory: Specification, development and integration*.

Associate Professor Roz Walker (author and editor)

Associate Professor Roz Walker has over 25 years' experience as a researcher and educator working with Aboriginal communities building local capacity within both Aboriginal and non-Aboriginal organisations. Roz worked at the Centre for Aboriginal Studies for many years, and was Deputy Director of the Curtin Indigenous Research Centre for several years prior to working with Kulunga Research Network at the Telethon Institute for Child Health Research. Her key areas of interest include developing transformative and decolonising strategies at individual, organisational and community levels as well as promoting system level change. Roz has taught extensively at undergraduate and graduate levels in Aboriginal community management and

development and early years education in remote areas. 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. Most recent examples include her involvement in communicating and disseminating the *Western Australian Aboriginal Child Health Survey* throughout Western Australia to communities and key stakeholder groups and implementing the Australian Early Development Index and the Indigenous AEDI adaptation across the Pilbara. One of her key projects over the last three years has been the *Staying on Track* substance use reduction project funded through BHP Billiton Iron Ore Health Partnership with Telethon Institute for Child Health Research. This has involved working with young people and relevant agencies and stakeholders in Hedland, particularly the Hedland Youth Leadership Coalition and the Hedland Youth Stakeholder Action Group, assisting the development of a Youth Charter and Youth Strategy. Roz was co-editor of Gunada Press at Curtin University and provided extensive support to *Working With Indigenous Australians: A Handbook for Psychologists* (2000) edited by Associate Professor Pat Dudgeon.

Rosemary Wanganeen

Rosemary describes herself as a Griefologist—one who studies and applies holistic approaches to loss and grief counselling and educational models. Her commitment to transforming a preceding loss and grief model has enabled her to modernise her now innovative and unique Seven Phases to Reconciling Losses with Grief for the 21st century. Her study and research in weaving holistic approaches into a standard mainstream loss and grief model has led to the School of Psychology at the University of South Australia awarding her the title of Adjunct Research Fellow. Her passion and commitment to loss and grief had her involved in a number of research projects and her proudest moment is her Seven Phases being described in a publication called *Anger and Indigenous Men*. She has presented her work to a range of audiences, both nationally and internationally.

She spent a year as a research officer with the Committee to Defend Black Rights in Sydney, which became instrumental in forcing the government to call for the Royal Commission into Aboriginal Deaths in Custody. She spent a further two and a half years on the Royal Commission, which enabled her to ‘see, feel and hear’ intense grief from families around Australia about the death and dying of other family members. She also became aware that many if not all families had members with compounded suppressed unresolved grief and so it was just a matter of time before she was able to acknowledge a major gap in the services to herself and many Aboriginal people around Australia. This gap was any form of counselling for Aboriginal people, but more specifically there was no culturally appropriate counselling and, perhaps for her, what was more challenging was identifying that there was no culturally appropriate loss and grief counselling model. This inspired Rosemary to apply her personally developed Seven Phases and become the founding Director of the Australian Institute for Loss and Grief P/L (est. 2006), which formerly traded as the Sacred Site Within Healing Centre (est. 1993). The Institute is based at Port Adelaide. 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, giving her 22 years working with loss and grief.

She is a mother of three and grandmother of five.

Associate Professor Edward Wilkes

Edward Wilkes is an Associate Professor working for the National Drug Research Institute at Curtin University. He has a wide and extensive knowledge of Aboriginal Health. Ted 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 sits on the

Australian National Council for Drugs and is the Chair of the National Indigenous Drug and Alcohol Committee.

Dr Michael Wright

Michael is a Yuat Nyungar man from Western Australia. His mother's and grandmother's booja (country) is located just north of Perth, in the area known as the Victoria Plains, which includes the townships of Mogumber and New Norcia. Michael has extensive experience in the area of Aboriginal mental health and Aboriginal health. He has worked as a social worker in an inner-city hospital and was the manager of an Aboriginal mental health service located within the Derbarl Yerrigan Health Service in Perth. The mental health program was both innovative and unique, because it was 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. He is currently undertaking his PhD exploring the experiences of caregiving for Aboriginal people living with a serious mental illness. In 2009 he was awarded an NHMRC Training Fellowship. His post-doctoral project will investigate the effectiveness and appropriateness of the publicly funded mental health system in its provision of services to Aboriginal people living in a defined region in the Perth metropolitan area. The project will involve Aboriginal families, Aboriginal and non-Aboriginal service providers, policy-makers and managers.

Professor Stephen Zubrick

Professor Zubrick holds an appointment in the Curtin University of Technology Centre for Developmental Health at the Institute for Child Health Research where he is the Head of the Division of Population Science. 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 has worked in Western Australian hospital and outpatient health and mental health settings for many years before commencing work in 1991 at the Telethon Institute for Child Health Research. His research interests include the study of the social determinants of health and mental health in children, systematic studies of youth suicide, and large-scale psychosocial survey work in non-Indigenous and Indigenous populations. He chairs the Consortium Advisory Group that is implementing the Longitudinal Study of Australian Children and is a member of the Steering Committee for the Longitudinal Study of Indigenous Children. He is particularly 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.



Abbreviations

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
ACER	Australian Council for Educational Research
AD	adjustment disorder
AEDI	Australian Early Development Index
AGPS	Australian Government Publishing Services
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AHW	Aboriginal Health Worker
AIATSIS	Australian Institute of Aboriginal Torres Strait Islander Studies
AIHW	Australian Institute of Health and Welfare
AIMHI NT	Australian Integrated Mental Health Initiative in the Northern Territory
AIPA	Australian Indigenous Psychologists Association
AIRRFI	Awareness, Identify, Reclaim, Reconcile, Forgive, Inspire
AMHW	Aboriginal Mental Health Worker
AMSANT	Aboriginal Medical Services Alliance of the Northern Territory
ANPPEIMH	Australian Network for Promotion, Prevention and Early Intervention for Mental Health
ANU	Australian National University
APA	American Psychiatric Association
APS	Australian Psychological Society
ASD	acute stress disorder
ATSIC	Aboriginal and Torres Strait Islander Commission
AUSIENET	Australian Network for Promotion, Prevention and Early Intervention for Mental Health
BTH	<i>Bringing Them Home</i>
BTHC	Bringing Them Home Counselling
CAEPR	Centre for Aboriginal Economic Policy Research, ANU
CARPA	Central Australian Rural Practitioners Association
CDHAC	Commonwealth Department of Health and Aged Care
CDHSH	Commonwealth Department of Human Services and Health
COAG	Council of Australian Governments
DCS	dysfunctional community syndrome
DEETYA	Department of Employment, Education, Training and Youth Affairs

DRUID	Darwin Region Urban Indigenous Diabetes
DSM IV-TR	<i>Diagnostic and Statistical Manual of Mental Disorders</i> , Fourth Edition, Text Revision
EPDS	Edinburgh Postnatal Depression Scale
HPF	Health Performance Framework
HREOC	Human Rights and Equal Opportunity Commission
HRSCEET	House of Representatives Standing Committee on Employment, Education and Training
ICD-10	International Statistical Classification of Diseases and Related Health Problems 10th Revision
ICMD	Indigenous Management and Community Development
IHI	innate human instincts
IPS	Indigenous Psychological Services
KICA	Kimberley Indigenous Cognitive Assessment
MCDS	Ministerial Council on Drug Strategy
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MHFA	mental health first aid
MSE	mental state examination
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHSWP	National Aboriginal Health Strategic Working Party
NATSIHC	National Aboriginal and Torres Strait Islander Health Council
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NDS	National Drug Strategy
NHMRC	National Health and Medical Research Council
NPSMHW	National Practice Standards for the Mental Health Workforce
NSEATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health
NSP	needle and syringe program
NSPS	National Suicide Prevention Strategy (formerly National Youth Suicide Prevention Strategy, NYSPS)
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OID	Overcoming Indigenous Disadvantage
PTSD	Post-Traumatic Stress Disorder
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
RTO	Registered Training Organisations
SCRGSP	Steering Committee for the Review of Government Service Provision
SEWB	social and emotional wellbeing
SEWB RCs	Emotional and Social Wellbeing Regional Centres
SUG	suppressed unresolved grief
VET	Vocational Education and Training
WAACHS	West Australian Aboriginal Child Health Survey
WASC-Y	Westerman Aboriginal Symptom Checklist—Youth
WGIR	Working Group on Indigenous Reform
WSU	Workforce Support Unit

Introduction



The purpose of the book

There is a lack of suitable resources to educate and assist 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 clinicians in mental health have little cross-cultural validity.

The purpose of *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* is to provide an appropriate resource for a range of health professionals who work with Aboriginal and Torres Strait Islander people, including Aboriginal and Torres Strait Islander health workers, counsellors, and other staff of Indigenous health services. It provides 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 the effects of past policies and practices. The book is also suitable for students studying in relevant fields.

The book has been written by a range of acknowledged experts in the mental health field and thus presents a variety of perspectives relating to the social and emotional wellbeing and mental health issues for Aboriginal and Torres Strait Islander people. A strong Indigenous voice permeates the book. Indeed the high number of Aboriginal and Torres Strait Islander authors and collaboration between authors has made this text unique.

A social and emotional wellbeing perspective

Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice is a unique and invaluable resource to educate and assist health professionals to work with Indigenous Australians.

Indigenous Australian people usually take a holistic view of mental health. To reflect this, we have adopted a social and emotional wellbeing approach to mental health in this 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 Indigenous Australians is evident in their capacity to sustain self and community in the face of a 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 loss, grief and trauma.

Aboriginal writers 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, the late Mr Joe Roe in Chapter 17 of this book argued that successful counselling and community development needs to include empowering Aboriginal peoples to bring back the systems of care, control and responsibility that once existed. His model and those of Lorraine Peeters (Chapter 20) and Rosemary Wanganeen (Chapter 19) are examples of how traditional ways of healing involve addressing people's emotional, spiritual, physical, and social needs—they are holistic and focus on wellbeing.

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 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 people's 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 people's 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*, p. 6)

Background to the book

Although this book came about because chapter authors gave their time and shared their wisdom about the social and emotional wellbeing of Indigenous Australians, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* had its origins in the Australian Government's commitment to the improvement of mental health services nationally.

The process

The Australian Government Department of Health and Ageing, through OATSIH, commissioned the Australian Council for Educational Research (ACER) and the Kulunga Research Network to produce this book.

Our task was to identify, commission and coordinate key Indigenous and non-Indigenous experts and stakeholders in the mental health sector to provide written contributions to the book. A list of potential contributors was drawn up at the commencement of the project. The list included clinicians, and cultural and educational experts. Both Indigenous and non-Indigenous experts who are stakeholders in the mental health sector were considered. The list was compiled from the editors' knowledge of people working in the field, their extensive networks among Indigenous communities and academic personnel, internet searches, and recommendations from the Expert Reference Group (ERG).

The scope of the book was to include content relating to historical and present-day social health and emotional wellbeing issues and the evolution of current Indigenous social and emotional wellbeing and mental health policy directions. It was to incorporate specific clinical mental health assessment processes and culturally appropriate programs and interventions.

In addition to health professionals who work with Aboriginal and Torres Strait Islander people, the target audience for the book was to include Vocational Education Training (VET) and Tertiary Education Training (TET) students to assist them to understand a variety of perspectives relating to social and emotional wellbeing and mental health issues for Aboriginal and Torres Strait Islander people. The book will also be an invaluable resource for professional development in key discipline areas associated with Aboriginal and Torres Strait Islander social and emotional wellbeing such as mental health nursing, occupational therapy, psychiatry, general medicine, psychology, and social work.

To achieve these things, we drew on the expertise of a range of individuals, groups and organisations including:

- the OATSIH Expert Reference Group for Improving the Capacity of Workers in Indigenous Communities
- relevant individuals from organisations listed in Chapter 21 of this book
- the ACER Standing Committee on Indigenous Education
- an Internal Advisory Group at the Telethon Institute of Child Health Research in Western Australia
- those located through our existing networks.

We developed a framework for the book (section and chapter themes) and invited key people to be chapter leaders. These leaders took responsibility for the chapters, although they generally worked with other authors who we also had identified as eminent people for the various chapters.

Individual draft chapters were sent out for external review to at least one and usually two reviewers who were recognised experts in relevant areas. Authors were invited to make changes to their chapters on the basis of reviewers' and editors' comments.

When all chapters had been completed, the draft manuscript was sent to several sites for market testing. We asked market testers:

- to provide an overall assessment of the manuscript in about 250 words
- to list the major uses of the work
- whether the work could be better organised or sequenced differently, and if so, in what way
- to comment on readability and writing style/s
- whether they would recommend this book to practitioners and students working in Indigenous mental health
- what would set this book apart from others in its field
- to which special areas or fields the work would make a good contribution.

Each author, or group of authors, speaks with their own voice. Although authors were given guidelines about the book before they commenced their work, we felt it was important to encourage diversity rather than conformity in the perspectives they presented. Authors were, however, encouraged to frame their chapters in accepted wisdom rather than around untested claims.

The structure of the book

Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice is divided into four parts.

Part 1 contains four chapters that outline the historical, social, cultural, and policy contexts that have shaped Aboriginal and Torres Strait Islander mental health and wellbeing.

In Chapter 1, Robert Parker examines the concepts of physical and mental health for Aboriginal and Torres Strait Islander people, both before and after the European colonisation of Australia. Parker points to some national and international innovative thinking that may assist Aboriginal and Torres Strait Islander people to regain the health that has been so significantly lost.

In Chapter 2, Debra Rickwood, Pat Dudgeon and Heather Gridley discuss the history of the discipline and practice of psychology with Australian Aboriginal and Torres Strait Islander people in relation to mental health. The key engagements of psychology with Aboriginal and Torres Strait Islander people are outlined. The authors suggest positive ways that psychologists can work together to bring about improved social, emotional and spiritual wellbeing for Indigenous Australians.

Chapter 3 by Pat Dudgeon, Michael Wright, Yin Paradies, Darren Garvey and Iain Walker helps us understand the contemporary issues faced by Aboriginal and Torres Strait Islander Australians by providing an overview of the social, cultural and historical contexts that have shaped their lives today. 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 Indigenous people are included, with particular attention to racism.

Chapter 4 by Steve Zubrick, Kerrie Kelly and Roz Walker outlines the role of policy in setting directions for and achieving change in Aboriginal and Torres Strait Islander mental health. Key national policies, frameworks and reports addressing the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander people are presented.

Part 2 contains seven chapters on a number of issues that are particularly relevant to Aboriginal and Torres Strait Islander mental health and wellbeing.

In Chapter 5, by Robert Parker, common types of mental disorders, such as anxiety disorders, mood disorders, psychosis and personality disorders are outlined. These disorders are discussed in terms of what Aboriginal and Torres Strait Islander people may have experienced in traditional as well as in contemporary contexts.

Chapter 6 explores current understandings of the determinants of Aboriginal and Torres Strait Islander social and emotional wellbeing and its development. Its authors, Stephen Zubrick, Pat Dudgeon, Graham Gee, Belle Glaskin, Kerrie Kelly, Yin Paradies, Clair Scrine and Roz Walker, show that the determinants of this wellbeing are multiple, interconnected, and develop and act across the life course from conception to late life. The authors also show that the risk and protective factors impacting on the wellbeing of Aboriginal and Torres Strait Islander people differ in important ways from those endorsed in mainstream concepts of mental health.

Chapter 7 by Sven Silburn, Belle Glaskin, Darrell Henry and Neil Drew examines epidemiological trends in suicide and attempted suicide for Indigenous and non-Indigenous Australians and in other nations such as Canada, the USA and New Zealand. The meaning of suicide within Indigenous community contexts is explored, and the authors show how this can inform preventive action, early intervention and post-intervention.

Chapter 8 by Jenny Adermann and Marilyn Campbell outlines issues of excessive anxiety in Indigenous youth. It describes what an anxiety disorder is and its consequences, and how Indigenous youth seem to be at risk for developing such disorders. Issues concerning the delivery of traditional prevention and intervention programs are discussed and possible interventions are provided.

In Chapter 9, Edward Wilkes, Dennis Gray, Sherry Siggers, Wendy Casey and Anna Stearne examine substance misuse and mental health among Aboriginal Australians, as well as related harms and the social determinants of mental health and substance misuse. They also examine a range of services that have been developed to address these issues, and the National Drug Strategy's demand, supply and harm reduction framework. They argue that a multi-systemic strategy is required that addresses issues of cultural security, and that evidence-based practice is needed to enhance treatment outcomes. Until the social and structural determinants of good mental health are addressed, the co-morbidity of substance misuse and mental health among Aboriginal Australians will linger.

Chapter 10 by Judy Atkinson, Jeff Nelson and Caroline Atkinson focuses on how the effects of experiencing trauma are transmitted within and across generations. The chapter introduces the reader to a selection of views and conceptions of trauma, and theories of its transgenerational transfer. It also explores the links between unresolved childhood trauma and participation in violence, sexually inappropriate behaviour, and incarceration as adolescents and adults. The second part of the chapter discusses the challenges associated with working in Indigenous communities, and it gives an example of a program that is achieving positive results.

Chapter 11 by Kyllie Cripps briefly examines the context in which Indigenous family violence occurs. In particular, it explores how Indigenous people define and contextualise the violence they or their family members are experiencing. This context is important in considering pathways forward for healing for the victim, their families, and the broader kin network who inevitably feel the ripple effects of such violence.

Part 3 contains five chapters that focus on practice within the field.

Chapter 12 is about working as a culturally competent mental health practitioner. The authors, Roz Walker and Christopher Sonn, address such workforce issues as working in a multidisciplinary team; developing core competencies, knowledges, skills, understandings and attributes regarded as essential for practitioners; and the relations between the disciplines and professions and between those professions and Aboriginal and Torres Strait Islander people. The chapter also provides a range of tools and strategies, and a reflective framework to assist students and practitioners from various disciplines to develop key competencies.

Chapter 13 by Pat Dudgeon and Karen Ugle focuses on communication and engagement with Aboriginal and Torres Strait Islander people in urban contexts. Aboriginal and Torres Strait Islander people living in urban contexts may not portray stereotypical images of what Aboriginal and Torres Strait Islander people look like or live like; however, urban identity is very strong and people have

strong territorial affiliations. Cultural concepts such as kinship affiliations, community obligations and values of Aboriginal and Torres Strait Islander people living in urban contexts are outlined.

Chapter 14 by Neil Drew, Yolonda Adams and Roz Walker addresses issues of mental health assessment with Indigenous Australians. The authors examine the history of assessment and testing with culturally diverse groups, and they explore a range of emergent principles and guidelines for practice to improve and govern assessment practices with Aboriginal and Torres Strait Islander people. They note that assessment and practitioners conducting assessment must be repositioned (and reposition themselves) to play an important role in the development of procedures and practices in the provision of mental health care for Aboriginal and Torres Strait Islander people in Australia.

Chapter 15 is based on the work of the late Mark Sheldon and concerns psychiatric health assessment in remote Aboriginal communities. Sheldon's work is informative for all mental health and wellbeing practitioners intending to work with Aboriginal people, especially in service delivery in remote areas. Sheldon sought alternative ways of working clinically in the cross-cultural setting of traditional and semi-traditional Aboriginal society. He worked to develop approaches to suit the setting. His work required adjustments in history-taking, mental state examination, diagnosis, management, professional boundaries, and the way he worked with his colleagues.

In Chapter 16, Sue Ferguson-Hill considers factors relating to perinatal mental health, culture, environmental context, and ways of working with Aboriginal and Torres Strait Islander families. Protective and risk factors related to perinatal mental health are discussed from the perspective of mother, child and father. Ways of strengthening wellbeing and of recognising and managing perinatal distress and perinatal depression are explored. The chapter also briefly explores pathways and models of care, screening, and tools of assessment used in the perinatal period.

Part 4 presents examples of models and programs for practitioners working with different groups. The models are responses by individuals and groups of people to a perceived need. Some are based on people's personal experiences; others are based on existing models of healing that have been reinterpreted to meet the specific contexts and needs of Aboriginal and Torres Strait Islander people.

Chapter 17 presents a cultural model for keeping the spirit strong. The Ngarlu program was developed by Karajarri man Joe Roe (deceased) as an aid to working with Aboriginal men in their recovery from a major psychiatric illness. It is a path to spiritual, emotional and social wellbeing. The model has both practical application and policy impact; for instance, it underpins the current framework for the Western Australian Aboriginal drug and alcohol strategy.

Chapter 18 by Maria Morgan and Neil Drew outlines a model for engagement with remote Aboriginal communities in the East Kimberley region of Western Australia. The model was developed and implemented over the last four years as a partnership between Aboriginal communities and the University of Notre Dame Australia. The engagement model is based on authentic program ownership by the Aboriginal communities to reduce the incidence of youth suicide. The model is holistic, based on a multifaceted wellness framework that includes personal, group and collective wellness.

Chapter 19 is by Rosemary Wanganeen. It describes the potential of a holistic loss and grief model to heal anger, rage and violence and empower people who see and find themselves as victims. The Seven Phases to Healing model of self-healing and spiritual reconnection provides a basis for elements related to counselling processes. The basis for Wanganeen's model is five years of her personal life experiences and over 15 years in professional practice. Drawing on this deeply personal experience, this chapter emphasises the importance of positive self-healing and each person's responsibility for this.

Chapter 20 by Lorraine Peeters outlines the Marumali program which she developed as an Aboriginal model of healing for the Stolen Generations. The program was examined and endorsed in 2000 by psychiatrist Professor Beverley Raphael (co-author of the *Ways Forward Report*) as being safe and effective practice. The program was also endorsed by the National

Aboriginal Community Controlled Health Organisation (NACCHO) in 2001 as being a positive training and education model in social and emotional wellbeing. The Marumali program is used extensively in the Koori justice system in Victoria.

Chapter 21 provides examples of mental health services and programs that provide specific assistance for Aboriginal and Torres Strait Islander people and the practitioners who work with them. There are different programs and services for different groups and types of mental health issues. The information has been provided by the organisations or has been gleaned from their websites. The services listed in this chapter are not the only ones available but the chapter does provide a starting point for people looking for information or a place to go.

Care and protection

Issues within this book may have an impact on readers and self-care mechanisms may be useful. Some Indigenous students and practitioners may have experienced loss, grief and trauma themselves. Some non-Indigenous people may find aspects of the book challenging and should also be aware of the need for self-care. Teachers' duty of care to students may require them to alert students to the possibility that some chapters may have an impact on them as they reflect on their own experiences. When working with clients, practitioners need to acknowledge the need for self-care as discussed in Chapter 12, 'Working as a Culturally Competent Mental Health Practitioner'. Chapter 21, 'Mental Health Programs and Services', provides information about support for mental health and wellbeing professionals who work with Aboriginal and Torres Strait Islander people.

Terminology

In Australia, there are many Indigenous nations, languages and cultures. This is shown clearly in 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.

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

In this book, a number of different terms have been used when referring to Indigenous Australian peoples. 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 what term most Aboriginal and 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.

The term 'Stolen Generations' is used to refer to Aboriginal and Torres Strait Islander peoples affected by past government removal policies and practices. The plural 'Generations' is used to draw attention to the transgenerational impacts of past removal practices.

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Part 1:

History and Contexts



Part 1 contains four chapters that outline the historical, social, cultural, and policy contexts that have shaped Aboriginal and Torres Strait Islander mental health and wellbeing.

[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 wellbeing. (Swan & Raphael, 1995, Ch. 1)

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Australian Aboriginal and Torres Strait Islander Mental Health: An Overview



Robert Parker

OVERVIEW

This chapter initially examines the concepts of physical and mental health for Aboriginal and Torres Strait Islander peoples over the vast majority of the last 40,000 years or so. The devastating consequences for Aboriginal and Torres Strait Islander peoples of the European colonisation of Australia are then described. The chapter concludes with some innovative thinking from Australia and overseas that may assist Aboriginal and Torres Strait Islander peoples to regain the 'health' that has been so significantly lost.

MENTAL HEALTH AS A HUMAN RIGHT

It has been well recognised through the recent progress of the human race to set some benchmarks for the higher aspirations of mankind in general that health is an essential component of human development and an important ambition for individuals and their society. The International Conference on Primary Health Care at Alma-Ata in 1978 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 world wide goal'. This concept was recently reaffirmed in the United Nations Declaration on the Rights of Indigenous Peoples in 2007 through Article 7, which states: 'Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of the person' (United Nations 2007, p. 5).

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 (Flood 2006, p. 121). 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 (p. 122).

In terms of mental health, traditional Aboriginal culture had a number of strong reinforcing factors that have been well defined by Associate Professors Helen and Jill Milroy (Milroy et al., 2003). Aboriginal sense of self was seen in a collective sense, intimately connected to all aspects of life, community, spirituality, culture and country. The culture also provided for everyone by sharing rules and 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 allowed 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 aunts and older siblings able to take over the childcare role if the mother was stressed.

These concepts mean that Aboriginal society before European contact provided the optimal conditions for mental health that have been enunciated in later documents such as *Ways Forward*. Swan and Raphael (1995) 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. (p. 19)

In the context of such parameters for general mental health, reports of severe mental illness affecting Aboriginal people in the traditional cultural setting do exist. Jones and de la Horne (1972, 1973) describe the occurrence of schizophrenia and mood disorders in Central Desert cultures. Eastwell (1976, 1977) reported on a potential familial susceptibility to delusional disorder in Arnhem Land. Meggitt (1962) also described Aboriginal people suffering from psychosis and a probable dissociative disorder due to severe cultural stress in the Centre. These reports appear to indicate that the experience of severe mental illness was a rare event in traditional Aboriginal culture. Aboriginal society and culture probably 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 (Eastwell, 1988).

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 (Trewin & Madden, 2005). 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 (Altman, 2000) may be a further contributing factor to this improved health status. 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.

Marsat Ketchell (2004) reports on a number of cultural mechanisms that are important for Torres Strait Islander family members to complete for the maintenance of 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 *Uman 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. 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 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 reports that Torres Strait Islanders may be affected by reports of *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).

CURRENT ISSUES

These reports of occasional mental illness in Aboriginal and Torres Strait Islander culture notwithstanding, the decimation of Aboriginal populations, destruction of Aboriginal culture and significant disempowerment and marginalisation of Aboriginal and Torres Strait Islander peoples following the British colonisation of Australia has resulted in what is widely regarded as 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.

The current significant disadvantage of Aboriginal health and social determinants is well recognised. Hospitalisation rates for cardiovascular disease in Aboriginal and Torres Strait Islander were 67% higher in 2004–06 than for other Australians (AHMAC, 2008). In 2006, rheumatic heart disease was nine times more common for Aboriginal and Torres Strait Islanders than for other Australians in the Top End of the Northern Territory and Central Australia (p. 34). 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 to other Australians (p. 38). Hospitalisation rates for Aboriginal and Torres Strait Islander people with diabetes are almost six times higher than for other Australians (p. 38). End stage renal disease, often the consequence of poorly controlled diabetes, was eight times higher for Aboriginal and Torres Strait Islander peoples than for other Australians (p. 40). Given these alarming statistics, it is not surprising that life expectancy for Aboriginal and Torres Strait Islander people is estimated to be 11.5 years for males and 9.7 years for females less than for other Australians (p. 7), an issue now well recognised in the Close the Gap agenda (AHMAC, 2008).

Aboriginal and Torres Strait Islander disadvantage is also apparent in other social indices. The 2008 National Aboriginal and Torres Strait Islander Social Survey estimated that 25% of the Aboriginal and Torres Strait Islander population over 15 were living in overcrowded housing. The overcrowding becomes more common/problematic in remote areas where it is estimated that 48% of Aboriginal and Torres Strait Islanders live in such housing (ABS, 2009). In respect to education, the National Schools Statistics Collection reported that the retention rate of Aboriginal and Torres Strait Islander students in Year 7/8 to Year 10 was 91% compared to 99% for other students. Unfortunately, the retention rate for Aboriginal and Torres Strait Islander students from Year 7/8 to Year 12 was only 43% compared to 76% for other students (AHMAC, 2008). Given this trend in education, the accompanying statistics of significant Aboriginal and Torres Strait Islander disadvantage in employment and income compared to the rest of Australia are no surprise; neither are data from the Australian criminal justice system which show that Aboriginal and Torres Strait Islander people are 13 times more likely to be in prison than other Australians (p. 110).

Poverty and racism also provide a framework for these statistics. Walter and Sagers (2007) point to the significant association between poverty and adverse health outcomes. They note that a significant proportion of Australia's Indigenous 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 diarrhea, are directly related to inadequate sanitation and living conditions (p. 101). The issues of Indigenous poverty appear particularly marked in rural 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. Welfare colonialism (Anderson, 1997) affects Aboriginal communities that rely heavily on the provision of public sector resources. Over time, the mechanisms to deliver these 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 (Paradies, 2007).

A perception of safety is also a crucial element of wellbeing. Surveys have shown that Aboriginal and Torres Strait Islander people aged over 18 are twice as likely to report being victims of violence or threatened violence than other Australians (AHMAC, 2008). A further alarming statistic in respect to child safety was that in 2006–07 the rate of substantiated child protection notifications per 1000 was 32 for Aboriginal and Torres Strait Islander children compared with six for other children (p. 112)

Given the above, it is not surprising that Aboriginal and Torres Strait Islander peoples report significantly higher levels of stress than the remainder of the 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 (AIHW 2009). 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 (p. 23–4). The significant effect of stress on Aboriginal children in Western Australia is also of concern. *The West 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 stress life events had occurred over the preceding 12 months (De Maio et al., 2005). Associate Professor Helen Milroy (personal communication) refers to the phenomenon of ‘malignant grief’ being the result of persistent stress experienced in Indigenous communities. Malignant grief is a process of irresolvable, collective and cumulative grief that affects Indigenous individuals and communities. The grief causes individuals and communities to lose function and become progressively worse; ultimately it leads to death. Milroy further comments that the grief has invasive properties, spreading throughout the body, and that many of Australia’s Indigenous people die of this grief.

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 substance abuse (p. 465).

Given this level of background stress, it is not surprising that substance abuse also figures prominently as a background factor to mental illness. It is well recognised that Aboriginal and Torres Strait Islander people experience harmful rates of alcohol and other substance use and that this tends to be more pronounced in rural communities (Trewin & Madden, 2005). It is also unfortunate that Aboriginal and Torres Strait Islander men are hospitalised at over four times the expected rate for population with severe mental illness related to substance abuse, and over double the expected rate for severe chronic mental illnesses such as schizophrenia (Pink & Allbon, 2008, p. 112). 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 (p. 112).

Death rates in the Aboriginal and Torres Strait Islander population secondary to substance abuse and mental illness are alarming. The death rate for Aboriginal and Torres Strait Islander people from mental and behavioural disorders due to psychoactive substance use is almost 12 times the rate for the Australian population in men and almost 20 times the rate of the Australian population for women (p. 161). In addition, the rates of death by suicide for Aboriginal and Torres Strait Islander men are almost three times the rate for the Australian population generally (p. 169).

WAYS FORWARD

Evidence from overseas indicates that enlightened government policy and enhanced control of socioeconomic factors by Indigenous communities in respect to their health can lead to improved health outcomes including mental health. Recent 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 (Ratima et al., 2007). 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 (Kunitz & Brady, 1995). Ring and Brown (2003) note a recent reduction in overall death rates for Indigenous people in the USA and New Zealand. The reduction in First Nation mortality in the USA relates to injury prevention, while the reduction in Maori mortality relates to fewer deaths from circulatory conditions. While there does not appear to be a direct correlation between improved health services for Indigenous peoples in the two countries and improved mortality, the two appear to travel together well. In comparison, the 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 (Chandler & Lalonde, 1998).

Another example of an overseas innovative government program was the strategic leadership recently shown in Canada through the Canadian Aboriginal Horizontal Framework (Canada's Performance, 2005), a government policy 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.

In the context of this international emerging policy background, the approach of the broader Australian community to issues of Aboriginal and Torres Strait Islander mental health and illness is also of interest. Professor Ernest Hunter (1997) notes an evolutionary progression of thought from an ethnographic fascination with issues of mental illness in Aboriginal and Torres

Strait Islander people 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, the Commission into the Separation of Aboriginal and Torres Strait Islander Children from their Families and the establishment of National Aboriginal Community Controlled Health Organisation and the Office of Aboriginal and Torres Strait Islander Health also form a background framework for these and other developments. These developments are explored in more detail in Chapter 4.

It appears, therefore, that any way forward to better mental health for Aboriginal and Torres Strait Islander people will involve a general revision of government attitudes and policies towards Aboriginal and Torres Strait Islander welfare generally, in addition to specific programs to address improvements in services for Aboriginal and Torres Strait Islander social and emotional wellbeing and Aboriginal and Torres Strait Islander 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 (Veazie et al., 2001). There have been a number of recent successful examples of this for Aboriginal and Torres Strait Islander communities in the Australian context. The OXFAM family place projects in the Gulf of Carpentaria (OXFAM, 2007) looked to enhance community resilience against the effects of substance abuse by developing safe family place houses. A similar community project, Domestic Violence – It's Not Our Game, used local sportsmen as role models to reduce the incidence of domestic violence in the Gulf communities (p. 2). 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 (Norris et al., 2007).

The Australian policy environment has also recently produced a number of innovative solutions in government approaches to Aboriginal and Torres Strait Islander disadvantage. The recent paper by Ken Henry (2007) suggests a broad approach across Australian Government departments to address Aboriginal and Torres Strait Islander health disadvantage, similar in some ways to the Canadian Framework. Henry 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 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 Australians in the design of policy frameworks that might improve these incentives and capacities. 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 Indigenous people to be engaged in policy development.

Dillon and Westbury (2007) also look to a number of ways that government can rebuild capacity within Aboriginal and Torres Strait Islander communities. They look at seven directions for an enhanced government role. The first is an 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.

The second is investment in cross-cultural communication and governance capacity. The third is a rationalisation of short-term program delivery in Aboriginal and Torres Strait Islander communities through an increasing ‘connecting government’ approach. The fourth is 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. The fifth is 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. The sixth is a need to replace a myriad ‘small niche programs’ within Aboriginal and Torres Strait Islander communities with negotiated priorities for funding and support, and flexible program funding arrangements. Finally, the authors argue that mainstream programs retain (or build up) the inherent flexibility 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.

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 strategies specifically targeted to Aboriginal and Torres Strait Islander social and emotional wellbeing and services for those suffering from mental illness.

A major strategic direction for the progression of mental health services for Aboriginal and Torres Strait Islander people was the development of the *Ways Forward* document in 1995. Swan and Raphael (1995, p. 11) recommended a range of initiatives to deal with the major burden of mental illness within the Aboriginal and Torres Strait Islander population. Key initiatives included self-determination within Aboriginal and Torres Strait Islander mental health service development, a holistic approach to Aboriginal and Torres Strait Islander mental health, specific services for population sub-groups, improved coordination of service delivery for Aboriginal and Torres Strait Islander people within mainstream health services, Aboriginal and Torres Strait Islander mental health worker and other staff development, and improved research. Many of these themes are continued in the key strategic directions of more modern policy frameworks for Aboriginal and Torres Strait Islander mental health such as the *Social and Emotional Wellbeing Framework 2004–2009* (Social Health Reference Group, 2004). 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 credentialling of standards for health professionals working with Aboriginal and Torres Strait Islander people, as well as improved recognition of the role of Aboriginal and Torres Strait Islander Mental Health Workers (Parker, 2009).

From the preceding, it can be seen that Aboriginal and Torres Strait Islander peoples appeared to have had a particularly effective system of mental health in place for the 40,000 years before European contact. Chapter 3 describes pre-contact life as well as discussing some of the major impacts of colonisation on Aboriginal and Torres Strait Islander people. In the current policy environment, the way back to mental health for these people 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 social and emotional wellbeing, 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 Commonwealth Department of Health and Ageing and the National Aboriginal Community Controlled Health Organisation is working towards, a brighter future for mental health for Australia’s Aboriginal and Torres Strait Islander peoples appears probable.

Reflective exercises

- 1 What are the features of 'mental health' in pre-contact Aboriginal society and how would the disruption or loss of these lead to 'mental illness'?
- 2 What are the features of Torres Strait Islander 'mental health'?
- 3 Identify a number of social issues underlying current Indigenous mental illness in Australia.
- 4 This chapter may present different information from other concepts of health and histories you have learnt about. What are those differences?

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2



A History of Psychology in Aboriginal and Torres Strait Islander Mental Health

Debra Rickwood, Pat Dudgeon and Heather Gridley

OVERVIEW

This chapter discusses the history of the discipline and practice of psychology in relation to the mental health of Australian Aboriginal and Torres Strait Islander people. It acknowledges that a history of cultural and institutionalised racism has meant that the profession has been part of the colonising process. The key engagements of psychology with Aboriginal and Torres Strait Islander people are outlined; these have led to the Indigenous mental health movement, which heralded a significant change in thinking about mental health—and, importantly, the empowerment and inclusion of Aboriginal and Torres Strait Islander peoples at all levels of mental health service provision. The chapter concludes with some important milestones in psychology and in Aboriginal and Torres Strait Islander mental health, pointing to positive ways in which psychologists can work together to bring about improved social, emotional and spiritual wellbeing for Indigenous Australians.

The chapter provides an historical account of the different ways that psychology has had an impact upon Aboriginal and Torres Strait Islander people: through science, practice and advocacy. It discusses how each of the three domains intersect and interrelate and the different ways in which they affect our understanding of and responses to Aboriginal and Torres Strait Islander mental health.

THE DISCIPLINE OF PSYCHOLOGY

Psychology, as both a science and profession, has impacted significantly on knowledge in the mental health field, in general and specifically in relation to Aboriginal and Torres Strait Islander mental health. For this reason, it is important to briefly review the history of psychology in this area. This review is relevant for psychologists and other practitioners working in the mental health field. ‘Knowing the past’ is complex, however, and certainly not objective. The recording of history has been and is done by those with the power to do so. There are multiple histories, and those that are prevalent generally come from sources with the most powerful voice. All historical accounts need to be interpreted within this understanding (Dudgeon & Pickett, 2000).

Psychology is a complex field, and comprises both scientific investigation and professional practice as applied to understanding human thoughts, feelings and behaviour. Many psychologists are also strongly committed to improving community wellbeing, and the mission of the Australian Psychological Society (APS), the peak professional body representing psychology in Australia, is ‘[t]o represent, promote and advance psychology

within the context of improving community wellbeing and scientific knowledge' (APS, 2008). However, the history of the discipline shows that psychology has been complicit in the colonising process and, as a dominant discourse, has a documented past that has been ethnocentric and has objectified, dehumanised and devalued those from culturally different groups. Furthermore, psychology has been enlisted as an agent that supported assimilation and oppression (Dudgeon & Pickett, 2000). There have, however, been significant changes in recent times within the discipline that augur well for a promising future where the empowerment and self-determination of Aboriginal and Torres Strait Islander people could be a key consideration. Dudgeon and Pickett (2000) highlighted how the discipline was well placed to understand this and help facilitate it: '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' (p. 86).

PSYCHOLOGY AS SCIENCE

Psychology as a science is fundamentally concerned with understanding human behaviour. Consequently, psychological researchers have taken part in a range of scientific endeavours that have involved Aboriginal and Torres Strait Islander Australians. The main fields where psychology has been involved include 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 comprehensive overviews of the history of psychology and Indigenous people are available, such as in Garvey et al. (2000) *Australian psychology has black history*, this chapter addresses the key events of that history.

Early scientific relationships with Indigenous Australians were influenced by the dominant evolutionary views of social Darwinism (Darwin, 1859) and social evolution (Spencer, 1855), which held that all things changed over time in one direction—from simple to complex and from relatively undifferentiated to more differentiated. Spencer applied this theory to both psychological and social processes, and maintained that not only did human intellectual functioning proceed from simple cognitions and reflex actions to more complex and more general cognitions, but so also did society become progressively more complex and highly organised. Spencer's theory incorporated the Lamarckian notion of inheritance of acquired characteristics (Lamarck, 1809), so that humans acquired, during their lifetime, certain mental traits that favoured their continued existence, and these were passed on to their children.

At that time, the Indigenous peoples of Australia were of interest as representatives of humanity 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. A practical reason for scientific interest in Aboriginal and Torres Strait Islander peoples lay in the isolation of Australia, which, as an island continent, was seen to have been separated from outside influence on its flora, fauna and human inhabitants, and thus provided 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 (Chase & von Sturmer, 1973, p. 4).

The theories of race that came from this view of human evolution during the late 19th century coincided with the establishment of modern science as the arbiter of truth and the emergence of psychology as a new branch of science (APS, 1997). Biological determinists invoked the traditional prestige of scientific knowledge to argue 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 (Gould, 1984). Importantly, although there is now extensive evidence to the contrary, these scientific views had a profound impact and Aboriginal and Torres Strait Islander Australians were the main subjects in some influential early research studies.

For example, the Cambridge Anthropological Expedition took place in the late 19th century to study the people of the islands of the Torres Straits as a study 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; for example, reaction times did not differ. The differences that were found were hard to interpret and some favoured the Murray Islanders.

Later, in the early 1900s, S. D. Porteus, a teacher at a special school, devised a series of maze tests to be used as a screening device for the school’s ‘mentally defective’ pupils. Porteus used his test in a study of Aboriginal mission children (Porteus, 1917) and, later, Aboriginal adults of the North Western and Central regions of Australia. He found that Aboriginal adults of these regions performed at generally lower levels than the norming samples, although there were interesting variations (Kearney, 1973). The Aboriginal peoples with the most exposure to Western school experience, such as the Hermannsburg people of Central Australia, achieved a higher ‘mental age’ than those with less exposure.

Following Porteus, over the next two decades from the 1930s a study was undertaken by Fowler, Traylen and McElwain from the Department of Psychology at the University of Western Australia. Fowler and his colleagues tested Aboriginal men and women on stations in the Gascoyne region of Western Australia, and remarked on the wide range of scores, which led Fowler to comment that ‘some natives have intelligence of a high degree’ (Fowler, 1940, cited in Kearney et al., 1973, pp. 41–2). The study by Fowler and colleagues indicated test score equivalence between Aboriginal and white Australian people, and also raised the question of the effects of differential experience.

Nevertheless, 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, cited in Kearney, 1966), confirming the prejudice of mainstream society and very likely influencing government policy towards Aboriginal and Torres Strait Islander Australians.

From the late 1950s, McElwain conducted a series of investigations of cognitive ability, using the Queensland Test, with over 1000 Aboriginal children and adults varying in extent of contact with white Australian culture. McElwain and Kearney (1973) concluded that ‘the Aboriginal groups are inferior to Europeans, and in approximately the same degree as they have lacked contact with European group ... It seems clear that test results are dependent to a considerable degree upon contact or some variable related to contact’ (p. 47). Despite concerted efforts to modify the Queensland Test to be non-verbal and non-representational, this research clearly demonstrated that it is not possible to create a culture-free test free of the pronounced effect of Western cultural experience on test performance of non-Western children. Indeed, tests appear to be measures of Western learning.

From the mid-1960s a number of researchers undertook Piagetian studies among Aboriginal children in remote areas. These studies revealed consistently later than ‘average’ development of the concepts under study, particularly for the concept of conservation (de Lemos, 1969). Again, greater Western culture contact, particularly Western schooling, was shown to accompany higher Aboriginal scores.

The wide coverage of these results, 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 of the very recent past, would not have helped teachers' expectations of Aboriginal children. The Piagetian research also seems to have been partly responsible for 'deficit' views, following suggestions by de Lemos (1969) for changing Aboriginal children to fit better into education. 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.

Mental functioning and testing

Psychologists have been involved in the 'race debate', particularly with respect to testing of 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 (Hernstein & Murray, 1994; Jensen, 1972; Rushton, 1995). 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' (Butler, 1998, p. 41). There is a long history of biopsychological explanations being used to give scientific legitimacy to dominant social values. Both the general public and psychologists themselves tend to accept biological explanations as being scientifically objective. This has resulted in a psychological determinism that has supported those espousing a racist agenda. Within Australia, the intelligence-testing movement pioneered by Porteus supported educational, vocational and social policies that have oppressed Indigenous people (Davidson, 1995, 1998). 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.

At the end of the protectionist social policies prior to the 1970s, the first Australian psychology volume focusing on Aboriginal people was published in 1973: *The psychology of Aboriginal Australians*. The following year a cognitive symposium was held in Canberra, in conjunction with the Biennial General Meeting of the Australian Institute of Aboriginal Studies (now the Australian Institute of Aboriginal and Torres Strait Islander Studies). An edited volume of the symposium was produced, *Aboriginal cognition: Retrospect and prospect* (1976). In 1981, Judith Kearins published *Visual spatial memory in Aboriginal children of desert regions*, which challenged previous work and proposed that Aboriginal Australians have different cognitive strengths from other Australians. Then in 1985, the First Australian Conference on Testing and Assessment of Ethnic Minority Groups was held in Darwin, where a number of psychologists and educators from around Australia discussed Aboriginal and other cultural group issues in education (Davidson, 1988).

The Australian Psychological Society Position Paper on racism, *Racism and prejudice: Psychological perspectives* (1997), argued that developments in the study of the genetic basis of human diversity showed that the concept of race had no basis in fundamental biology, and should be abandoned by scientists. With the precise tools of molecular biology, the old racial categories appear increasingly arbitrary. 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 (Phinney, 1996). Nevertheless, these 19th-century notions have proved to be very resilient among some sectors of society, and while the validity of the biological concept of race is questionable, it remains a highly salient political and social construct (Fraser, 1995; Hernstein & Murray, 1994). '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' (Lonner, 1990, p. 56).

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 it is fundamental to human cognitive processing to 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 inevitably from this categorisation process. It has been argued that both categorisation and stereotyping are adaptive in that they simplify the complexity of the social world and provide us with cognitive shortcuts to help us negotiate social reality (Fiske & Taylor, 1991).

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 (Tajfel, 1981). 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, however, have argued that equally important in the manifestation of prejudice are affective or motivational factors, which are learned dispositions that do not automatically derive from cognitive categorisation (i.e. Devine, 1989). Developmental psychology and social learning theory maintain that there are mechanisms by which children acquire the particular stereotypes of their culture. For example, they may receive direct instruction, for example 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. Furthermore, it has been demonstrated that if ingroup/outgroup distinctions are de-emphasised in the child's social world, positive models are provided; if the social distance between the child's group and other groups is reduced, the development of prejudicial attitudes can be significantly reduced (Garcia Coll et al., 1996).

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' (Adorno et al., 1950; Altmeyer, 1988) maintains that some individuals are predisposed to prejudice as a result of personality tendencies to be politically conservative and fascist. 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 also 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 (Dudgeon & Oxenham, 1989; Paradies et al., 2008; Pheterson, 1990). 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. Such research supports the urgent need to focus on empowerment and self-determination for Aboriginal and Torres Strait Islander Australians.

There are pervasive effects of cultural and institutionalised racism that exist within professions, disciplines and institutions. These are often invisible and can take the form of the dominant group being seen as normal or the standard against which all else are judged, while those who are 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. Psychologists belong to a profession that has historically been conservative and identified with the dominant Anglo-based and Western European cultural tradition of Australia (Davidson et al., 2000; Dudgeon & Pickett, 2000). The following historical account reveals some of this culpability of institutionalised racism, but also describes psychology's more recent efforts to use its science, practice and advocacy in ways that 'work with' rather than 'work on' Aboriginal and Torres Strait Islander Australians.

PSYCHOLOGY AS PROFESSIONAL PRACTICE

Professional practice comprises the human service delivery applications of psychology. 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 and self-determinism of Aboriginal and Torres Strait Islander Australians, and the input of community and health psychology to understanding the social determinants of health and wellbeing, particularly the impact of 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, because the profession was not clearly established. However, during the period up to the 1970s, there was a pervasive influence of mainstream scientific views, which psychology contributed to, in the policies of the day. Notably, the policies of 'Aboriginal protection' derived from the prevailing scientific views, described earlier, 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 1969. During this period, children who were deemed by authorities to be 'neglected, abused or abandoned' or would benefit from assimilation were forcibly removed from their families and communities. Authorities applied values that Aboriginal children would benefit from assimilation through the Aboriginal Protection Acts and State Boards that implemented them. Welfare, health and other authorities played a major role in identifying Aboriginal children for removal. These policies continued to operate in some form across Australia, until the growing focus in mainstream developmental psychology on attachment theory and the essential nature of mother–infant bonding began to prevail (i.e. Bowlby, 1969, 1973, 1988).

Consequently, Aboriginal and Torres Strait Islander peoples have 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 support the removal of children, 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 (1991). Similarly, analyses under the National Aboriginal Health Strategy revealed pervasive indifference and disadvantage experienced by Aboriginal peoples and Torres Strait Islanders within the mental health system

(Hunter & Garvey, 1998). The ethnocentric 'expertise' of mainstream mental health services negated awareness of the unique needs of Aboriginal peoples and Torres Strait Islanders, and impeded acknowledgment of the profound impact of invasion and colonisation through social and emotional distress in Aboriginal and Torres Strait Islander communities (Swan et al., 1994). Misdiagnosis has been common because of a failure by mainstream services to recognise and understand the social and emotional context of presenting problems for Aboriginal peoples and Torres Strait Islanders. Stigma and lack of cultural understanding have inhibited acknowledgment of mental health problems. As noted earlier, the vast majority of psychology tests have been constructed by and for people who are members of Western individualistic cultures; these have questionable validity in assessment of people from other backgrounds, and particularly Aboriginal and Torres Strait Islander peoples.

PSYCHOLOGY AS ADVOCACY

The professional representation of psychology in relation to Aboriginal and Torres Strait Islander mental health and wellbeing has a fairly recent history. Although the APS has been involved in Indigenous issues since the 1960s—when a Queensland group became active with submissions to government on secondary education, child welfare and Aboriginal welfare—a major turning point was in 1988, which was a significant year for two main reasons. First, it was the year of the bicentennial of European settlement in Australia or, to use an Indigenous description of the event, the invasion of the continent by the English. Second, it was the year when about 4000 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, which were 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 Indigenous content or discussion as part of the program of the International Congress. The only Indigenous representation at the Congress 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' (Turtle & Orr, 1989), displayed without apology or apparent recognition of the insensitivity of such a display.

Shared concerns about these representations and omissions led 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. The Board sponsored a symposium on the Psychology of Indigenous People at the 25th Annual Conference of the APS 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 Aboriginal psychologist Patricia Dudgeon and anthropologist Darlene Oxenham (1989). 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 highlight first-hand the issues of social (in)justice and their effects on Aboriginal people (Mudaly et al., 1991).

At the 26th Annual Conference in Adelaide in 1991, the APS Interest Group on Aboriginal Issues, Aboriginal People, and Psychology, was formed, and gradually took over from the Board of Community Psychologists as the Society's principal advocate on Indigenous issues. The Interest Group has been engaged in a variety of activities, including the continuation of the development and promotion of Indigenous issues at the APS Annual Conferences; organisation of mini-conferences in Perth in 1993 and 1998; professional development programs with psychologists and other professionals, including Aboriginal Health Workers, in several states; contributions to APS Position Papers and submissions to national inquiries; and mentoring of Aboriginal students in psychology programs (Gridley et al., 2000).

In 1993, the APS established a working party to prepare guidelines to assist psychologists who work with Indigenous people (Davidson et al., 1995). The resulting *Guidelines for the provision of psychological services for and the conduct of psychological research with Aboriginal and Torres Strait Islander people 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 (1997/1999) 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’ (p. 1). 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 most recent revision of the Code (2007/2009) goes further, affirming all people’s ‘right to linguistically and culturally appropriate services’ (p. 11) and incorporating potential for an advocacy role when psychologists become aware of discriminatory practices or systems experienced by their clients.

Since 1995, there has been a program of Aboriginal content at each APS Annual Conference, with a substantial proportion of Indigenous mental health professionals presenting papers. In 1997, the APS was a signatory to the ACOSS Statement of Apology and Commitment to the Stolen Generations of Aboriginal Children (ACOSS, 1997). In 1997, the APS *Position paper on racism and prejudice* (APS, 1997; Sanson et al., 1998) reviewed recent Australian research in the area. This was a significant step towards formally recognising that racial and ethnic prejudice exists in Australia today, reducing professional ignorance about various forms of present-day racism, and increasing psychologists’ sensitivity to the effects that racism has on Indigenous people.

In 1998, the Centre for Aboriginal Studies and the School of Psychology at Curtin University convened a mini-conference in Perth to specifically overview and discuss Indigenous content in the psychological curriculum. Some of these educational activities were presented in a special issue of the *Australian Psychologist—Australian Indigenous Psychologies* (Sonn et al., 2000; Williams, 2000). This volume was unprecedented in its focus and in its genuine collaboration between Indigenous and non-Indigenous mental health professionals.

The APS is now committed to enabling the profession and discipline of psychology to support the social and emotional wellbeing of Aboriginal and Torres Strait Islander Australians. This includes a benchmarking exercise in the teaching of Australian Indigenous content in undergraduate psychology courses, offering bursaries and other supports to encourage and enable Indigenous Australians to become part of the profession of psychology, as well as ongoing examination of the role and impact of the profession in this field through the Interest Group and other mechanisms of the APS. ‘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’ (Davidson & Sanson, 1995, p. 3).

A recent development and one of the most significant for Australian psychology is the formation of the Australian Indigenous Psychologists Association (AIPA), a new body established under the auspices of the APS. AIPA had its beginnings in Melbourne in March 2008, when the APS hosted the first ever meeting of Aboriginal and Torres Strait Islander psychologists in their own right. AIPA members are already much 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 Indigenous health equality campaign.

THE INDIGENOUS MENTAL HEALTH MOVEMENT

In the late 1970s, there developed a groundswell of activity by Aboriginal mental health professionals to establish a voice and a place in matters concerning the mental health of Indigenous Australians. The formation in 1979 of the National Aboriginal Mental Health Association (NAMHA) from a founding representative group of more than 50 Aboriginal Health Workers marked their concern 'that Aboriginal mental health problems were being largely ignored by health providers' (Fua, 1980, p. 41). Aboriginal community-controlled health services were established in most states in the 1970s, and NAMHA advocated mental health training and services by and for Aboriginal people, with the result that mental health training was incorporated as a component of all Aboriginal Health Worker training over the next two decades.

One of the most significant events affecting Indigenous mental health was the *Ways Forward* report (Swan & Raphael, 1995). Hunter (1997) and Dudgeon and Pickett (2000) defined the historical period of this consultancy and report about Aboriginal and Torres Strait Islander mental health as one of collaboration between non-Indigenous and Indigenous people in the field and as a landmark event symbolising a different focus. Indigenous constructions of health and mental health that were politically and culturally informed began to emerge. Perceptions of Indigenous mental health changed and, rather than the 'disease model' perspective, wellness, holistic health, and culturally informed and appropriate approaches were prioritised.

Dudgeon and Pickett (2000) described these changes in perceptions towards Indigenous mental health as underpinned by key elements that includes a philosophical approach of empowerment and self-determination in the provision of mental health services for Indigenous people. Services that worked with Indigenous people needed to ensure that mechanisms were in place for collaboration and direction from the client groups, and Indigenous people needed to be fully involved in any mental health activity aimed at them. Indigenous people themselves needed to direct the engagement, at all levels, whether this was 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 Indigenous researchers continue to call for appropriate inclusion of Indigenous people. Brideson and Kanowski (2004), in a special issue of the *Australian e-Journal for the Advancement of Mental Health* on Aboriginal and Torres Strait Islander mental health, stated that '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' (p. 7).

As well as facilitating a culturally competent profession, an Indigenous workforce in mental health needs to be a priority. In 2000, there were fewer than a dozen registered Aboriginal psychologists in Australia. In 2009, there are at least 39. However, commensurate rates mean that a target of at least 336 Indigenous psychologists should be achieved (Australian Indigenous Psychologists, 2009). For the discipline, there is still a considerable way to go to support the development of Aboriginal mental health professionals.

CONCLUSION

This brief history of psychology and Aboriginal and Torres Strait Islander mental health aims to assist people working in the field to understand the past role of psychology in contributing to cultural and institutionalised racism. Acknowledging and owning this history can ensure that we do not repeat the mistakes of the past, but rather learn from them and move forward. Awareness of this history also helps psychologists to understand the reluctance to engage with the profession and the suspicion in which the profession is sometimes held. Historically, the science and practice of psychology have been aligned with the mainstream Western scientific values that have contributed to perpetuating and excusing racism. The science and practice of psychology has matured to acknowledge some of its role in this, but there must be ongoing vigilance of the theories, research methodologies and professional practice. It is essential that

psychology continue to work towards the goal to ‘train members of our profession to be part of the multiple solutions to racism and Indigenous disadvantage, rather than part of the problem’ (Turner, 2006, p. 6). This is consonant with the Apology delivered by the Prime Minister on behalf of the nation and Australian peoples in February 2008, which recognised the harm caused by the mistreatment of Indigenous Australians through the policies and practices of past governments. Similarly, psychology needs to acknowledge its past and look towards new solutions and approaches, and a commitment to principles of mutual respect, inclusion and shared responsibility in moving forward to a better future.

Reflective exercises

- 1 This chapter provides a particular perspective on the impact of psychology in Aboriginal and Torres Strait Islander mental health. Discuss these perspectives and your thoughts on this history.
- 2 Why is it important for mental health professions to ‘know the past’?
- 3 How can psychology and other mental health disciplines play an empowering role in Indigenous mental health?
- 4 What were some of the key factors supporting the Indigenous mental health movement?

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3



The Social, Cultural and Historical Context of Aboriginal and Torres Strait Islander Australians

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

OVERVIEW

To understand the contemporary life of Indigenous Australians, a historical and cultural background is essential. This chapter sets the context for further discussions about Aboriginal and Torres Strait Islander people and issues related to their social and emotional wellbeing and mental health. The history of colonisation is addressed, the subsequent devastation of Indigenous Australians, and their resilience and struggle to claim equality and cultural recognition, and to shape the present. 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 Indigenous people are included, with particular attention to racism.

ABORIGINAL AND TORRES STRAIT ISLANDER POPULATIONS

The Australian Bureau of Statistics estimated that in 2006 there were 517,000 Aboriginal and Torres Strait Islander people living in Australia. Overall, Indigenous people make up 2.5% of the total Australian population. Among the Indigenous population in 2006, it is estimated that 463,700 (90%) were of Aboriginal origin, 33,300 (6%) were of Torres Strait Islander origin only, and 20,100 (4%) were of both Aboriginal and Torres Strait Islander origin (ABS, 2008b).

In 2006, 32% of Indigenous people lived in major cities, with 21% in inner regional areas and 22% in outer regional areas, while 9% lived in remote areas and 15% lived in very remote areas (ABS 2008a). While the majority of Indigenous people live in urban settings, the Indigenous population is much more widely dispersed across the country than the non-Indigenous population, constituting a much higher proportion of the population in Northern Australia and more remote areas (ABS, 2008a).

ABORIGINAL CULTURAL HISTORY

To appreciate the contemporary realities of Aboriginal and Torres Strait Islander Australians, their cultural ways of life need to be understood. In the recent decades there has been a strong renaissance of Indigenous culture and forms of creative expression, and a reconnection and

reclaiming of cultural life. Aboriginal culture has roots deep in the past. Australia's Indigenous cultural traditions have a history and continuity unrivalled in the world.

Far from signifying the end of Indigenous Australian traditions, new forms of adaptation are bringing new vitality to older cultural themes and values that need to be addressed. Contemporary Indigenous 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 approximately 300,000 Aboriginal people living in Australia when the British arrived in 1788 (Commonwealth of Australia, 1998).

At the time of colonisation there were approximately 260 distinct language groups and 500 dialects. Indigenous Australians 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 (Berndt & Berndt, 1992; Broome, 1994).

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 (HREOC, 2008) 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. (p. 414)

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.

Complex and sophisticated kinship systems placed each person in relationship to every other person in the groups and determined the behaviour of an individual to each person. The kinship system also took into account people external to the group. 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, an individual was not alone; kinship systems placed each person securely in the group (Berndt & Berndt, 1992).

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 (Berndt & Berndt, 1992).

TORRES STRAIT ISLANDER CULTURE AND HISTORY

The following section provides a brief overview of some features of Torres Strait Islander culture and history. Details are provided about an interesting history that is distinctive yet inseparable from the broader Indigenous story.

Origins and features of the Torres Strait

The Torres Strait is the seaway between the northernmost east coast of Australia and Papua New Guinea, between the Coral Sea and the Arafura Sea. There are approximately 100 islands in the Torres Strait. The Sahul Shelf was a land-bridge that linked the Australian mainland and Papua New Guinea between 80,000 and 90,000 years ago, and the Torres Strait islands are the result of this (Rowe, 2006).

Torres Strait Islanders live permanently in 18 communities on 17 of the 100 islands, as well as in locations in every Australian state. In 1879, the Torres Strait was annexed and as such was considered part of Queensland when the islands became crown land. Queensland has the highest population of people identifying as Torres Strait Islanders (20,902), followed by New South Wales (5,248) and Victoria (2,200) (ABS 2008a). People identifying as having both Aboriginal and Torres Strait Islander heritage follow a similar population distribution among Australian states (Garvey, 2000).

History

The Torres Strait itself bears the name of the Spanish explorer Luis Vaez de Torres, who travelled through the area in 1606. Torres Strait Islander culture has a unique identity and associated territorial claim (Shnukal, 2001). Oral history and journals written by European seamen from the late 18th century have preserved knowledge about traditional pre-contact Torres Strait Islander culture and society. These stories point to the diversity of Islander people, which came about from the differing conditions in each island, and they are informed by the social and spiritual material incorporated by those Islanders. Torres Strait Islanders had close contact with both Papua New Guinean communities to the north and with mainland Aboriginal communities to the south in and around the Cape York Peninsula (Philp, 2001).

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 (Mosby & Robinson, 1998). 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 gardeners, fishers and hunters, as well as warriors. They were also expert sailors and navigators (Philp, 2001). Reference to this traditional and contemporary skill and the use of stars for navigation is symbolised in the flag of the Torres Strait.

Much of the early recorded history between Europeans and Islanders was punctuated by accounts of attacks and reprisals (Mosby & Robinson, 1998). It should be noted that many resources aimed at facilitating good working relationships with Torres Strait Islanders today focus on the need for visitors to respect *Ilan Pasin* and Islander ways of working, rather than assume certain privileges or levels of access (Garvey, 2007; Mina mir lo ailan mun, n.d.; Mosby & Robinson, 1998).

Torres Strait history may be divided into two periods: *bepo time*—the ‘time before’, or pre-Christian time, and the ‘time after’, or Christian time (Mosby & Robinson, 1998). The Strait was seen as a strategic waterway but the population was also seen as valuable to the efforts of Christian missionaries, in particular, the London Missionary Society (Nakata, 2007).

There were many disadvantages of missionary influences, such as the destruction of traditional cultural religious practices (Lawrence, 2004). But the positive consequences were also numerous, particularly the hybridisation that was given to forms of religious and secular music. Christianity also provided a shared identity with the focus on unity that Christians reinforced through inter-island church meetings, religious festivals and church openings (Shnukal, 1988). Today, for many Torres Strait Islanders, ‘The Coming of the Light’ is commemorated on the first of July each year and is regarded as National Torres Strait Islander Day.

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. McGrath (1995, p. 104) identified many historical events that affected Islander life over the ensuing years, including:

- the 1936 maritime strike, a turning point in collective Islander assertiveness in rejecting government repression
- the 1937 inaugural Island Councillors meeting, which resulted in the revised *Aboriginal Protection Act* of 1939 giving Islanders greater authority in their own affairs
- participation in the 1939–45 war
- from 1960, the beginning of large-scale southward migration to the Australian mainland because of the decline in the pearling industry
- the call for independence in the early 1980s as a result of Islander concerns about the slow pace of improvements to basic infrastructure in their communities
- the 1992 Mabo Case that confirmed Meriam ownership over their islands.

These events continue to influence Islander culture and identity.

The main languages of the Torres Strait are identified as Kala Lagaw Ya, Meriam Mir and Torres Strait Kriol (ABS, 2008b). Comparatively, Torres Strait Island languages are some of the most widely spoken Indigenous languages in Australia today, second only to the Arnhem Land and Daly River Region language groups (ABS, 2008b). Torres Strait English, a regional version of Standard Australian English, is also spoken by Islanders in the Strait and on the mainland (Shnukal, 2001).

There are mixed opinions about the various influences brought to the Torres Strait and opportunities available to Torres Strait Islanders on the Australian mainland. Introduced religion can be acknowledged as both replacing traditional spirituality and as serving a cohesive function. The anthropological and other research conducted on Islanders and the collections of artefacts that took place are both examples of Western colonisation and appropriation, but served as a means by which traditional culture is now being reclaimed by Islanders. Access to opportunities beyond the Straits has brought both prosperity and disappointment as individuals and groups contend with the reality of living away from home, staying connected to home or wanting to return home.

There are numerous examples of Torres Strait Islander people's endeavours and achievements (Shnukal, 2001), as well as symbols of solidarity and unity. 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 did not belong to anyone and therefore could be 'settled'. Thus, while Torres Strait Islander history and culture is characterised in many ways by cultural adaptation and migration (Shnukal, 2001), the essence and origins of Islander identity—the psychological and the geographical—are still fought for, defended and celebrated today. Into the future, it is likely that the label of 'voiceless minority' will become a less accurate description for Torres Strait Islanders (Garvey, 2007; Nakata, 2007; Wilson, 1988).

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 (1994) calls the rapidly moving frontier of the mid-1800s the most 'fantastic land grab which was never again to be equaled' (p. 37). 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 (Reynolds, 1987). 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 (Campbell, 2002); entire tribes were wiped out. 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 (Broome, 1994; Reynolds, 1999). There has been a recent proliferation of significant texts that include detailed accounts of Aboriginal resistances and warfare (Lowe, 1994). Military analyses of frontier warfare between Aboriginal people and the British (Conner, 2002) have been complemented by local histories with an Aboriginal perspective such as the work of Howard Pedersen and Banjo Woorunmurra (1995), *Jandamarra and the Bunuba Resistance*.

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 (Broome, 1994). Disruptions to traditional life led to many groups of 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 (McGrath, 1995), and there are many examples of Aboriginal groups across the country successfully adapting to colonisation and making new independent lives amid this immense change (see *Rebellion at Coranderrk* [Barwick, 1998],

and *Cumeroogunga* [Broome, 1994]). 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 Indigenous Australians. Each state of the newly formed federation framed and enacted suites of legislations and policies that were punitive and restrictive towards Indigenous 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* (NSW Department of Aboriginal Affairs, 2001). Other states passed similar legislation in an attempt to control Indigenous people (McGrath, 1995): in South Australia the 1911 *Aboriginal Protection Act* (Brock, 1993); the *Cape Barren Island Act 1912* in Tasmania (AIATSIS, 2008); the Queensland *Aboriginals Protection and Restriction of the Sale of Opium Act 1897* (AIATSIS, 2008); and the *Northern Territory Aboriginal Ordinance of 1911* and the *Welfare Ordinance 1953* (AIATSIS, 2008). Victoria introduced the *Aborigines Act 1869*, before Federation in 1901 (AIATSIS, 2008). The intention underlying these punitive and restrictive laws was clear, for under the pretense of *for their own good* (Haebich, 1988), the effects were a form of cultural genocide of Indigenous Australians, through the loss of language, family dispersion and the cessation of cultural practices.

The Western Australian *Aborigines Act 1905* (AIATSIS, 2008) 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. Nineteen hundred and five marked the start of a period of formidable surveillance and oppression of Aboriginal people. While the *Native Administration Act 1936* consolidated the absolute rights of the State over Aboriginal people, the 1905 Act is symbolic of Indigenous oppression, just as the 1967 National Referendum, when Aboriginal rights were won back, is symbolic of emancipation.

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 co-habitation of Aboriginal women with non-Aboriginal men was prohibited. Local Protectors implemented these new regulations.

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' (Milnes, 2001, p. 32). 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 (HREOC, 1997; McCorquodale, 1987).

State control of and intervention in the lives of Aboriginal people was extreme. Not one Aboriginal person could be said to have been untouched by the legislation that was 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. It should be noted, however, that Indigenous people and white supporters have continued to resist and struggle for justice since colonisation. The movement

for Indigenous rights began in the 1920s, with the establishment of Aboriginal political organisations, in particular the Australian Aborigines League led by William Cooper and the Aborigines Progressive Association led by William Ferguson (Bullimore, 2001). Over time, various Indigenous political and support groups were established across the country.

THE 1967 COMMONWEALTH REFERENDUM

In Australia, the 1967 Commonwealth Referendum symbolises the granting of full citizenship rights to Australian Aboriginal peoples. But problems continued for Aboriginal people after 1967. According to Stokes (1997), who surveyed Aboriginal political commentary after this period, as well as striving towards political equality and self-determination, the quest for a cultural identity became central, gaining a new significance. Continual difficulties with racism and disadvantage have persisted. Since then, 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 from the late 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 Indigenous rights, acknowledging that Aboriginal people possessed certain rights that did not pertain to other Australians. These changes could be captured under three stages or events: the prohibition on racial discrimination, land rights and the facilitation of self-determination (Chesterman & Galligan, 1997).

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. Indigenous activists gained national attention, leading public protests, rallies and political agitation (Foley, 2001). The 1960s and 1970s saw significant achievements that have now 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.

Indigenous people in Australia are still grappling with the effects of colonisation. Kevin Gilbert (1977), in *Living Black*, stated that as invasion occurred, Aborigines 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. (pp. 2–3)

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

SIGNIFICANT CONTEMPORARY ISSUES

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 Indigenous families have experienced

removal of children or displacement of entire families into missions, reserves or other institutions. There was a period of history when children, who were usually 'part white', were taken from their families so that they could be 'civilised'. They were placed into institutions for educating and training to live and work in white society as menials. This was a widespread phenomenon across the nation. As many as one in ten Indigenous children were forcibly removed from their families and communities in the first half of the 20th century. Various reports such as *Bringing Them Home* (HREOC, 1997) have shown that in certain regions at different times the figure may have been much more. In that time, not many Indigenous families escaped the effects of forcible removal, and most families have been affected over one or more generations. Drawing on her research in the Northern Territory, McGrath (1987) described these policies for the removal of children as 'the ultimate racist act'. Her statement can be generalised to the rest of Australia.

Haebich's (2000) comprehensive analysis of the removal of Indigenous Australian children across the country describes the removal of children as not a single event but a process stretching from colonisation to the present. This process and its consequences are part of Indigenous identity. It has been only in recent times that the practice has been officially recognised, with the former Prime Minister Paul Keating's historic Redfern Park Speech in 1992, followed by Prime Minister Rudd's momentous National Apology to the Stolen Generations on 13 February 2008. Mellor and Haebich's edited volume (2002) offers comprehensive accounts of the removal of Indigenous people across Australia, by those who were affected by the policy as well as by the carers and officials involved. The legacy of that practice remains today, in terms of alienation and colonial identity.

Forcible removals of children and their subsequent effects have been and still are a profound part of the Indigenous Australian 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 (Morgan, 2002). 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 Indigenous children from families and communities was not only driven by an aim of assimilation, but also aimed to achieve the disintegration of Indigenous communities, and to transform the relationship between Indigenous people and their environment.

The transgenerational effects of the policies of forced removal of Indigenous children on Indigenous emotional and social wellbeing are profound and enduring, and will be further discussed in other chapters.

Descent, country and kinship

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' (Morrissey, 2003, p. 59).

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. In Oxenham et al. (1999), the Indigenous authors position themselves in the introduction by locating themselves on a map of Australia, indicating where they came from and what tribal

groupings they belong to. 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.

The relationship Aboriginal people have to their country is a deep spiritual connection that is different from the relationship held by other Australians (Choo, 2001). Several texts articulate the spiritual feeling of country for Aboriginal people: for example, Paddy Roe in *Reading the country* (Benterrak et al., 1996), Sunfly Tjuperla in *Two men dreaming* (Cowan, 1995), David Mowaljarlai in *Yorro Yorro: Everything standing up alive* (Mowaljarlai & Malnic, 1993) and Bill Neidjie in *Story about feeling* (Neidjie, 1989). These texts attempt to capture the feeling of relationship with country in different ways. This could be described as a spiritual, bodily connectedness, as Neidjie (1989, p. 182) 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.

The need to be able to describe relationships to land in different ways has been taken up by Moreton-Robinson (2003). Here Indigenous relationships with land are described as forming an 'ontological belonging'. Indigenous people's spiritual beliefs are based on 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' (p. 31). 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 Indigenous

Being part of an Aboriginal community is another facet of Aboriginal identity. Other Indigenous people know who you are and what family you belong to. Dudgeon et al. (2002) provided a comprehensive overview of what community means for Aboriginal people. They acknowledge that the concept of a community has a political agenda for the state, whereby Indigenous 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. (Dudgeon et al., 2002, p. 248)

Indigenous people have created communities of significance and meaning for themselves, and membership still includes Indigenous descent. It should be noted that Western and Indigenous 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 Indigenous 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.

While there are contestations about the definitions of Indigenous identity, it is generally accepted that an Aboriginal person is one who is a descendant of an Indigenous inhabitant of Australia, who identifies as an Aboriginal person, and who is recognised as Aboriginal by members of the community where they live. Indigenous 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 Indigenous 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 Indigenous peoples is to challenge previously held assumptions about them and work towards creating new constructions of identity.

Many Indigenous authors (e.g. Oxenham et al., 1999; Paradies, 2006) have written about Indigenous identity and discussed the lived experience of being an Indigenous person. Taylor (2001) described it in these words:

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). (p. 139)

CONTEMPORARY SITUATIONS: INDIGENOUS AUSTRALIA

The national *Overcoming Indigenous disadvantage report: Key indicators 2005/2007/2009 Reports* (SCRGSP, 2005, 2007, 2009) show that Indigenous people are the most disadvantaged group in Australia.

- The life expectancy of Indigenous people is around 9.7 to 11.5 years lower than that of other Australians.
- Indigenous students are half as likely to continue into Year 12.
- The average Indigenous income is lower.
- A much lower proportion of Indigenous people own their homes.
- Suicide death rates are much higher.
- The rate of child protection notifications are rising faster than for others.
- Homicide death rates are six times higher.
- Indigenous people are 12 times more likely to be hospitalised for assault than other people.
- Both men and women experience more than double the victimisation rates of others.
- Indigenous women's imprisonment rates have increased.
- Juveniles are 20 times more likely to be detained.

- Hospital admission rates for children are twice that of others.
- Infant mortality rates are two to three times higher.
- Sixty-five per cent of Indigenous homicides involve both the victim and offender having consumed alcohol at the time, which is three times more than the occurrence for others.
- Indigenous people, both men and women, are over four times more likely than other people to be in hospital for alcohol-related mental and behavioural disorders.

While Torres Strait Islander people have their own distinctive culture, they share many of the same disadvantages as Aboriginal people (ABS, 2006). The *Ways Forward* report (1995) highlighted Torres Strait Islander issues and reported that Torres Strait Islander people suffered the same disadvantages and racism as Aboriginal people; however, there were specific issues such as lack of recognition of Torres Strait Islanders as belonging to a separate and unique cultural group, lack of appropriate representation, exclusion and hostility from Aboriginal groups when attempting to access services, and ignorance about Torres Strait Islander people and culture from mainstream Australia. The report recommended that there was a need for research into Torres Strait Islander mental health, that there should be a recognition of Torres Strait Islanders as a distinct cultural group, and a need to recognise Torres Strait Islander healing methods and healers.

This litany of impoverishment and disadvantage in an otherwise wealthy nation is shameful. 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 Indigenous people and culture lie at the core of the causes. As noted in the *Overcoming Indigenous Disadvantage Report* (SCRGSP, 2009), racism at individual and institutional levels continues to reproduce the impoverishment and disadvantage experienced by most Indigenous Australians.

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 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 do characterise racism, to be sure, 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. While these occur interactively and simultaneously, they may manifest differently as society changes.

Although 'race' has been largely discredited as a scientific concept, the term continues to be used as a way of organising our thinking about people and the groups they belong to (McCann-Mortimer et al., 2004). Thus, race can be seen to be socially defined, sometimes on the basis of physical criteria. Race as a social and cultural construction has been used to separate groups that have been defined by physical and cultural difference and by the supposed superiority and inferiority of 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. Even though in contemporary times most scientists agree that there is no biological basis to race, the general population still uses pseudo-scientific explanations for cultural differences. However, the use of the idea of race 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' (Jones, 1997, p. 364).

While individual people are, rightly, seen as the agents of racism, it is important to appreciate how racism operates at a cultural and an institutional level (Jones, 1997). Cultural racism is a part of the atmosphere of a society; it is just part of the tacit, assumed way of doing things. Culture comprises all the ideas, values, beliefs and shared understandings that together allow members of a culture to interact with one another without having to explain and reinvent them all the time. It refers to what is taken for granted. Accordingly, cultural racism:

comprises the cumulative effects of a racialized worldview, based on belief in essential racial differences that favor the dominant racial group over others. 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. (Jones, 1997, p. 472)

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.

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. According to Jones they are:

those established laws, customs, and practices which systematically reflect and produce racial inequities in American 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. (1997, p. 438)

An institution can engage in racist practices without any of its members being individually racist. This is an important point to comprehend if we are to understand the damaging health and educational outcomes affecting Indigenous 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 is:

one who considers 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 are determinants of social behaviour and of 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. (Jones, 1997, p. 417)

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 (Pedersen & Walker, 1997; Pedersen et al. 2004; Walker, 2001). 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. Subtle racism is also much harder to change, as it is rarely recognised as racism, by the perpetrator 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 Indigenous people in Australia there is ample evidence of active oppression manifested 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 Indigenous 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 indicators of the consequences of entrenched institutionalised racism (Dudgeon et al., 2000).

Jones stated that 'culture is to society as personality is to the individual' (1997, p. 471), and culture is integral to discussions of racism. For Jones, cultural racism comprises the cumulative effects of a racialised worldview, based on a belief in essential racial differences, that favour the dominant racial group over others. The effects of these are suffused throughout the culture via institutionalised structures, ideological beliefs and personal everyday actions of people in the culture, and these effects are passed on from generation to generation.

The effects of racism on oppressed groups led to the development of an array of responses and mechanisms such as low self-esteem, mistrust of the dominant culture, internalised racism, and denial. However, members of minority groups with strong ethnic identity often, but not always, have more positive self-conceptions (Jones, 1997; Pedersen & Walker, 2000). 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 Indigenous Australians. First, modern racism 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. In many ways, life is a struggle for people of colour. Even for those who have 'made it' and have overcome obstacles, different forms of racism emerge that need to be confronted. Racism is inescapable.

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 inextricably a part of the colonising project; the belief that all things Western were superior and all things Indigenous were inferior was initially imposed by military might and enshrined in laws specifically legislated to control the lives of Indigenous people. In turn, it has had a central influence on Indigenous 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. The effects of racism cannot be underestimated. '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' (Thompson & Tyagi, 1996, p. ix).

RACISM IN AUSTRALIA

The small body of research on racism against Indigenous peoples in Australia conveys a mixed, but alarming, picture of its extent and nature. Most of this research has focused on the prevalence of self-reported interpersonal racism, with some studies of systemic racism and virtually no studies examining the extent of internalised racism.

In Australia, national surveys suggest that between half and three-quarters of respondents give racist responses to key self-report questions assessing racist attitudes and beliefs (Forrest et al., 2007; Gallaher et al., 2009; Larson et al., 2007; Paradies & Cunningham, 2009; Paradies et al., 2008). Historical reviews of research trends (Walker, 2001) 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.

About 16% of the 5757 Indigenous adults in the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) who were asked about their experiences of racism reported that, in the last 12 months, they felt treated badly because they were Aboriginal/Torres Strait Islander (Paradies et al., 2008). Of the 9400 Indigenous respondents in the 2002–03 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), 18% reported experiencing discrimination as a personal stressor in the last 12 months (ABS, 2004). Similarly, 22% of the 1073 children aged 12–17 years in the 2001–02 Western Australian Aboriginal Child Health Survey (WAACHS) reported experiencing racism (defined as being treated badly or refused service due to being Aboriginal) in the past six months (Zubrick et al., 2005). A 2001 survey found that approximately 30% of Indigenous peoples reported experiencing racism (defined as discrimination due to ethnic origin) (Dunn et al., 2003) and a 2003 survey found that 40% of Aboriginal respondents reported being physically or emotionally upset as a result of treatment based on their race (Larson et al., 2007).

The prevalence of systemic racism is more difficult to establish. However, a range of studies and inquiries highlight the widespread nature of such racism in domains such as national politics (Augoustinos et al., 1999), media (Cunneen, 2001), education (Sonn et al., 2000) and the welfare system (Sanders, 1999), as well as in the provision of public housing (Equal Opportunity Commission, Western Australia, 2004) and the legal/criminal justice systems (Blagg et al., 2005). Evidence from Victoria indicates that when apprehended by police, Indigenous people are half as likely to be given a caution as non-Indigenous people and ‘were nearly three times less likely to be cautioned when processed by police’ than non-Indigenous youth (Department of Justice, 2005; Indigenous Issues Unit, 2006). Research on systemic racism against Indigenous peoples in the health care sector has been the most common to date. The direct effect of racism on Indigenous health will be discussed in Chapter 4.

CONCLUSION

Contemporary life is always shaped by history and culture. This is perhaps especially so for Indigenous Australians. Since white people first came to Australia in 1788, Indigenous people 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 racist world that systematically devalues Indigenous culture and people. Such experiences have profound effects on health and social and emotional wellbeing, for individuals, families and communities. These experiences have been resisted over the years, and the histories of resistance and resilience are as much part of contemporary Indigenous culture and identity as are the experiences of devastation. It is important to remember also that Indigenous 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.

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 Torres Strait Islander people and non-Indigenous Australians?
- 3 What are the main characteristics of Aboriginal and Torres Strait Islander 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 According to this chapter, overt racism may have declined, but other forms of racism have not. Imagine being born as an Aboriginal and/or Torres Strait Islander person. What would your life be like? What forms of racism do you think you would encounter?

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4

The Policy Context of Aboriginal and Torres Strait Islander Mental Health



Stephen R. Zubrick, Kerrie Kelly and Roz Walker

OVERVIEW

This chapter outlines the role of policy in setting directions for and achieving change in Indigenous mental health. Key national policies, frameworks and reports addressing the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander people are presented. Historical milestones surrounding key policies together with the effects these policies have had on Indigenous individual and community 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 or services were implemented and/or any practices or processes were 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 implementing policies or programs. Unlike earlier chapters that describe the historical and social context of colonisation and how successive policies have impacted on Indigenous social and emotional wellbeing, this chapter focuses on the policies and reports that specifically address Indigenous mental health and social and emotional wellbeing together with the relevant reports and commissioned inquiries that have influenced these policies.

THE CHANGING POLICY CONTEXT

In the last decade there has been an increasing policy focus on Aboriginal and Torres Strait Islander social and emotional wellbeing through the development of several key policy documents. These include the *National Aboriginal Health Strategy* (NAHS), the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (NSFATSIH) and the *National and Strategic Framework for Aboriginal and Torres Strait Islander People’s Mental Health and Social and Emotional Well Being*. In addition, the *Aboriginal and Torres Strait Islander Health Performance Framework* (HPF) was developed under the auspices of the Australian Health Ministers Advisory Council to monitor progress in Indigenous health, and comprises 71 performance indicators including a specific indicator on social and emotional wellbeing.

Increasingly, it is recognised that policy areas relevant to social and emotional wellbeing extend well beyond the influence of health and mental health systems to encompass other sectors such as education, law and justice, human rights, Native Title, and families and communities (ANPPEIMH, 2007; AUSEINET, 2008). Thus, coordinating policy inputs across multiple sectors

to guide planning and services for Aboriginal and Torres Strait Islander mental health and encourage interagency collaboration remains a complex and daunting task.

In addition, the commonly used term ‘mental health’ has proved particularly problematic in the Aboriginal and Torres Strait Islander context. Most mainstream mental health services tend to focus primarily on treating mental illness and/or on psychiatric care. According to some studies, while there have been consistent efforts to broaden community understanding about the promotion of mentally healthy behaviour and the prevention of mental illness, the term mental health continues to carry negative connotations and stigma about mental illness, psychiatric treatment and people needing mental health care, particularly for Aboriginal and Torres Strait Islander people (Thomson et al., 2005). It is not surprising then—given the concerns repeatedly expressed by Aboriginal and Torres Strait Islander people regarding the failure of Western medical and health philosophies and practices to adopt a more holistic approach—that recent attempts to transpose these current mental health practices into Aboriginal and Torres Strait Islander health services have been widely resisted.

Over the last decade, Aboriginal and Torres Strait Islander people have continued to identify, articulate and request a more culturally appropriate, holistic policy position and program implementation governing Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health. This has resulted in recognition of a definition of mental health that more appropriately reflects Aboriginal and Torres Strait Islander philosophies and views.

During the same period in Australia the mental health system has undergone a sustained process of reform, and there has been a greater focus on prevention and promotion in mental health policy. This has resulted in greater recognition in mainstream policies of positive mental health—as opposed to mental illness—that is more in accord with an Aboriginal and Torres Strait Islander emphasis on emotional and social wellbeing (Thomson et al., 2005). The 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. (Australian Health Ministers, 2003, in Thomson et al., p. iv)

This definition is closer but still does not reflect Aboriginal and Torres Strait Islander perceptions of social and emotional wellbeing described below:

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 social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual. Social and emotional wellbeing problems cover a broad range of problems 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. (Social Health Reference Group, 2004, p. 9)

In the definition above, Aboriginal and Torres Strait Islander people have clearly identified the determinants currently influencing their social and emotional wellbeing and mental health: grief, loss, trauma and abuse, racism, discrimination, domestic violence, adversity, cultural dislocation, substance misuse, forcible removal of children, and enduring disadvantage.

POLICIES, FRAMEWORKS AND REPORTS

While there are numerous policy documents and frameworks governing mental health in Australia, the key foundation developments of Aboriginal and Torres Strait Islander mental health policy are the following:

- *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* (1997)
- *The National Strategic Framework for Aboriginal and Torres Strait Islander Health* (2003–13)
- The Council of Australian Government's *Mental Health Reform Initiative* (2006)
- Apology to Australia's Indigenous peoples, February 2008
- The Council of Australian Governments' Indigenous Reform Agenda (2008).

As described in Chapter 4, 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 of these previous policies have had a detrimental effect on the health, social and emotional wellbeing, and survival of Aboriginal Australians, and have limited their capacity to control and direct their future development. Several important inquiries, commissions and evaluations have examined the impact of past policies on Aboriginal and Torres Strait Islander people and communities. Many of these have influenced the response to the stark health and mental health disparities between Aboriginal and Torres Strait Islander peoples and other Australians. These reports include:

- *The Royal Commission into Aboriginal Deaths in Custody Report* (1991)
- *Human Rights and Mental Illness: Report of the National Inquiry into Human Rights and Mental Illness* (the Burdekin Report) (1993)
- *National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (1995)
- *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (1997)
- *Evaluation of the Emotional and Social Well Being (Mental Health) Action Plan* (1996–2001).

Each of these reports have contributed to the development of national action plans and strategic frameworks, including those discussed in this chapter relating to the mental health of Aboriginal and Torres Strait Islander peoples. The most significant of these national frameworks briefly discussed here are:

- The Council of Australian Government's *Reconciliation Framework* (2000)
- *The National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being* (2004–09)
- The Council of Australian Governments' *Overcoming Indigenous Disadvantage Indicator Framework* (2004).

Royal Commission into Aboriginal Deaths in Custody Report (1991)

The Royal Commission into the Aboriginal Deaths in Custody (RCIADIC) was a landmark report handed down in 1991 that has had a significant influence on Aboriginal and Torres Strait Islander mental health policy. This report concluded that there was an absolute urgent need to address Aboriginal and Torres Strait Islander mental health, as it was seen to be contributing to the overrepresentation of Aboriginal people in the criminal justice system, and was also an overwhelming factor in the majority of suicides in custody. The RCIADIC

argued that approaches to Aboriginal and Torres Strait Islander mental health needed to be respectful and sensitive to the legacy of Australia's colonial history. The report further stresses the importance of law reform and changes in policing strategies (HREOC, 2005). The report made a number of recommendations that have been identified as a major milestone in addressing Aboriginal and Torres Strait Islander mental health issues.

Bringing Them Home (1997)

Another landmark report is the Human Rights and Equal Opportunity Commission's 1997 report *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*. This report has been equally vital in shaping the evolution of policy in Aboriginal mental health. It provides a comprehensive review of testimonies collected from Aboriginal people who were removed under policies initiated by government, and discusses the effects of these policies and the actions needed to commence a process of healing for the survivors and their families. The report findings have raised the awareness of governments and communities to the links between past government policies of removal, human rights abuses and current social and health concerns for Aboriginal and Torres Strait Islander people (ANPPEIMH, AUSEINET, 2007). In particular, the findings have highlighted the mental health consequences of government child removal policies and the inaccessibility of existing mental health services and their inadequacy to deal with these issues. Further, the report found that racial discrimination, cultural ignorance and the inability to recognise or understand the complex causes for mental health among Aboriginal and Torres Strait Islander peoples remain a predominant concern among practitioners and the wider society. As several other chapters in this book show, these issues are transgenerational and are still impacting on young children today.

There have been significant symbolic and practical responses to the report. On a practical level the Australian Government responded to the recommendations by providing a range of initiatives including additional funds to Link-Up for family reunions; funding for mental health counselling to help heal the grief, loss and trauma experienced by forcibly removed children, their families, descendants and communities; and for parenting support programs. At 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. Since then more than 400 Sorry Books have been distributed and apologies signed by churches, non-government organisations and individuals around Australia. These largely symbolic measures have been identified by many Indigenous Australians as equally as important as the practical measures to begin their journey of healing and mental wellbeing (Dow, 2008). This is evident in a paper prepared for the National Sorry Day Committee on the progress on the implementation of the *Bringing Them Home* recommendations:

The journey towards healing for a stolen generations person can be lengthy. Many have not yet started, while others have only just begun. Val Linow tells of the sight of a large white 'Sorry' created in the sky above the Sydney Harbour Bridge on the day in May 2000 when 250,000 people joined in solidarity in walking across that bridge. Val's experience that day was the start of her personal journey of healing. That so many people cared overwhelmed her and diminished her feelings of anger for her past treatment to an extent that she could begin to forgive and, in doing so, to heal (cited by Dow, 2008).

POLICY MILESTONES ADDRESSING ABORIGINAL AND TORRES STRAIT ISLANDER MENTAL HEALTH

As outlined above, both the RCIADIC and the *Bringing Them Home* reports have influenced the policy reform process to address the life circumstance of Indigenous Australians. They have resulted in greater awareness of the links between Australia's colonial history and

its enduring consequences on Aboriginal and Torres Strait Islander health and social and emotional wellbeing. However, the *Ways Forward* report (Swan & Raphael, 1995) was the first national analysis to report specifically on Aboriginal and Torres Strait Islander mental health and to generate a specific plan of action.

Ways Forward: National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health (1997)

Throughout 1994 and 1995, Swan and Raphael conducted extensive consultation with Aboriginal and Torres Strait people and communities, Aboriginal-controlled health services and senior government officials, as well as a comprehensive review of the findings and recommendations of previous relevant reports. The *Ways Forward* report confirmed what had been identified previously—that the devastating impact of the removal of children from their families, the dispossession of Aboriginal and Torres Strait Islander people, and their continuing social and economic disadvantage have contributed to widespread social and emotional wellbeing 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. (Swan & Raphael, 1995, p. 2)

Importantly, the findings highlighted the need for:

- greater understanding among health professionals about the influences upon, and extent of, mental illness among Indigenous people
- mental health services to address the underlying grief and emotional distress experienced by Indigenous 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 and other Aboriginal community-based resource people as Mental Health Workers
- tertiary courses for non-Aboriginal mental health professionals (particularly psychiatrists and nurses) that include material on Aboriginal history and contemporary Aboriginal society.

This seminal report also recommended that mental health policy, planning and program delivery be developed in consultation with Aboriginal people. It listed 16 key elements to be incorporated into mental health policy including self-determination, children, women, men, the elderly, information collection, and research and evaluation. The report was wide-reaching and although it has taken considerable time for all the recommendations and findings to be taken up, they continue to influence contemporary policy initiatives. In addition, a number of guiding principles have influenced the development of policies, frameworks and action plans, particularly the Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan 1996–2000 (OATSIH, 1996).

Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan—2000

In addition to the *Ways Forward* report, the Aboriginal and Torres Strait Islander Emotional and Social Wellbeing (Mental Health) Action Plan 1996–2000 was also a response to findings and recommendations of two other major reports: the *Royal Commission Into Deaths in Custody* (1991); and, the *Human Rights and Mental Illness:*

Report of the National Inquiry into Human Rights and Mental Illness (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 (Urbis, Keys & Young, 2001). The aim of the Action Plan was to provide an integrated and consistent approach to Aboriginal and Torres Strait Islander mental health that acknowledged and acted upon Indigenous Australian perspectives outlined in these key reports.

The Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan 1996–2000 was informed by the following principles:

- Aboriginal and Torres Strait Islander health is viewed holistically, encompassing mental health, physical, cultural and spiritual health. Land is central to wellbeing. Crucially, when the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill health will persist.
- Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services.
- Culturally valid understandings must shape the provision of services and guide assessment, care and management of Aboriginal and Torres Strait Islander people's health problems generally and mental health problems in particular.
- Recognition 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.
- The human rights of Aboriginal and Torres Strait Islander peoples must be recognised and respected. Failure to do so constitutes continuous disruption to mental health (versus mental ill health). Human rights relevant to mental illness must also be specifically addressed.
- 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.
- 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.
- 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.
- Recognition 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.

The Action Plan was the first national initiative to recognise and address the emotional and social wellbeing of Aboriginal and Torres Strait Islander people. It commenced in late 1996 and was administered by the Office for Aboriginal and Torres Strait Islander Health (OATSIH); funding was originally available from 1996/97 to 1999/2000. The Action Plan set out priority areas for Commonwealth expenditure for Aboriginal and Torres Strait Islander 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 Australian/state Aboriginal and Torres Strait Islander Health Framework Agreements that will 'provide 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' (HREOC, 2005).

The goals and intended outcomes of the Action Plan were to enhance the appropriateness and effectiveness of both mainstream mental health organisations and Aboriginal and Torres Strait Islander-specific primary health care services for Aboriginal and Torres Strait Islander people with mental health needs; improve access to culturally appropriate, high-quality health care; improve mental health outcomes for Indigenous Australians; and reduce the rate of suicide by Aboriginal and Torres Strait Islander youth by ensuring the availability of culturally appropriate and high-quality mental health services and support mechanisms.

The Action Plan encompasses a series of priority areas which are discussed in respective sections of this chapter or in specific chapters within this book:

- 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.

The Action Plan 2001 resulted in several Social and Emotional Wellbeing Regional Centres (SEWB RCs) being established around Australia to develop curricula and deliver training, to develop models for intersectoral linkages and interagency cooperation, to provide clinical support to health workers, and to develop information systems to clarify the level of need in the region and test the efficacy of existing services and existing/proposed training. The National Action Plan funded a range of innovative initiatives to develop culturally appropriate mental health models and therapies. Resources were provided to establish Social Health Teams in Aboriginal Community Controlled Health Services to provide SEWB counselling, such as Wuchopperen Health Service in Cairns, Gallang Place in Brisbane, Nunkuwarnin Yunti in Adelaide, Biripi Aboriginal Corporation in Taree, and the Koori Kids program at the Victorian Aboriginal Health Service Cooperative. Other projects included theatre and storytelling as counselling such as HEATworks/Kimberley Aboriginal Medical Services Centre, *Deadly Vibe Magazine*, and the development of the We al-Li Indigenous Therapies in Lismore. An Aboriginal controlled charitable foundation, the Lumbu Indigenous Community Foundation, received \$1 million seed money for social justice grant-making to Aboriginal communities.

There is little doubt that the *Emotional and Social Wellbeing (Mental Health) Action Plan* helped to consolidate and bring forward the concept and importance of social and emotional wellbeing in relation to Indigenous individuals, families and communities. The Action Plan also represented a significant first move into an area that had received little attention from government in the past. Many of the projects funded at that time were innovative, culturally appropriate and have proved to be sustainable. An independent evaluation conducted in 2001 found the Action Plan to be timely and to have reflected the vision of the *Ways Forward* report. However, it noted that it only partially implemented policy elements of *Ways Forward*; it may have been overly ambitious in its scope and it has had little influence on state and territory mental health services and the services they provide to Indigenous people. It suggested that the Action Plan be revised and developed into a strategic document that sets out a conceptual framework, identifies appropriate

roles and planning mechanisms, and identifies core areas for action in the state, territory and Commonwealth sectors. Essentially, this set the framework for the development of the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2004–2009*.

Many of the social and emotional wellbeing programs begun during the Action Plan have continued under the auspice of OATSIH, in the Department of Health and Ageing. Programs include the Link Up and Bringing Them Home programs which provide support to members of the Stolen Generation and the SEWB workforce support programs, as well as the Improving the Capacity of Workers in Indigenous Communities measure which forms part of the COAG Mental Health Package.

The programs administered by OATSIH were evaluated in 2007 (Urbis, Keys & Young, 2007). The evaluators made the following recommendations:

- Ensure Link-Up and BTH services have a stronger focus on first-generation Stolen Generations members.
- Require minimum skill levels for Link-Up and BTH workers and provide access to regular training and professional support.
- Develop national guidelines for all four programs.
- Extend the geographical reach of the programs.
- Improve the operation of Regional Centres by requiring them to be accredited as Registered Training Organisations (RTOs).
- Encourage evaluation and good practice activities.
- Enhance coordination between Link-Up and BTH services.
- Improve processes for accessing records.
- Conduct further research on the trans-generational impacts of Stolen Generations experiences.

Considerable variation in the performance of the SEWB Regional Training Centres was noted by the evaluators, who concluded that 'most have focused on only one of their four core roles (curriculum development and training), and have not given enough attention to their other three roles (training needs assessments, provision of support to the health workforce in terms of professional supervision and the development of cross-sector linkages' (Urbis, Keys & Young, 2007, p. iv). As a part of the reform process the Department of Health and Ageing has redefined the role of the SEWB Regional Centres and implemented new arrangements for the provision of social and emotional support services to the Indigenous health workforce. This is reflected in a change of name from SEWB Regional Centres to SEWB Workforce Support Units. This process has been coupled with the transfer of all responsibility for the delivery of training services to the Vocational Education and Training (VET) sector which now delivers SEWB training (up to Graduate Diploma level).

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* was developed for the delivery of health services to Aboriginal and Torres Strait Islander people. The Australian and state and territory governments subsequently developed implementation plans for the strategic action areas outlined in the Framework. The Framework identifies Social and Emotional Wellbeing as one of the nine 'Key Result Areas' for government action and in particular targets mental health, suicide, alcohol and substance misuse, family violence issues including child abuse, and male health (NATSIHC, 2003).

Zubrick et al. (2005) confirm the need to collect data related to the mental health morbidity and mental health care of the Aboriginal and Torres Strait Islander population. However, they

are critical that indicators of mental health and emotional and social wellbeing tend to focus on the measurement of severe mental health outcomes—rates of hospitalisation for anxiety, depression, self-harm and child abuse substantiations (p. 564). The emphasis on these aspects can inadvertently limit the funding and development of programs and services that focus on more holistic approaches to Aboriginal and Torres Strait Islander mental health; these encompass social justice, self-determination, sense of cultural connectedness or reconnecting with kin and country.

Australian Government Implementation Plan 2007–2013

The *Australian Government Implementation Plan 2007–2013* was developed by the Department of Health and Ageing in consultation with all relevant Australian Government agencies and the National Aboriginal and Torres Strait Islander Health Council. It has a strong emphasis on a whole-of-government approach to addressing the key priorities identified; it 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, is relevant here. Reporting against these action items occurs through qualitative reporting against this Implementation Plan and quantitative reporting through the Aboriginal and Torres Strait Islander Health Performance Framework. This Key Result Area contains actions that align with the *Overcoming Indigenous Disadvantage Framework's* 'Substance use and misuse' and 'Functional and resilient families and communities' strategic areas for action in the 2007 report and 'Healthy lives' in the 2009 report.

Key Result Area Four: Social and Emotional Wellbeing

Objectives:

Social justice and across-government approaches

- Reduced intergenerational effects of past policies, social disadvantage, racism and stigma on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.
- Increased resilience and stronger social and emotional wellbeing in Aboriginal and Torres Strait Islander people, families and communities.

Population health approaches

- Promotion and prevention approaches that enhance social, emotional and cultural wellbeing for Aboriginal and Torres Strait Islander people including families and communities.
- Reduced prevalence and impact of harmful alcohol, drug and substance use on Aboriginal and Torres Strait Islander individuals, families and communities.

Service access and appropriateness

- Accessible mainstream services that meet the social and emotional wellbeing needs of Aboriginal and Torres Strait Islander people, particularly those living with severe mental illness and chronic substance use.
- Coordination of policy, planning and program development between mental health, social and emotional wellbeing and drug and alcohol agencies that provide services to individuals and families with specific attention to individuals and families with mental health conditions and co-morbidities to ensure care planning, provision of coordinated services and referral to services as required.

Workforce

- A workforce that is resourced, skilled and supported to address mental health, social and emotional wellbeing and substance use issues for children, adults, families and communities across all Aboriginal and Torres Strait Islander settings.

Quality improvement

- Improved data collection, data quality and research to inform an evaluation framework for continued improvement in services, policy and program review, and the development/promotion of best practice.

National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2004–2009

The *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2004–2009* builds on Swan and Raphael's *Ways Forward, the Aboriginal and Torres Strait Islander Emotional and Social Wellbeing (Mental Health) Action Plan 1996–2000*, and the *Evaluation of the Aboriginal and Torres Strait Islander Emotional and Social Wellbeing (Mental Health) Action Plan 1996–2001* (Urbis, Keys & Young, 2001).

The *Social and Emotional Wellbeing Framework 2004–2009* was designed to complement the National Mental Health Plan and the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013. AHMAC endorsed the Framework in 2004.

Part One of the SEWB Framework sets out the guiding principles and policy thinking underpinning the concept of social and emotional wellbeing. Part Two of the document 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 set out in this document aim to achieve three fundamental elements of care for each Aboriginal and Torres Strait Islander community:

- action across all sectors to recognise and build on existing resilience and strength to enhance social and emotional wellbeing, to promote mental health, and to reduce risk
- access to primary health care services providing expert social and emotional wellbeing and mental health primary care, including Social Health Teams
- responsive and accessible mental health services with access to cultural expertise.

The final part of the SEWB Framework sets out roles, responsibilities and timeframes for the implementation, monitoring and evaluation of the document.

The *Social and Emotional Wellbeing Framework 2004–2009* has provided an important reference point informing the development of policy and programs in both government and the community sector, including the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013 and the Australian Government Implementation Plan 2007–2013.

APOLOGY TO AUSTRALIA'S INDIGENOUS PEOPLES

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 Aboriginal people who are among the Stolen Generations cannot be underestimated. Dow (2008) emphasises the importance of the Apology and the word 'sorry' in the healing process. She cites Christina King, spokesperson for Stolen Generations Alliance: 'Sorry is the most important word because it has great meaning in our community, it means having empathy and compassion and understanding.' This landmark event has great significance for the social and emotional wellbeing of all Aboriginal and Torres Strait Islander people. On 16 and 17 September 2008, approximately 60 delegates met in Canberra to discuss examples of successful healing programs and possible strategic policy directions to address issues identified by the Stolen Generations, Aboriginal and Torres Strait Islander practitioners

and organisations working in healing at local and national levels and key government agencies. Participants agreed that healing is needed and called for a Healing Foundation as a means to ensure that action is taken.

ONGOING POLICY IMPLEMENTATION AND REVIEW

A number of related policy developments in Aboriginal and Torres Strait Islander affairs have shaped the evolution of policy on Aboriginal and Torres Strait Islander people's mental health.

The Council of Australian Government Reconciliation Framework 2000

The *Council of Australian Governments (COAG) Reconciliation Framework* acknowledges that:

Governments have a particular responsibility for addressing social and economic disadvantage and for improving the way agencies do business with communities to get better outcomes. The COAG framework provides governments with a solid foundation for measuring any improvements and ensuring that changes are structurally based and sustainable (COAG, 2001).

The Reconciliation Framework also provides the basis for governments to work together and become more responsive in addressing the needs of Aboriginal and Torres Strait Islander people through community partnerships.

As Zubrick et al. (2005, p. 564) point out, in addition to the continuation of support for reconciliation through the promotion of recognition, respect and understanding between Aboriginal and non-Aboriginal Australians, three priority areas for governments were agreed:

- investing in community leadership and governance issues
- 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
- forging greater links between the business sector and Aboriginal communities to help promote economic independence (COAG, 2001).

A milestone in the implementation of the *COAG Reconciliation Framework* was the commissioning of a major review of government service provision. Since 2001 the Council of Australian Governments have continued to endorse the Reconciliation Framework and affirmed that they will continue their efforts to advance reconciliation and address Indigenous disadvantage. Following extensive public consultation the COAG Steering Committee for the Review of Commonwealth/State Service Provision released its *Overcoming Indigenous disadvantage: Key indicators 2003* report. Underpinning the report is the vision of an Australia 'in which Indigenous people come to enjoy the same overall standard of living as other Australians—that they are as healthy, live as long and are as able to participate in the social and economic life of the nation' (HREOC, 2007).

The endorsement of the report marked the commitment of Australian governments to tackle the root causes of Aboriginal disadvantage and to systematically monitor the outcomes across jurisdictional and portfolio boundaries.

Recent COAG developments

In December 2007 and March 2008 the Council of Australian Governments (COAG) agreed to six long-term targets for closing the gap between Indigenous and non-Indigenous Australians on health, early childhood development, education, housing, and economic outcomes. The National Indigenous Reform Agreement (NIRA) provides the overarching framework for the six Closing the Gap targets across the Indigenous-specific National Partnership Agreements (NPAs), and is underpinned by key performance indicators and benchmarks. These performance indicators and

benchmarks will be used to monitor progress through annual public reporting and analysis by the COAG Reform Council from 2009–10.

The Australian Government recognises that a multifaceted and sustained approach addressing factors both within and beyond the health system is required to address Indigenous disadvantage. The COAG has identified seven 'building blocks' which are the strategic platforms that need to be in place in order to comprehensively address the current state of Indigenous disadvantage, and they include: healthy homes; safe communities; health; early childhood; schooling; economic participation; and governance and leadership. The 'building block' approach integrates policy reforms and implementation to comprehensively address Indigenous disadvantage.

To date, the COAG has agreed to six NPAs under the NIRA totalling \$4.6 billion. On 29 November 2008, the COAG agreed to a \$1.6 billion investment through the National Partnership on Closing the Gap in Indigenous Health Outcomes to help close the gap in life expectancy between Indigenous and non-Indigenous Australians.

The Commonwealth's contribution of \$805.5 million (over 4 years) from 2009–10 will address chronic disease risk factors; encourage better management of chronic disease in primary health care services; improve follow-up care; and increase the capacity of the primary care workforce to deliver effective health care to Aboriginal and Torres Strait Islander peoples.

Commonwealth's commitment to the Social Inclusion Agenda.

The Australian Government's vision of a socially inclusive society is one in which all Australians feel valued and have the opportunity to participate fully in the life of our society.

Achieving this vision means that all Australians will have the resources, opportunities and capability to:

- learn by participating in education and training
- work by participating in employment, in voluntary work and in family and caring
- engage by connecting with people and using their local community's resources
- have a voice so that they can influence decisions that affect them.

Another key report in monitoring the progress against the COAG Closing the Gap agenda is the biennial report against the *Aboriginal and Torres Strait Islander Health Performance Framework* (HPF). The HPF 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 datasets 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.

But what are some of these determinants? How are these best understood in the context of mental health and wellbeing? What should people actually do to achieve changes in these key indicators? The answers to these questions are explored in detail in Chapter 6 where we consider the main underlying determinants of social and emotional wellbeing and discuss ways to modify the effects of the determinants of social and emotional wellbeing.

Policies for improved information and data quality

The first national survey of Aboriginal and Torres Strait Islander people was conducted in 1994 (CAEPR, 1994) in response to the 1991 recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC, 1991). These data were notable for the inclusion of questions on a diversity of topics, including health. Since this first survey there has been an increasing effort to improve the quantity, timeliness and quality of information on Australia's

Aboriginal and Torres Strait Islander population. These efforts include the Aboriginal and Torres Strait Islander components of the 1995, 2001 and 2004–05 National Health Surveys, the 1994, 2002 and 2008 National Aboriginal and Torres Strait Islander Social Surveys, as well as the biennial reports on the health and welfare of Australia's Aboriginal and Torres Strait Islander peoples. Additionally, the Australian Government has commissioned *Footprints in Time: the Longitudinal Study of Indigenous Children*. This ambitious project will seek to provide the first comprehensive longitudinal data on the development of Australian Aboriginal children.

These surveys, along with the *Western Australian Aboriginal Child Health Survey* (Zubrick et al., 2005), represent significant milestones in the gathering of data for and about Aboriginal Australians. With these data and the evidence that flows from them come expectations of actions and initiatives to address the difficulties they describe.

More recently, the COAG performance reporting framework, developed through the new Intergovernmental Agreement on Federal Financial Relations, has led to a focus on performance indicators and data, including the need for accurate and timely data about Indigenous Australians. In response, and as part of the Integrated Strategy for Closing the Gap in Indigenous Disadvantage, the Commonwealth will provide \$46.4 million over four years to fund Indigenous data development work to address key data quality issues. This includes the enhancement of existing data collections, such as those mentioned above.

The *Aboriginal and Torres Strait Islander Health Performance Framework* (HPF) is a foundation document for informing COAG indicators. Most indicators in each Indigenous-specific agreement relating to health are derived from the HPF. The substantial HPF data development work is informing the data sources and data development requirements for the COAG performance indicators. The HPF is critical for informing progress towards the COAG Close the Gap agenda for Indigenous health.

ONGOING POLICY DEVELOPMENTS—NATIONAL MENTAL HEALTH REFORM INITIATIVES

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

COAG National Action Plan on Mental Health 2006–2011

In February 2006 COAG committed to \$1.9 billion in new funds for the improvement of 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 funding covers areas for which the Australian Government has responsibility:

- 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
- 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. These areas of common action include:

- 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, including through the National Health Call Centre Network
- support for families and carers including respite care.

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

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 by all Health Ministers and ministers with responsibility for mental health to the continual improvement of Australia's mental health system. It works towards ensuring that Australia has a mental health system that 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 aims of the Policy are 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
- 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

On 4 September 2009 the Australian Health Ministers' Conference (AHMC) endorsed the *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009–2014*. The Plan has been developed to further guide reform and identifies key actions that can make meaningful progress towards fulfilling the vision of the Policy.

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.

While led by Health Ministers, the Plan takes a whole-of-government approach. This approach acknowledges that the best mental health outcomes are achieved through a partnership approach involving sectors other than just health. It is envisaged that the Fourth 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.

Aboriginal and Torres Strait Islander initiatives

In addition, \$20.8 million has been provided by the Australian Government to OATSIH, in the Department of Health and Ageing, over five financial years under the COAG mental health reform package. An Expert Advisory Group of key stakeholders from the Aboriginal and Torres Strait Islander health and mental health sectors has been established to guide and monitor the implementation of this initiative. A key focus will be Improving the Capacity of Workers in Indigenous Communities. This includes a mental health training program targeting 840 Aboriginal Health Workers, and a culturally appropriate mental health first aid training program for 350 transport and administration workers in Aboriginal and Torres Strait Islander-specific health services. Aboriginal Health Workers, counsellors and clinic staff in Indigenous specific health services will be trained to identify and address mental illness and associated substance use issues in Aboriginal and Torres Strait Islander communities, to recognise the early signs of mental illness and make referrals for treatment where appropriate. Specific projects to enhance Aboriginal and Torres Strait Islander mental health include:

- a training program to recognise and address mental illness
- provision of Mental Health First Aid training to increase mental health literacy
- new mental health worker positions and associated infrastructure
- a mental health toolkit
- the development of this mental health textbook
- culturally appropriate mental health assessment tools.

The success of the five-year plan will require a continuing effort by all governments. A network of COAG Mental Health Groups has been established in each state and territory to coordinate this work both across sectors and between governments. These groups will provide an avenue for the oversight of and collaboration on how the initiatives in the five-year plan will be delivered. They are vital in ensuring that all relevant Australian, state and territory government agencies work together and consult with the non-government and private sectors as well as consumer and carer representatives. The *Mental Health Action Plan 2006–2007 Progress Report* identified a number of initiatives that have been put in place including a new Centre for Women's Mental Health (\$1.1 million) at the Royal Women's Hospital in Melbourne to provide mental health consultations to vulnerable client groups, including women with substance abuse issues, young mothers and Aboriginal and Torres Strait Islander women. In Queensland, 20 organisations across the state have received funding to provide independent living and social support services to people with mental illness residing in the community. This initiative includes a component for Aboriginal and Torres Strait Islander-specific services and sector development. The Queensland Government Department of Communities has established a Blueprint for the Bush Service Delivery Hubs and Indigenous Domestic and Family Violence Counselling Services. These hubs are designed to provide a comprehensive range of services, including mental health services, with a focus on children and families, rural communities, and Aboriginal

and Torres Strait Islander communities (COAG, 2008). The success of the five-year plan will continue to be monitored against nationally agreed progress measures over a five-year period and will then be subject to an independent review (COAG, 2006).

CONCLUSION

This chapter has mapped the policy developments in Australia relating to Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing. Different ways of approaching the policy formulation and implementation process have influenced several successive policy reforms in Aboriginal and Torres Strait Islander health over the past 20 years, including those relating to Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing. These policy reforms include the recognition of the impact of past policies on the health of Aboriginal and Torres Strait Islander people, and more culturally appropriate concepts of mental health and service delivery. There has also been greater emphasis on the need to form a coalition of interests throughout the policy formulation process between different levels of government (as with COAG) and across sectors, as well as greater consultation and shared agreement among key stakeholders to reallocate funding and resources. There has also been a growing recognition of the need for a whole-of-government policy response with immediate targets, long-term objectives and continuing commitment and cooperation between government departments and agencies. The current COAG National Action Plan 2006–2011 is unique in that it is the first time that governments have worked together to address mental health needs through commitments to services and initiatives that encompass the key areas of housing, employment, education and correctional services, all of which have an important part to play in addressing the mental health needs of all Australians. This whole government approach is being advanced through implementation of the Fourth National Mental Health Plan under the National Mental Health Policy 2008. These recent policy reforms are intended to provide the frameworks and mechanisms for action to address the many related and significant issues and social determinants that contribute to mental health and social and emotional problems for Aboriginal and Torres Strait Islander populations.

In summary, there has always been considerable volatility in the policy setting that governs not only the direction and creation of approaches to address the social and emotional wellbeing of Indigenous Australians, but also the arrangements for the delivery of services. A potential strength in the current policy climate is a focus on the multiple causes of Aboriginal disadvantage and a government imperative for accountable joint action sustained over a longer period. Significantly improved data, at least in some jurisdictions, will assist in monitoring progress, although there is still an urgent need to ensure timely data collection and delivery to meet needs.

Policy Action Response Timeline

Policies, Frameworks and Inquiries	
1987	The Royal Commission into Aboriginal Deaths in Custody was established by Commonwealth, state and territory governments. The royal commission was a response to the deaths in custody of 99 Aboriginal and Torres Strait Islander people between 1 January 1980 and 31 May 1989.
1991	The report of the Royal Commission into Aboriginal Deaths in Custody was a landmark document handed down in 1991 that has had a significant influence of Indigenous mental health policy. This report concluded that there was an absolute urgent need to address Indigenous mental health because it was seen as contributing to the overrepresentation of Aboriginal people in the criminal justice system, and had also been an overwhelming factor in the majority of suicides in custody. The RCIADIC argued that approaches to Indigenous mental health need to be respectful and sensitive to the legacy of Australia's history.

1989	The <i>National Aboriginal Health Strategy</i> (NAHS), released in 1989, was built on extensive community consultation to produce a landmark document that set the agenda for Aboriginal health and Torres Strait Islander health. Although never fully implemented (as indicated by its 1994 evaluation), the NAHS remains the key document in Aboriginal and Torres Strait Islander health. It is extensively used by health services and service providers and continues to guide policy-makers and planners.
1993	National Aboriginal Mental Health Conference This conference brought together more than 900 Aboriginal people from around Australia, the majority coming together for the first time to discuss mental health issues.
1995	<i>National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families.</i> <i>Ways Forward: National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health</i> was the first national analysis of Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health.
1996	<i>The Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan 1996–2000</i> was the first national initiative to recognise and address Indigenous emotional and social wellbeing issues.
1997	The HREOC released <i>Bringing Them Home: A Guide to the Findings and Recommendations of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families.</i> <i>Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy.</i>
1998	The inaugural Sorry Day was launched on 26 May on the anniversary of the day the HREOC report was tabled in parliament.
2001	The <i>Evaluation of the Emotional and Social Well Being (Mental Health) Action Plan</i> recommended a more strategic approach to build on the Action Plan.
2003	<i>National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013.</i> This National Strategic Framework is a complementary document that builds on the 1989 NAHS and addresses approaches to primary health care and population health within contemporary policy environments and planning structures.
2004	COAG endorsed the <i>Overcoming Indigenous Disadvantage Indicator Framework.</i> <i>The National and Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being 2004–2009.</i>
2006	COAG makes a long-term commitment to address Indigenous disadvantage and recognises the importance of closing the gap in health disparities between Indigenous and non-Indigenous Australians across the key areas of action identified in the OID framework. <i>The National and Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being.</i> COAG's <i>Action Plan on Mental Health 2006–2011.</i>
2007	In December 2007, COAG agreed to explicit targets for improving the lives of Aboriginal and Torres Strait Islander people, and established the Working Group on Indigenous Reform (WGIR) to make progress towards achieving these targets. Given the similarities of this framework and the Overcoming Indigenous Disadvantage framework, the OID Steering Committee and WGIR agreed to work together to align the WGIR and OID frameworks.

2008	<p>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.</p> <p>In December 2008 and March 2007 COAG agreed to six long-term targets for closing the gap between Indigenous and non-Indigenous Australians on health, early childhood development, education, housing, and economic outcomes.</p>
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Reflective exercises

Select from one of the following policies to answer the questions below:

- LIFE, a framework for prevention of suicide and self-harm in Australia: Learnings about Suicide
- Policy Framework for Aboriginal and Torres Strait Islander Mental Health
- The Mental Health Action Plan
- Link-Up Guidelines
- Bringing Them Home Guidelines
- National Strategic Framework for Aboriginal and Torres Strait Islander Health
- COAG National Action Plan on Mental Health (www.coag.gov.au).

Questions

- 1 What has influenced the development of the policy?
- 2 What are the key aims of the policy?
- 3 What are the issues it aims to address, i.e. suicide, depression, drugs and alcohol?
- 4 What initiatives have been successful?

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Part 2:

Issues of Aboriginal and Torres Strait Islander Mental Health and Wellbeing



Part 2 contains seven chapters on a number of issues that are particularly relevant to Aboriginal and Torres Strait Islander mental health and wellbeing. Issues discussed include types of mental disorders, determinants of Aboriginal and Torres Strait Islander social and emotional wellbeing, suicide, anxiety in youth, substance misuse, trauma, and family violence.

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. (Wilkes, Gray, Siggers, Casey, & Stearne, Ch. 9)

5



Mental Illness in Aboriginal and Torres Strait Islander Peoples

Robert Parker

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' (DSM-IV-TR, 2000, p. xxi). The common types of mental disorders that affect people are Anxiety Disorders, Mood Disorders, Psychosis and Personality Disorder 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 substance abuse (Chapters 2, 6 and 9). I 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 to discuss available treatments with their clinicians.

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. The introduction to DSM-IV-TR (2000), a standard text for classification of psychiatric disorders, reviews a history of classification of mental illness in a Western cultural context and emphasises the need for explicit definitions as a way of promoting reliable clinical diagnoses (p. xxii). 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 rates for mental disorders, and the tension between universal and group-specific approaches to mental health research and policy (Chang, 2003).

An inherent concept in the reliability of the definition of such data is an atmosphere of cultural safety as an essential component of any mental health intervention with Aboriginal and Torres Strait Islander people. 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’ (Clear, 2008, p. 2). 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’ (Morgan, 2006, p. 203). English is usually not the first language of remote community-based Aboriginal people and might be the fifth or sixth. 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 (p. 204). 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. (Lette et al., 2000, p. 95)

Hunter (2003) also comments on the increasing complexity of defining mental illness in Aboriginal and Torres Strait Islander peoples. He notes an increasing coincidence of mental disorders associated with substance abuse 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’ (p. 129). 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’ (p. 130).

A number of factors therefore contribute to the accuracy of diagnosis or definition of any mental illness in Aboriginal and Torres Strait Islander people. Mark Sheldon (2005) 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. The involvement of family along with Aboriginal and Torres Strait Islander Mental Health Workers 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 (Parker, 2003). Additional factors involve the use of translation services where appropriate along with social and emotional wellbeing workers where the affected person may have specific needs in respect of grief or loss and the Stolen Generations.

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 DSM-IV-TR (2000) and ICD 10 (WHO, 1992) classification systems 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 (commonly known as Manic Depression) and Dysthymic Disorder, which is a more emotionally pervasive depression.

Major Depression, as defined by DSM-IV-TR, 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.

Pink and Allbon (2008), 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-Indigenous population, with the rate for Aboriginal and Torres Strait Islander women being the same as the non-Indigenous population. However, individual Aboriginal community surveys have found differing rates of mood disorder, with these being variously reported at 2.5% for Mornington Island, 6% at Bourke but 1% for a community in the Kimberley (Hunter, 2003). McKendrick et al. (1992) conducted a survey of Aboriginal people attending a community-controlled health service in Victoria. She reported that 54% of the people tested with standard psychiatric rating scales were suffering from psychiatric illness and that depression was the most common among this group.

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 (1972), 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. But 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 (1987) also describes a number of features of atypical depression experienced by Aboriginal people. 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 also described depression precipitated by a person being shamed or being fearful that they were subject to sorcery or payback. Morice (1986) has reported that the Pintubi have a range of words to express a range of feelings of sadness and depression from mild to severe.

Ketchell (2004), following a description of normal funeral rituals required to be performed 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.

Anxiety

Anxiety disorders encompass a range of mental illness conditions where there is elevated psychological arousal accompanied by physical sensations of fear (DSM IV-TR, 2000). The psychological and physical features, along with avoidance behaviour to reduce these issues, are core features of the disorders. Other associated symptoms then further define the condition. This may be fear of a particular object or situation (Phobia), intrusive thoughts and associated ritualistic avoidant behaviour (Obsessive Compulsive Disorder), fear in response to certain social or performance situations (Social Phobia), emotional numbing and recurrent traumatic memories and dreams following exposure to a severe traumatic incident (Acute Stress Disorder and Post Traumatic Stress Disorder), chronic persistent fear with physical overactivity (Generalised Anxiety Disorder) and sudden unexpected episodes of fear (Panic Attack). The symptoms of anxiety disorders may sometimes be the consequence of medical conditions such as thyroid disease and are frequently associated with substance abuse, both intoxication and withdrawal, so it is important to have these matters properly examined before a diagnosis of Anxiety Disorder can be definitively made.

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% of community members in Mornington Island and 1.4% of community members in the Kimberley to 5% of community members in Bourke (Hunter, 2003). Recently, more focused surveys such

as the West Australian Aboriginal Child Health Survey (Zubrick et al., 2005) showed that up to a quarter of children surveyed from the ages from 4 to 17 may have been at risk of developing emotional and behavioural disorders that may be associated with anxiety conditions. This finding is not surprising against a background where Aboriginal and Torres Strait Islander people 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% 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 people living in remote and rural locations (Trewin & Madden, 2005).

This high level of current exposure to stress can be contrasted with Aboriginal and Torres Strait cultural factors that appeared to reduce stress and anxiety in traditional cultures. Hunter et al. (1999) and Eastwell (1988) have commented on the ability of Aboriginal and Torres Strait peoples to express strong feelings within a defined cultural context such as a funeral. 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. But 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 (1962) described what is most likely a case of dissociative fugue secondary to intense anxiety resulting from a woman accidentally viewing sacred items. Morice (1986) reports that Pintubi language describes extreme fear in addition to other grades of anxiety that could also account for such a phenomenon.

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 (DSM IV-TR, 2000). 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 abuse. 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 (1968) estimated that the rate of schizophrenia among tribal Aboriginal people in Central Australia was about 0.46%. This estimate stands in significant contrast to the high rate of psychosis currently affecting the Aboriginal and Torres Strait Islander population. Pink and Allbon (2008) report that Aboriginal and Torres Strait Islander men were admitted to hospital with mental disorders due to psychoactive substance abuse 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 abuse and 2.5 times the expected rate of hospital admission for schizophrenia and related disorders. It appears, therefore, that the experience of psychosis, particularly in the context of substance abuse, is a significant current issue for the Aboriginal and Torres Strait Islander population at present.

The recognition of cultural factors and use of Aboriginal and Torres Strait Islander mental health workers is an important component of 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 (Parker & Milroy, 2003).

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 (1972, 1973) in Central Australia in the 1970s. Morice (1986) notes that the Pintubi words to describe someone suffering from schizophrenia are having closed ears or living in a world of their own. Meggitt (1962) 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. Eastwell (1976, 1977) commented on transient delusional states in certain Yolgnu family groups in East Arnhem Land. Ketchell (2004) 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.

Personality disorder

Personality is described in DSM-IV-TR (2000) as ‘enduring patterns of perceiving, relating to and thinking about the environment and oneself’ and Personality Disorder is defined as ‘an enduring pattern of inner experience and culture that deviates markedly from the expectations of the individual’s culture’ (p. 630). Pink and Allbon (2008) 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. The rate of admissions for Aboriginal and Torres Strait Islander women with a similar issue is 0.8. Community prevalence surveys have reported rates of Personality Disorder of 4% in Mornington Island, 16% in Bourke and 8.2% in a Kimberley community (Hunter 2003). 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 (1979) 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. (p. 296)

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 (e.g. Hart et al., 1988; Hiatt, 1965; Strehlow, 1970) 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-IV-TR (2000). The significant amount of stressors affecting young Aboriginal and Torres Strait Islander people currently (Trewin & Madden, 2005), seen against the historical background of the destruction of their health, culture and society generally, may be considered vulnerability factors for further continuing personality dysfunction. This may be an issue in the case of members of the Stolen Generations in Western Australia, where surveys have shown that they 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 (Zubrick et al., 2005).

ISSUES FOR FAMILIES

The recent submission of the Royal Australian and New Zealand College of Psychiatrists to the Australian Government House of Representatives Standing Committee on Family, Community, Housing and Youth Inquiry into Better Support for Carers (RANZCP, 2008a) outlines a number

of general 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. (p. 3)

These issues are further complicated for the families of Aboriginal and Torres Strait Islander people with mental illness in remote Australia. According to Dillon and Westbury (2007), 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. A similar situation may also face families of Aboriginal and Torres Strait Islander people with mental illness who reside in cities where they tend to be poorer and more marginalised than their non-Indigenous counterparts (Dillon & Westbury, 2007), thus reducing their access to quality support services.

Thus, an appropriate clinical response to the large majority of Aboriginal and Torres Strait Islander people suffering from mental illness would involve a comprehensive appreciation of the community that they live in (Crawford et al. 2000; Sheldon, 2005). Further, the essential interaction between the family of individuals suffering from mental illness and Aboriginal Mental Health Workers within a primary health setting is considered an important component of the management of that individual (Mckelvie & Mallard, 2000). The authors go on to suggest a range of ways that mental health clinicians, including Aboriginal and Torres Strait Islander Mental Health Workers, 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.

Forensic issues

Aboriginal and Torres Strait Islander people 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-Indigenous Australians (Butler et al., 2007). It is estimated that approximately 19% of men and 30% of women in full-time custody in Australia are Aboriginal and Torres Strait Islander. Butler et al. suggest 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. Forensic mental health issues are particularly pertinent for Aboriginal and Torres Strait Islander adolescents. Over a third of young people under juvenile justice supervision during 2005–06 were identified as being Aboriginal and Torres Strait Islander (AIHW, 2007),

with the rate of almost 15 times the non-Aboriginal and Torres Strait Islander population (44.9 per 1000 population compared to 2.9 per 1000 population for non-Indigenous young people Australia wide; Butler et al., 2007).

Another recent review (Jones & Day, 2008) 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; for example, a local prisoner health study found that one out of seven Aboriginal and Torres Strait Islander men and one out of 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 abuse, post-traumatic stress disorder, acquired brain injury and co-morbidity were evident or inferred for Aboriginal and Torres Strait Islander prisoners. A strong link between substance abuse 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' (Jones & Day, 2008).

Overall, the findings in the report by Jones and Day (2008) pointed to the need for more culturally attuned mental health assessments and responses for Aboriginal and Torres Strait Islander people involved in the criminal justice system, and a much higher standard of culturally appropriate data collection in the mental health field.

There have 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 people within prisons who may be vulnerable to mental illness. Stathis et al. (2006) describe a program conducted in a prison for Aboriginal and Torres Strait Islander adolescents that was coordinated across a number of departments. 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 abuse disorders. The recruitment of an Aboriginal and Torres Strait Islander Health Worker to the team was a further incentive for Aboriginal and Torres Strait Islander adolescents to engage in the program (Stathis et al., 2006, 2007). In addition, the Health Worker 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 Health Worker also engaged the adolescents in concepts of emotional and spiritual wellbeing. Other strategies such as the use of a 'buddy system' (Troth & Grainger, 2000) have also been suggested to assist Aboriginal and Torres Strait Islander adolescents adjust to custody.

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 in this regard by the Royal Australian and New Zealand College of Psychiatrists (RANZCP, 2008b) 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. 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 and they may be able to be treated in their community with the help of family, Aboriginal Mental Health Workers and Mental Health Services. People affected by mental illness and their families may be aware of National Standards in Mental Health (1996),

which emphasise treatment in the least restrictive environment for people affected by mental illness. Other publications such as the CARPA manual (CARPA, 1997) also have protocols for treating Aboriginal people with mental illness in their community. 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 for a period before returning to their community and family.

There have also been a number of recent innovative strategies to improve the outcome of Aboriginal and Torres Strait Islander people affected by mental illness. The Northern Territory AIMhi project has developed a Story Telling Project (Nagel & Thompson, 2007) in order to improve compliance and reduce recurrence of mental illness in Aboriginal people living in remote communities, as well as attempting to reduce the stigma in the community for people affected by mental illness. The developed stories are produced in collaboration with a range of clinicians, helping agencies and the communities concerned. They 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 Indigenous and non-Indigenous way of working together to improve the outcome for the affected 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 Aboriginal people suffering from severe mental illness (Nagel et al., 2008). Other resources include the recent DVD collection of personal stories of Aboriginal and Torres Strait Islander people affected by mental illness, in addition to a guide for the care of Aboriginal and Torres Strait Islander people experiencing severe mental illness produced by ORYGEN (2008a,b). The use of these resources to inspire and educate Aboriginal and Torres Strait Islander people so affected, their families and helping agencies is a welcome trend.

CONCLUSION

I hope to have demonstrated in this chapter 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 in Aboriginal and Torres Strait Islander people 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 settlement 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 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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6



Social Determinants of Aboriginal and Torres Strait Islander Social and Emotional Wellbeing

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OVERVIEW

This chapter explores current understandings of the determinants of Aboriginal and Torres Strait Islander social and emotional wellbeing (SEWB) and its development. We show that the determinants of this wellbeing are multiple, interconnected, and develop and act across the life course from conception to late life, all of which influence the expression of positive or negative wellbeing. This chapter discusses those determinants that prompt, facilitate or constrain social and emotional wellbeing in all individuals. It then discusses a range of risk factors identified by Aboriginal and Torres Strait Islander peoples as specifically influencing or determining the development and expression of their wellbeing. Importantly, the chapter focuses on those determinants, or combination of determinants, that increase the likelihood of poor outcomes for Aboriginal and Torres Strait Islander people—the risk factors as well as those that promote or protect positive wellbeing, and the unique protective factors contained within Indigenous cultures and communities that serve as sources of strength and resilience. Finally, it shows that the risk and protective factors impacting on the wellbeing of Aboriginal and Torres Strait Islander people differ in important ways from mainstream concepts of ‘mental health’ and the experiences of other Australians.

INFLUENCES ON THE DEVELOPMENT OF SOCIAL AND EMOTIONAL WELLBEING

What do we, as health practitioners, policy-makers and community and government agencies need to do to improve the social and emotional wellbeing of Aboriginal Australians? What do we do to promote and protect the development of optimal social and emotional wellbeing and to prevent or reduce the development of poor social and emotional wellbeing? To begin to address this question, it is necessary to have an understanding of the determinants of social and emotional wellbeing.

The Social Health Reference Group for the National Aboriginal and Torres Strait Islander Health Council and National Mental Health Working Group (2004) responsible for developing the *National Strategic Framework for Aboriginal and Torres Strait Islander People’s Mental Health and Social and Emotional Wellbeing 2004–2009* draws an important distinction between the concepts of ‘social and emotional wellbeing’ used in Aboriginal and Torres Strait Islander settings and the term ‘mental health’ used in non-Indigenous settings:

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 social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual. Social and emotional wellbeing problems cover a broad range of problems 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. (Social Health Reference Group, 2004, p. 9)

Most determinants do not occur in isolation from others. Many occur together and many accumulate as time goes on. The timing, intensity and duration of determinants and the presence or absence of protective factors are likely to influence the level of social and emotional wellbeing experienced at any point in time. The determinants of 'mental health' are generally accepted to include a range of psychosocial and environmental factors such as income, employment, poverty, housing, education, access to community resources, physical health, and demographic factors such as gender, age and ethnicity (Commonwealth Department of Health and Aged Care, 2000).

The development of social and economic wellbeing can be prompted, facilitated and constrained by several key mechanisms that modify its determinants. 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 (Zubrick et al., 2005).

Prompts for the development of social and emotional wellbeing

The three major prompts of optimal social and emotional wellbeing 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 (Zubrick et al., 2005).

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 (Loeb et al., 2004; Smith et al. 1997).

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

Social and economic wellbeing is facilitated by intellectual flexibility and an outgoing personality, easy temperament and tolerance of new situations (Werner, 1992).

Good language development

Good speech and language functioning is associated with physical health and wellbeing. Children with poor speech are at high risk of clinically significant emotional or behavioural difficulties relative to those children who do not have problems with speech. While there is an obvious association of hearing with speech (Zubrick et al., 2004), speech problems increase the risk of clinically significant emotional or behavioural difficulties (Zubrick et al., 2005).

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 (Ramey, 1998). Most parents want their children to succeed and generally protect them from excessively adverse experiences. For many children, parental encouragement in the face of difficulty, support in failure, and celebration of success are critical facilitators of their social and emotional wellbeing (Silburn & Walker, 2008).

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' (Grant, 2003, p. 448).

Chaos

As Zubrick et al. (2005 p. 559) 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 (Bronfenbrenner & Evans, 2000).

Not only do such contexts disrupt social and emotional wellbeing, but they have the potential to establish alternative developmental processes that lead to poor outcomes (Evans, 2002). Chaotic systems disrupt attachment, emotional regulation and autonomy (Ackerman et al. 1999). 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 (Collins et al., 2000; Zubrick et al., 2005).

Social exclusion

Social exclusion is a powerful disrupter of the development of social capacities in both children and adults because it restricts access to opportunities and choices to participate socially, economically and civically (Zubrick et al., 2005). Social exclusion operates across all levels from system-wide neglect through to interpersonal interactions. Zubrick et al. show how

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 (Paradies, 2006; Williams & Mohammed, 2009). Racism has been identified as a determinant in its own right (Paradies, 2006; Paradies et al., 2008) and is discussed in greater detail below.

With respect to addressing social exclusion at system-wide level, governments have a duty, through legislation and regulatory frameworks, 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, and to support mechanisms that promote access and equity (Zubrick et al., 2005).

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. 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 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 people's 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 (Reynolds, 1998; Zubrick et al., 2005).

Racism

After accounting for a range of other contributing factors, racism has been significantly associated with poor self-assessed health status, psychological distress, substance use and attempted suicide among Indigenous Australians (Paradies et al., 2008; Zubrick et al., 2005).

There are four main pathways through which racism can affect ill health: reduced access to the societal resources required for health (e.g. employment, education, housing, health care); 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; and maladaptive responses to racism such as smoking, alcohol and other drug use (Paradies et al., 2008).

There is strong evidence that systemic racism leads to reduced opportunities to access societal resources required for health. While there is little research that quantifies the health effects of systemic racism, Paradies et al. (2008) identified several studies in Australia which suggest that racism impacts on health care delivery. For instance Indigenous Australians are three times less likely to receive kidney transplants than other Australians with the same level of need (Cass et al., 2004; Paradies et al., 2008).

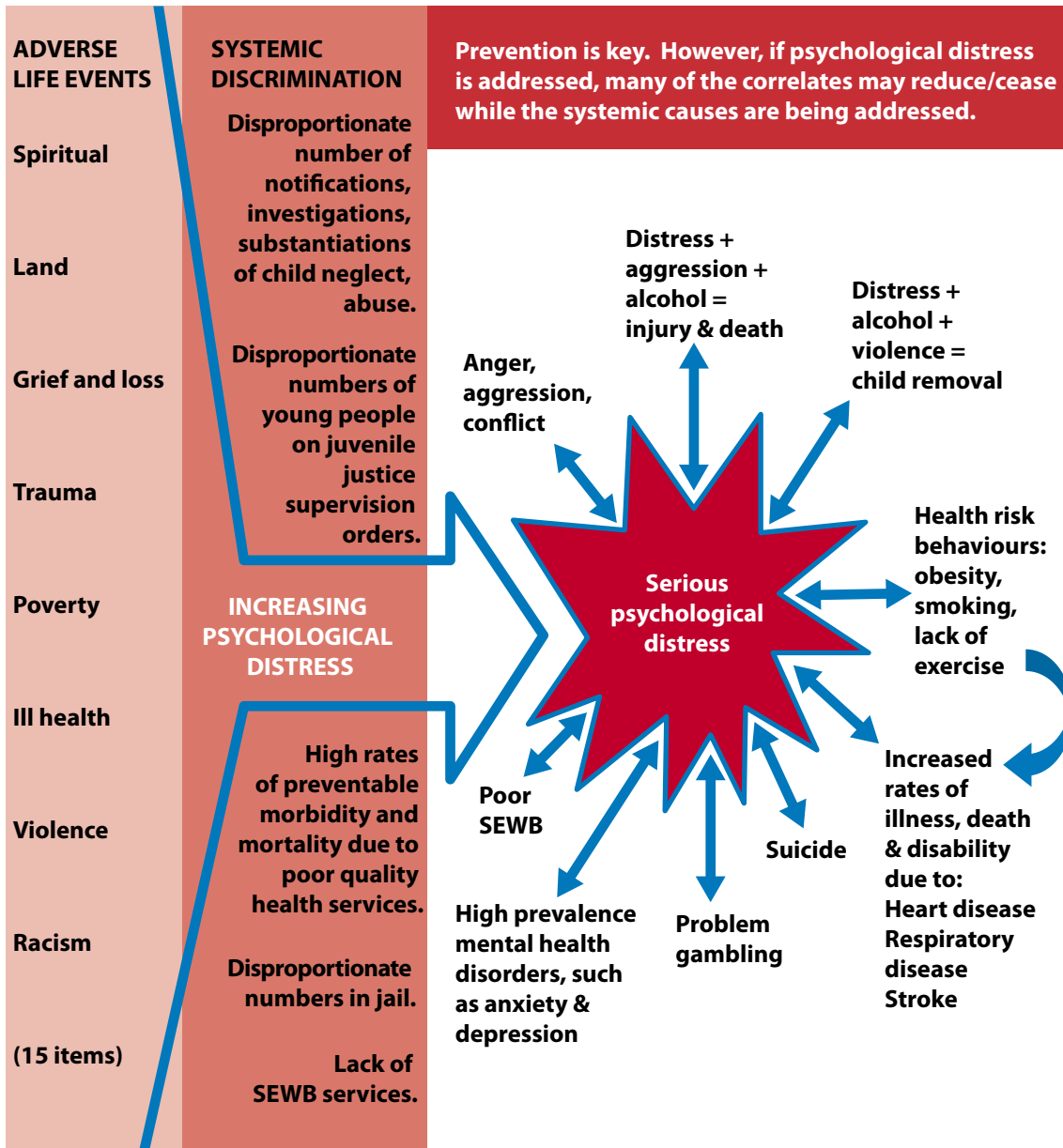
In addition, several studies provide good evidence that self-reported racism is associated with a range of adverse health conditions. After accounting for the effects of other contributing factors, racism was significantly associated with poor self-assessed health status, psychological distress, diabetes, smoking and substance use in the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) (Paradies, 2007), and with depression, poor self-assessed health status and poor mental health in the Darwin Region Urban Indigenous Diabetes (DRUID) study (Paradies, 2006). Analysis of the DRUID study indicated that racism explained a third of the prevalence of depression and poor self-assessed health status among Indigenous Australians (Paradies, 2006). A study in a rural Western Australian town demonstrated that racism was associated with reduced general physical and mental health after accounting for age, gender, employment and education (Larson et al., 2007). Racism was also associated with increased smoking, marijuana use and alcohol consumption in the West Australian Aboriginal Child Health Survey (WAACHS), after accounting for the effects of age and gender (Zubrick et al., 2004).

There is some preliminary evidence from the DRUID study that the effects of interpersonal racism on Indigenous health are mediated by acute and chronic stress and a lack of control over one's life (Paradies, unpublished data). These findings highlight the particular need to understand the role played by acute and chronic stress in the relationship between racism and ill-health (Ahmed et al., 2007; Paradies, 2007).

Social inequality

Social inequality results in the unequal distribution of, and access to, resources required for the development and social and emotional wellbeing 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 (Zubrick et al., 2005). Several studies have demonstrated the relationship between social inequality and developmental outcomes (Keating & Hertzman, 1999; Marmot et al., 1991; Wilkinson, 1999). 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 both within and across contexts for particular groups and sub-populations. Social inequality has been a persistent feature of innumerable reports in which the circumstances of Aboriginal people are compared to those of the majority population. Findings from the WAACHS highlight the extent of social inequality affecting families with Aboriginal children (Zubrick et al., 2004). Along with the other constraints on development, social inequality poses a substantial barrier to effective gains in improving the physical health and the social and emotional wellbeing of Aboriginal children and young people.

In summary, this section has detailed the prompts, facilitators and constraints in the development of social and emotional wellbeing (see Figure 6.1). As well as increased exposure to life events with the potential to cause psychological distress, there are additional dimensions of Aboriginal and Torres Strait Islander wellbeing that differ when compared to other Australians. Generally, at an individual level, Aboriginal and Torres Strait Islander wellbeing will depend on the balance between the number of stressors experienced and the capacity to cope—those who are psychologically overwhelmed or unable to cope effectively are more likely to exhibit higher levels of psychological distress. Psychological distress indicates that an individual's wellbeing is under threat, regardless of whether the source is neurological, physiological, social, cultural, spiritual, religious, or economic (Kelly et al., 2009).



© Australian Indigenous Psychologists Association Source: National Aboriginal & Torres Strait Islander Health Survey 2004-05

Figure 6.1: Factors that contribute to serious psychological distress and its outcomes

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 in Chapter 12.

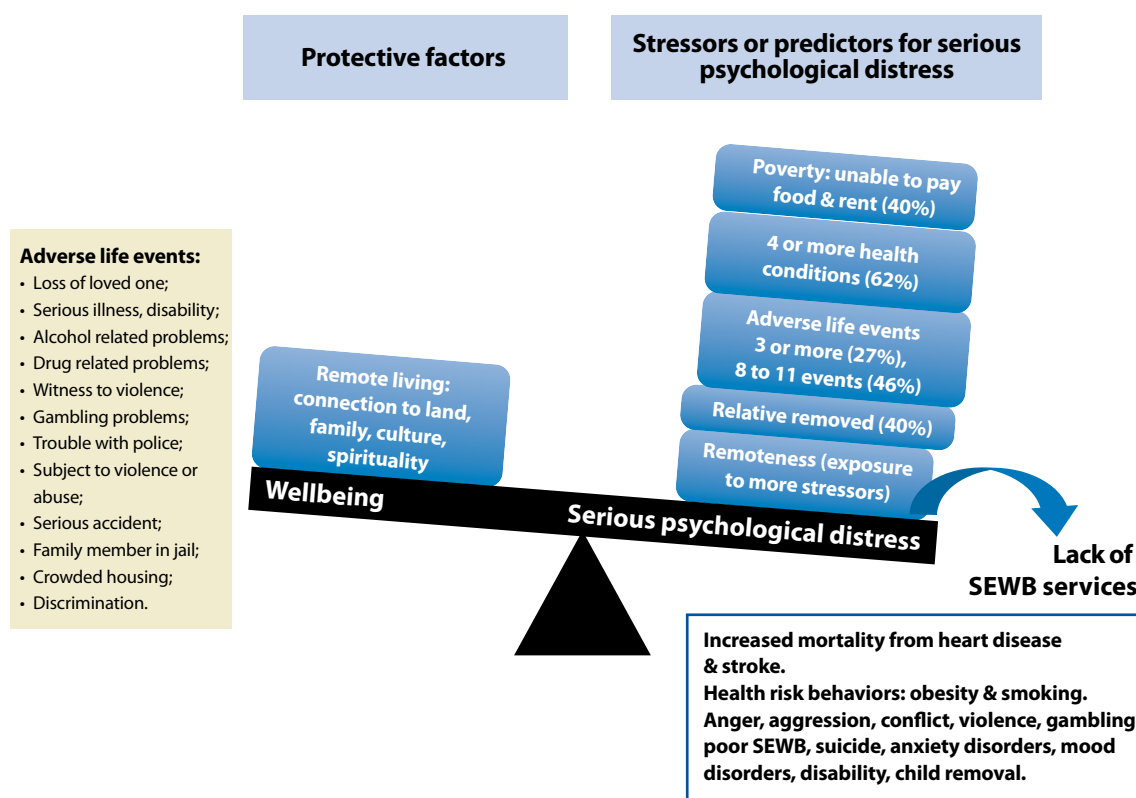
We now consider some specific determinants that evidence shows to be related to the development of social and emotional wellbeing.

RISK AND PROTECTIVE FACTORS

Risk and protective factors for ‘mental health’ at an individual level occur in all facets of everyday life, such as family and relationships, conditions in the workplace and schools, social, cultural and recreational environments, income and social opportunities, personal health practices, and access to a range of health and other services.

There is ample evidence to show that many Aboriginal and Torres Strait Islander people experience the interrelated and cumulative effects of a set of risk factors that impact negatively on their social and emotional welfare. Single risk factors, such as particular negative life events, might have a minimal effect on their own, but when combined can have a strong interactive effect, and exposure to multiple risk factors over time can have a cumulative effect (Kazdin & Kagan, 1994). Additional risk factors are unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage (Social Health Reference Group, 2004).

Protective factors can be effective by reducing the exposure to risk, or compensatory, by reducing the effect of risk factors (Rutter, 1985). Aboriginal and Torres Strait Islander cultural concepts such as connection to land, culture, spirituality, ancestry and family and community are commonly identified by Indigenous Australian people as protective factors, which can serve as sources of resilience and can moderate the impact of stressful circumstances on social and emotional wellbeing at an individual, family and community level (see Figure 6.2). For Aboriginal and Torres Strait Islander people, these factors can serve as a unique reservoir of strength and recovery when faced with adversity (Kelly et al., 2009).



© Australian Indigenous Psychologists Association Source: National Aboriginal & Torres Strait Islander Health Survey 2004-05

Figure 6.2: Risk and protective factors for serious psychological distress

Risk factors on Aboriginal and Torres Strait Islander wellbeing

This section considers some of the evidence that links specific risk factors to Aboriginal and Torres Strait Islander people’s social and emotional wellbeing. In describing how these factors differ from mainstream concepts of ‘mental health’ and experiences, there is a risk that such evidence may be used in ways that disempower rather than empower Aboriginal Australians, and if presented in the wrong context may actually reinforce negative perceptions.

Many of the factors that Aboriginal and Torres Strait Islander people identify as impacting on their wellbeing are examples of systemic or institutional discrimination, which occurs when policies and procedures, or laws, serve to disadvantage specific groups or limit their rights

(Krieger, 1999). 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. The National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2004–05 reported that 11.6% of Aboriginal Australian respondents in urban areas and 13% in remote and very remote areas experienced discrimination. Systemic discrimination is thus measured by outcomes and results rather than intentions—it is not necessary to examine the motives of the individuals involved but rather the results of their actions.

National evidence shows that stressful life events or conditions can adversely affect the lives of individuals, families and communities. In some instances, an adverse event has the potential to have an ongoing impact on an individual's capacity to live a satisfying and productive life or the family's capacity to operate as a fully functioning unit. Participants in the NATSIHS were asked to select from 15 possible stressors or adverse life events which had impacted on them, their families or friends in the previous 12 months. Stressors included serious illness or disability; serious accident; death of a family member or close friend; divorce or separation; not able to get a job; involuntary loss of job; alcohol-related problems; drug-related problems; witness to violence; abuse or violent crime; trouble with police; gambling problem; member of family sent to jail/currently in jail; overcrowding at home; and discrimination/racism.

This section discusses relevant data pertaining to Aboriginal and Torres Strait Islander people's social and emotional wellbeing from the NATSIHS 2004–05, the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) 2002, and the 2006 and 2008 Overcoming Indigenous Disadvantage Reports—which draw from a range of national and jurisdictional data collections—and aligns or integrates these findings with *Aboriginal and Torres Strait Islander-identified determinants* of social and emotional wellbeing. These additional Aboriginal and Torres Strait Islander-identified risk factors include widespread grief and loss, child removals, unresolved trauma and cultural dislocation and identity issues. These determinants of wellbeing highlight how the cumulative and interrelated effects of determinants such as family violence, substance use/abuse and mental health disorders impact negatively on other aspects of life. Together these various findings create a composite picture of the risk factors influencing poor wellbeing. These are manifested in a range of conditions from anxiety and depression, through to serious psychological distress, depending on the frequency and intensity and range of stressors experienced by an individual or family or community as well as the existence of protective factors.

Aboriginal and Torres Strait Islander-identified risk factors to wellbeing

Aboriginal and Torres Strait Islander people were exposed to stressful life events at a ratio of 1.4 times that of other Australians, and the risk exposure for each of the stressful life events ranged from two to five times greater for Aboriginal and Torres Strait Islander respondents. Some events, such as losing a loved one, impacted on nearly half of all Aboriginal and Torres Strait Islander respondents. While Aboriginal and Torres Strait Islander people were at higher risk than other Australians for all stressors across all geographic areas, risk exposure increased for certain events where respondents lived in urban or remote locations. The majority of Indigenous adults (77%) reported experiencing at least one stressor in the 12 months before the survey. Most Indigenous respondents reported one to three stressors, with an overall average of 2.6 stressors, and 27% had four or more life stressors to cope with in the previous year (AIHW, 2009).

Widespread grief and loss

The survey findings confirm that grief and loss was the largest single factor to impact on the wellbeing of Aboriginal and Torres Strait Islander people. Many deaths involving infants, children, young adults, and men and women in their prime were sudden, unexpected and preventable and therefore very traumatic. Extended family networks serve to extend grief across

communities and regions, and the funeral costs deplete the financial reserves and resources of family networks. The NATSIHS 2004–05 found that almost half of Indigenous adults (47%) had lost a family member or friend in the last 12 months and almost half of (47%) Indigenous adults had attended a funeral in the last 12 months, 2.4 times the rate for other Australians (ABS, 2004).

Child removals and unresolved trauma

The NATSIH Survey 2004–05 included questions about whether respondents had been taken away from their natural families by a mission, the government or welfare; or whether a relative had been taken away (i.e. the Stolen Generations). Eight per cent reported they had been taken away and 43% reported that a relative had been taken away. Relatives most commonly removed from the family were grandparents (44%), followed by parents (28%) or aunties or uncles (27%). A lower proportion of those who had been removed from their natural family reported positive wellbeing (resilience) compared with those who had not been removed.

Despite half of the Indigenous population being affected by forcible removal either directly or through their family, no systematic examination has been conducted to determine the psychological effects of Stolen Generations policies across the lifespan, across families and communities or across generations.

Cultural dislocation and identity issues

The NATSIH Survey 2004–05 included a cultural identification domain, which consisted of four items to identify the level of attachment to language group and traditional lands. Questions about cultural identification were only asked of those in non-remote areas (major cities, inner and outer regional). Most (60%) identified with a language group and knew where their traditional lands were, and 15% of these were living on their own lands. About 38% of Aboriginal and Torres Strait Islander respondents living in urban areas reported that they did not know the location of their traditional country.

Economic and social disadvantage

Two household indicators were used to determine financial stress in the NATSIHS 2004–05: the ability to obtain \$2000 within a week for something considered important, and whether respondents had money for basic living expenses such as food during the last two weeks or the previous year. More than half (54%) of Indigenous respondents reported they were in households that were unable to raise \$2000 in a week if they needed it. This compared to 13% of non-Indigenous Australians responding to the same item in the General Health Survey (2006). Many Indigenous households (40%) had insufficient money to pay for basic living expenses such as food and rent. Overcrowding at home was reported by 17% of respondents and was highest in remote and very remote areas (29%) (AIHW, 2008).

Physical health problems

Serious illness or disability affected 28% of Indigenous respondents and was highest (30%) in major cities. Overall, only 19% of respondents did not report a serious illness likely to last six months or more, with 18% reporting one condition, 30% reporting two or three conditions, and 33% reporting four or more long-term health conditions. Indigenous adults were hospitalised at six times the rate of other Australians for conditions usually managed in the primary care setting, for example by GPs (AIHW, 2008). This stands in contrast to the majority (60%) of non-Indigenous respondents to the General Social Survey 2006 who reported they had no long-term health conditions or disabilities.

Incarceration

Aboriginal and Torres Strait Islander individuals, families and communities were 13 times more likely than other Australians to be, or have a family member, sent to jail or already incarcerated. The risk of incarceration was increased by a history of being removed from natural family, being a victim of violence, and receiving treatment for mental illness (AIHW, 2008). Some 19% of respondents reported having a family member sent to jail, or currently in jail, with a higher proportion (25%) in remote areas.

A study which examined the factors that underpin Aboriginal and Torres Strait Islander 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 abused drugs or alcohol, had not completed Year 12, were unemployed, experiencing financial stress, living in an overcrowded household, or were a member of the Stolen Generations (Weatherburn et al., 2006). The two most important factors related to Aboriginal and Torres Strait Islander prosecution and imprisonment were high-risk alcohol consumption and illicit drug use, with those living in remote areas more likely to be imprisoned.

Child removal by care and protection orders and juvenile justice supervision

Across Australia, nearly one in 10 Aboriginal and Torres Strait Islander families were subject to investigations about how they cared for their children—a rate four times greater than that of other families. The proportion of Aboriginal and Torres Strait Islander children aged 0–17 years on care and protection orders was 41 per 1000, seven times higher than other children (AIHW, 2008). The most common reasons given for removal were parental substance abuse, mental health issues and family violence (AIHW, 2008).

Young Aboriginal and Torres Strait Islander people aged between 10 and 17 years were also placed under juvenile justice supervision at 27 times the rate of other young people in 2006–07. This was highest in Western Australia, where the rate was 42 times that of other young people: 662 Aboriginal and Torres Strait Islander young people per 100,000 population compared to 16 others (AIHW, 2008). Research suggests that families with low incomes or a reliance on pensions and benefits, those with alcohol use/abuse problems or a psychiatric disability, and those with a history of family violence are overrepresented in families that come into contact with child protection and support services.

Violence

Indigenous Australians were three times as likely as other Australians to report a recent injury that was the result of an attack by another person (AIHW, 2008). Overall, Indigenous Australians were hospitalised for assault at 14 times the rate of other Australians (AIHW, 2008, p. 862). Males and females were eight and 35 times more likely to be hospitalised for injuries due to assault as other males and females, respectively. Indigenous Australians died from assault at 10 times the rate of other Australians (AIHW, 2008). Most (63%) Indigenous homicide victims had been killed by intimate partners or family members, compared to 45% of other Australian homicide victims. Alcohol-related arguments were involved in one in five (22%) of all Indigenous homicides (AIHW, 2008). Mental disorders were an associated cause of death for 8% of Indigenous deaths due to assaults: all of these were associated with psychoactive substance use.

Family violence

The survey findings suggest that family violence, substance use/abuse and mental health disorders increase the risk of hospitalisation, death or incarceration and of children being removed on protection orders. The implications of domestic violence on Aboriginal wellbeing and approaches to assisting people are explored in the next section. Fifty per cent of Aboriginal Australian women hospitalised for assault were victims of family violence, compared to one in five for males (AIHW, 2006). Spouse or partner violence accounted for 82% of female admissions for family violence. Almost a third of Indigenous hospitalisations for family violence-related assaults had an additional diagnosis of mental disorders (31%). The most common type of mental disorder for Indigenous Australians hospitalised for family violence-related assaults was associated with psychoactive substance use (29%).

Some 15% of Aboriginal and Torres Strait Islander adults reported witnessing violence in the last 12 months; 10% reported being subject to abuse or being a victim of violent crime and 20% being a victim of physical or threatened violence in the last 12 months (AIHW, 2008).

Substance use/abuse

The links between alcohol and substance use are discussed in detail in Chapter 9, so are only briefly covered here. The NATSIHS 2004–05 found that more than half of Aboriginal and Torres Strait Islander respondents reported they had not drunk any alcohol in the previous week, and over 80% of respondents reported they had not drunk alcohol at risky/high-risk levels in the last 12 months (AIHW, 2008). Alcohol-related problems impacted on 20% of respondents, and drug-related problems were reported by 16.4% of Aboriginal and Torres Strait Islander respondents. The proportions of Aboriginal and other Australians who engaged in long-term risky use of alcohol were similar. However, despite the similar prevalence of high-risk alcohol use, Aboriginal Australians who had used or abused alcohol appeared to be exposed to a range of risks negatively impacting on their wellbeing. For example, Aboriginal people were taken into custody for public drunkenness at 43 times the rate of other Australians in 2002, with the median length of time spent in custody being six hours (AIHW, 2008, p. 896).

Protective factors for Aboriginal and Torres Strait Islander wellbeing

Protective factors can reduce the exposure to risk, or may reduce or ease the effect of risk factors (Rutter, 1985). However, people who have high resilience (that is, the capacity to bounce back following adversity) may still be vulnerable to adverse events and circumstances. While a balance of risk and protective factors may improve wellbeing, it cannot be assumed that protective factors will always override the effect of risk factors, since resilience can be put under extreme pressure in some environments (see Figure 6.2).

Little work has been done to identify the factors that have helped Aboriginal and Torres Strait Islander people to survive several generations of trauma and extreme disadvantage. Aboriginal and Torres Strait Islander people have been forced to rely on each other, and the cultural, spiritual and other forms of support that are an integral part of the oldest continuous cultures on earth, to manage wellbeing in individuals, families and communities. More work is needed to identify the protective factors known by Indigenous people as part of wellbeing knowledge. Certainly, the interdependent nature of family, kinship and community connectedness found in many Indigenous communities appears to offer some protection and warrants further examination.

Social cohesion

Social cohesion—defined as the quality of social relationships and the existence of trust, mutual obligations and respect in communities or in the wider society—helps to protect people and their health (Wilkinson & Marmot, 2003). Cultural identification and the reciprocal relationships that underpin Indigenous cultures would offer some protection against the ravages of multiple stressful events.

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 woven with, and connected to, 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. (Dodson, 1977)

Land is central to social relationships and the spiritual and emotional wellbeing of Indigenous individuals, families and communities. To fully understand this wellbeing it is necessary to understand the cultural dimensions of wellbeing. Biomedical research on the

influence of the homelands on health in central Australia shows an association between connection with land and lower prevalence of diabetes, hypertension and obesity, and lower mortality and hospitalisation rates (Rowley et al., 2008).

Sense of wellbeing and resilience

Despite multiple levels of disadvantage, the majority (71%) of Indigenous respondents to the NATSIHS 2004–05 reported being a ‘happy person’ all or most of the time; 56% reported they felt ‘calm and peaceful’ all or most of the time, and 55% felt ‘full of life’ all or most of the time during the previous month. Interestingly, there were marked differences between the responses to the wellbeing measures of Indigenous respondents in non-remote areas and those living in remote areas; a greater number of respondents in non-remote areas reported feeling none of those positive feelings in the past month.

The survey suggests that, despite a higher proportion of Indigenous respondents in remote areas reporting more negative life events, living in remote areas on, or near, traditional lands appears to mitigate the effects of the negative risk factors on people’s wellbeing. That is, remote living appears to improve resilience. Another possible explanation for differences in wellbeing in urban and remote Indigenous respondents is the concept of ‘minority stress’. Aboriginal and Torres Strait Islander people living as dispersed minorities in urban areas are likely to experience racism and discrimination differently from those living in small communities where they form the majority, rather than the minority, of the population. There is a need to investigate the concept of resilience in diverse Indigenous settings.

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 abuse and family violence (Fitzgerald, 2001). 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. 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 preserve and rehabilitate their own cultures, languages and traditional practices (Chandler, 1998). This highlights the importance for communities of maintaining cultural beliefs and traditional practices that assist people, especially young people, to maintain their sense of personal continuity and cultural identity in the face of rapid developmental and cultural change.

In terms of social determinants of Indigenous people’s social and emotional wellbeing, priority needs to be given to further identifying the types of protective factors that have assisted Indigenous individuals, families and communities to survive multiple and widespread adverse life events over several generations. Moreover, developing appropriate Indigenous measures that adequately assess such factors would be an essential part of this research process.

CONCLUSION

This chapter has examined the complex array of environmental, social, economic, cultural and historical factors that influence and determine the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. These include negative life events such as unresolved grief and loss, trauma and abuse, domestic violence, substance misuse, physical health problems, identity issues, child removals, incarceration, family breakdown, cultural dislocation, racism, discrimination, and social disadvantage. We have also identified some of the unique protective

factors that have contributed to the resilience of Indigenous people and communities, and that underpin wellbeing.

It is important to be able to identify and counteract some of the sources of stress that Indigenous people identify as impacting on their wellbeing. More than anything, an examination of the determinants of Indigenous people's wellbeing shows that quick-fix solutions do not exist. Instead, 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 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 Indigenous and non-Indigenous 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 how the complex array of social determinants 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 complex reasons discussed in the chapter 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.

Discuss the viewpoints above—do you agree/disagree? Consider the implications for your practice for clients.

2 Exercise

A study which analysed responses to the NATSISS 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 abused 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 (Weatherburn et al., 2006).

- 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 people?

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7



Preventing Suicide among Indigenous Australians

Sven Silburn, Belle Glaskin, Darrell Henry and Neil Drew

OVERVIEW

This chapter begins with an overview of the recent epidemiological trends in suicide and attempted suicide for Indigenous and non-Indigenous Australians and how this compares with the situation in other post-colonial English-speaking nations such as Canada, the USA and New Zealand. We then review qualitative studies exploring the meaning of suicide within the Indigenous community context, how these inform our understandings of suicidal behaviour and their value for informing preventive action. These highlight the individual, community or situational factors which appear to be associated with increased risk for suicide and suicidal behaviour. Life-course studies of individuals who develop suicidal behaviour or complete suicide are also considered to identify the specific situations and processes that trigger or escalate suicidal behaviour. Recent Australian and international data indicate certain social circumstances, particularly contexts of 'bereavement overload', where suicidal behaviours may become socially contagious, with 'copy-cat' suicidal behaviour. The chapter concludes with a discussion of what works in prevention, early intervention and post-vention including proactive bereavement support, containment of suicide clusters, as well as longer-term strategies for community healing following collectively experienced trauma.

WHAT IS THE CURRENT SITUATION IN AUSTRALIA?¹

Suicide is an extremely distressing event that can have profoundly disruptive effects on the family, friends and communities of those who take their own lives. While suicide is believed to have been a rare occurrence among the Indigenous peoples of Australia in pre-colonial times, since the late 1970s it has become increasingly prevalent and is now an issue of major concern for many Indigenous communities (Tatz, 1999; Elliot-Farrelly, 2004). Reducing suicide and suicidal behaviour among Indigenous Australians is now a public health priority for all Australian governments (SCRGSP, 2003, 2009).

The Australian Bureau of Statistics only reports Indigenous mortality data from those states and territories that have official records with reliable identification data for Indigenous people (Queensland, Western Australia, South Australia and the Northern Territory). The most recently available ABS data for these jurisdictions indicate that suicide was the leading cause of death from external causes for Indigenous males over the years 2001–05 (ABS, 2008).² In 2007,

¹ Editors' comment: For more recent data, see: ABS. (2010). Causes of Death, Australia, 2008. Catalogue No. 3303.0. Canberra. ABS. Available online at <<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3303.02008?OpenDocument>>

² These data are based on ICD-10 codings X60-X84 in the Australian Institute of Health and Welfare (AIHW) National Mortality Database and reflect deaths based on the year of death registration. The combined data from these jurisdictions are used as an indication of the overall Australian Indigenous rates as reliable Indigenous death data are not presently available for NSW, Victoria, ACT and Tasmania.

suicide was the sixth leading cause of death among Indigenous Australians, with 3.7% of all deaths in Indigenous Australia being due to suicide. The rate of suicide in the Indigenous population is almost three times greater than that of the non-Indigenous population (3.7% compared to 1.3%) (Department of Health and Ageing, 2009). While suicide deaths account for a much higher proportion of all deaths among Indigenous people than non-Indigenous people, this also varies by state and territory. It is well recognised that Indigenous Australians experience disproportionate bereavement stress due to the higher overall rates of premature death. What is less well understood is that Indigenous Australians experience a substantially greater burden of bereavement stress because of the traumatic nature of suicide and its relative frequency as a cause of death.

The actual rates of Indigenous suicide are also believed to be significantly higher than the officially reported rates (Elliot-Farrelly, 2004). This is due to a number of factors including the misclassification of Indigenous status on death certificates and other data systems (ABS and AIHW, 1999), differences between jurisdictions in their coronial processes, the procedures around reportable deaths (i.e. deaths that 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 (ABS, 2006; Harrison et al., 2001). To reduce these uncertainties there are presently discussions occurring between all Australian governments and the Australian Coroners' Association to establish a nationally uniform coronial data system which can better inform preventive action through more reliable monitoring of trends and a more consistent understanding of the various factors associated with suicide.

The averaged suicide rates among Indigenous males for Queensland, Western Australia, South Australia and the Northern Territory were between three to four times higher than those of non-Indigenous males, with the highest rates among Indigenous men aged 25–34 years whose age-specific rate was more than 110 per 100,000 in comparison with around 30 per 100,000 for non-Indigenous men (ABS, 2008). However, differences in rates are evident between these jurisdictions. For example, within the Northern Territory, Measey et al. (2006) found that the suicide rates among the Indigenous males aged 45 or less increased by 800% over the period 1981–2002, while the rates for non-Indigenous males aged 65 or less increased by 30%. The all ages rate of suicides of Indigenous men in Western Australia increased by 700% from five per 100,000 in 1986 to 35 per 100,000 in 2002, while the comparable rates for non-Indigenous men remained essentially unchanged at around 21 per 100,000.

For purposes of comparison, the overall 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 population (Kirmeyer et al., 2007). In 2000 the overall First Nations suicide rate was 24 per 100,000, 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 USA 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 to 1987. But significant increases in Maori suicide have occurred subsequently, particularly among the age group 15–29 years. In 1999 the Maori male suicide rate of 26 per 100,000 was more than three times the general population rate of eight per 100,000 (Ferguson et al., 2004).

Is Indigenous suicide different?

Within each of the above-mentioned post-colonial nations, the increase in Indigenous suicide over recent decades has been largely a function of the dramatic increases among Indigenous men. Within the Indigenous Australian population there are now around five to six male suicides for each female suicide (see Figure 7.1). Female Indigenous Australians under the age of 25 years complete suicide at around five times the rate of their non-Indigenous counterparts (see Figure 7.2.). However, the rates of suicide among Indigenous women aged 45 and older are similar to, or lower than, those of non-Indigenous females (ABS, 2008).

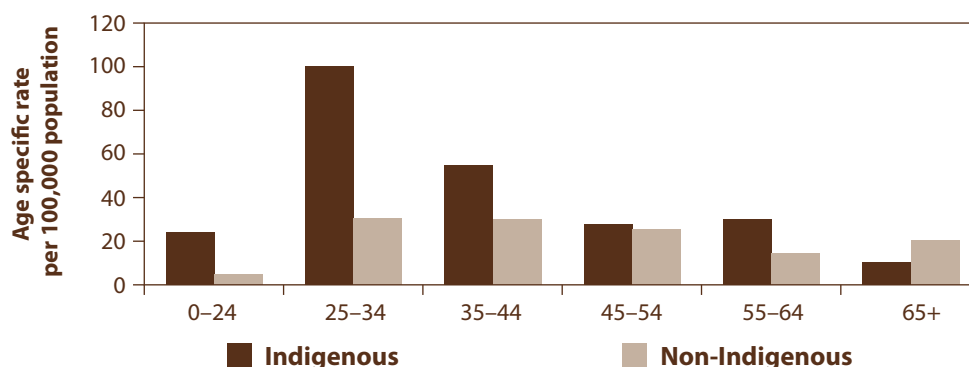


Figure 7.1: Male Death Rates – Intentional Self-harm^{(a)(b)}
(Suicide) by Indigenous status and age – 2001 to 2005

(a) Data for Qld, WA, SA and NT combined. (b) Deaths defined by ICD-10 codes X60-X8

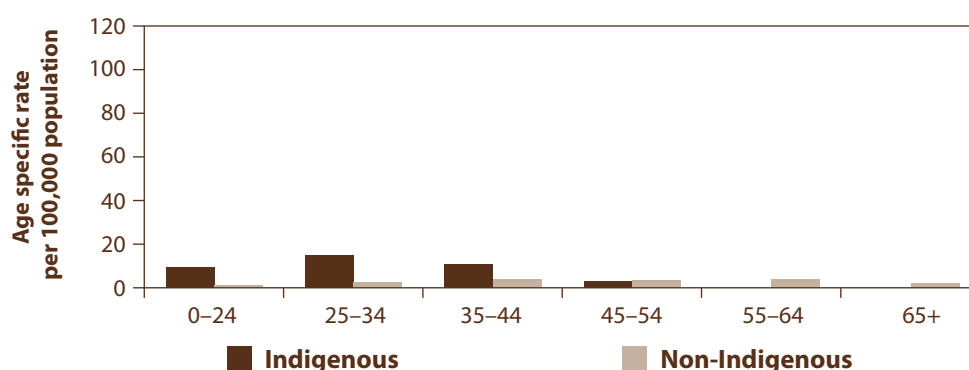


Figure 7.2: Female Death Rates – Intentional Self-harm^{(a)(b)}
(Suicide) by Indigenous status and age – 2001 to 2005

(a) Data for Qld, WA, SA and NT combined. (b) Deaths defined by ICD-10 codes X60-X8

While Indigenous and non-Indigenous males have higher rates of suicide deaths, females make many more non-fatal suicide attempts. Comparable data on hospital admissions for self-inflicted injury (suicide attempts) are not presently available for all Australian jurisdictions. However, the Western Australian data for the period 2001–05 provides an indication of the frequency of non-fatal self-harm injury of sufficient severity to warrant hospital admission. Figure 7.3 below shows the age and gender variation in self-harm injury hospital admissions for Indigenous and non-Indigenous people within that state (Health Department of Western Australia, 2007).

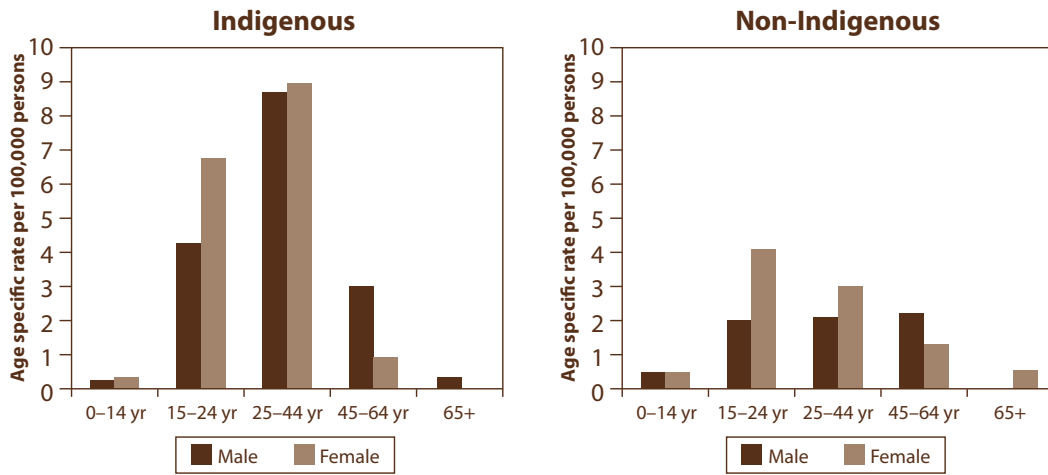


Figure 7.3: Hospital admissions for intentional self-harm injury by gender and Indigenous status – Western Australia 2001–2005

This shows a distinctly different age-specific pattern for Indigenous and non-Indigenous admissions. Among the 15–24-year age group, Indigenous females have about a 30% increased likelihood of intentional self-harm injury over Indigenous males; and both male and female Indigenous rates are around double those of their non-Indigenous counterparts. For those aged 25–44 years Indigenous males and females have very similar rates (8.5 and 9.0 per 1000 persons, respectively). These rates are two or three times higher than those of non-Indigenous males and females (two and three per 1000 persons, respectively). Finally, among the 45–64 age group, the Indigenous male admission rate is 3 per 1000 which is only marginally higher than among non-Indigenous males; while the Indigenous female rate drops to around 1 per 1000 which is similar to the rate for non-Indigenous females (1.3 per 1000).

Given the differences in the geographic distribution between Australia's Indigenous and non-Indigenous populations, and the wide diversity of socioeconomic and cultural living circumstances, it is not surprising that there are significant regional variations in the occurrence of Indigenous suicide. Hunter (2001) has described how the far north of Queensland contains approximately half of the Indigenous people living in Queensland but accounted for almost two-thirds of Indigenous suicides. Three communities constituting less than 20% of the far north Queensland region's Aboriginal and Torres Strait population accounted for 40% of the deaths by suicide. Furthermore, these communities contribute to this excess at different times with overlapping 'waves' of suicides, suggesting a condition of community risk that varies by location and time (Hunter et al., 1999).

The mobility of Indigenous people between remote communities and regional centres, particularly in the more remote areas of northern and central Australia, is another difference. This means that these locations need to be considered part of a larger system when considering the occurrence of suicide and its impact on communities. The age distribution of the Australian Indigenous population is much lower than that of the non-Indigenous population because of higher adult-to-child ratios and shorter average 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 and prevention. It is also relevant to another distinct feature of Indigenous suicide: the phenomenon of 'suicide clustering'. This is where an unusual number of suicides and episodes of suicidal behaviour occur in close proximity to one another (i.e. in time and/or place) within a particular community or region.

Hanssens and Hanssens' (2007) investigation of Indigenous suicide in the Northern Territory from 1996 to 2005 suggests that 'clusters' of suicide (i.e. closely related in time and location) have been an enduring feature of Indigenous suicide in the Northern Territory over this period. Initial findings from this study found that 77% of Indigenous suicides were part of a cluster of suicides and this may have been a significant factor accounting for the escalating occurrence of Indigenous male suicide in the Territory over the past two decades. During the 10-year period of the initial stage of this study, suicide clusters were identified in both urban and rural health districts and regions and sub-regions of the Northern Territory. The Darwin region experienced 16 clusters within five communities; the Alice Springs region had 13 clusters within seven communities; the Katherine region had six clusters within five communities; East Arnhem had eight clusters within three communities; while the Barkly region had three clusters within two communities. The next stages of this study are investigating the mechanisms of 'social contagion'. Previous overseas research using psychological autopsy interviewing methods suggests that 'people who are vulnerable to suicide may cluster well before the occurrence of any overt suicidal stimulus' (Joiner, 1999). Hanssens and Hanssens (2007) suggest that suicide in communities should be seen as a social issue with roots in the economic dispossession of Indigenous people: 'when marginalized, unemployed Indigenous men experience severe negative events, including the suicidal behaviour of a member of the cluster, all members of the cluster are at increased risk of suicide.'

The first systematic Australian studies of Indigenous mental health and self-harming behaviours were based in medical anthropology, clinical epidemiology and sociological methods of enquiry (Cawte et al., 1968; Nurcombe et al., 1970; Brady et al., 1991). But the event that brought national attention to the growing problems of suicide among Indigenous Australians was the Royal Commission into Aboriginal Death in Custody (RCIADIC, 1991). The Commission's final report drew particular attention to the links between substance misuse and mental health disorders in the years and months before most of the deaths that it investigated. It also highlighted the disproportionate number of these deaths (over three-quarters) where there was a history of having been forcibly separated from natural families as children. The interconnected 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 while in custody and in the 12 months following release from prison. Most of these practice recommendations were systematically implemented 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 overrepresentation of Aboriginal people in the justice system—received considerably less attention.

Hunter's studies of Indigenous suicide in the Kimberley region of Western Australia and far north Queensland since the late 1980s have charted the historical impact of colonisation on the role of men in Indigenous society and the fairly recent emergence of suicidal behaviour as a sociocultural phenomenon (Hunter, 1991, 1993; Hunter et al., 1999). Hunter notes that willed or self-willed death associated with sorcery or physical debility in traditional Indigenous societies could be considered 'suicide equivalent' phenomena. These are very different from the disturbing increase in deaths by hanging of young men over recent decades. He argues that both phenomena are meaningful but in different ways: the former can be a socially understood and affirmed consequence of behaviour (transgression) or circumstance (debility), while the latter can be considered as a statement and communication that is meaningful in the particular intercultural political context of the then current Australian society and Indigenous communities of the 1990s. Understanding Indigenous suicide, therefore, demands a consideration of the historical context in which this change is located (Elliot-Farrelly, 2004; Hunter & Milroy, 2006).

An example of the importance of understanding historical context is Hunter's discussion of the implications of the extension of drinking rights to Aboriginal people in the Kimberley in 1971 (Hunter 1991). This resulted in a sudden increase in Aboriginal deaths due to motor vehicle accidents and homicide. But it was the social disruption of alcohol on Kimberley communities that had its most potent effects on young adults, particularly unemployed men, who were already leading culturally dislocated lives in town camps. Almost 15 years after these developments there was a dramatic increase in suicide and self-destructive behaviours among young (mostly male) Aboriginal adults in the late 1980s. Hunter describes these young males as 'the first generation to have grown up in an environment of widespread drinking and its social consequences'. This would suggest that alcohol was not the immediately contributing factor for suicide but rather it was the chaotic environment of childrearing that helped create the fundamental cause. This hypothesis would seem to be supported by another finding of this 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. The challenge therefore for those seeking to address these problems is how to provide culturally appropriate treatments to alleviate individual suffering while at the same time facilitating community action to address the problems posed by the social worlds in which Aboriginal communities live.

As noted earlier, the variation of suicide by location and time in these remote regions of northern Australia suggests that socially mediated factors within communities provide a more pertinent explanation than the descriptive epidemiological conceptions of individual risk inferred from psychological autopsy studies and clinically based investigations of suicidal behaviour. Hunter and his co-authors observe that since 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 (Hunter et al., 1999).

Colin Tatz's sociological analysis of the historical, political and social contexts of contemporary Aboriginal life explains 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, 2001). He uses the term 'decolonisation' to refer 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. His analysis takes issue with the medicalisation of suicide as a mental health problem in much of the previous research and reports such as the Royal Commission into Aboriginal Deaths in Custody. This, he argues, has prevented the problem being examined and understood in a wider context.

Tatz further suggests that many of the mainstream social risk factors for suicide simply do not apply to Indigenous people and their communities. His studies of communities in New South Wales, the ACT and New Zealand identified the following community factors as being most relevant to explaining increases in suicide: lack of a sense of purpose in life; lack of recognised role models and mentors outside 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 manifest 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.

Hunter and Milroy (2006) have more recently taken this a step further in understanding the underlying processes through which these broader historical, socioeconomic and community factors become internalised and how this can lead to the impulse of self-annihilation. They argue that Indigenous self-harm reflects vulnerability stemming from internal states informed by individual experience and collective circumstance. Most particularly, the way in which historical forces have impacted on the environment of family life appears critical in shaping individual identity, health and wellbeing:

Considering 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 (Hunter & Milroy, 2006, p. 150).

WHAT WORKS IN PREVENTION, EARLY INTERVENTION AND POST-VENTION?

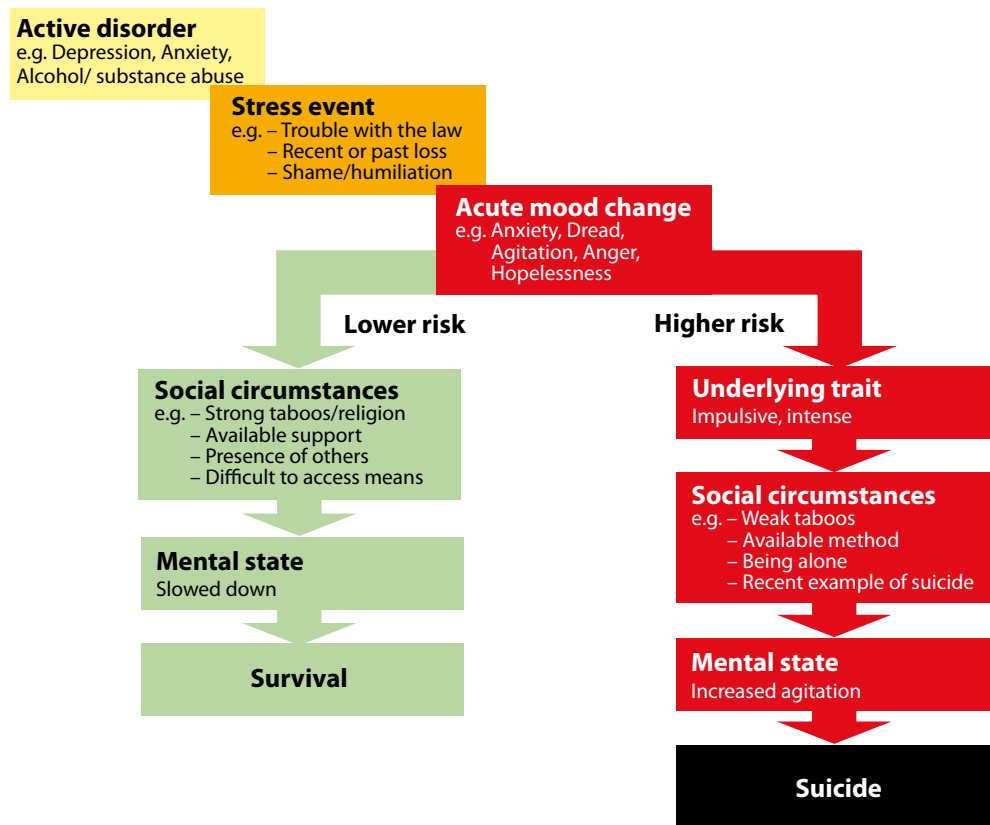
Current mainstream initiatives to reduce suicide and suicidal behaviour in Australia have largely been informed and supported by the *National Suicide Prevention Strategy* (NSPS), which commenced in 1999 and built upon and extended the initiatives of the former *National Youth Suicide Prevention Strategy* (NYSPS) to include all age groups. In July 2006, the Council of Australian Governments agreed to a *National Action Plan on Mental Health 2006–2011*, a key element of which was the expansion of the NSPS and funding of \$62.4 million. The Australian Government provides NSPS funding for the development of national and community-based suicide prevention initiatives. The key objectives of the NSPS are to support national suicide prevention across the life-span; and develop and implement a strategic framework for whole-of-government and whole-community approaches to suicide prevention across all levels of government and business. Over the period 2008–09 the Australian Government has committed funding under the NSPS to projects that have strengthened emphasis on developing and implementing evidence-based suicide prevention in high-risk groups. It is also focusing on the development of strategies to address groups at highest risk, which include boosting the capacity of community organisations in rural areas; developing bereavement response services for families and friends who have been bereaved through suicide; and building the capacity of Indigenous communities to provide culturally appropriate suicide prevention activities.

These strategies have been informed by current international research in suicide prevention, which highlights the importance of two sets of risk factors. The first are immediate (proximal) factors, such as an individual's mental state, and precipitating circumstances, such as recent life stress events and heavy drug and alcohol use in the weeks and months preceding suicide. The second are longer-term (distal) factors, which have a cumulative effect from early childhood and through the life course. Clearly, different prevention strategies and interventions are required to counter the effects of each of these sets of causative influences.

PREVENTIVE EARLY INTERVENTION FOR INDIVIDUALS IN DISTRESS

Preventive early intervention for distressed individuals showing signs and symptoms of acute suicidal risk generally aims to interrupt the proximal risks for suicide and to stabilise and reduce their 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. This should wherever possible be done in consultation with others rather than making potentially life-and-death decisions alone. 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: a) in the immediate future (e.g. over the next two hours); b) in the short-term (over the next two days); or c) in the longer term (e.g. over the next two weeks). Such assessments usually require speaking directly with the individual 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, for example the *Gatekeeper Training Programme* (Ministerial Council for Suicide Prevention 2009), the Indigenous Psychological Services *Whole of Community Suicide Prevention Forums* (Indigenous Psychological Services, 2009) and the *Aboriginal Mental Health First Aid Training and Research Program. Suicidal Thoughts & Behaviours and Deliberate Self-Injury: Guidelines for providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Person* (ORYGEN & *beyondblue*, 2008). (Further details about these programs are included in Chapter 21.) 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 that often underlie suicidal behaviour, and build understanding of the social and clinical supports that 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 on as ‘gatekeepers’ to link and refer suicidally distressed individuals with the clinical or other supportive interventions they may need. Figure 7.4 below outlines some of the relevant issues covered in these programs and emphasises the importance of interrupting the escalating state of mental arousal, feelings of hopelessness, dread and agitation which typically precede fatal and non-fatal impulsive suicidal behaviour.



Source: Ministerial Council for Suicide Prevention, 2009

Figure 7.4: Recognising and addressing proximal risks for suicide

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 Indigenous suicide reviewed earlier

which suggests that the social and community determinants of Indigenous suicide contribute 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 that arise through multiple risk exposures over time or that are highly prevalent at lower levels of risk (Doll, 1997). Improved scientific knowledge of the early-life factors that 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. Figure 7.5 provides a schematic overview of the key individual, family and community processes found to be most influential in shaping positive developmental outcomes in the *Western Australian Aboriginal Child Health Survey* (Zubrick et al., 2008).

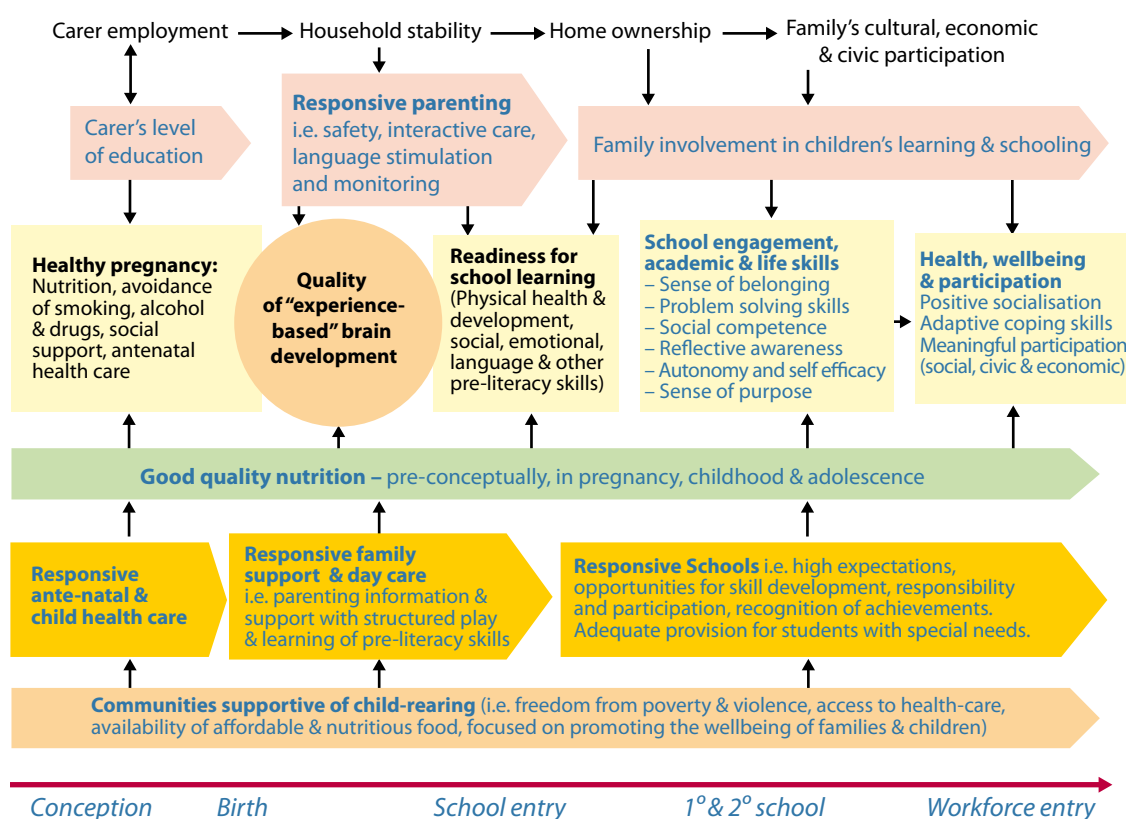


Figure 7.5: Developmental pathways to health, wellbeing and participation

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 abuse) 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.

PROACTIVE BEREAVEMENT SUPPORT AND CONTAINMENT OF SUICIDE CLUSTERS

The high levels of bereavement suffered by Aboriginal and Torres Strait Islander families and communities are a growing concern for many communities. While suicide can be seen as an indicator of distress in communities, it is also the case that the personal tragedy of suicide has a wide impact affecting many people. As discussed earlier, it is not uncommon for Aboriginal

families and communities to be affected by numerous deaths and suicides within a fairly short period. 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 may 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. This community distress and heightened awareness of suicide can be further exacerbated by unthinking or sensational media reporting, particularly graphic reporting of the actual methods of suicide.

A feature common to most communities that have experienced suicide clusters is that the level of bereavement stress appears to have overtaken the community's usual resources for coping and containing suicidal behaviour. Without access to additional emergency support and outreach services to stabilise the situation, these communities have experienced a local 'outbreak' of suicidal behaviour and deaths (Silburn, 2007). The extremely distressing nature of such events highlights the need for developing and maintaining bereavement support and counselling expertise within communities and Indigenous community organisations. At the same time, the trauma and additional stresses associated with suicide may also require more specialised mental health intervention, as well as consultative back-up and proactive support for 'front-line' community workers.

Community healing approaches to prevention

It is in this context that the population data describing the intergenerational effects of forced removal on family breakdown, mental health problems and suicide among Australian Indigenous families affected by these past policies is of particular relevance (Silburn et al., 2006). Similar rates of social and mental health problems have occurred among Canadian Indigenous families affected by abuse and historical trauma that occurred with the residential school system. The Canadian Government's support of Indigenous Healing Centers over the past decade has proved to be one of the most effective components of its overall national strategy in redressing the individual and collective trauma suffered by Indigenous peoples through these past policies. These 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 (Aboriginal Healing Foundation, 2006).

While Prime Minister Kevin Rudd's 2008 apology to the Indigenous 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 begs the question of what is needed in terms of reparation and restorative justice. Given the Canadian evidence of the value of communities being supported by a National Foundation supporting community healing initiatives, it was encouraging that on 13 February 2009, the first anniversary of the Motion of Apology to Australia's Indigenous Peoples, the government announced the establishment of the Healing Foundation. The Foundation's inaugural Board was appointed in late 2009.

In the meantime, several Australian communities have been developing community healing initiatives in response to the collective trauma of child abuse and multiple bereavements. In Western Australia, Darrell Henry has developed a promising three-level model of community healing through his therapeutic support of a number of Western Australian

Aboriginal communities recovering from suicide clusters (Henry, 2008). This integrated community healing model involves a strategic response to suicides and suicidal behaviour, which includes Aboriginal community people as the key 'first-response' service providers, has a primary focus on the whole issue for the community, and involves a whole-community approach.

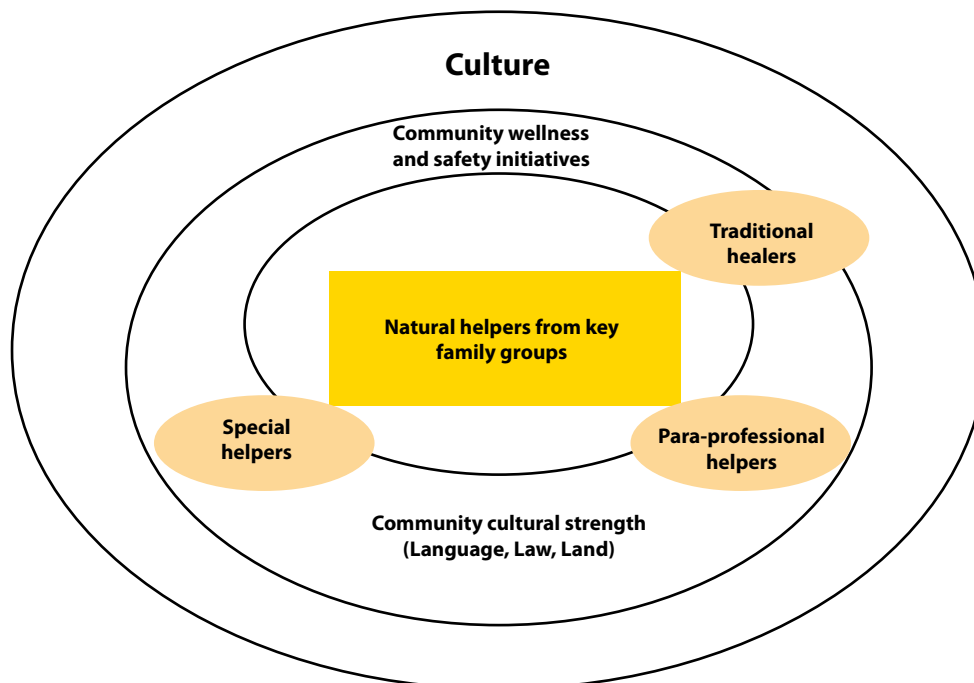


Figure 7.6: Henry's three-level model of community healing and helping

This model recognises the essential and significant role of cultural work in Aboriginal communities. It involves actively supporting cultures and working with cultures using traditional practices such as being placed and 'held' through a formal community process with strong men and women for cultural, spiritual and personal learning. Successful examples of the cultural use of this process of 'holding' are described by McCoy (2008) in the context of the Kutjungka region in the south-east Kimberleys in Western Australia. Henry suggests that such healing practices could be further enabled by funding support such as going to country, re-created use of or development of rituals of healing such as the use of smoke, water, stones, leaves and plants to cleanse the spirit and clear aberrant and distorted spirits from the being. Importantly, this depends on the existent layers of natural helpers in the community, which is seen as fundamental to all other therapeutic work.

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. They would include Aboriginal health and mental health workers as well as dedicated community counsellors who can provide counselling for shock and trauma; these would assist in managing critical responses to family violence and disclosures of abuse and so on. Counselling training is generally available, but at present there are few stable employment opportunities and limited career paths for such urgently needed community-based workers. While professional bodies such as the Australian Psychological Society have set guidelines for the assessment, diagnosis and treatment of Aboriginal people, including the use of cultural advisers in the interview process, Henry highlights the need for specialist training in adapting psychological and psychiatric methods for use with Aboriginal people. He suggests that this level of service could be improved by scholarships and personal support for tertiary training of Aboriginal people in the helping professions, by professional mentoring and co-working, and by specialist practitioner training delivered in communities.

By integrating all three of these layers of helping, this community healing model brings together Aboriginal cultural, spiritual and community processes. This can lead to or regenerate a full spectrum of individual and community healing responses. This in turn can become a vehicle of cultural respect and revivification, at the same time presenting opportunities for strengthening social infrastructures and creating job potentials for long-term community residents with clear lines of professional development and mainstream support where required.

CONCLUSION

This review of the emergence of suicide and suicidal behaviour as major concerns within the Australian Indigenous 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 restorying the past and creating a future that includes the opportunities needed for individual and communal healing.

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 tried to ask him 'what's wrong?' She has contacted you now because he has begun talking about killing himself over the past few days. Thinking about the issues discussed in this chapter:
 - a. How would you go about engaging 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 In your conversations, counselling sessions or other interactions with Aboriginal or Torres Strait Islander people in your community, are you able to identify key narrative threads that indicate that they may be 'disconnecting the individual from the life affirming stories that are central to cultural resilience and continuity' (Hunter & Milroy, 2006, p. 150). If so can you describe some examples of this?
- 3 Thinking about Henry's Community Healing Model as it might be applied in your own community (or the communities you work with) in the situation where there has been a high rate of suicide and suicidal behaviour over several years:
 - 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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8



Anxiety and Aboriginal and Torres Strait Islander Young People

Jenny Adermann and Marilyn A. Campbell

OVERVIEW

This chapter outlines issues of excessive anxiety in Indigenous youth. It describes what an anxiety disorder is and its consequences and how Indigenous youth seem to be at risk for developing such disorders. Issues concerning the delivery of traditional prevention and intervention programs are discussed and possible interventions are provided.

WHAT IS ANXIETY?

Anxiety can be described as a response to a threat (Campbell, 2004) 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 (Robinson et al., 1992). 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. It has been shown that anxiety-related behaviours such as obsessional activities, the need for reassurance, low self-esteem, poor concentration, fatigue, headaches, stomach aches and other reactions to excessive anxiety can hinder a child's academic success at school and affect their social relationships (American Psychiatric Association, 1994). Furthermore, research has shown that anxiety is linked to depression (Costello & Angold, 1995; Manassis & Menna, 1999) and that in some cases it leads to suicide (Wicks-Nelson & Israel, 1997). This is significant for Indigenous youth, as suicide rates in this group are disproportionately higher than for non-Indigenous youth. While it is now believed that there are suicidal risk factors that are uniquely Aboriginal (Westerman & Vicary, 2000), mainstream factors such as anxiety and depression also need to be considered.

The distinction between what is normal anxiety and what constitutes a more serious problem is important. An anxiety disorder is distinguishable from normal anxiety by its continued duration over what would reasonably be expected and the severity of the anxiety in relation to the situation. When young people are no longer able to participate fully in usual activities due to excessive or persistent anxiety, there is cause for concern. While the last 15 years have seen research into childhood anxiety increase significantly, there has been little research on minority groups in this important area, especially in Australian Indigenous youth.

Incidence of anxiety in Indigenous youth

The Western Australian Aboriginal Child Health Survey showed that Indigenous young people have a higher overall incidence of general mental health problems than non-Indigenous young

people (Zubrick et al., 2005). Twenty-six per cent of Indigenous young people compared to 17% of non-Indigenous children in the 4–11-year age group were shown to be at high risk of suffering mental health difficulties. Of even greater concern, 21% of Indigenous 12–17-year-olds were likely to be at risk of mental health difficulties compared with 13% of non-Indigenous youth. The exact prevalence of anxiety disorders was not reported separately in this Western Australian survey or in the recent *National Survey of Young Australians* (Mission Australia, 2006). However, up to 18% of young people suffer from one or more anxiety disorders (Costello et al., 2003; Ford et al., 2003), and while it is acknowledged that Indigenous youth have many strengths, there is no evidence to suggest that this group would suffer less anxiety than their non-Indigenous counterparts, especially given the many stress-provoking issues in their lives.

Life stressors for Indigenous youth and anxiety

Indigenous young people are exposed to many anxiety-provoking stressors. The *Bringing Them Home* report (HREOC, 1997) showed that forced separation and institutionalisation of Indigenous people resulted in health problems and a range of emotional distress, including anxiety in adults. Further, children of depressed parents were more likely to show higher levels of anxiety and depressive symptoms. Generational poverty (Payne, 1996; Saggors & Gray, 1991) also contributes to psychosocial stress. The Human Rights and Equal Opportunity Commission (2005) stated that social and economic disadvantage placed Indigenous youth at greater risk of behavioural and environmental problems that affected physical and mental health, and encouraged self-destructive tendencies. In addition, the World Health Organization (2002) included anxiety as one of the many psychological problems linked to exposure to violence.

The *Western Australian Aboriginal Child Survey* (Zubrick et al., 2005) indicated that 26% of Aboriginal children aged 4–17 years are at a high risk of suffering clinically significant emotional or behavioural difficulties. Factors linked to this were the 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 people other than their original parents, and 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 smoking and marijuana use.

Consequences of anxiety disorders

Anxiety disorders in the general youth population have been shown to reduce academic achievement (Ialongo et al., 1995) and contribute to peer relationship problems (Strauss et al., 1987) and to impairments in general social competence (Messer & Beidel, 1994). In an educational setting, an anxious child may have difficulty remaining on task, have problems interacting with peers and forming and maintaining friendships, or may avoid school or classes that are anxiety-provoking. Consequently, children with anxiety often have difficulty in responding appropriately to normal developmental challenges and many underachieve in school (Woodward & Ferguson, 2001). Excessive school absenteeism and impaired peer relationships associated with anxiety can also lead to poor vocational adjustment (Hibbert et al., 1990) and self-concept problems (Asher & Coie, 1990), as well as psychiatric disorders later in life (Kovacs & Devlin, 1998). In addition, anxious children do not necessarily grow out of their discomfort (Kendall & Ollendick, 2004; Pine et al., 1998) with many becoming anxiety-disordered adults (Ollendick & King, 1994).

There is also preliminary evidence to suggest that anxiety disorders may predispose adolescents to developing substance use disorders (Burke et al., 1994; Deas-Nesmith et al., 1998; Rodhe et al., 1996). Furthermore, research has shown that anxiety is linked to depression (Costello & Angold, 1995; Manassis & Menna, 1999) and in some cases can lead to suicide (Wicks-Nelson & Israel, 1997). This is significant for Indigenous youth, as suicide rates in this group are disproportionately higher than for non-Indigenous youth.

CULTURAL DIFFERENCES IN CONCEPTS OF EMOTIONAL WELLBEING AND ANXIETY

It is acknowledged that, while anxiety is a universal human condition and there will be similarities across cultures, differing constructs of mental health and emotional wellness may also result in differences in presentation of some symptoms, in the importance placed on symptoms and the meaning attached to them. It is therefore essential to appreciate that because of the complexity and diversity of Indigenous groups there are likely to be constructs of anxiety and opinions that differ from Western-held beliefs. Reflecting the holistic nature of Indigenous views of health, however, social and emotional wellbeing is often defined as ‘not just the physical wellbeing of the individual, but the social, emotional and cultural wellbeing of the whole community’ (NAHSWP, 1989). It 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’ (AUSEINET, 2008, p. 22).

Identification

While accurately assessing anxiety in children and adolescents is generally complex (Campbell & Rapee, 1996), further complications may arise when the young people are Indigenous. Bias, validity and reliability concerns in the assessment of Indigenous groups have long been an area of contention due to some cultural issues that can misrepresent actual abilities or states of mental health (Drew, 2000). It has been suggested 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 intervention. Problems in obtaining an inaccurate 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 (Westerman, 2002a).

One culturally appropriate psychological measure that has been validated for use with Indigenous youth in Australia is the *Westerman Aboriginal Symptom Checklist—Youth* (WASC-Y) (Westerman, 2002b, 2003). 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-year-old group. In conjunction, Westerman (2003) has developed a model to assist in considering cultural factors that affect validity in assessments. Future research into Indigenous mental health will probably rely on more measures like this being developed.

Issues in supporting anxious Indigenous students

When planning support for anxious Indigenous youth, an understanding of the various levels of influence on their social and emotional wellbeing is essential (AUSEINET, 2008), including individual, community and structural levels. Such an approach acknowledges the holistic constructs of Indigenous wellbeing 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. 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* (Department of Health and Ageing, 2000a, 2006). 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 (Campbell, 2004).

School attendance and participation

Indigenous students, however, often have interrupted school attendance and poor school completion rates. In 1970, fewer than 10% of Indigenous students attended secondary school.

In 2004, this rate had risen to approximately 40% (McRae et al., 2005). However, of the Indigenous students who attended secondary school in 2004, 30% left between Year 10 and Year 11 compared to 10% of non-Indigenous students. In addition, only 39.5% of Indigenous students progressed to Year 12 in 2004 compared to 76.8% of other students (MCEETYA, 2006)¹. Alarming, Schwab (1999) cautions that retention rate data do not reflect completion rates, which are usually lower than retention rates.

This poses a problem for the delivery of anxiety prevention and intervention in schools to Indigenous students. However, while there are no studies that specifically address links between Indigenous youth, anxiety and school participation, given the potential life stressors and factors identified as affecting school attendance and completion, it is likely that significant numbers of Indigenous young people are suffering anxiety 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 (Davies et al., 1997; HRSCEET, 1996; Lowell & Garrutju, 1997; Petrie, 1982).

Social exclusion, economic hardship and marginalisation resulting from colonisation have been closely linked to health (Devitt et al., 2001; Raphael & Swan, 1997; Rollock & Gordon, 2000) because they limit access to resources, networks and support, and increase stress (Malin, 2002). The alienation felt by some Indigenous students and their families towards schools is associated with less consistent school attendance and high dropout rates (DETYA, 2000; Schwab, 1998). Formal education systems make cultural assumptions that many Indigenous families and students find perplexing or stressful. For example, while child autonomy may be highly valued as a child-rearing practice in Indigenous families, being autonomous does not necessarily fit with behavioural expectations at school (Malin et al., 1996). While many Indigenous children bring a rich cultural competence to school, they find that this often has little value in mainstream systems of education (MCEETYA, 2000), and it could be expected that for some children anxiety would be connected to the discomfort and lack of connection they feel for school. 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 Indigenous children (Education Queensland, 2000).

One of the many interlinking factors for lower Indigenous retention rates in schools identified by Schwab (1999) is fear of failure, embarrassment and shame. Many Indigenous children experience learning delays linked to poor readiness for school (Education Queensland, 2000a; Zubrick et al., 2006) or physical health issues, such as speech and language development, impaired as a result of sensory deprivation from otitis media (MCEETYA, 2000). Students who do not speak Standard Australian English fluently may feel alienated. Low achievement levels have been attributed to absenteeism (Bourke et al., 2000) and low literacy and numeracy levels are associated with increased rates of early school leaving (Schwab, 1999). It is significant, then, that Indigenous national benchmark results in literacy and numeracy at Years 3, 5 and 7 are generally about 20% below the national average (MCEETYA, 2006) and that gaps in knowledge as a result of absenteeism are likely to add further stress and anxiety. While it is unknown to what extent anxiety is a factor, emotional difficulties have been linked to low academic performance and poor attendance of Indigenous youth (Zubrick et al., 2006).

Furthermore, the transition from primary to secondary school can be stressful for Indigenous youth, particularly for those who are forced to leave their communities to continue their formal education. Cultural, social and language differences (Education Queensland, 2000a), being inadequately prepared, being away from familiar support and feeling shame at not having higher achievement levels may lead to anxiety and school leaving. Finally, Indigenous youth share the universal development tasks of their age group with their non-Indigenous peers. These include the need to develop a strong sense of personal identity and

¹ Information in Schools, Australia, 2009 indicates that the apparent retention rate for full-time Indigenous students from their first year of secondary school, through to Year 12 in 2009 was 45% compared with 77% for non-Indigenous students. From 1999, the apparent retention rate to Year 12 increased by 10 percentage points for Indigenous students and 4 percentage points for non-Indigenous students (Schools, Australia, 2009).

self-esteem. Indigenous youth, however, have a distinctive sense of identity as Indigenous people and in early adolescence this may be a source of confusion and embarrassment (MCEETYA, 2001). This is not made easier by racism, discrimination and harassment often experienced by Indigenous youth, which can further result in marginalisation and low self-esteem (Groome & Hamilton, 1995; Malin & Maidment, 2003). Studies examining the impact of racism have shown that attack on sense of self can lead to mental health problems such as anxiety and depression (Malin, 2002).

Some suggestions for encouraging school attendance and participation

One of the first avenues to addressing anxiety in Indigenous youth is to create opportunities for participation, social support and development of connectedness and a sense of belonging to school. The importance of this in terms of both emotional wellbeing and school participation has been emphasised in the literature (Education Queensland, 2000; Hunter & Schwab, 2003; Pittman et al., 2003). Malin and Maidment (2003) reported that Indigenous parents wanted to know more about school processes, curriculum and financial issues related to schooling, but many Indigenous parents and caregivers find schools alienating and far removed from the experience of their everyday lives (MCEETYA, 2001). Parent interest is increased along with greater numbers of Indigenous people working in schools through establishment of school and community networks, and community liaison improves home and school communication (Education Queensland, 2000).

The Department of Education, Training and the Arts (2007) *Linking Families and School Initiative* in Queensland has been developed specifically to promote and support positive relationships between Indigenous communities, students and school staff and aims to nurture partnerships, thereby improving attendance, retention and learning outcomes for Indigenous students. The value of healthy relationships between teachers, Indigenous families and students is recognised for student success. One example of how this initiative has been successfully put into practice is in Weipa, north Queensland, where a modified *Parents as First Teachers* program is running at the Western Cape College. Now in the second year of a two-year trial, anecdotal evidence indicates decreased school-related stress and anxiety, and increased engagement between Indigenous families and students and the school (Anecdotal reference supplied by Letitia Murgha and Yvette Carter at Western Cape College, Weipa, 23 April 2008).

Another model that may have wide application in schools for developing support programs is the *Holistic Planning and Teaching Framework* developed for use by teachers with Indigenous students (Grant, 1998; Indigenous Schooling Support Unit, 2007). In order to organise and present information holistically, the Framework links land, language and culture to time, place and relationships, and reflects Aboriginal worldviews. 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.

Individual programs

Scant research is available for anxiety prevention and intervention programs for minority youth populations. A pilot study, conducted by Barrett et al. (2000), using the FRIENDS program for prevention of anxiety in former Yugoslavian adolescent refugees, found that the nine participants in the program reported fewer anxiety symptoms than the 11 wait-list control refugees. Promising results were also shown using the FRIENDS program with children from Yugoslavian, Chinese and mixed ethnic backgrounds (Barrett et al., 2001). In 2005, Cool Kids was also used without adaptation in a low socioeconomic area and demonstrated its effectiveness (Mifsud & Rapee, 2005). The only study to date that seems to have specifically modified a group cognitive behaviour therapy program was conducted in the USA by Ginsburg and Drake (2002) for six anxious low-income African American adolescents. It is surprising that no Indigenous Australian young people have been studied, especially as both FRIENDS and Cool Kids emanate from Australia.

It is suggested that support programs must include Indigenous constructions of reality and involvement of Indigenous people (Dudgeon & Williams, 2000) from the initial assessment through to intervention and evaluation (Garvey, 1994). Program development therefore requires extensive consultation with the Indigenous community, including the young people for whom it is intended. This will help to ensure that it is meaningful and that there is ownership of both the materials produced and strategies for use or distribution (Lette et al., 2000).

Furthermore, it is important initially that all involved in program development see it as a priority (Hunter, 1998), since when people are living in adverse circumstances mental health may not be considered a high priority. Differences between Western and Indigenous concepts of mental health must also be considered. Research in the general population indicates that cognitive behaviour therapy is an effective treatment for young people with anxiety (Ollendick & King, 1998, 2000); however, Indigenous peoples who have belief systems that encompass holistic concepts of mental health may not recognise health in terms of the mind and body connection (Slattery, 1994). Vicary and Bishop (2005) reported that Aboriginal people are sometimes unaware of mental health implications because the concept of mental illness is an unfamiliar one or something not discussed in the community. In addition, physical signs or moods are not necessarily attributed to feelings (Roe, 2000) but can be associated with culturally-based external wrongdoing (Reid & Trompf, 1991; Westerman, 2003) or character traits (Vicary & Bishop, 2005), making most Western anxiety prevention programs based on cognitive behaviour therapy of little use to many Indigenous people (Westerman, 2004). In fact, in a study conducted in Western Australia looking at Aboriginal conceptualisations of mental health, Vicary and Bishop (2005) found that study participants were frustrated by Western therapies that encouraged them to self-explore. This may have significant implications and may limit intervention options available to therapists.

Vicary and Bishop (2005) propose 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 in the development and dissemination of programs or to vouch for any non-Indigenous person presenting a program. This is particularly pertinent if there is to be acceptance and understanding that all communities are different (Sambono, 1993). Dudgeon and Williams (2000) further suggest that the presence of Aboriginal people in programs is essential because of the life experiences most Aboriginal people share.

Some options for overcoming sadness or worries recommended in the 1999 Ruah Inreach Project (Lette et al., 2000), which may have application in schools, included activity-based challenges, connecting to the land, cultural activities and art. Mason (2000) suggests that art and art therapy can assist Indigenous people in identifying their cultural beliefs and values and this may have a significant impact on reducing anxiety. In addition, Rydberg (2001) maintains that art gives children the opportunity to express fear and confusion without having to talk about these things. Similarly, play may be used as an appropriate intervention. Play is universal across cultures. In addition to providing a range of developmental benefits (Reddy et al., 2005), it has been used to alleviate emotional issues with moderate to large positive effects (LeBlanc & Ritchie, 1999; Ray et al., 2001).

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 writers (Burke, 2007). Narrative therapy has been adapted with success for use with Indigenous peoples (Aboriginal Health Council of South Australia, 1995). It reflects Indigenous oral traditions and provides an outlet for alternative stories of marginalised people to be told, thereby empowering them (White, 1997; Solomon, 2005), and it may have applications in assisting anxious Indigenous youth.

CONCLUSION

While there are still significant gaps in the knowledge of anxiety disorders and 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 wellness. The paucity of accurate and current information regarding prevalence of anxiety in Australian Indigenous youth is of great concern, and culturally appropriate research is required to determine the prevalence of this disorder in this group and effective prevention and intervention options. Hunter (2002) and Westerman (2004) refer to the desperate need for mental health strategies for all Indigenous people (Cleworth et al., 2006) and there are increasing calls for education systems to develop appropriate support for Indigenous students with emotional difficulties (Craven & Bodkin-Andrews, 2006; Zubrick, et al. 2006). 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 such as anxiety. Further research is urgently required to inform intervention and prevention strategies in educational settings for anxious Indigenous youth (Craven & Marsh, 2004).

Reflective exercises

- 1 In your experience, what are some of the ways that Indigenous students may exhibit excessive anxiety?
- 2 How would you go about measuring anxiety in Indigenous young people?
- 3 How do you think that Indigenous youth can be assisted to attend and complete school?
- 4 How do you think the shame factor can be eased for Indigenous students?
- 5 Reflect on the factors that may cause anxiety in Indigenous youth and discuss possible interventions.

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9



Substance Misuse and Mental Health among Aboriginal Australians

Edward Wilkes, Dennis Gray, Sherry Siggers, Wendy Casey and Anna Stearne

OVERVIEW

In this chapter, we briefly examine substance misuse and mental health among Aboriginal Australians¹. We explore a range of issues including current substance use and related harms, social and emotional wellbeing and co-morbidity, and the social determinants of mental health and substance misuse. 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 misuse and mental health workforce. We reiterate that until the social and structural determinants of good mental health are addressed, the co-morbidity of substance misuse and mental health among Aboriginal Australians will linger.

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 that has been particularly associated with the harmful use of alcohol and other psychoactive substances. More and more frequently, alcohol and other substance misuse is being represented as *the* problem of Aboriginal Australia, the source of all or most of its ills, especially poor physical and mental health. Alcohol and other substance use by Aboriginal people is influenced by many factors—including use as an escape mechanism but also as a focus of socialising—and it is apparent that the causes and effects of alcohol and other drug use among Aboriginal Australians need to be better understood. Without such understanding, there is a great risk that policy interventions will be simplistic and ineffective and that the current opportunity for change will be lost.

The search for effective answers to today's problems with alcohol and other substance misuse must start with the facts and not with the slogans and stereotypes that are thrown around so liberally in the media. Each Aboriginal person has a lived experience and as such can and should tell their stories themselves. The experience of assimilating into Western ways or holding onto Aboriginal ways creates anxieties for many Indigenous people 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 in settings where others are welcomed. Furthermore, in some instances Indigenous Australians are still denied access to public places.

¹ Editors' comment: In this chapter, Aboriginal Australians includes both Aboriginal people and Torres Strait Islander people.

The apology by the Prime Minister of Australia on 13 February 2008, recognising past wrongs against the Stolen Generations of Aboriginal Australians, may provide some relief but it can never be the solution on its own. In reality, there is still a demeaning stereotype of Indigenous Australians that has to be dismantled.

In the non-Aboriginal population, the prevalence of substance use is thoroughly documented (AIHW, 2006) and the *National Mental Health Survey* (Teesson et al., 2000) has documented the high prevalence of co-morbid substance misuse and mental illness in that population. The authors of the latter report concluded that there is growing evidence for some direct causal relationships between substance misuse and poor mental health, in particular cannabis use leading to psychosis in the vulnerable (Teesson et al., 2000, p. 49). 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.

What then is the extent of co-morbid substance misuse and mental health problems among Aboriginal people? Several reports and studies have documented high rates of substance use among Aboriginal people in general and young people in particular (ABS & AIHW 2008; SCRGSP, 2009; Zubrick et al., 2005). While there are no large-scale studies of Aboriginal mental health (such as the *National Mental Health Survey*), evidence from a number of sources indicates that co-morbidity is more common than in non-Aboriginal populations, although as Hunter (2003) observes, identifying disorders of social and emotional wellbeing in Aboriginal and Torres Strait Islander populations is problematic. He also notes that among Aboriginal people mental health disorders and substance use problems continue to be treated separately (Hunter, 2003, p. 129) and that this contributes to poor prognosis.

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 being done to address harmful substance use among Aboriginal people? What else needs to be done?

SUBSTANCE MISUSE AND RELATED HARMS

It is important to note that not all substance use is substance misuse (Gray et al., 2008). Here we use the term 'substance misuse' 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* (American Psychiatric Association, 2000; see also Gray et al., 2008).

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 (Chikritzhs & Brady, 2006). 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 use in the previous 12 months) presented in Table 9.1 have been compiled from AIHW publications (2005, 2006) for the year 2004.²

Table 9.1: Current substance use (previous 12 months), percentage of persons aged ≥14 years, 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 (including petrol)	≈1.0	0.4.
Heroin	≈0.5	0.2
Injected drugs	≈ 3.0	0.4

Source: AIHW, 2005, 2006.

² Note limited Indigenous sample size for the NDSHS (AIHW, 2005).

- The NDSHS had a sample size of 29,445 Australians aged 12 years and older with a response rate of 46%.
- The NDSHS does not have an enhanced Indigenous sample. Only a small number of Indigenous respondents are included in this survey with 460 Indigenous Australian participants. This sample size is very small and therefore the estimates should be interpreted with caution. The small sample size also limits the reliability of time series analysis.

There have been dramatic reductions in tobacco use among non-Aboriginal Australians over the past two decades, to the point where in 2004 approximately 23% were current smokers. Among Aboriginal people, however, the rate was more than double, at about 52%.

Alcohol is the most widely used substance among Aboriginal people, as it is among non-Aboriginal Australians. Among those aged 14 years or older, more Aboriginal people abstain from alcohol use (about 21% compared to about 16%). However, a reason for this higher rate of current abstinence is that more Aboriginal people are ex-drinkers (rather than lifetime abstainers), many of whom have given up because of the serious health consequences of their drinking (Brady 1995; CDHSH, 1996). Among those who do drink, considerably more Aboriginal people consume alcohol in a manner that poses high risks to their health in both the short (52% versus 35.5%) and long term (22.7% versus 9.7%).

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

In Table 9.2, we have estimated changes in the prevalence of use of various substances by comparing the data in Table 9.1 with that for Aboriginal people in 1994 and 1993, and non-Aboriginal people for 1993 (CDHSH, 1996). Apart from increases in the use of amphetamine-type stimulants (10%) and the non-medical use of painkillers and analgesics (7%), in the period 1993–2004, there were significant reductions among non-Aboriginal Australians in the use of tobacco (–22%), alcohol (–14%) and cannabis (–13%). 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%) and cannabis (5%) and, in particular, amphetamine-type stimulants (204%) and painkillers and analgesics (107%). Similarly, over the same periods, while there was a reduction of 20% in the prevalence of injecting drug use among non-Aboriginal people, there was about a 50% increase among Aboriginal Australians. As highlighted in several studies, poly-drug use is common among Aboriginal Australians (Burns et al., 1995; CDHSH, 1996; Gray et al., 1997; Shoobridge et al., 2000). 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.

Table 9.2: Percentage changes in current prevalence of substance use, 1993/1994 to 2004, by Indigenous status

Substance	Aboriginal/ Torres Strait Islander % change 1994–2004	Non-Aboriginal / Torres Strait Islander % change 1993–2004
Tobacco	-4	-22
Alcohol	15	-14
Cannabis	5	-13
Meth/amphetamines	204	10
Pain killers/analgesics	107	7
Injected drugs	50	-20

Source: CDHSH, 1996; AIHW, 2005, 2006.

Although confined to Western Australia, the results of the *Western Australian Aboriginal Child Health Survey*—the most comprehensive study undertaken of Aboriginal children and young people—indicate levels of substance use among young Aboriginal people. In the survey young people aged 12–17 were asked about their experiences with cigarette smoking, alcohol

and marijuana (cannabis). Of the 17-year-olds in the survey, 58% smoked regularly, over 61% of males and 43% of females were drinking alcohol, and 45% of males and 21% of females were using marijuana at least weekly. These rates are a major concern, particularly the high level of cannabis 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 (ABS & AIHW, 2008).

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 substance abuse, and tobacco smoking has been identified as the single most preventable cause of death among Aboriginal people (ABS & AIHW, 2008, p. 113; Cunningham, 1994; Measey et al., 1998; Unwin et al., 1994). Alcohol abuse causes about 7% of Aboriginal deaths and Aboriginal people die at much younger ages from these conditions than do non-Aboriginal Australians (ABS & AIHW, 2008, p. 140; Chikritzhs et al., 2007). Alcohol also makes a significant contribution to the hospitalisation of Aboriginal people (ABS & AIHW, 2008, p. 113). There is little published data on Aboriginal deaths and hospitalisation associated with illicit drug use. In Western Australia, however, in 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 person years 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 Indigenous Australians relating to substance use in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory, around twice the rate of other Australians (AIHW 2008, p. 1030).

SOCIAL AND EMOTIONAL WELLBEING AND CO-MORBIDITY

In the non-Aboriginal population it has been shown that there is a high prevalence of co-morbid substance misuse and mental health problems (Shand et al., 2003; Teesson & Proudfoot, 2003). For example, it has been estimated that among those with an alcohol-dependence disorder 20% have an anxiety disorder and 24% an affective disorder (Shand et al., 2003). 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' (Teesson et al., 2005, p. 43). These shared risk factors for mental health and substance misuse have implications for prevention and treatment, with potential co-morbidity issues needing to be addressed as soon as symptoms of one disorder appear (Teesson et al., 2005).

There has been no comprehensive study of co-morbidity in the Aboriginal population, but evidence of the relationship comes from a number of sources. In Table 9.3 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 (ABS & AIHW, 2008, p. 112). Of particular relevance here is the fact that the table shows that Aboriginal men are over four times, and Aboriginal women over three times, as likely to be hospitalised for 'mental disorders attributable to psychoactive substance misuse' than their non-Aboriginal counterparts.

Table 9.3: Hospitalisations for mental and behavioural disorders, ratio of observed to expected cases among Aboriginal males and females, 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: ABS & AIHW 2008.

Aboriginal suicide is covered in detail in Chapter 6, but we highlight it here because of its relationship to substance misuse. In the period 2001–05, the suicide rate among Aboriginal males in Queensland, South Australia, Western Australia and the Northern Territory 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 (ABS & AIHW, 2008, p. 169). The relationship between substance misuse—specifically alcohol misuse—and suicide is evident in Table 9.4, 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 (Chikritzhs et al., 2007).

Table 9.4: Most common causes of alcohol-attributable death among Aboriginal males and females (based on aggregates 1998–2004)

Condition	n	%	Mean age at death
Males			
1 Suicide	222	19	29
2 Alcoholic 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 Alcoholic 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.

It is important to note that the hospitalisation and suicide data presented above are only the tip of the iceberg. A study of cannabis use in remote Aboriginal communities in the Northern Territory found that some mental health symptoms increased as cannabis use increased (Clough et al., 2005). 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. (Zubrick et al., 2005, p. 207)

This and other research on the frequency of mental health problems (ABS & AIHW, 2008; Swan & Raphael, 1995; Zubrick et al., 2005) and high levels of harmful substance misuse indicate that levels of co-morbidity are likely to be significant (Hunter, 2007; Kelly, 2006; Parker & Ben-Tovim, 2002; Santhanam et al., 2006). In turn, this highlights the need for interventions which address both sets of morbidities, since addressing one without the other is likely to have limited efficacy.

SOCIAL DETERMINANTS OF MENTAL HEALTH AND SUBSTANCE MISUSE

Poor Aboriginal mental health and risky health behaviours are not simply the fault of individuals (Saggers & Gray, 2007; Walter & Saggers, 2007). We have known since medieval times—when high rates of disease were noted among miners—that social conditions are implicated in the health status of communities. The legendary work by John Snow, who mapped cases of cholera in London and traced them to a public water pump, resulted in much greater recognition of the importance of environmental conditions such as water and sanitation to health (Lynch, 2000). In more recent times, it was a study of British civil servants which showed the impact of occupational status on health that was to lead to a renewed interest in the social determinants of health (Townsend & Davidson, 1982). In Australia, Turrell and his colleagues have similarly demonstrated that Australians in low socioeconomic positions suffer more ill health at all stages of life (Turrell & Mathers, 2000).

Social factors which cause or protect against ill health and substance misuse 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 (Lynch, 2000; see also Chapter 6). These have important implications for intervention. With respect to substance misuse, 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 substance misuse, many mental health problems are influenced by social factors outside the control of individuals and their immediate contexts (Hunter, 2007). It is not simply about 'individual problems with individual psyches' (Tatz, 2004, p. 22).

Contemporary social indicators

The history of oppression has contemporary consequences for the structural position and health status of Aboriginal Australians (RCIAIDC, Johnson, 1991; RCIADIC, Dodson, 1991; Saggers & Gray, 1998). Despite improvements in recent years, Aboriginal Australians continue to lag behind the general population on virtually every social indicator. In 2004, only 52% of Year 7 Aboriginal students met national benchmarks for reading literacy, compared to 91% among the non-Aboriginal population. This reflects wide discrepancies in a range of educational indices including numeracy and overall academic performance (ABS, 2006). Aboriginal adults are more than twice as likely as non-Aboriginal adults to be unemployed, and Aboriginal household incomes are only 59% of those of the wider population. Overcrowding and housing in poor states of repair are also much more common among Aboriginal people. These factors are implicated in poorer general health, lower life expectancies, higher substance misuse and higher reported mental health problems (ABS & AIHW, 2008).

Dispossession and the Stolen Generations

For Aboriginal Australians, the social determinants of health include the consequences of invasion and dispossession, and issues such as racism which impact on people's everyday lives. When Europeans invaded Australia in 1788, they declared the land *terra nullius* (occupied by no one) despite the presence of hunter-gatherer societies which had occupied the country for at least 60,000 years. Numbering an estimated 750,000 people, they lived in small semi-nomadic groups in diverse environments ranging from the coast to the arid interior, and maintaining complex social and religious lives (Saggers, 2003).

As European settlement spread north and into the interior of the continent, Aboriginal groups were dispossessed of their country and many were herded into missions or government settlements. Until the middle of the 20th century, Aboriginal people's lives were ruled by discriminatory legislation that intruded into every aspect of their lives—dictating where they could live, attend school and work, who they could marry and even what they could eat and drink. The rations of flour, sugar, meat, tea and tobacco established nutritional habits that helped transform them into one of the unhealthiest populations in the world (Saggers, 2003).

Government policy towards Aboriginal people has fluctuated between attempts to protect them from European violence and the consequences of settlement, to assimilation with the European population, which saw the forced removal of many Aboriginal children from their families. The numbers affected by these racist policies are highly contentious, but the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (HREOC, 1997) reported that 'Nationally we can conclude with confidence 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' (p. 37). This history of separation is strongly implicated in the poor mental health and substance misuse problems of many Aboriginal Australians (Swan & Raphael, 1995).

From the early 1970s to the mid-1990s, at the national level, there was bipartisan support for policies of Aboriginal self-determination and/or self-management. Although implementation of these policies was under-resourced, the policies provided for the growth of Aboriginal community-controlled services, including health and substance misuse services.

However, under the Howard Liberal-National Party coalition government, there was a backing away from support for self-determination, the Aboriginal and Torres Strait Islander Commission (ATSIC) was abolished and there was a move to 'mainstreaming' of Aboriginal service provision. 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* (Wild & Anderson, 2007) report on child abuse. 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 (Brown & Brown, 2007; CAONT, 2007; Central Land Council, 2008).

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 (Gray et al., 2002). In fact some, such as that conducted by Benelong's Haven (Chenhall, 2007), pre-date policy and funding commitments by governments.

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* (MCDS, 2004), 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. (MCDS, 2004, p. 2)

The *National Drug Strategy* (NDS) is based on three major strategies to minimise drug-related harm: demand, supply and harm reduction. In non-Aboriginal populations, there have been extensive reviews of these strategies and their effectiveness (Babor et al., 2003; Hulse et al., 2002; Loxley et al., 2004; Stockwell et al., 2005).

To complement the NDS, a plan focusing specifically on alcohol and other drug use among Aboriginal Australians has also been developed; the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* (MCDS, 2003). 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 from within which particular state and territory jurisdictions can implement strategies they deem appropriate to their own jurisdictions. 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.

Demand reduction

As the name implies, demand reduction strategies are designed to reduce or prevent substance-related harm by reducing demand for those substances (CDHAC, 1999; MCDS, 2006). They include broad-based prevention projects and both community-based and residential treatment services.

Prevention and early intervention programs to address substance misuse 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 1999/2000 financial year on behalf of the Australian National Council on Drugs (Gray et al., 2002) identified a total of 57 such projects nationally. Since that time, there has been a steady expansion of these projects, but as there is no regular auditing of interventions on a national basis, the current number of such projects is not available.

In 1999–2000, there were 107 Aboriginal-specific treatment services. Of these, 32 provided alcohol-focused residential treatment, most with an abstinence-based approach (Gray et al., 2002).

Over the past decade, a number of services have responded increasingly to calls for a more diverse range of treatment options or alternatives to an abstinence-only approach (Brady, 1995). An example of such a response is that of a residential treatment service in Western Australia, Milliya Rumurra, which employs a diverse approach to meet the needs of individual clients (Strepel et al., 2004).

Although the number of evaluations of such interventions is relatively small, there are clear indications of their effectiveness (Gray & Siggers, 2005; Gray et al., 2008).

Supply reduction

Generally, the greater the availability of a particular substance, the higher the levels of use and related harm. Supply reduction strategies are those that aim to reduce availability and thus the levels of harm. Such strategies 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 (MCDS, 2006).

In the non-Aboriginal population, a combination of taxation and purchase age restrictions and health promotion campaigns (a demand reduction strategy) has significantly reduced tobacco consumption. In the Aboriginal population, however, both these measures and the few Aboriginal-specific strategies (Ivers, 2001, 2003) have had limited success.

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 (d'Abbs, 1998) and the most successful has been licensing restrictions (National Drug Research Institute, 2007).

In contrast to community-initiated alcohol supply reduction measures, as part of its Northern Territory Intervention, the Australian Government imposed alcohol restrictions in many remote communities. At the time of writing, however, these restrictions have not been evaluated.

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 (Access Economics, 2006; Shaw et al., 2004).

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 (Delahunty & Putt, 2006; Gray et al., 2006).

Harm reduction

Harm reduction strategies are those designed to decrease immediate harms associated with substance misuse. 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 that they be supported (RCIADIC, Johnson, 1991). Although the current number of operating patrols is not known, in 1999–2000 there were 69 (Gray et al., 2002).

Sobering-up shelters provide safe surroundings for intoxicated people. As in the case of night patrols, there was an expansion of sobering-up shelters following the RCIADC and in 1999–2000 there were 22 of them. Most focus on those intoxicated by alcohol but some have also provided beds for those intoxicated on volatile substances. 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 (Dolan et al., 2005).

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 (van der Sterren et al., 2006; Williams et al., 2006).

Addressing co-morbidity

The issue of co-morbidity is of concern and the Australian Government through the Department of Health and Ageing has a 'National Co-morbidity Initiative' which aims to increase awareness, provide support to service providers and improve access to resources (Butler, 2008). It is also providing capacity-building grants for non-government organisations. As yet, however, although there are interventions that address mental health and substance misuse issues separately, there are very few that specifically address co-morbidity in Aboriginal contexts. An example of a program that does so is that operated by Warlpiri Youth Development Aboriginal Corporation (formerly the Mt Theo-Yuendumu Substance Misuse Aboriginal Corporation). One of the objectives of this Northern Territory-based program is to prevent suicide and petrol sniffing among the young people in the community (Saggers & Stearne, 2007).

In an attempt to address the gap in services for those suffering from co-morbidities, the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) has developed a model for integrating substance misuse, mental health, and primary health care services (AMSANT, 2008). At the time of writing, one of AMSANT's member organisations, Central Australian Aboriginal Congress, is conducting a trial of this model.

Recent initiatives

Unpublished data supplied to the National Drug Research Institute by Australian and state and territory governments shows 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. In 2006–07 few of the substance misuse services were specifically addressing issues of co-morbidity, and a study of services in Queensland found that the staff of many services felt they did not have the expertise to do so (Gray et al., 2009). Since 2006–07, resourcing of both Aboriginal substance misuse and mental health received a significant boost under agreements reached by 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, alcohol and other drug misuse plays a significant role in the disruption of Aboriginal people's lives. Having also established that this drug misuse 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 multisystemic approach. But this is not always utilised. While it appears that much is already being done, the 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, but it should be further reiterated that a fundamental principle when working with Aboriginal people is to ensure that engagement is maintained in a culturally secure manner (Houston, 2001). 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
- 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.

Practice to enhance treatment outcomes

Social Learning Theory (Bandura, 1977) 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.

It is critical that services are culturally secure and evidence-based to increase access to services and improve treatment outcomes. Services need to ensure that treatment models adhere to these principles and adapt accordingly to maximise effectiveness.

In the development of any intervention strategies, recognition of the historical, socioeconomic and political factors must be considered. Alcohol and other drug misuse cannot be seen in isolation from other factors because there is always a multiplicity of causes (Edwards, 1982). In a report by RCIADIC, 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’ (RCIADIC, Dodson, 1991, vol. 2, p. 738).

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. However, there is a need for significantly increased levels of investment in such programs, for at present levels the gaps between Aboriginal and non-Aboriginal Australians are likely to continue (Altman et al., 2008). Under the Closing the Gap initiative \$4.6 billion is provided to address these gaps. The government will work in partnership with Indigenous Australians, state and territory governments, business, community organisations and all Australians to improve Indigenous outcomes.

The evidence indicates that individuals and families who seek treatment and support for substance misuse problems are more likely to succeed if change can be seen as worthwhile. Saunders and Allsop (1989, 1991) 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

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. Swan & Raphael (1995) and Teesson & Proudfoot (2003) clearly identify the need for new programs to provide both improved identification and service delivery in the assessment, treatment and management of people with co-morbid 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 co-morbid disorders.

An example of a working collaboration is that between Milliya Rumurra Aboriginal Corporation (residential alcohol and other drug treatment service) and Northwest 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 co-morbid 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 across-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 has been an area of neglect for many years and there is a need to provide support and training for the existing workforce. Gray et al. (2004, p. 24) 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.'

Workforce development is a key result area of the *Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003–2009*. The Complementary Action Plan clearly articulates 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' (p. 7).

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 in 2005. This unique program, led by the Western Australian Drug and Alcohol Office, has established national partnerships with the Northern Territory, Queensland, ACT, New South Wales and South Australia to deliver the Indigenous National Alcohol and Other Drug Worker Training Program, CHC30802 Certificate III in Community Services Work. Consolidating partnerships across jurisdictions to develop and sustain a competent and skilled workforce will provide the initiative to enhance service delivery and produce better outcomes.

Workforce development measures must include a greater understanding of the co-morbidity of substance misuse 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 co-morbidity 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 substance misuse 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 Aboriginal substance misuse. The *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* 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 substance misuse 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 abuse rates of alcohol and drugs for the Aboriginal and Torres Strait Islander population compared to the non-Aboriginal and Torres Strait Islander population? Discuss what you think are the contributing factors of these outcomes.
- 2 What forms of approaches are in place to address alcohol and drug abuse?
- 3 One of the key issues in addressing alcohol and drug abuse is workforce development. How can this help?

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10



Trauma, Transgenerational Transfer and Effects on Community Wellbeing

Judy Atkinson, Jeff Nelson and Caroline Atkinson

OVERVIEW

This chapter focuses on how the effects of experiencing trauma are transmitted within and across generations, and how whole communities can be affected by a single experience of trauma by a single member of a community. The chapter introduces the reader to a selection of views and conceptions of trauma, theories of its transgenerational transfer, an explanation of the impact of lived or transferred trauma in the lives of Aboriginal and Torres Strait Islander families and communities, and an overview of dysfunctional community syndrome. It also explores the links between unresolved childhood trauma and participation in violence, sexually inappropriate behaviour, and incarceration as adolescents and adults. The second part of the chapter discusses the challenges associated with working in Indigenous communities; it provides an example of a program that is achieving positive results through education and community empowerment, and an appreciation of the need to embed trauma-recovery in all facets of service provision.

TRAUMA: EVENT, ENVIRONMENT, OR REACTION?

It remains contentious whether the word 'trauma' relates to an event, a series of events or 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 (2006) argued that trauma should only be used to refer to 'major events that are psychologically overwhelming for an individual' (p. 3) and refer their readers to the DSM-IV-TR definition of 'extreme traumatic stressor' (American Psychiatric Association, 2005, p. 463) for clarification. Under the American Psychiatric Association classification, a stressor must be assessed as extreme¹ 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. This assumption ignores individual differences and discounts the effects of previous histories or current living conditions.

Figley (1985) breaks his definition of trauma into two clear but related areas. He defines *psychological* trauma as 'an emotional state of discomfort and stress resulting from memories of

¹ DSM-IV-TR's list of traumatic events include, but are not limited to, military combat, violent personal assault (sexual assault, physical assault, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness.

an extraordinary catastrophic experience which shattered the survivor's sense of invulnerability to harm' (p. xviii). He also defines trauma *behaviourally* as 'a set of conscious and unconscious actions and behaviours associated with dealing with the stresses of catastrophe and the period immediately afterwards' (p. xix). 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 (2001) and van der Kolk (2007) 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. Whether we focus on trauma as the event or as the experience of and reactions to the event is not the focus of this chapter. It is more important to understand that overcoming the effects of trauma-related illness requires addressing not only the illness (individual) but also the prevalence of events (community) that lead to re-experiencing, and poor mental health.

Trauma-related illness, identified in the DSM-IV-TR as PTSD, ASD, and AD, is conventionally managed by psychologists, usually through individual or group therapy and behaviour modification techniques. Leaving aside the usual criticisms about the effectiveness of mainstream psychology for Indigenous people (Hunter, 2003; Ranzijn et al., 2007), more recent reservations have been expressed about the ability of American Psychiatric Association constructs to capture the challenges facing Indigenous people living in today's society. Specifically, Atkinson, C. (2008), Atkinson, J. (1990, 2002), Cameron (1998), Milroy (2005) and O'Shane (1993) have argued that diagnoses such as PTSD are unable to conceptually capture the levels of chronic ongoing stress that Indigenous people experience in their everyday lives. The sources of this stress are argued to be multiple, repeated, and of great severity; and the levels of this stress are argued to be unacceptably high and compounded by (1) the inability to identify and overcome a single source of stress, (2) the presence of cumulative stressors, and (3) the realisation that many of these stressors are inflicted by people well known to the victims. Not only is there the problem of inadequacy at diagnosis but there are more substantial problems at the levels of treatment and control.

The individual and community costs of unresolved trauma

Van der Kolk (2007) argued that childhood trauma was probably today's single most important public health challenge and a challenge that could be overcome by appropriate prevention and intervention. His work provided a comprehensive insight into effects of experiencing trauma in childhood, demonstrating links with ongoing physical health problems, with intra- and intergenerational transference of negative attitudes and troubled behaviour, and with the transference of historical trauma across family and communal systems. Van der Kolk argued that childhood trauma violated a child's sense of safety and trust and reduced their sense of worth, that it established and/or increased their levels of emotional distress, shame and grief, and increased the proportion of destructive behaviours in the child's normal repertoire. 'Destructive' behaviours included unchecked 'aggression, adolescent suicide, alcoholism and other substance misuse, sexual promiscuity, physical inactivity, smoking, and obesity' (pp. 226–27). Survivors of childhood trauma were also shown to be more likely to have difficulty developing and maintaining relationships with caregivers, peers and marital partners. He also argued that adults with a childhood history of unresolved trauma were 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 eradicate the behaviours that are compounding their already serious conditions.

Atkinson (2008) recently investigated the link between being a victim (direct or indirect experiencing) of childhood trauma and being a perpetrator of higher-level violence in adulthood. The results of her study showed that a statistically significant proportion of her sample (Indigenous men who were incarcerated for violent offending) reported experiencing traumatic and violent events in their youth, and doing so frequently. The results also revealed a positive statistical association between

the number of traumatic stressors or cumulative degree of traumatic exposure and the likelihood of displaying PTSD symptomology.² Atkinson argued that 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 Atkinson's study was the consistency of identifying as being victims of particularly severe child sexual abuse from early ages. 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's research also identified a substantial lack of services that effectively supported victims of abuse and interrupted its intergenerational progression. Atkinson concluded that the link between childhood trauma and adult offending was mediated by the presence of unresolved trauma and undiagnosed PTSD.

The intergenerational transmission of trauma

Blanco (in Levine & Kline, 2007) developed a five-generation account of the effects of violence on subsequent generations in South America that can be mapped onto the history of Indigenous Australia:

1st Generation: Conquered males were killed, imprisoned, enslaved or in some way deprived of the ability to provide for their families.³

2nd Generation: Many men overused alcohol and/or drugs to cope with their resultant loss of cultural identity and diminished sense of self-worth. Unfortunately, government responses to emerging substance misuse problems have not always been effective and have directly and indirectly led to the traumatising of individuals who had not been previously affected, and the exacerbation of trauma in those already suffering the effects of trauma-related illnesses. The Queensland Government's solution to their developing substance-use problem was to pass the *Aborigines Protection of Alcohol and Opium Act 1897*, which enabled Indigenous offenders to be removed to and forced to remain on reservations, though without the support they required to overcome their substance-use issues.

3rd Generation: The intergenerational effects of violence manifest in the increased prevalence of spousal abuse and other forms of domestic violence. The breakdown in the family unit that accompanied this violence 'required' caring governments of the day to remove 'at risk' children from their mothers and place them in the care of suitable, in many cases non-Indigenous, families. Unfortunately, the compassion shown for the children was not replicated in the case of the mothers, whose situations were not improved by government intervention.

4th Generation: Trauma begins to be re-enacted and directed at the spouse and the child; signifying a serious challenge to family unit and societal norms of accepted behaviour.

5th Generation: In this generation, the cycle of violence is repeated and compounded, as trauma begets violence, with trauma enacted through increasingly severe violence and increasing societal distress.

Blanco's depiction of the absolute breakdown of functional society within a five-generation time-span shows strong similarities to progression mapped in Atkinson's (2002) six-generation traumagram. Atkinson successfully linked the historical events associated with the colonisation of Aboriginal lands ('accidental' epidemics, massacres, starvations, and the removal of people to reserves) to increases in the rates of family violence, child sexual abuse and family breakdown in Indigenous society. She traced one family line across six generations, listing the known memories of being victims of sexual and/or physical violence, being a perpetrator of violence, suffering from mental health illness, attempting suicide, and having substance misuse problems. Her ability to trace the one family across several generations provided a unique line of evidence

² Atkinson (2008) 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 Australian Aboriginal peoples (Atkinson, 2008).

³ Intergenerational transmission of trauma occurs through directly experiencing trauma or through visually or aurally sharing the traumatic experiences of others.

to support the view that the presence of unacknowledged or unresolved trauma in previous generations was linked to dysfunction in later generations of an extended family.

Atkinson's research provided evidence of a link between the imposition of government policies and interventions and variations, usually upwards, in behaviours associated with trauma experiences in Aboriginal people. She argued that the removal of Aboriginal children was not only a racist policy but also reflected a desire to 'breed them out'. These policies and interventions that arguably did so much damage were often presented as bureaucratic generosity to people who were frequently living in clear distress. For example, a widow having her children removed 'for their own good' rather than providing support for the family's immediate crisis or a couple forced to live in extreme poverty by the instruments of the state and then having their children removed because of their imposed poverty. There is little doubt that Atkinson's work was primarily focused on investigating the link between unresolved trauma and generational wellbeing, but it was also pivotal in exposing the role of government inactivity and intentional racism in the plight of Australian Aboriginal people.

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' (Muid, 2006, p. 36). Milroy (2005) 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. (p. xxi)

Duran and Duran (1995) suggested that historical trauma becomes embedded in the cultural memory of a people and is passed on by the same mechanisms by which culture is generally transmitted, and therefore becomes 'normalised' within that culture. This model of historical trauma provides a link between the intergenerational transmission of trauma and 'dysfunctional community syndrome' (Duran et al., 1998; Muid, 2006; Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, 2000; Ralph et al., 2006; Robertson, 2006; Whitbeck et al., 2004). Memmott et al. (2001) defined dysfunctional community syndrome (DCS) as:

A situation whereby multiple violence types are occurring and appear to be increasing over generations, both quantitatively (numbers of incidents) and in terms of the intensity of violence experiences, for example, victims of sexual abuse include very small children; pack rape is being committed by boys as young as 10 years old. (p. 51)

Memmott et al. (2001) suggested that the typical cluster of violence types in a dysfunctional community would include male-on-male violence, female-on-female violence, child abuse, substance use-related violence, male suicide, pack rape, infant rape, rape of grandmothers, self-mutilation, spousal assault and homicide. They further argued that when a community deteriorates to the point of DCS, it has devastating immediate and generational effects on the members of that community, particularly the children. Exposure to community

violence results in dangerously high levels of emotional distress and antisocial behavioural problems, and has been identified as an independent risk factor for problems such as depression, anxiety and aggression in youth (Scarpa, 2001).

Ralph et al. (2006), 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. (p. 123)

In fact, Ralph et al. demonstrated a clear link between being exposed to trauma and developing PTSD symptoms and suicidal ideation, particularly in young Aboriginal girls who identified as being victims of childhood abuse.

Child sexual abuse, trauma, and recovery

While there is evidence that at least 40% of all psychiatric inpatients have histories of sexual abuse in childhood (Putnam, 1997), the sexual abuse of children does not occur in isolation. Other stressors and trauma are generally present within a family or social group in which the abuse is occurring. Giller (1999) argued that about a third of abused children display few or no symptoms and that a large proportion of children who do become symptomatic are able to recover. Fewer than one in five adults who were abused as children show serious psychological distress. According to Giller (1999), 'Acute psychological distress is associated with more severe abuse: longer duration, forced penetration, helplessness, fear of injury or death, perpetration by a close relative or caregiver, coupled with lack of support or negative consequences of disclosure' (p. 1).

Of greater concern, the evidence shows that as many as one-third of child victims of physical (including sexual) and psychological abuse grow up to experience parental difficulties or become abusive of their own children; one-third of previously abused parents do not have this experience; but the remaining third remain vulnerable and, under stress, have an increased likelihood of becoming abusive (Oliver, 1993). According to Green (1993), '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' (p. 582).

The NSW Aboriginal Child Sexual Assault Taskforce (2006) identified the normalisation of violence that only comes with generations of abuse as a determining factor in the 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' (Transcript 24, p. 61). According to Atkinson and Atkinson (1999), 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' (p. 7).

The information included in this section is intended to provide a basis for understanding some of the more salient challenges facing Aboriginal and Torres Strait Islander people living in contemporary society. The authors acknowledge that there are many non-Indigenous individuals

and families who face identical challenges and who, like their Indigenous counterparts, have reason to feel unsupported by their governments. The next part of this chapter will focus on the challenges of working in communities to support positive change and will provide an example of one program that is using community resources to their greatest potential.

The challenges of community recovery

The single most difficult challenge facing a service provider who is responsible for working with a remote Indigenous community to overcome its problematic behaviours is establishing a space that encourages and supports open communication. While this is a challenge for all, it is infinitely more difficult when the service provider is not known by community members and is unfamiliar with the complex relationships that exist in communities. This problem is further compounded if the visiting service provider is non-Indigenous. From our experience, it is our understanding that it can take up to a year to establish a quality of relationship that will enable in-depth therapeutic work to commence and much longer to contemplate deeper issues (violence against and neglect of children and domestic violence) and challenge more serious behaviours. This estimate may be excessive, but the negative history of service provision in most Indigenous communities must be considered.⁴

Developing a new relationship between parties when there has been no history of mistrust or unmet expectations is not difficult if people are honest and consider each other's views and feelings. Trust between parties develops as a function of the degree of consistency in the nature of interactions (honesty, openness and dependability), the depth of familiarity between the parties, and as a function of time. Unfortunately, there would be many Indigenous community members who have heard numerous accounts of failed relationships with service providers. Whether responsibility for these failures lay with the practitioners or the underlying system will be discussed at a later stage. The important aspect of this history is its limiting effect on the probability of developing new trusting relationships between communities and service providers, and how that affects people in genuine need of care and assistance. The default perception of a new service provider in most communities is more likely to be one of mistrust over ambivalence, especially if the service provider is non-Indigenous and comes with new ideas, new plans and an inability to learn from their new environment. So how does a service provider overcome this very important challenge?

Entry into a community to provide therapeutic services should be prefaced by a series of consultations with as many community people as possible and preferably by the invitation of community members who are familiar with the provider's work. This is not always possible so there needs to be a process of introduction and familiarisation that goes some way towards overcoming the potentially limiting effects of previously failed interactions. From the outset, it is advisable that service providers recalibrate their expectations around timing and achievement. Achieving and supporting positive change in Indigenous communities unfolds slowly, at a much more leisurely rate than happens elsewhere, and necessitates a long-term commitment from service providers. Because of the slowness of change in these communities and the failure to recognise this, there has been a history of prematurely terminated programs and failed expectations. An essential part of any successful community program is having local people support and become active participants in the change process. This requires, in many cases, that people alienate themselves from the normal activities of the community, align themselves with outsiders, and be isolated accordingly by their own family members. When a program is prematurely terminated and its service providers geographically remove themselves, those who supported the initiative are left to face ridicule and torment for being so trusting. There are many community members who identify as casualties and who actively dissuade their family members from participating in any further programs.

⁴ Community does not necessarily refer to a place but to a network of people who are in regular contact and live as a collective of similarly-minded people.

On entering the community it is essential that the service provider makes him or herself available to all community members to have informal discussions about the intentions of the visit; what is anticipated will happen over the longer term; how the process has worked or not worked in other communities; how local people can become involved and contribute to developing and implementing the program; and to share personal information that allows trust to develop and relationships to be built. It is essential that the service provider is honest in these early interactions and is willing to listen to what they are being told. If the intention of the visit is to support overcoming child sexual abuse, remember that there have already been many programs run in the community to combat this problem. If the intention is to overcome domestic violence it is again the case that this program is not the first and people are aware of this. Community people have the advantage of having seen the success or failure of many programs and are a rich resource of information for those astute enough to capitalise on it. Being open to the suggestions of community people not only makes this information accessible but also strengthens relationships and builds trust.

That an invitation has been extended by a community does not guarantee that everyone in the community will welcome or support the change process. There are likely to be individuals who prefer the status quo because of their vested interests in certain behaviours or situations, their inability to appreciate that there is a better way of living, or from their experience of previous programs that were abandoned or failed to achieve their promised outcomes. Consider the following advice: 'If a community is not vocal about changing their own circumstances and you cannot easily identify any natural leaders don't waste your time. If the community is using lots of gunja [marijuana] it is even more useless to attempt change' (personal communication, Komla Tsey, 2008).

We-Al-Li: A successful community-based program

Achieving sustained positive in-community change requires a substantial investment of resources, personnel and time, and many organisations cannot afford this investment. It is partly because of this demand that successful programs such as the Family Wellbeing Program (Tsey et al., in press) and the We-Al-Li Workshops (Atkinson & Ober, 1995) use the 'train the trainer' model to achieve and support community change over the longer term. These programs focus as much on the development of 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 antisocial and unlawful behaviour, substance and alcohol misuse and family violence and neglect, these programs are contributing to the development of safe, structured and stable Indigenous communities. These programs provide formal qualifications to their participants and enhance their ability to gain full-time employment either in their own or other communities.

The We-Al-Li workshops provide opportunities for interested community members to pursue formal qualifications up to doctoral level through the Gnibi College of Indigenous Australian Peoples at Southern Cross University. The successful completion of the community-based program (four units) allows its participants to graduate with an accredited Certificate of Community Recovery. The units offered in this course include Community Wellbeing, Indigenous Counselling, Trauma and Recovery, and Family Violence and Recovery. Completing these units allows participants to work through personal issues, to develop the skills necessary to initiate and support positive changes in the community, and to work with individuals as required. The premise that underpins Gnibi's in-community education is that there are eight factors that contribute to individual, family and community wellbeing and that achieving a balance between them is critically important. The factors include environmental wellbeing, spirituality, relationship wellbeing, physical wellbeing, emotional wellbeing, stress regulation, sexuality and life purpose. Education is provided in a familiar setting (usually an established meeting place), in an informal manner (focusing on non-judgmental group discussions), with an

emphasis on encouraging people to discuss their current situations and to understand how the eight factors contribute to their situation. Conversations about deeper, more sensitive issues are usually reserved for the art sessions where the groups create paintings and other artworks. These conversations usually result in good-natured explorations of the historical and current issues that are limiting personal growth and the achievement of a holistic sense of wellbeing.

Participants in the Certificate course are provided with:

- 1 an overview of five counselling techniques (narrative therapy, cognitive-behavioural therapy, somatisation, loss and grief counselling and art therapy) and instruction in how to combine them for the best outcome
- 2 instruction on the use of deep listening, the rules of conversation, and how to facilitate effective group discussions about sensitive topics
- 3 an overview of the issues pertaining to unresolved trauma, its effect on daily functioning, how to manage the rage that accompanies unresolved trauma, and how to make sense of themselves and their environment
- 4 an overview of the issues contributing to domestic violence, sexual assault, substance misuse, parental non-responsibility and child neglect.

Graduates with the Certificate of Community Recovery are presented with additional opportunities to extend and refine their skills and are assisted to develop and maintain support networks within their communities. Adopting a role as a support person is not easy and is quite often unrewarded, but there are a number of individuals who have participated in the We-Al-Li workshops who are providing services in their own communities, though without formal recognition or remuneration. An unexpected source of validation for the workshops came from a group of qualified practitioners who participated in the workshops as a part of their professional development. They all reported that the workshops allowed them to identify and work through personal experiences of trauma that they had previously 'shelved'. They further claimed that dealing with their trauma had allowed them to grow and to become more effective in the field and in their personal lives.

That the We-Al-Li workshops are able to improve the effectiveness of service provision in Indigenous communities through their effect on established practitioners and community members demonstrates their capacity to initiate and support change. They further show that trauma is an all-encompassing pathology that does not spare its victims regardless of their status, their profession or their identity as Indigenous or non-Indigenous. Members of different practitioner groups have all suggested that in the interest of the sufferers of trauma-related illnesses, all mental health practitioners be required to work through their own trauma issues before being accredited to work in the field.

CONCLUSION

This chapter has provided a brief overview of the understandings of trauma, and how the different forms of trauma impact on Australian Indigenous people. The authors have given special consideration to the transgenerational nature of trauma. In order to understand dysfunctional community syndrome, the consequences of colonisation expressed in trauma have been examined in some detail. The links between unresolved childhood trauma, violence, inappropriate sexual behaviours and incarceration have been examined. Importantly, the challenges of engaging with Indigenous communities are discussed and examples of successful programs for community empowerment are outlined. While this chapter focused on a perspective of life in Indigenous Australian communities that is disadvantaged and fraught with dysfunction, this reflects the reality of some people and is mitigated by the fact that empowering solutions are available. However, these solutions are not simple and require full and long-term commitment by communities themselves and government. The bleak life of some Indigenous

people and communities is a reality that can be changed if appropriate preventions and interventions are identified and implemented in culturally appropriate and safe ways.

Reflective exercises

- 1 There are many factors that contribute to the traumatisation of individuals and communities. Demonstrate your knowledge of 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 Indigenous 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 transgenerational nature of trauma.

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Indigenous Family Violence: Pathways Forward

Kyllie Cripps

OVERVIEW

This chapter briefly examines the context in which Indigenous family violence occurs. In particular, it explores how Indigenous people define and contextualise the violence they or their family members are experiencing. This context is important in considering pathways forward for healing for the victim, their families, and the broader kin network who inevitably feel the ripple effects of such violence. This chapter also, using the available evidence, poses several key considerations for the development and implementation of interventions responding to Indigenous family violence in what is often a maze of complexities.

THE CONTEXT

The issue of family violence and sexual abuse in Indigenous communities across Australia, but more specifically the Northern Territory, has been the subject of intense media coverage over the past several years.

It is not a new issue. State-commissioned inquiries and government reports over the past decade have consistently reported that the occurrence of violence in Indigenous communities and among Indigenous people is disproportionately high in comparison to the Australian population as a whole (Gordon et al., 2002; Memmott et al., 2001; Mow, 1992; NSW Aboriginal Child Sexual Assault Taskforce, 2006; Robertson, 1999; Victorian Indigenous Family Violence Taskforce, 2003; Wild & Anderson, 2007).

This chapter puts into context how Indigenous people define and contextualise the violence they or their family members are experiencing. This context is important in considering pathways forward for healing for the victim, their families, and the broader kin network who inevitably feel the ripple effects of such violence (Morrison et al., 2007). Mainstream approaches to healing and justice have consistently been identified as problematic and in some cases requiring significant reform (Gordon et al., 2002; Memmott et al., 2001; Mow, 1992; NSW Aboriginal Child Sexual Assault Taskforce, 2006; Robertson, 1999; Victorian Indigenous Family Violence Taskforce, 2003; Wild & Anderson, 2007). Many programs specific to Indigenous people have arisen as a consequence of the inadequacy of mainstream responses, yet there remains a lack of knowledge about whether these programs are effectively responding to and reducing the violence in the communities in which they operate. This situation arises from a minimal investment in evaluation processes (Calma, 2008). The Social Justice Commissioner in his 2007 report indicated that the lack of formal evaluations does not

mean that Indigenous and/or non-Indigenous individuals, organisations and communities are not working, often despite immense odds, to tackle the confronting problem of violence within their communities; the problem is that they are rarely recognised publicly for their efforts. This chapter, using the available evidence, poses several key considerations for the development and implementation of interventions responding to Indigenous family violence in what is often a maze of complexities.

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 family violence (Barnett et al., 1997). The communicative choices and discursive practices employed by academics, researchers and professionals working in this field have, over 40 years, variously named, structured and defined this problem according to a Western scientific discourse, a discourse that in practice 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 largely due to the process of interpretations that often differ from individual to individual, service to service, country to country, culture to culture and from one research discipline to another (Easteal, 1994; United Nations, 1989). The problem of naming and defining 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 child abuse and neglect.

For people outside such 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 the names and definitions created in academic and professional discourses to their own experiences. Bagshaw et al. (1999) have found evidence to support this claim in their national study of Australian domestic violence, where 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 (Bagshaw et al., 1999). Cripps (2004) reiterated these comments and has added that ‘it is not an Indigenous way to be able to use words like this [family violence, domestic violence, sexual assault] to describe our experiences’ (Cripps, 2004, p. 71). Against this background, what are the words being used to name this problem in Indigenous communities by those experiencing it?

According to the literature in this area, 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 common phrases used in discussions about violence in Indigenous communities. To the untrained professional, statements such as these may not be of concern, but to those who have worked in Indigenous communities for some time and who are familiar with this language, what these terms mean in reality is that ‘she was beaten with a 2×4 [piece of wood]’ or ‘she was raped’ (Cripps, 2004, pp. 71–72, 154–56). Words common to professionals 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 confronting and fear the consequences should they use them (Phillips, 2000). In describing the use of this veiled language, Cripps (2004) coined the term ‘language of minimisation’ to refer to the practice of describing instances of violent behaviour as some everyday, innocuous happening. There are several reasons for the use of veiled language or the language of minimisation. Much of it has to do with protecting families from unwanted intrusion, and in many ways dealing with violence is easier using this circuitous language because it is not confrontational; it does not require action unless the victim/survivor chooses it; it does not make anyone look bad and it does not aggravate the situation (Cripps, 2004). There is also evidence to suggest that just as ‘violence has become a normal and ordinary part of life’, so too has the language (O’Donoghue, 2001, p. 15). 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 because they are of the opinion that 'what I might class as abuse, someone else may accept as being OK' (Office of the Status of Women, 1995, p. 35). Thus this war of words and perceptions contributes to the inaccurate and often under-recording of Indigenous experiences of violence in statistical data collections.

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. The recording of accurate data relies on individuals reporting their experiences of violence to professionals who keep such records. Literature in this field indicates that as little as 31% of domestic violence incidents are reported to the police; that figure drops dramatically to 14.9% for sexual assault (Lievore, 2003). These percentages are not specific to Indigenous people. I would argue, as have others before me, that an Indigenous-specific study of reporting rates would indicate a significantly lower rate of reporting (Gordon et al., 2002; Robertson, 1999; Wild & Anderson 2007). For example, in 1999 the Queensland Taskforce reported having 'heard many stories about crimes that women did not report for fear of reprisals from the perpetrator, his kinfolk or the justice system' (Robertson, 1999, p. xiv).

Cripps (2008) provides a useful way for 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 given in Figure 11.1. 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 and/or fear, 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 will then go on to see a health professional to have their injuries treated and/or to be 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 have 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 police decide whether the evidence has enough weight and credibility to go to court. Of the cases that do make it to the courts, only a small number result in a conviction, as Figure 11.1 illustrates.

This figure offers an insight into the reporting process; it is not prescriptive. Some victim/survivors will choose to go to police instead of health professionals or even family members, and individual circumstances will dictate how a victim/survivor chooses to negotiate the groups identified in Figure 11.1 (see Wild & Anderson, 2007, p. 250).

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, or indeed the amount of time it takes. Indigenous 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 them should not underestimate the complexity and gravity of their clients' decisions and should be careful not to judge them without knowing the full circumstances.

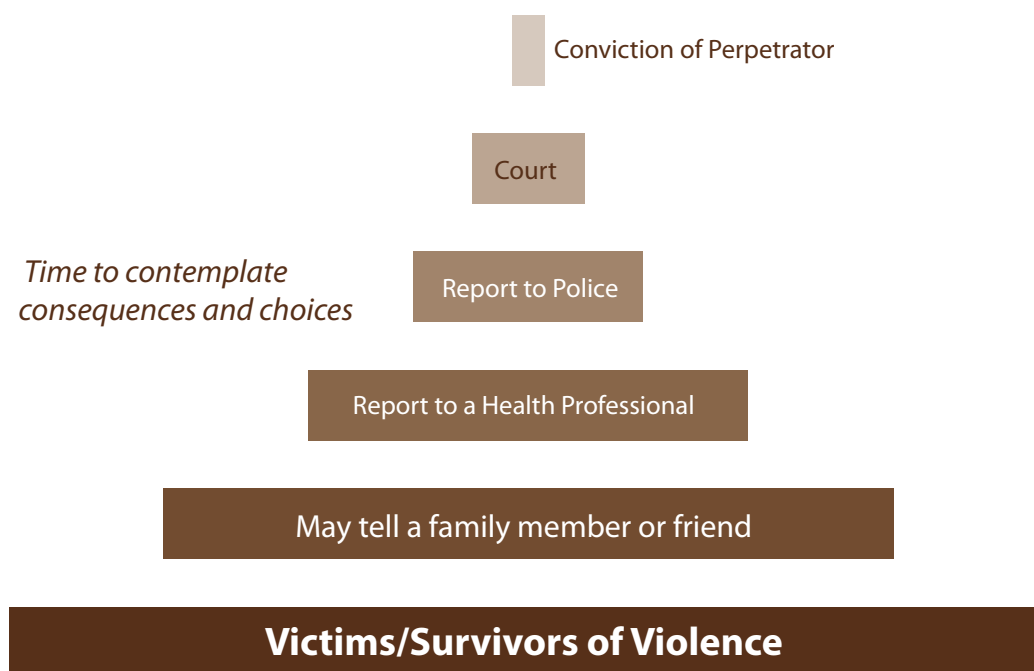


Figure 11.1: Process of reporting victimisation

Contextualising Indigenous family violence

It is not necessary to provide pages of graphs to illustrate the increasing incidence of family violence in our communities; many of us working in this field and/or working in Indigenous communities are already familiar with this material and have been for the past decade. Indeed, Mick Dodson proposed that as Indigenous people if we haven't experienced violence personally then we know somebody close to us who has (Dodson, 2003).

As well as being familiar with the statistics, we are also familiar with the factors contributing to their incidence. We know that no one factor can be singled out as the cause of family violence; it can often be attributed to many interrelated factors. Figure 11.2, developed by Cripps (2004), illustrates how these factors can accumulate and result in family violence.

Figure 11.2 is versatile in that any one (or more) of Group 2 factors could be a contributing factor to an incident(s) of family violence for any population, and there is now enough research evidence to support this (e.g. Dibble & Straus, 1980; Gill & Theriault, 2005; Malcoe & Duran, 2004; Malcoe et al., 2004; Oetzel & Duran, 2004; Raphael & Tolman, 1997). For many Indigenous peoples, however, our experience would tell us that any of the factors in Group 1 could also contribute to current experiences of violence. Results from the 2002 National Aboriginal and Torres Strait Islander Social Survey illustrate this point. This survey found that of the 24% of people who reported being victims of violence in the 12 months before the survey, the rate was highest among those who had been removed from their natural families (38% compared with 23% among those not removed). For Group 2 factors, the 2002 National Aboriginal and Torres Strait Islander Social Survey pointed out that victims reported higher rates of disability (29% compared with 22% among those without a disability); living in low-income households (2% compared with 1% among those in high income levels); and unemployment (3% compared with 21% among the employed) (Al-Yaman et al., 2006, p. ix; Cripps, 2008).

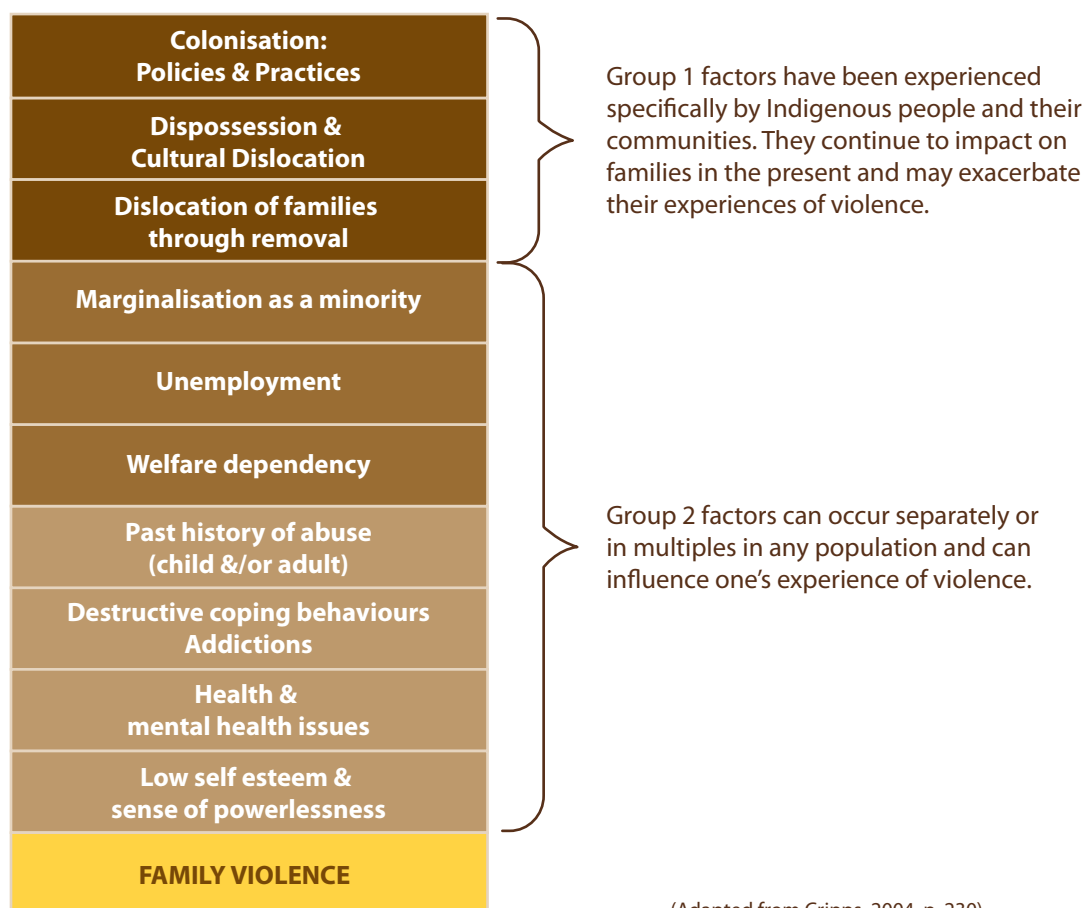


Figure 11.2: Factors contributing to family violence in Indigenous communities

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 family violence as it occurs in Indigenous communities (HREOC, 1997; Robertson, 1999). 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 social and emotional wellbeing, and also on their ability to engage with service providers. For example, a victim of violence wants to attend sexual assault counselling, but the service is 45 minutes by car from where they live, they do not have a car or driver's licence, they have a disability that makes catching public transport difficult and they have very limited funds so a taxi is not an option—and then who is going to look after the kids? In these circumstances, how does the client get to the service to get the help they need to get on with life? These are the everyday problems that Indigenous victims are confronted with—in these circumstances the question for service providers is how do you make your service more accessible?

Report recommendations on appropriate interventions

In the last decade this information has been made widely available through a plethora of reports commissioned by the Australian and state governments. These reports have arisen, in part, as a consequence of the moral panic that so often surrounds Indigenous issues, family violence in particular. The recommendations in these reports should be essential reading for all service providers because they provide specific information on pathways forward for better service delivery and accessibility for Indigenous victims of violence.

Cripps (2007) has made a comprehensive analysis of the major government reports over the past decade, and says that several recurring themes are evident. These include, in particular, recognition of community diversity and needs, and the need to facilitate community choice in responses to problems. This is followed by a strong focus on strengthening the capacity of the existing workforce through accredited specialised training and the employment of Indigenous workers, particularly counsellors. Where Indigenous workers are unavailable, all reports have recommended mandatory cultural awareness training for all non-Indigenous workers. They have also made it clear that a one-size-fits-all approach does not work—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. This is not an easy task. It demands that the ‘silos’ service providers/government agencies so often work in should be broken down in the best interests of clients. The experience of violence and its aftermath can require the input of several agencies, which need to work together to minimise the retraumatisation of individuals and families from repeatedly having to tell their graphic stories to every service provider they encounter. A 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 Indigenous family violence, child abuse and sexual assault (Gordon et al., 2002; Memmott et al., 2001; Mow, 1992; NSW Aboriginal Child Sexual Assault Taskforce, 2006; Robertson, 1999; Victorian Indigenous Family Violence Taskforce, 2003; Wild & Anderson, 2007).

Unsung heroes

Not surprisingly, and again in light of the pressures detailed above, professional helpers have typically not been the first line of support that Indigenous peoples have sought in circumstances of family violence. Instead, we have often relied on informal helping systems, in particular our sisters, mothers, aunts and grandmothers. They are the people who are often available to provide emergency shelter, advice and practical support 24 hours a day, seven days a week. They do this work often without any form of formal recognition, support or protection. They are in all respects the unsung heroes in Indigenous communities across the country, and as professionals we should ask how might we better support and value their vital work.

Accessing services

In some circumstances, however, situations develop in which we need and choose to use professionals to help us heal. Quite often such help is unavailable or inappropriate, because those providing the services understand little of the experiences of Indigenous peoples in the past or in the present. Indeed, there is now quite an extensive literature that illustrates what has long been known at a community level: that typical Western responses to family violence such as women’s refuges, criminal justice responses and therapeutic programs have mostly been culturally inappropriate and ineffective (Cripps, 1998; Gordon et al., 2002; Robertson, 1999). These approaches are largely based on Western models of intervention that have sought to separate the victim from the perpetrator, which in the process has divided families. While this option might be appropriate in the short term by granting some reprieve from the immediate danger of assault, Indigenous families do not see it as a long-term option given that we have almost universally been subjected to forced removals and separations since colonisation. Nor do we see a solution solely in criminalising violence and institutionalising the offender to protect the victim. These interventions may well be appropriate in non-Indigenous communities but in Indigenous communities they are seen as mechanisms by which families and communities can be further torn apart with few positive outcomes. If anything, it is believed that such actions can exacerbate an already volatile situation, and women fear ‘they would get it worse’ from their partner when they are released from custody (Atkinson, 1990–96; Bolger, 1991; Robertson, 1999). Thus the impact of mainstream programs and interventions addressing family violence in the Indigenous setting is slight, depending on the community context and the violent situations

they are confronting (Oetzel & Duran, 2004). The reason for this, according to Oetzel and Duran, is that the interventions rarely address the determinants of violence at multiple levels but tend to focus on the victim's or perpetrator's behaviours and immediate experience without delving into the familial or cultural context in which the violence has occurred. I would also add that they rarely adopt a family violence approach advocated by Indigenous peoples to the problem, one that rejects solely punitive responses in preference for community healing responses. These responses recognise that men, women and children are interconnected through a system of kinship and mutual obligations and remain so even after violence has occurred.

Given the above context, Indigenous peoples and communities have been developing and implementing their own initiatives to combat the violence. The approaches taken in the past decade have developed from the premise that the answers to the problem of violence lie within the communities themselves. These are initiatives that are guided and supported by community autonomy, capacity and development. They also fundamentally recognise the importance of a holistic approach to the problem that considers and responds to the needs of men, women and children, in addition to the differing needs of victims, perpetrators, witnesses and family supporters. Further, they are developed by and for the community in which they operate, they recognise the importance of community engagement in decision-making, and they build on community knowledge and strengths, valuing in particular Indigenous staff expertise and networks. They are based on partnerships with government and non-government organisations, and they respond in a flexible and holistic manner to the multiplicity of factors contributing to the occurrence of violence and to the many people affected by it (Calma, 2008, pp. 189–92). The fact is, however, that they often operate outside the mainstream and remain largely unrecognised. At best such grassroots and community-level programs are poorly documented in one-off newspaper or magazine/journal articles or annual reports, and fail to be noticed in any broader context (Memmott et al., 2001). Some examples of Indigenous family violence programs achieving success despite the pressures include Indigenous family violence prevention legal services, Indigenous night patrols, Indigenous women's refuges, Indigenous men's groups, and numerous community education and awareness programs. Most of these programs, however, rely heavily on government funding and this raises serious concerns about their sustainability. Government grants often fund organisations on a yearly basis and so organisations are never secure in their ability to provide services over a period longer than a year. Further, the funds allocated are for specific purposes and can constrain the scope of services; a number of grants may be needed by a specific organisation to deliver the holistic response and integrated programs being demanded by families and communities. Indeed, in independent audits of government-funded programs conducted by the Office of Evaluation and Audit, the limited reach and short-term nature of government funding has been found to compromise the overall impact of interventions into Indigenous family violence (Department of Finance and Deregulation, 2007).

CONCLUSION

With or without government funding, the consequences of Indigenous family violence continue to be felt long after the bruises fade. The practical response to the problem means thinking outside the box, thinking outside what is mainstream. A decade of reports clearly articulates that any response or intervention must fundamentally involve Indigenous 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 Indigenous and non-Indigenous community members and professionals already have from working with Indigenous communities and families. It also requires a commitment to working in partnership with other agencies, both Indigenous and non-Indigenous, 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.

The latter involves taking the time to know what is happening locally in terms of the extent of the problem, the current services available, and Indigenous community members'

access to such services. It also involves developing relationships for better service delivery with a variety of key players including other services, Indigenous organisations, elders, and most importantly the unsung heroes described earlier. Plans for sustainability are also crucial and mean planning for what happens if the grant applications are not successful, considering how funds can be obtained from other sources, and working out how existing services could do better with existing resources.

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? 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 Indigenous community? How might we reform our practices and/or approaches to become 'safe'? What and who might this involve? (see Chapter 12, in which issues of cultural competence are addressed in some detail).

The survival of Indigenous families means nothing less than the survival of Indigenous peoples and cultures. Failure to provide the support needed to address the problem of family violence jeopardises our very existence. Our children represent the future. The decisions they make will carry Indigenous 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 Indigenous 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 have access?
- 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?

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Part 3:

Mental Health Practice



Part 3 contains five chapters that focus on practice within the field. The authors have addressed issues concerning practitioner cultural competence, communicating and engaging with Aboriginal and Torres Strait Islander people in urban contexts, mental health assessment, and perinatal mental health.

Entry into a community to provide therapeutic services should be prefaced by a series of consultations with as many community people as possible and preferably by the invitation of community members who are familiar with the provider's work. This is not always possible so there needs to be a process of introduction and familiarisation that goes some way towards overcoming the potentially limiting effects of previously failed interactions. (Atkinson, Nelson, & Atkinson, Ch. 10)

12



Working as a Culturally Competent Mental Health Practitioner

Roz Walker and Christopher Sonn

OVERVIEW

This chapter explores what is involved in being a professional practitioner working in the area of Aboriginal and Torres Strait Islander mental health. It does this with regard to the principles, standards and practice frameworks that contribute to the capacity and empowerment of mental health practitioners and Aboriginal and Torres Strait Islander clients, families and communities.

This chapter covers workforce issues such as working as part of a multidisciplinary team and social health teams—their ethical practice and professional responsibilities. The National Practice Standards for the Mental Health Workforce (2002) identify five professions that contribute significantly to the mental health workforce: mental health nursing, occupational therapy, psychiatry, psychology and social work. This chapter discusses the core competencies, knowledges, skills, understandings and attributes regarded as essential for these practitioners and extends these to include Aboriginal and Torres Strait Islander health workers. We provide an overview of the historical context, highlighting some of the relations between the disciplines and professions and between those professions and Aboriginal and Torres Strait Islander people. This is part of the context that has given rise to new ways of working that are empowering, respectful and ethical.

There are consistent and complementary themes identified in the literature to working effectively as Mental Health practitioners with Aboriginal and Torres Strait Islander people, such as adopting a community development approach and using primary care models, and the crucial role of cultural competence. A case is made for the importance of practitioners providing cultural safety and care (as well as culturally responsive and appropriate services) for Aboriginal and Torres Strait Islander clients, their families and communities. Equally important is the need to develop strategies for self-care and support such as mentoring, journaling, peer support, counselling and engaging in self-reflective, transformative practice.

This chapter provides a range of tools and strategies and a Critical Reflective Framework for Analysis to assist students or practitioners from various disciplines to develop these key competencies in their practice in Aboriginal and Torres Strait Islander mental health. The Framework aims 'to enhance professional competence as practitioners' through reflection upon self, others, the discipline and professional codes of conduct, and the broader contemporary and historical contexts in which practitioners and their clients, and their families and communities are situated.

THE MENTAL HEALTH PRACTITIONER/PROFESSIONAL

Under the COAG mental health reform to improve Indigenous health and wellbeing, Aboriginal and Torres Strait Islander health workers, counsellors and clinical staff in Indigenous-specific health services require the capacity and competence to identify and address mental illnesses and associated substance use issues in Indigenous communities, to recognise the signs of mental illness and to make referrals.

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 majority groups in Western culture. Several reviews of Australian Indigenous mental health policy implementation suggest that much of the work being done in this area has been ineffective. This is attributed to the silos within government agencies and services, to the boundaries between different health professionals, and to services and organisations that are unresponsive and inappropriate to the needs of Indigenous individuals, families and communities. Individual factors can be the assumptions and attitudes of practitioners, particularly non-Indigenous practitioners. These assumptions can be influenced by colour or cultural blindness as well as overt racism. They can blind the practitioner's ability to understand and appreciate the pervasive, transgenerational impact of colonisation upon Indigenous individual, family and community health, and mental health and wellbeing described in Chapter 3.

Further, the impacts of monoculturalism have proved particularly challenging for practitioners aiming to implement the reforms of successive *National Mental Health Plans*. This has highlighted the importance of ensuring that staff can acquire and maintain the skills to deliver service reform in new ways. The *Second National Mental Health Plan 1998–2003* pointed out the need for education and training initiatives to ensure an appropriately skilled workforce to work effectively with culturally diverse client groups. The *National Practice Standards for the Mental Health Workforce* (CDHA, 2002) identify five professions that contribute significantly to the mental health workforce: mental health nursing, occupational therapy, psychiatry, psychology and social work. Each of these is governed by codes of professional conduct and ethical guidelines.

Guidelines, protocols and principles of practice

There are a number of national and community-based ethical guidelines, protocols and principles of practice available for practitioners working with Aboriginal and Torres Strait Islander peoples and communities. These guidelines encourage practitioners to familiarise themselves with local history, customs and ways of working, as well as the local mental health issues.

In addition to its code of ethical conduct, the Australian Psychological Society (1996) has also produced a set of guidelines for engaging in an empowering manner when researching within or delivering health services to Indigenous peoples. These guidelines and codes of ethical conduct are invaluable resources for practitioners to engage in intercultural relations that are empowering, safe and respectful. These values and principles are not only about guiding individual behaviour of professional practitioners, but also guide the actions of mental health and other service systems. See for example the Australian and New Zealand College of Psychiatrists, Australian Indigenous Mental Health Ethics, Protocols and Guidelines.

NATIONAL COMPETENCY STANDARDS IN MENTAL HEALTH

The *National Standards for Mental Health Service* and the *National Practice Standards for the Mental Health Workforce* (NPSMHW) form the basis of the key competencies expected of individuals upon graduation from their higher education training, and this is linked to the

provision of mental health services. These standards are geared to graduates of psychology and other mental health professions.

The NPSMHW outline the knowledge, skills and attitudes required when individual members of these five professions work in a mental health service. Others 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 standards also provide a strategic national framework for the education and training of the future mental health workforce and it is expected that they could be used to:

- promote clinical best practice
- identify appropriate skill levels and workplace training and education needs
- guide clinical supervision, mentoring and continuing education
- influence the development of relevant undergraduate and postgraduate curricula.

The NPSMHW 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 the three tiers of government. It is expected that this 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*.

The 12 practice standards are listed below, but only the first three National Practice Standards have been identified as key focus areas to be introduced in all training and postgraduate courses for practitioners in mental health services. These three standards have particular value for all groups including professional groups and mental health services, key policy-makers in each of the states and territories, and universities and Vocational Education and Training sectors that offer undergraduate and postgraduate services in mental health.

Twelve practice standards for the mental health workforce

1. Rights, Responsibilities, Safety and Privacy—of family members, carers, rights of clients, privacy, confidentiality and safety guidelines.
2. Consumer and carer participation—mental health professionals are supposed to know about supporting bodies and consumers.
3. Awareness of diversity—this is explored in this chapter.
4. Knowledge of mental health problems, mental disorders and applying this to our practice.
5. Promotion and prevention—adopting a preventive approach and educating others in order to promote optimal wellbeing.
6. Early detection and intervention—looking for early signs and symptoms of mental health problems; assessment, treatment, relapse prevention and support.
7. Evidence-based assessment, treatment, and support services that could prevent relapse.
8. Integration and partnership—mental health professionals to provide continuity of care by working with other organisations and services.
9. Service planning, development and management—developing skills for the planning, development, implementation and evaluation of management of mental health services.
10. Documentation and information systems.
11. Evaluation and research.
12. Ethical practice and professional responsibilities.

There are a range of core competencies, knowledge, skills, understandings and attributes regarded as essential for all mental health practitioners, including Indigenous Health Workers, to be a competent health professional in accordance with these Practice Standards. Competence is gained through education and training supervision and experience and demonstrated through the acquisition or existence of specified knowledge, skills, values and attitudes. For example, all 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 Indigenous contexts. This chapter touches on rights, responsibilities, safety and privacy, and consumer and carer participation; it explores in depth the issues associated with awareness of cultural diversity since this is fundamental to the purpose of the text.

Rationale for developing cultural competence

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 people. It is based on the recognition that existing services and approaches to improving the health and wellbeing of Aboriginal Australians have not been successful (AHMAC, 2004). There is increasing recognition of the need for health practitioners and those responsible for delivering health services to take account of the historical, cultural, and environmental experiences and contemporary circumstances of Aboriginal people.

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*. This describes a model with national application and is aimed at high-level policy-makers. Stewart suggests that this guide has the potential ‘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”’ (NHMRC, 2005, p. 1).

In addition, the Australian Health Ministers Advisory Council has also developed the national *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009*, which sets out a number of principles and examples of practice to guide services and practitioners when working with Aboriginal and Torres Strait Islander peoples. The Framework consists of building blocks aimed to improve knowledge and awareness, skilled practice and behaviour, to develop strong relationships and create equity of health outcomes. For example, the NHMRC has produced a document about values and ethics in Aboriginal

and Torres Strait Islander health research. These values—reciprocity, respect, equality, responsibility, survival and protection, and spirit and integrity—provide the basis of guidelines for conducting health research.

Cultural competence

Cultural competence is a commitment to engage respectfully with people from other cultures. A commitment to cultural competence is the beginning of an ongoing process that requires motivation and a willingness to improve cross-cultural communication and practice in both individuals and organisations. Cultural competence encompasses and extends elements of cultural respect, cultural awareness, cultural security and cultural safety. Cultural competence is 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 (Cross et al., 1989). Importantly, for individuals, cultural competence requires more than becoming culturally aware or practising tolerance. It can be defined as the ability to identify and challenge one's own cultural assumptions, one's 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 (Fitzgerald, 2000 cited in Stewart, 2006).

Cultural respect

Cultural respect is a fundamental element of cultural competence which involves the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples.

Cultural respect is about shared respect. Cultural respect is when the health system is a safe environment for Aboriginal and Torres Strait Islander peoples, where cultural differences are respected and where the health care system and services respect the legitimate cultural rights, practices, values and expectations of Indigenous peoples. The goal of cultural respect is to uphold the rights of Indigenous peoples to maintain, protect and develop their culture and achieve equitable health outcomes (AHMAC, 2004).

The national Cultural Respect Framework endorsed by AHMAC 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 and Torres Strait Islander peoples. It builds on the recommendations put forward in several milestone reports designed to improve the health and wellbeing of Aboriginal and Torres Strait Islander peoples:

- *Royal Commission into Aboriginal Deaths in Custody: National Report*
- *Ways Forward: The Report on the National Consultancy on Aboriginal and Torres Strait Islander Mental Health*
- *Bringing Them Home: A Report on the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families*
- *Health Is Life: Report on Inquiry into Aboriginal and Torres Strait Islander Health.*

It is recognised that despite the imperative for government policy-makers 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 commitment and the recognition that cultural respect needs to be embedded across all sectors of the system and at 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 (AHMAC, 2004). 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 (AHMAC, 2004).

CULTURAL SAFETY AND COMPETENCE IN INDIGENOUS CONTEXTS

In recent years, a focus on developing cultural competence has arisen from recognising the importance 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.

Cultural safety

The notion of cultural safety has its roots in nursing research in Aotearoa, New Zealand, and derives from a Maori reality. Ramsden (1993) states that cultural safety is in part about Maori asserting the legitimacy and diversity of Maori realities in New Zealand as well as a response to the difficulties experienced by Maori with Western-based models of nursing. In her view, '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' (Ramsden, 2002, p. 112).

Since then 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'. This is a critical area of practice, and Parker (2008, citing Morgan, 2006, p. 203) points out that 'serious and unrecognised miscommunication is pervasive in non-Aboriginal doctor/Aboriginal patient interactions', particularly in remote communities. It is important to recognise that failure to instil culturally safe practices is a diminution and erosion of fundamental cultural and human rights for Indigenous peoples. There is a need to establish processes and protocols to ensure culturally safe practices that are appropriate for diverse Indigenous community contexts in Australia. Cultural safety is about acting in ways that enhance rather than diminish individual and communal cultural identities and empower and promote individual and community wellbeing. To create a culturally safe space involves a high level of critical reflexivity (a concept that will be explored in detail later in this chapter), as practitioners may not always be aware of how their behaviour and method of interaction could make people from different cultures feel unsafe, with negative consequences for client access and continuity of care.

Definition of cultural competence

Cultural competence is defined as 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 (American Psychiatric Association, 2002; Betancourt et al., 2003; Richardson & Molinaro, 1996; Sue, 1998, 2006; Whitbeck, 2006). 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. The purpose of cultural competence is to foster constructive interactions between people of different cultures. However, it is now generally recognised that cultural competence for one population may not necessarily translate to another (Kim et al., 2006; Sue, 1999, 2003), so cultural competence needs to be regarded as an ongoing process developed in a particular intercultural context. Sue and Sue (1990) suggest that cultural awareness requires that mental health professionals are cognisant of, and 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, therefore, they need to develop appropriate practices and intervention strategies that take into account their client's historical, cultural and environmental context.

Cultural competence involves the knowledge, skills, attitudes and values necessary for effective intercultural transactions within diverse social, cultural and organisational contexts (Sue, 1998, 2006). Cultural competence is a dynamic process that is constructed by and in the context of human relations, including the processes of crossing cultural boundaries. Here, context can be understood using the notion of social ecology, where people and their environments are seen as interdependent. The issues that arise for people in developing 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. These are different levels of analysis that are interdependent. 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. By connecting cultural competence with the notion of social ecology, we recognise the 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 staff members need to develop significant aspects of cultural competence; and organisations need to respect and cater for cultural diversity, through their physical layout and presentation and the implementation of policies, procedures and practices that promote culturally safe, responsive environments. As Kessarlis (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’ (p. 358). Many of these unequal power relations operate within and between the various service delivery and policy sectors.

In a national study to incorporate Australian Indigenous content into the undergraduate psychology curriculum, Ranzijn et al. (2007) conducted focus groups on cultural competence in mental health professions and organisations. They identified some key issues:

- 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
- the need for understanding of, and strategies for, challenging prejudice, ethnocentrism and racism.

The conclusions reached in the focus group workshops regarding the need to examine the nature of the mental health professions confirm the need and value of the *Critical Reflection Framework of Analysis for students and practitioners* (Walker, 1999, 2004) which frames the discussion. The findings also inform the further development of culturally competent framework(s) that encapsulate the various multidimensional elements of cultural competence to inform curriculum and teaching across all social service and health professions (Ranzijn et al., 2008).

ELEMENTS OF CULTURAL COMPETENCE

Sue (2006) outlined a model of cultural competence that encompasses the knowledge, values and beliefs, and skills considered necessary to be culturally competent. These have been further articulated by different authors, including by such as Ranzijn et al. (2008) and McConnochie et al. (2008) in the context of education and training in the Australian context. The different dimensions need to be understood within a nested system that operates simultaneously at both individual and system levels, recognising that a culturally incompetent system can undermine culturally competent practitioners. Cultural competence encompasses a dynamic interaction between interconnected ‘elements’ identified in the critical reflection framework for analysis and action, and developing and maintaining cultural competence through critical reflection. The list below captures some of the aspects of the different dimensions of cultural competence, and we have included the notion of reflexivity, which we discuss later in the chapter.

Knowledge

- broad or generic understanding of the nature of worldviews and culture, and the implications of culture for understanding human behaviour
- an understanding of the specific cultural and historical patterns that have structured Indigenous lives in the past and the ways in which these patterns continue to be expressed in contemporary Australia.

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.

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:

- all aspects of triage/intake practice including mental status examination
- risk assessment, crisis assessment and management
- investigative and history-taking skills
- analysis of information
- decision-making
- problem-solving skills
- determining priorities
- ability to work as a team member
- working collaboratively with a broad range of health services and providers
- written and verbal communication
- ability to incorporate the principles of culturally sensitive practice in mental health care
- conflict resolution
- debriefing skills
- ability to self-monitor.

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 interactions to organisational and political systems
- the nature and impacts (on both Indigenous and non-Indigenous 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 Indigenous Australians and systems and professions
- the effects of this history on Indigenous perspectives about the professions and the extent to which each profession is constrained by the culturally constructed models and disciplinary knowledges/theories used by the profession.

HUMAN RIGHTS

Mental health practitioners need to show a commitment to natural justice and the fundamental rights of the 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 have a professional responsibility and require skills to work as part of a larger multidisciplinary mental health team and to be willing and able to share relevant information.

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 must use professional interpreter services rather than family or unqualified personnel when conducting a mental health assessment.

WORKING IN PARTNERSHIP

There is broad agreement from both Indigenous clients and Indigenous and non-Indigenous practitioners that practitioners need to work in genuine partnership with Indigenous Australians to be effective. Working in true partnership is a very different model from the conventional individualistic Western way of working. This has a number of important implications for practice, and a growing literature is now available, including detailed protocols for working with Indigenous Australians, to guide the practitioner in this area:

- Recognise that the individual 'client' (in the case of individually oriented practice), their family and community, Indigenous co-workers and other professionals are equally 'experts' in the process. Letting go of the 'expert' role can be very difficult and is likely to involve a lot of critical self-reflection on the unequal power inherent in the therapist–client relationship.
- Developing an effective partnership takes time, trust and personal relationship. For most Indigenous Australians, *who* you are is more important than *what* you are.
- Have regard for Indigenous 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.
- Work in collaboration with cultural consultants, who will advise about cultural matters, provide guidance in appropriate behaviour, and mediate between the practitioner and the community.

STAGES TO CULTURAL COMPETENCE

There is widespread agreement within the literature that the development of cultural competence is a continuous process—*the process of becoming, not a state of being* (Campinha-Bacote, 2008). Wells (2000) elaborates on the continuum provided by Cross et al. (1989), who offer a model that links the elements of cultural competence (knowledge, attitudes and skills) to a developmental framework. 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; Cross et al., 1989). 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.

Both Cross et al. and Wells suggest, however, that this is a constant state of learning dependent on our willingness to remain forever vigilant and reflective.

EXTENDING COMPETENCE THROUGH CRITICAL PRAXIS

Letting go of the 'expert' role can be very difficult and involves a lot of critical self-reflection, as well as recognition of the unequal power inherent in the practitioner–client relationship. What are some resources for extending the dynamics of cultural competence? In this section, we consider the concepts of whiteness studies, Indigenous knowledge, power, anti-colonialism and multidisciplinary.

Indigenous knowledge and whiteness studies

The work done by Indigenous authors can be important in showing how mainstream services and practices work in exclusionary ways to the detriment and disadvantage of Indigenous populations. Several authors (e.g. Oxenham, 2000; Rigney, 1997) highlight the importance of incorporating and applying Aboriginal terms of reference (which means values, aspirations and ways of being and doing) into policies, practices and processes that impact on Aboriginal people. This work is important in showing how health service systems can be made more responsive and sensitive to Indigenous people and their particular needs. The work of ethnic minorities, women's studies and whiteness studies can also show 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. 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.

In 2006, Sonn and Green reviewed a series of articles that consider some of the challenges of engaging in transformative practice across intercultural boundaries. The articles present examples of how *subjectivity and reflexivity* are used to promote empowering interactions in the context of research and practice relationships between Indigenous and non-Indigenous people. Central to this work is the requirement that we understand histories of colonialism and the role racism has played in the oppression of indigenous peoples. The authors engage with the writing of Australian Indigenous and Maori scholars, taking up the challenges set out by those scholars for working towards liberation and decolonisation. This work is important because it 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 example, Smith (1999) in Aotearoa, New Zealand, and Gilbert (1977), Martin (2003), Moreton-Robinson (2003) and Nakata (2002) in Australia argue that the colonising ways of Western research and practice need to be disrupted. They reveal how different disciplines have participated in the construction of knowledge about Indigenous and ethnic groups that extends into psychology, health practice and policy and service provision. For example, some colonising practices are reflected in how ethnic and racial minorities are constructed as an inferior or exotic 'other'. These constructions have implications for how individuals and communities are treated in different social settings, including health contexts. A shared feature of anti-colonial writing is the focus on decolonisation (among other projects), which in part engages with examining

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 (Smith, 1999). At another level, it is about developing and promoting ways of knowing, being and doing that are anchored in the lived social and historical realities of indigenous peoples (McPhee & Walker, 2001). 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?

A related area of work is concerned with understanding how dominance and privilege is constructed and maintained (e.g. Frankenberg, 1993; Green et al., 2007). 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 (Hurtado & Stewart, 1997). Green et al. (2007) 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*. In terms of knowledge and history construction, it has been argued that Western views and ways of knowing and doing have been privileged at the expense of other ways of knowing and doing (Riggs, 2004). For example, Sarra (2005) and Dudgeon, Mallard and Oxenham (2000) have discussed the powerful and oppressive effects on Indigenous people of externally imposed definitions of self and community. Sarra noted that many white people speak about Indigenous people in terms of negative representations generated by non-Indigenous people, thereby reproducing racism. McKinney (2005) 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 can be detrimental and harming. To this end, whiteness studies also afford a set of resources that may enable researchers and practitioners to make visible their normative assumptions, thereby opening up spaces for negotiation and interrogation (Roberts et al. 2001; Walker 2004). Green and Sonn (2005), for example, identified several narratives that informed non-Indigenous people's engagement in reconciliation. 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 also work to reproduce the privilege of non-Indigenous people (Roberts et al., 2001).

However, engaging in critically reflective practice and crossing intercultural boundaries involves different challenges: it 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, so 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 Indigenous contexts may find themselves confronted by the potentially challenging nature of engaging in decolonising practice at the individual level, as well as supporting 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 would include mentoring, journaling, peer support, counselling and engaging in self-reflective, transformative practice.

BRINGING IT TOGETHER: CRITICALLY REFLECTIVE PRACTICE

This section explores the range of reflective activities and learning processes that can give mental health practitioners skills and techniques and understandings to enhance their work. These activities and processes assist practitioners to develop a clearer understanding of their roles, the power relations operating within their work, and the range of strategies to address the issues and concerns they are facing. The transformative potential of critical reflexivity resides in students or practitioners interrogating the political, social and cultural positioning of Indigenous people in temporal terms (historical and contemporary) and geographic contexts (including community contexts), to affirm and validate Indigenous identity and difference. The intersection of these different elements is reminiscent of Sue's multidimensional elements of cultural competence (Sue, 2001). These are explicit competencies that will enable students or practitioners to make a commitment and to navigate the cultural interface in a way that makes a genuine difference to Indigenous mental health and 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 (Walker et al., 2000). Critical reflection/reflexivity is an essential skill for all professional practitioners working at the highly politicised, complex and dynamic Indigenous and non-Indigenous interface (McPhee & Walker, 2001). This is in line with the idea of knowledge as 'knowing how to act'. 'To act is to contextualize behaviour, and being able to act skilfully implies that actions are appropriate to a given context' (Greenwood & Levin, 2005, p. 51). 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 et al. (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. (p. 322)

This suggests that as practitioners or action researchers we need to consider how our own social, cultural and professional positioning will influence the relations we have with different 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 are afforded 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 (2005) 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 co-researchers' (p. 35).

The process of critical reflection is a powerful tool for producing new knowledge and processes, and contributes to improving fundamental social justice outcomes for Indigenous people (Walker et al., 2000). In doing so 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 their health and wellbeing outcomes. As Walker et al. state, our desire and commitment to be ethical, effective, culturally competent practitioners therefore 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 we are working with
- make our own disciplinary and professional practice the subject of our inquiry in order to analyse and where necessary change it, 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 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 their own and [others'] beliefs, values and behaviour (Walker et al., 2000, p. 18).

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 context; our understandings and the formal and informal theories underpinning our professional practice are informed by a complex interaction of values, beliefs, assumptions, experiences and contextual factors.

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.

Critical Reflection Framework of Analysis

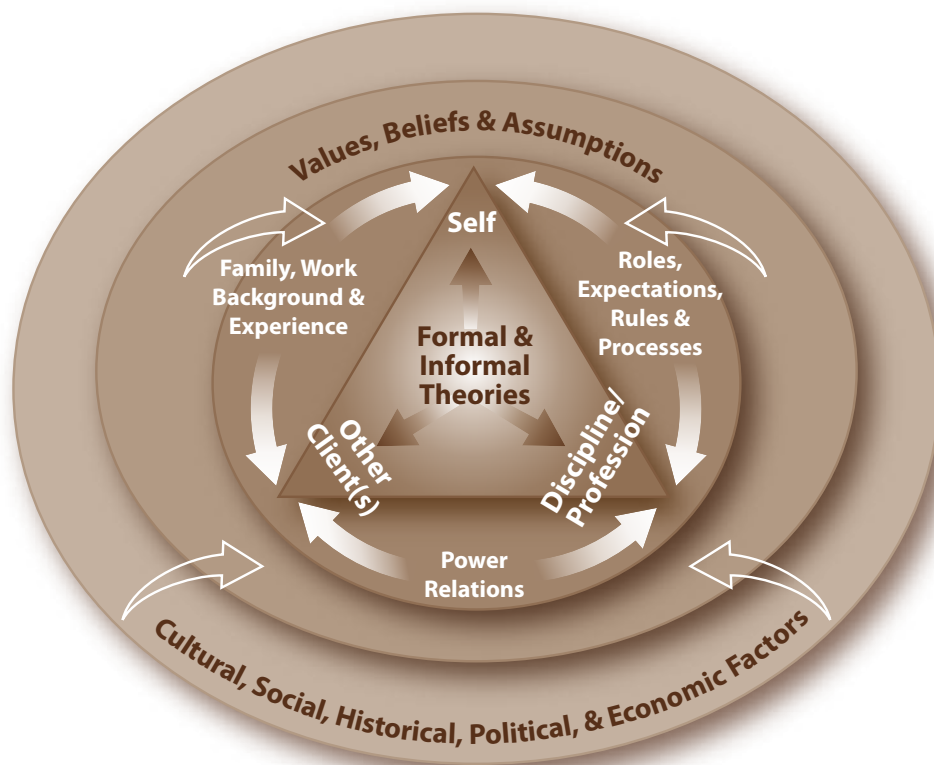


Figure 12.1: Critical Reflection Framework of Analysis (R. Walker, 1999)

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 Management and Community Development (ICMD) program as part of the transformative and decolonising project to improve the overall circumstances of Indigenous Australians (Walker, 2004). These same tools and techniques were used by students and practitioners as they attempted to identify, develop and apply Indigenous terms of reference (Oxenham, 2000) in their work with a range of professions in community management, policy-making and social services and community health and mental health areas.

TOOLS AND TECHNIQUES FOR CRITICAL REFLECTION

The main tools and techniques developed for the ICMD course materials were summarised in *Working with Indigenous Australians: A handbook for psychologists* (Dudgeon et al., 2000) as follows:

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 Indigenous/non-Indigenous interface contribute to and have the potential to transform their understandings about their own practice (Freire & Shor, 1987) as well as assist in their self-care and support.

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 (excerpt from Walker et al., 2000, p. 319, in Dudgeon et al., 2000a).

NEGOTIATING THE CULTURAL INTERFACE

Walker (2004) suggests practitioners employ the theoretical construct of the Indigenous/non-Indigenous interface as part of a practice framework that is both decolonising and transformative. The framework can also be used to position interactions within the university and VET sector curriculum for mental health practitioners, and to inform policy process at a state and national level. For example, Walker claims that *Working with Indigenous Australians: A handbook for psychologists*, edited by Dudgeon et al., inserts Indigenous ways of knowing, being and doing firmly into the discipline of psychology. It has been recommended by the Australian Psychological Society as a compulsory text for all psychology courses and crucial reading for all practitioners working with Indigenous clients (Dudgeon et al., 2000, p. ix). As such, ‘the Handbook exemplifies how the incorporation of Indigenous and non-Indigenous 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’ (Walker, 2004, p. 187). The Handbook is an example of transdisciplinarity—drawing on and sharing understandings, methods and experiences across a range of disciplines to interrupt, inform and transform the disciplines and knowledges.

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 Indigenous 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 (Walker, 2004, p. 188).

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 Indigenous and non-Indigenous ideas and practices and their own potentially ambiguous location within them (Walker, 2004). 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 (Greville, 2000; McPhee & Walker, 2001; Oxenham, 2000).

All practitioners working in the mental health area need to be aware of and take into account the complex nuances of cultural politics operating within the Indigenous and non-Indigenous interface in order to address the relations of power and issues of social justice and fundamental human rights (Walker, 2004). Negotiating the interface is underpinned by the idea that a decolonising and transformative potential resides in that space (Dudgeon & Fielder, 2006; McPhee & Walker, 2001; Walker, 2004). Incorporating human rights principles to inform our work at the Indigenous/non-Indigenous interface enables new ways of working that recognise equal power relations and partnerships (Walker, 2004).

Power, knowledge, culture and politics

Chapters 3 and 6 of this book confirm that Australia's colonial history, Indigenous 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 Indigenous health and mental health and wellbeing issues. The conceptual frameworks of critical reflection and cultural interface are frameworks of analysis which enable mental health students or practitioners to identify, understand 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 students and 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 Indigenous clients, families and communities (see Kowal & Paradies, 2005). This understanding and competence developed through critical reflection allows practitioners to 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.

CONCLUSION

Many of the ways of thinking about mental health in the various chapters in this book are examples of interrupting previously held theories about mental health that can result in blaming the victim, with negative outcomes for Indigenous clients, families and communities. This chapter outlines the *National Practice Standards for the Mental Health Workforce* (2002) and explores issues such as the professional responsibilities of working as part of a multidisciplinary team, engaging in ethical practice, understanding notions of cultural safety, and acquiring cultural competence. We argued that practitioners must provide cultural safety and care (as well as culturally appropriate services) for Indigenous clients, their families and communities, and they also need to develop strategies for self-care and support as they question some of their ways of thinking and doing while engaging in self-reflective, transformative practice.

Central to the chapter is the *Critical Reflective Framework for Analysis*, which aims to enhance professional competence as practitioners through reflection upon self, others, the discipline and professional codes of conduct. The broader contemporary and historical contexts in which work is situated should be included here. The relations between the disciplines and professions and between those professions and Indigenous people are part of the context that has given rise to new ways of working in ways that are empowering, respectful and ethical. In our view, cultural competency is a dynamic that is contingent and contextual—it is not an end state, but it is processual and about ensuring sensitive, democratic, just and transformative practice.

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. 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 (MacIntosh, 1992; Tannoch-Bland, 1998). Tannoch-Bland provides 40 examples of the kinds of invisible privilege and unearned benefits associated with whiteness. We have selected 10 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. (Tannoch-Bland, 1998, pp. 34–6)

Read the examples above and list three examples of benefits that you believe come from your race/gender/position/location.

2 Undertake 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?”’ Campinha-Bacote (2002) has developed a mnemonic ‘ASKED’ which poses some critical reflective questions regarding one’s awareness, skill, knowledge, encounters and desire.

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?

2b Consider these additional questions:

What do we know about 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?

3 Undertake organisational cultural competence audit

Westerman's (2007) 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. Westerman makes the point that 'We've had organisations where 80% 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'.

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. Do a cultural competence audit by identifying those issues that contribute to or diminish the sense of cultural safety and responsiveness for Indigenous clients and Indigenous families and staff that the organisation or service may or may not be aware of (Westerman, 2007). Taking into account the five components identified by Westerman, consider the following elements of organisational cultural competence suggested by Campinha-Bacote (2002):

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 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

Subjectivity

Reflexivity

Power

Cultural interface

Whiteness

Privilege

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13



Communication and Engagement: Urban Diversity

Pat Dudgeon and Karen Ugle

OVERVIEW

This chapter focuses on communication and engagement specifically with Aboriginal and Torres Strait Islander people in urban contexts. A brief discussion about Aboriginal and Torres Strait Islander concepts of community is considered. We place particular focus on the key cultural issues that arise when working with Aboriginal and Torres Strait Islander people in an urban context. Aboriginal and Torres Strait Islander people living in urban contexts may not portray stereotypical images of what Aboriginal and Torres Strait Islander people look like or live like; however, urban identity is very strong and people have strong territorial affiliations. In urban areas there is greater diversity among Aboriginal and Torres Strait Islander people than is often realised. Cultural concepts such as kinship affiliations, community obligations and values of Aboriginal and Torres Strait Islander people living in urban contexts are outlined here.

BEING YOURSELF

Throughout this book, there are many pertinent chapters providing the knowledge and skills the practitioner will require to operate effectively with Aboriginal and Torres Strait Islander clients, whether as individuals, families or communities. As a mental health practitioner, it is important to be yourself; Indigenous 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 delving into the issues that they are with you to address.

Although Aboriginal 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. Aboriginal people like to know that they are receiving a quality service with a trained professional who is also able to engage well—to be himself or herself.

CONTEMPORARY ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

This section outlines what contemporary Aboriginal and Torres Strait Islander understandings of 'community' are. As 'the community' has now become a commonly used term by Aboriginal Australians, practitioners working with Aboriginal people are required to have an awareness of

‘the Aboriginal community’ if they are to work effectively with members of the Aboriginal and Torres Strait Islander community.

As part of the history of colonisation, Aboriginal and Torres Strait Islander peoples were dislocated into reserves and missions. The term ‘community’ was initially an imposed idea for the purpose of control over and management of the Aboriginal and Torres Strait Islander population. As discussed in Chapter 2, this included disruption to Aboriginal and Torres Strait Islander social, political and religious life; and the relocation of distinct Aboriginal groups from different areas. Early constructions of ‘community’ did not recognise differences between Aboriginal groups, for example language group differences as well as social and spiritual differences. Thus, originally, ‘community’ was an imposition by colonial administrations to control Indigenous peoples. Despite this, Indigenous peoples across the world have made communities meaningful. Smith (1999, p. 126) wrote about the Maori experience: ‘Indigenous communities have made even their most isolated and marginalised spaces a home place imbued with spiritual significance and Indigenous identity.’

Aboriginal community groups vary considerably in their economic, social and geographic circumstances. The National Aboriginal Education Committee (1986) developed a model of Aboriginal societies that included four broad categories of the Aboriginal community: traditionally oriented, rural non-traditional, urban and urban-dispersed communities. The following definition remains the most appropriate: ‘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’ (p. 10).

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 community have two main facets: physical groupings and psychological belonging to a particular group or groups. 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 latter perception of community is held by those people who are in leadership positions, representing Aboriginal and Torres Strait Islander interests at various forums. Community can be a broad and fluid concept, uniquely shared by Aboriginal people and by those that work in the area (Dudgeon et al., 2002).

Contemporary Aboriginal 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:

- responsibilities to be seen to be involved and active within the community
- responsibility to support 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)
- affiliations to particular organisations. Feelings of loyalty and ownership sometimes extend to the organisation one works for, and in some ways may reflect Aboriginal cultural practices in that they have become another way of knowing and identifying individuals.

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.

- politics, of which there are many layers. Examples of this are representation, who should speak and on what matters, and recognising that at times Aboriginal and Torres Strait Islander people themselves can be both 'insiders' and 'outsiders', depending on the issue at hand (pp. 260–61).

The following section on Aboriginal and Torres Strait Islander people living in urban situations and urban diversity is an edited version of Chapter 14, 'Diversity in Aboriginal Culture' (Dudgeon 2000a) in *Working with Indigenous Australians: A handbook for psychologists* (Dudgeon et al., 2000). Urban diversity is an important consideration when working with Aboriginal and Torres Strait Islander people across diversity. Aboriginal and Torres Strait Islander people come from a variety of different cultural and personal backgrounds and histories and often urban cultural considerations are not articulated.

URBAN DIVERSITY

There is considerable diversity in Aboriginal culture. However, much of the literature on Aboriginal cultural awareness is written about remote area or semi-traditional Aboriginal groups. While some of this information can be generalised to an urban situation, it is limited and there are some specific issues that pertain to Aboriginal groups living in urban situations. A large proportion of the Aboriginal and Torres Strait Islander population live in urban settings (ABS, 2007). The specific cultural issues that a practitioner would need to be aware of when working with Aboriginal groups in urban settings have been addressed in some texts such as the handbook *Working with Indigenous Australians* (Dudgeon et al., 2000a,b) and *Between places: Indigenous mobility in remote and rural Australia* (Memmott et al., 2004). In these texts, the term 'urban' refers to people living in cities or large towns where they are distinctly the minority group, are more invisible, may move in and out of urban situations unless that area is their country, and have usually experienced a longer and more intense history of colonisation.

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 their 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.

Practitioners should be careful not to impose judgments on urban people from the literature and/or from their experience of working with traditionally oriented Aboriginal 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.

Just because urban populations may not overtly fit a picture of traditional Aboriginality as portrayed in the literature, it does not mean that urban people are not 'real' Aboriginal people. Urban identity is very strong and people still have strong territorial affiliations. All health and mental health practitioners working with Aboriginal people need to be aware of these territorial affiliations, such as who the original owners of the area are, and who can speak on local issues or certain topics. The practitioner should build a picture of the different groups, their main issues and the dynamics between them. The history of different groups will be important.

Aboriginal people and 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. Urban Aboriginal people overall may be more politically aware and resistant to dominant society because of a longer and more intense history of oppression. The reality for urban people is one of being a minority group that experiences racism on a day-to-day basis. As

well as racism, there are continual challenges to the authenticity of identity from mainstream society. For instance, urban Aboriginal people are often confronted by non-Aboriginal people who challenge the authenticity of their identity. This requires them to constantly negotiate and affirm their identity.

Aboriginal people who are daily confronted about their identity have become accustomed to being in a position of arguing their rights as members of a marginalised and discriminated group. The range of experiences for urban Aboriginal people can vary from positive to negative. For many, however, the experiences tend to be negative.

In an urban situation it is sometimes more difficult to locate or find people. It is important to make use of the Aboriginal network to track people. Young adults have different 'runs' within the metropolitan environment and travel more widely than they might in rural or remote areas.

In urban centres there is greater diversity of Aboriginal people. For instance, in Perth there are Nyoongar people who are the traditional owners of the immediate and surrounding country, and there are others from areas such as the Kimberley or Gascoyne regions. There are different reasons why people come to Perth. For some it could be for education, employment, health or domestic reasons. Similar patterns of mobility and urban migration by Aboriginal and Torres Strait Islander people occur in all major cities around Australia (Memmott et al., 2004). Some people from other areas have been here for a long time, due to early removal policies such as the 1905 Act which removed children from their families and placed them in missions, reserves and homes such as Sister Kate's. Consequently, many of these people never returned to their homelands and have been living in the metropolitan area for a number of generations.

Within the metropolitan area, there may be differences among the local groups in relation to their country of origin. For Aboriginal people, 'country of origin' refers to the geographic area where they were born. For example, among the Nyoongars, their country is the metropolitan area and the southwest region. But there are other distinctions within the group, for example the Bibbulmun, Balardung, Minang, Goreng and Wadjuk groups who come from the different areas within the local region. Other groups outside the metropolitan area include the Yamatji, Wongi and Bardi people, as well as those from interstate. Again, even within these groups there will be different reasons for being in the area such as forced removal or migration for education, employment and/or marriage.

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
- *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, drinking or work groups.

Family obligations

For urban people, cultural values and behaviours persist. Some local Aboriginal families continue to access the bush to go hunting and camping as part of their lifestyle. This activity is economically, recreationally and culturally motivated. Many of the local families will have a special relationship or affiliation with country towns and areas. Even those from considerable distances will have connections to certain towns and areas. Some may have especially strong affiliations if their families are taking part in a land claim. Aboriginal people from outside the local region will have the need to regularly visit their home country and people. In turn, their homes in the metropolitan area will be considered the town bases for relatives visiting from outside.

Aboriginal people have many family obligations and responsibilities. This may include assistance such as providing advice, helping other members of the family with money, sharing housing, transport and food if necessary. There is also an expectation for members to attend funerals, family gatherings for specific issues and other cultural obligations and activities.

Practitioners should consider developing a proforma to assist in finding out about urban Aboriginal clients. Good practice requires professionals to build a picture of all family members and others who might be significant in a particular case. 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 person does not seem to be Aboriginal by physical appearance, but identifies as such, the practitioner should never challenge that person's Aboriginality. It is crucial to be sensitive to where the client says they are positioned in regard to identity, their personal perspectives and feelings about their identity. Some clients may have been removed from their family and community and are just beginning to find out about their Aboriginal identity, and therefore they can be vulnerable and fragile.

Kinship is very strong in urban situations, with people identifying through family names rather than 'skin' names. Aboriginal people tend to work through family or personal relationships rather than through professional relationships.

Community obligations

Being a part of the urban Aboriginal community is a strong part of life for many Aboriginal people. Considering the consequences of removal, displacement and disenfranchisement, for many Aboriginal people urban life is the only lifestyle they may be familiar with, and this lifestyle is infused with a strong sense of identity and culture.

As mentioned earlier, being part of the community brings responsibilities and obligations. This includes 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. Nevertheless, whatever the level of involvement, each person is expected to fulfil his or her obligations.

When introducing themselves, the practitioner should be prepared to share some personal information about themselves, perhaps about their family, that is, if they are married, whether they have children, and where they come from. Do not hide behind a professional facade. Present as a person in the first instance.

However, do not belittle your profession, your skills and expertise. You are being employed to provide a service and while it is important to be prepared to learn and maintain an open mind about the group you are working with, you are expected to have some professional ability.

When giving personal information, do not overdo it. If a professional gives too much information or goes on too long it is off-putting to the Aboriginal client and can evoke suspicion. The practitioner may be perceived to be looking for something emotional or spiritual from Indigenous people; to be working with Aboriginal people for their own needs rather than for the needs of the client.

If a negative or suspicious attitude develops towards the practitioner, Aboriginal people may not fully engage and may keep a distance. It is hard to regain lost ground. Urban people have experienced some non-Aboriginal people who choose to work with Aboriginal people for their own psychological needs. That is, these practitioners perceive that Aboriginal people have closeness to the land and nature, and that they are very spiritual. To Aboriginal people, it appears that these practitioners want to absorb these things from Aboriginal people to fill their own needs.

The practitioner should be alert to and cautious of choosing only 'favourite' or popular Aboriginal people to advise on all issues. It is better to have a broad group of reference points for different issues, concerns and topics. It is important to attempt to maintain an apolitical stance.

If a practitioner is aware of the historical and cultural context of Indigenous 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 may do so for a variety of reasons and it is important not to take the behaviour personally and to 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.

Cultural considerations

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.

When Aboriginal people meet, there is a protocol that takes place in which information is exchanged between the parties in order to find out about each other. Knowing where other Aboriginal people fit is important. Placing who they are, who you are related to, where they are from, and where they work are all important. This protocol assists Aboriginal groups/people in relating and communicating with each other.

The lifestyle of urban Aboriginal people may appear to be similar to non-Aboriginals in that some Aboriginal people own cars and houses and have incomes. However, in spite of these similarities, the ways in which resources are used are different. With Aboriginal people, there is an expectation that resources will be shared. This is a strong cultural way that persists across diversity.

This practice, however, can be abused, in that some members will take resources and not reciprocate. Some of our 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. With some people, there are different consumption patterns and an attitude of using all the resources as they become available. This means that on pay day, for example, all the money may be spent quickly and none saved. This practice can create considerable stress in the family and within extended groups.

There are different value systems. Many Aboriginal people tend to place emphasis or value on certain things over others. Priorities generally lie in providing for the family; for example, buying food or lending money to a relative in greater need, in preference to paying other bills such as rent or electricity. Sometimes, because of limited incomes and resources, Aboriginal people are forced to make decisions between priorities.

CONCLUSION

In summary, urban Aboriginal populations, particularly in cities and large towns, are more diverse than other Aboriginal groups. The urban Aboriginal population also tends to be less visible as it is encompassed within the larger non-Aboriginal populations. Urban Aboriginal people have a longer and more intense history of colonisation that has had a detrimental impact on urban identity. This situation is now changing, with Aboriginal people throughout Australia challenging many of the stereotypes that persist about them. Urban Aboriginal people are in a process of reclaiming and strengthening culture.

Cultural protocols and processes still persist in urban contexts. Hence, all health and mental health practitioners working with urban Aboriginal people need to engage with them in a sensitive and respectful manner, and they need to become familiar with local Aboriginal organisations and resources to provide appropriate support.

REFLECTION

The following reflection written by Ross Humphries, then a staff member at the Centre for Aboriginal Studies, Curtin University, captures his comments on the importance of recognising, respecting and working with Aboriginal diversity in our everyday practice. While written as a teacher and support counsellor in a university context, it has relevance for all practitioners working with Aboriginal people in urban situations and especially in mental health. It is not intended to be more than an insight, and as mentioned in earlier sections of this chapter and throughout this book, the best knowledge is experience in interacting with the people.

As well as the mix of Aboriginality, most Aboriginal people in our region will have a non-Aboriginal ancestry that may be just as diverse, but probably less evident in the cultural identity of the individual. This will often be reflected in people's willingness to identify as an Aboriginal person.

Likewise, the degree of traditional versus contemporary cultural entrenchment fluctuates. We have Aboriginal staff and students at the university from both ends of the scale, so to speak, and at every level in between. The history of most Aboriginal people in the region is one of exploitation, racism, hardship, tragedy and cultural genocide woven into a social fabric that is expressed through durability, strength, adaptation, extended family and affinity with the land. The outcomes, expectations and effects of this historical concoction can vary tremendously within the individual.

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.

The degree of cultural obligations assumes many forms. Attendance at funerals to pay your respects and observe a 'sorry time' is very important and attains a high priority, as does any family issue. These obligations may vary from distributing wealth and looking after nieces and nephews, to resolving or [seeking retribution] in domestic violence situations.

The concept of time quite often differs from that of non-Aboriginal people. Primarily, its importance is devalued and consequently practitioners will need to be patient. This probably is from a combination of several major factors: The traditional concept of time was cyclic rather than continuous. Routines and regimens were virtually non-existent and were dictated by need and seasons. Decision-making processes for Aboriginal people have traditionally been structured upon the involvement of stakeholders, rather than meeting deadlines. Decisions would not be made until all relevant parties had input into the decision-making process.

In contemporary situations, the experience of time as a commodity that needs to be managed has been minimal due to the limited educational and employment opportunities

for Aboriginal people. Most Aboriginal people in the region exist in the lower limits of the socioeconomic scale, but there are many exceptions. Very few Aboriginal people embrace the concept of saving money and resources. Resources in the form of material possessions or money are expected to be shared and reciprocated with whichever family or community members are in need at the time. Wealth is measured more in terms of family and cultural knowledge than money or possessions.

Level of achievement, appreciation and acceptance of education vary, but in most instances these perceptions are at the lesser and lower end of the scale. This is due to many Aboriginal people being denied access to education until the 1960s. When they were permitted to attend schools before and after that time, they were often ostracised, discriminated against, or made to feel stupid and unwelcome. Many Aboriginal people are rich in knowledge about nature, the bush, animals, people, relationships, and other Aboriginal ways but their experience with Western education may have been unpleasant, therefore they may have little expertise in this area.

Communication among Aboriginal people in our region is very unique. The typical dialogue consists of a combination of English, Nyoongar, Aboriginal English and 'Creole'. Additionally, body language plays a very important part in communication, and many aspects of a conversation will be silently translated by hand gestures, facial expressions and head movements. If you receive no response to a comment, do not try to force a response. No response may mean the person does not have an opinion on the topic, or that they are not in a position to make comment, that is, it is not their place to say.

When Aboriginal people are together, they have a subtle sense of humour, and can often relate a humorous situation to each other with only one or two words which will set everyone else off laughing. The uniqueness of this humour may take a long time to grasp or appreciate, and it may rely on intimate knowledge of the individual personalities.

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.

Middle-aged people tend to respect their elders, but this does not necessarily apply to the younger generation. They are more likely to respect their peers or someone slightly older who they admire for physical accomplishments or leadership qualities, such as sportspeople. This is not strictly the rule for all Aboriginal people, and people from strong traditionally oriented backgrounds may respect and acknowledge age and experience above all else.

Occasionally there may be feuding among families, and this may mean that some students or clients will be absent or will avoid contact with certain other students from the opposing family or their friends. It is wise to wait for the resolution of the wider conflict rather than attempting to resolve the situation between the students/clients within a specific non-community domain.

At work, I do not make assumptions about situations on face value. I am patient and endeavour to investigate all the contributing factors before analysing the situation. This is because the cultural gap between Aboriginal students and a non-Aboriginal bureaucracy may lead to communications problems that often cause or exacerbate a problem.

We would also prefer students to attend university commitments with their children than not attend because of the children and lack of childcare. This is recognising the cultural commitment to the extended family.

Another way we recognise Aboriginal ways of working in the workplace is in networking and communication protocol. Going through the right channels, employing word of mouth, and personal contact are all very important. (Reprinted from Dudgeon (2000b), pp. 265–67)

Reflective exercises

- 1 List the cultural considerations that might be important when working with Aboriginal and Torres Strait Islander people in an urban context. Do you think this would differ from rural and remote areas?
- 2 What is the composition of the Aboriginal and Torres Strait Islander community where you work and/or live?
- 3 Create a map of the biggest local families and also the other Aboriginal and Torres Strait Islander people living there 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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Issues in Mental Health Assessment with Indigenous Australians

Neil Drew, Yolonda Adams and Roz Walker

OVERVIEW

In this chapter we briefly discuss the various elements that comprise the concept of assessment, as well as the distinction between assessment and testing. We explore the issues related to the lack of fit between Western and Australian Indigenous perspectives on mental illness. We examine the history of assessment and testing with culturally diverse groups, and explore a range of emergent principles and guidelines for practice to improve and govern assessment practices with Aboriginal and Torres Strait Islander people. We conclude that assessment and those practitioners conducting assessment must be repositioned (and reposition themselves) to play an important role in the development of procedures and practices in the provision of mental health care for Aboriginal and Torres Strait Islander people in Australia.

THE HISTORY OF ASSESSMENT

Assessment of Aboriginal and Torres Strait Islander peoples has a complex and contested history. Few would argue against the importance of assessment procedures and processes as part of the armoury of mental health professionals, but most would agree that the abuse and misuse of assessment has contributed to the perpetuation of myths and stereotypes based on race, culture and ethnicity. Indeed, the assessment of the racial characteristics of Aboriginal children provided the so-called objective yardstick for the rationale behind the Stolen Generations (Kinnane, 2003). Even so, assessment procedures, when understood and implemented appropriately and sensitively, significantly enhance our capacity to provide quality care in a domain that sorely needs diagnostic and standardised measurements that proper assessment can provide.

Over the past decade there have been significant improvements in our understanding of the issues of assessment with diverse cultural groups internationally (Acevido-Polakovich et al., 2007; Arzubiaga et al., 2008; Gone, 2007; Hays, 2008) and within Australia (Davidson, 2007; Garvey, 2007; Vicary & Andrews, 2001; Westerman, 2004, 2007). Even so, there are still 'few studies which provide mental health practitioners with practical insight into Aboriginal perspectives and experiences; in particular the beliefs held that relate to psychotherapy, mental health and non Aboriginal counselors/therapists' (Vicary & Bishop, 2005, p. 8); and 'low levels of confidence in managing and treating mental illness' among remote service providers (Nagel, 2005, p. 24). Nagel went on to say: 'An overarching framework of guidelines, policy, and best practice for mental health in primary care is also missing and there are few resources available for quality feedback and outcome measurement' (p. 24).

It appears, then, that while our understanding has grown significantly, our capacity to undertake the appropriate knowledge transfer from the literature to the field of practice has not. Davidson (2007), somewhat more optimistically, noted that the publication of the *Handbook for psychologists working with Indigenous people* (Dudgeon et al., 2000) and the work of Indigenous psychologist Tracey Westerman on assessment regimes for depression and anxiety in Aboriginal communities were areas of ‘outstanding progress’ (p. 132). Nevertheless, a recent Australian text on psychological assessment makes no mention of Aboriginal and Torres Strait Islander people, culture or ethnicity in the index (Shum et al., 2006). Topics such as how to determine whether a psychological test is necessary, selection of appropriate and technically sound tests, and scoring psychological tests make no mention of cultural issues. Under the heading ‘administration of psychological tests’ they include the following reference only: ‘Ensure that the test is appropriate for use with particular clients in terms of age, educational level, *ethnic background*’ (p. 28, italics added). They make no mention of culture in interpreting psychological tests. While they recognise the limitations of psychological tests as just tools that capture hypothetical constructs and may become obsolete, they conclude the section with: ‘Finally, although it may not be the intention of the test developer, sometimes... [such tools] can disadvantage a sub group of test takers because of their cultural experience or language background... [T]ests are not universally applicable and to treat them as such may do an injustice to *some*’ (Shum et al., 2006, p. 16, italics added).

This omission in a text on assessment exhibits widespread culture blindness on a reasonably grand scale (Arzubiaga et al., 2008) and reflects what many believe to be the monoculturalism of psychology in Australia (Riggs, 2004).

Notwithstanding the requirement of many university-based programs for courses on cultural issues, most practitioners working with Aboriginal clients still develop their skills by experience and from the anecdotal evidence of peers and colleagues (Vicary & Bishop, 2005; Westerman, 2004). This means that while some practitioners have begun to present their work in journals and conference papers, access to systematic research in these domains is still limited (Westerman, 2004). It is also true that the policies and practices of service organisations working with Aboriginal and Torres Strait Islander people do not yet fully reflect or embrace culturally appropriate ways of working (Westerman, 2004). As mental health services for Aboriginal and Torres Strait Islander people develop, more and more non-Aboriginal service providers will encounter clients from these communities, perhaps for the first time (Boyd et al., 2008; Brown, 2001).

WHAT IS ASSESSMENT?

The answer to this question is crucial and best understood by clarifying what it is not. Assessment is not just testing. This is a very important point because much of the debate on assessment tends to focus on the inadequacy and inappropriateness of testing in Aboriginal and Torres Strait Islander and other culturally diverse groups. If assessment is to be a credible process to address mental health concerns in Aboriginal and Torres Strait communities we need to differentiate it from testing per se (Suzuki et al., 2001). We also need to separate assessment from the politics of assessment (Jones, 1996; Okazaki & Sue, 1995; Riggs, 2004).

Assessment is typically based on a Western framework and therefore has a significant impact when working with Aboriginal people. It is important that the clinician respects the protocol of the process for the collection of information. This provides the basis of effective engagement, which will be discussed in more detail throughout the chapter.

Much of the suspicion that Aboriginal and Torres Strait Islander people have regarding assessment (Davidson, 1995) derives from the political misuse of assessment as a process of social and cultural control. Historically, assessment with Aboriginal and Torres Strait Islander people, like research, was deeply rooted in the power differential between Aboriginal and Torres Strait Islander and non-Aboriginal people. Santhanam (2007) notes that the power ‘in’ exceeds the power ‘of’ therapy in Aboriginal communities in the absence of ethical reflection. Similarly

Riggs (2004) noted the power in therapy as hegemonic practice that reproduces the inherent 'superiority' of non-Aboriginal practitioners and by inference the system they symbolise. The same is undoubtedly true of assessment (Sherwood & Edwards, 2006). To reinforce the political power of assessment, Padilla (2001) reported that over five million American children from diverse cultural backgrounds are routinely assessed by standardised assessment tools every year in the USA. In Australia the number is unknown but will undoubtedly be significant. The marginalising potential for Aboriginal and Torres Strait Islander children through the use of classroom standardised assessment tests for literacy and numeracy cannot be overestimated (Cataldi & Partington, 1998).

Assessment may include testing. 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 (Ponterotto et al., 2001). Despite the widespread problems of testing with culturally diverse groups, we are not advocating that they be discarded. Rather, they must be developed, used and understood within the complex collection of information obtained from the assessment process. 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' (cited in Brown, 2001, p. 34).

Assessment as a multifaceted process

Assessment is, or ought to be, a multifaceted process of exploration and decision-making in the interests of those being assessed. It is simultaneously a subjective and objective, qualitative and quantitative, clinical and scientific, behavioural, observational, contextual, historical, cultural, social, and emotional process of coming to understand the life circumstances of individuals, groups and communities, with the aim of providing opportunities for understanding and positive growth. Assessment should not be a process of pigeonholing, categorising, diagnosing, partitioning, curing or otherwise marginalising the person being assessed from the wider community or society.

Assessment is a socially and culturally mediated practice

Assessment, like most work with Aboriginal and Torres Strait Islander communities, is a socially and culturally mediated practice (Arzubiaga et al., 2008). It is important also to recognise that for Aboriginal people mental health is holistic, bound up in the social, emotional, spiritual and cultural life of people and communities (National Aboriginal Health Strategy: Swan & Raphael, 1995). The point here is not to compartmentalise an Aboriginal person's wellbeing, but to look at wellbeing as holistic in nature. An Aboriginal person may say they are generally unwell rather than expressing symptoms of unwellness (Roe, 2000 cited in Westerman, 2004). A full appreciation of this aspect of health and mental health is absolutely vital as part of the contextual matrix within which assessment takes place. Conceptions of mental health are deeply rooted in the history of colonisation and cultural understandings. Further, the intersection of conceptions of race and mental illness can be detrimental to the overall social and emotional wellbeing of a group. A recent report by Aboriginal Disability Network of New South Wales (2007) found that Aboriginal people with disability (including mental illness) 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. The wellbeing of the collective (community) is indivisible from the wellbeing of the individual (SCRGSP, 2007). Assessment needs to be systemic, taking into consideration individual, family and community factors.

Another key feature of mental health concerns is that for Aboriginal people the manifestations of mental disorders can take forms that are unique to their culture and experience. These are known as 'culture bound syndromes' (DSM IV-TR, 2000; Westerman,

2004, p. 5). It is highly advisable that family and respected community members are consulted to determine whether the symptoms an individual is experiencing are within their cultural context. Apart from the work of Westerman (2004, 2007), little is known about this aspect of understanding Aboriginal mental health. The key feature of culture-bound syndromes is that the locus of causality is within the cultural, historical, spiritual and social belief systems of the client, which as a result determine the clinician's focus for treatment. McMahon (2007), in his provocative paper on the historical construction of Aboriginal mental health, concluded that 'Aboriginal mental health...was something that would have to be discovered through negotiation, not imposed by medical fiat' (p. 44).

In short, assessment with Aboriginal clients is likely to be most accurate and effective when it is:

- qualitative and functional rather than normative and categorical
- undertaken from an Aboriginal perspective, not Indigenised
- about building relationships
- a socially just practice and a decolonising practice
- seen as an opportunity to reinvest trust and confidence in the relationship between Aboriginal people and the wider non-Aboriginal society represented by service providers.

THE HISTORICAL PROBLEMS WITH ASSESSMENT AND TESTING

Concern about the theory and practice of assessment and testing in culturally diverse settings is not new (Anastasi & Urbana, 1997; Davidson, 1995; Jones, 1996; Kearins, 1983, 1999). But much of the literature has focused on the problematic nature of testing, particularly psychometric testing, rather than assessment *per se*. Nevertheless, many of the issues raised in relation to testing could apply equally to assessment in the broader sense. There are a range of reviews of the problems of assessment and testing in general with cultural groups (Anastasi & Urbana, 1997; Cronbach, 1990; DSM IV-TR, 2000; Groth-Marnat, 1997). In addition, in recent years the difficulties in developing assessment tools which have validity and clinical usefulness in Aboriginal populations have been highlighted by a number of authors (e.g. Drew, 2000; Sheldon, 2000). The key themes in these earlier reviews inform the discussion of the principles and guidelines that follow.

A study by Robinson and Harris (2003) found that while a range of mental health outcome measures are used across Australia—including the Health of the Nation Outcome Scale, the Kessler-10 (adopted as a standard instrument by DHCS) and the Life Skills Profile—there is no one assessment tool used by any participating health centre (Robinson & Harris, 2003, p. 103). General practitioners report that any one of these instruments, if strictly applied, would be of little use in their practice, most notably because of their inadequacy for assessing mental health cross-culturally (Robinson & Harris, 2003).

The appropriateness of standardised tests for diverse cultures

The first set of arguments revolves around the appropriateness of standardised tests and the extent to which they misrepresent the actual abilities of the person being tested (Anastasi & Urbana, 1997). There are a number of issues in this area: the relevance of the attributes being assessed for different cultural groups; the interpretation of the attributes by different cultural groups; the omission of potentially relevant cultural attributes; the modalities used to access the attributes (verbal, non-verbal); cultural taboos in the exploration of certain attributes; the intrapsychic versus public expression of attributes; the validity of comparisons of attributes across cultural and other differentiating boundaries (including gender, for example); the sociohistorical, cultural and political climate of both the micro (assessment) and the macro (societal) setting—to name a few. These concerns gave rise to the development of the so-called culture-free tests (Jones, 1996). Culture-free tests proved to be impossible since they could not be separated from the culture in which they were developed.

Similarly, the movement towards 'culture-fair' tests was confounded by the fact that they measured only the transcultural aspects of the phenomenon being tested (Jones, 1996; Suzuki et al., 2001). It was found that despite the best efforts these tests again tended, inevitably, to favour the culture in which they were developed. The final turn towards culturally specific tests has also been problematic. Jones (1996) describes over 100 tests for use with African Americans. He argued that the criticism of culturally specific tests was misplaced because the yardstick for criticism was often that they failed to measure up against the standardised tests they were designed to replace (Jones, 1996). There were two key issues in the area of culturally specific tests. The first was the merit of creating cultural norms for existing tests (Lindsey, 1998; Padilla, 2001; Suzuki et al., 2001). The problems of translating psychological tests relate to the practical aspects as well as the cultural underpinnings. Directions can be too psychotechnical for adequate understanding in different cultural contexts, constructs are not transcultural, content can have different cultural meanings, and so on (Padilla, 2001).

Diagnostic tools such as DSM IV-TR and ICD10, which are both used to diagnose mental health problems in Aboriginal clients, have limited applicability (Janca & Bullen, 2003) because of different conceptions of time, for example. Nevertheless, practitioners still tend to use a range of common working categories when undertaking assessments. These draw on mainstream measures and concepts which are not necessarily acceptable to Aboriginal populations in Australia. The baseline survey found that general practitioners are aware of the limits to their diagnostic abilities in the cross-cultural context. This is extremely problematic for a number of reasons including the difficulties with diagnosis of conditions such as depression, some uncertainty about deciding on appropriate treatment responses, and underdiagnosis of some conditions (Robinson & Harris, 2003).

Testing that is based on phrases and words may present inherent problems and consequently are a disadvantage to Aboriginal people. The meaning or unfamiliarity of the terminology used presents problems with the validity of such tests such as misinterpretation. Therefore the preference is to use non-verbal tests, which give more appropriate forms of testing. The Westerman Aboriginal Checklist—Youth (WASC-Y) is targeted to Aboriginal and Torres Strait Islander youth aged 13–17 years. The WASC-Y is aimed at identifying early detection of anxiety, depression, low self-esteem and suicidal behaviours (Westerman, 2003). The Queensland Test developed by McElwain and Kearney (1970) is a test of general cognitive ability and one that relies heavily on non-verbal communication with specific non-verbal instructions that requires test-takers to use problem-solving skills by manipulating physical objects. However, Westerman & Wettinger (1997) state that the norms 'have been described as out-dated and vary considerably. The variation is hypothesized to be the result of the Aboriginal client's degree of Western cultural contact' (p. 4). Kearney has recently begun a process of revision and renorming of the Queensland Test for use in a wide range of settings (personal communication). The Kimberley Indigenous Cognitive Assessment (KICA) is a cognitive screening tool which has been validated for Indigenous people 45 years and over from the Kimberley and the Northern Territory (Kimberley Indigenous Cognitive Assessment, 2004).

Reliability and validity of standardised tests for use with diverse cultural groups

The second set of arguments presents a challenge for those with an affinity for and commitment to the use of standardised testing. There is a considerable literature with examples of studies that assess the reliability and validity of standardised tests for use with diverse cultural groups. However, issues such as misinterpretation and cultural bias beg the question of whether or not attempts to Indigenise these tests should be abandoned in favour of the development of more appropriate tests (Anastasi & Urbana, 1997; Jones, 1996; Lindsey, 1998; McCabe, 2007). The process of Indigenising concepts may have the appearance of reliability and validity, but the concepts being tested may not be culturally relevant and generally speaking the results of Indigenisation add nothing to our understanding of cultural difference beyond the mere observation (Lindsey, 1998). The Indigenisation of assessment tools may in fact, in the guise of culturally competent assessment, serve as a form of secondary colonisation (McCabe, 2007).

Another broad set of related issues is the contextual or circumstantial factors that impact on an individual or group performance in assessment. There is ample evidence that the modes of administration, including the cultural identity, age and identity of the tester and the physical location of the assessment, can have an impact on the assessment outcomes (Padilla, 2001). These are also known as method and item bias (Purdie & McCrindle, 2004). Hunter (1988), cited in Westerman (2004), reports that Aboriginal people assessed in a foreign environment can often present with elevated levels of distress and therefore this contributes to potential misdiagnosis. Rarely are members of cultural minorities involved in the development, conceptualisation and validation of assessment regimes (Jones, 1996). In the Australian context most authors conclude that Western standardised tests have limited, if any, usefulness (Davidson, 1998; Drew, 2000). The Australian Indigenous adaptation of the Australian Early Development Index (AEDI), the I-AEDI, has involved Aboriginal people in all stages of the adaptation process (Ferguson-Hill & Walker, 2009; Walker, 2008).

The consequences of poor assessment in general may be profound. At the school level, the consequences for Aboriginal and Torres Strait Islander children may include overrepresentation in 'remedial' classes. This will inevitably have knock-on effects on self-worth, on feelings of marginalisation and alienation, and ultimately on retention, which has been related to health outcomes in later life (SCRGSP, 2007). This kind of overrepresentation leads to the pathologisation of Indigenous people as problematic (Padilla, 2001).

Aboriginal people are often viewed by non-Aboriginal people as a problem (Green, 2007). Poor assessment practices perpetuate that myth. Similarly, poor assessment practices may lead to the provision of a basis for disadvantageous comparison and lower expectations from Indigenous people themselves, leading to self-fulfilling prophecies with respect to performance and self-evaluations (Lindsey, 1998). Lidz (2001) observed that 'assessment has proven benign and malignant' (p. 523).

The practical reality, however, appears to be that those with a commitment to quantitative assessment will try to increase their understanding through the development and application of culture-fair, culture-free or culture-specific tests. Those committed to qualitative assessment will continue to seek an understanding of their client's life-world. Both approaches must be undertaken in a culturally competent manner.

MODELS AND FRAMEWORKS OF ASSESSMENT WITH AUSTRALIAN INDIGENOUS PEOPLE

There have been a number of approaches to assessment suggested by the literature, including multiaxial assessment (Davidson, 1998; Drew, 2000; DSM IV-TR). All have arisen in the context of the imperative to provide culturally appropriate assessment to minority groups such as Indigenous people. Australian frameworks emphasise the importance of relationship-building and engagement as crucial to success. Notwithstanding the increased attention to this area, the Royal Australian and New Zealand College of Psychiatrists acknowledge that there are few mental health assessment tools (or tests) that are properly validated for Indigenous people. Some of the more appropriate guidelines and approaches are briefly discussed here.

Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR)

The fourth edition of the *Diagnostic and statistical manual of mental disorders* (DSM IV-TR) is 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). Both are categorical classification systems that provide prototypes of recognised mental health disorders. Categories are not discrete, but these manuals are designed for use by mental health professionals with clinical training. The DSM IV was first published in America by the American Psychiatric Association in 1952, with the last major revision being made in 1994, and a comprehensive text revision was published in 2000. All categories of mental health

disorders and the diagnostic criteria needed to meet them are based on a comprehensive literature review of available research to establish a firm empirical basis for all classifications.

The DSM IV-TR offers guidelines for cultural formulations in the assessment of people from diverse cultural backgrounds. Notwithstanding the problems associated with diagnosis and labelling, this is perhaps the most widely known framework for assessment with these groups. Criticisms of the DSM assessment formulation is that it is ultimately based on a pathogenic deficit model of mental illness (Riggs, 2004) that may not resonate with Indigenous people (Brown, 2001). Nevertheless, separating the cultural elements from the context of psychiatric diagnosis and labelling reveals some key dimensions that may need to be explored in any assessment process. The key domains are:

- 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
- overall cultural assessment.

Ponterotto et al. (2001) elaborated this approach to make it more compatible with culturally competent approaches to assessment by including the importance of understanding the power differentials and self-exploration and critical self-reflection by the practitioner (or whiteness in the terms discussed here). Their framework includes:

- explorations of the client's worldview and understanding of his or her problems
- 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.

This framework is similar to the framework of qualitative and quantitative assessment proposed by Takushi and Uomoto (2001) that covers client worldview, cultural identity and acculturation issues. This can be translated into practice in the approach outlined by Acevedo-Polakovich et al. (2007, p. 376), who recommend four stages of professional practice in the assessment process.

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.

Vicary and Bishop (2005) discuss a 10-stage process of engagement in therapeutic practice. Their model is supportive of the cultural competence approach briefly described in the earlier section and detailed in Chapter 9. There are, however, some elements that warrant review in the context of assessment practices. Like Acevedo-Polakovich et al. (2007), they strongly advocate a formative preparation stage, though the focus for this stage is more

elaborate and takes longer. The key is building strong relationships in the community. They also recommend a thorough understanding of the local community history, dynamics and politics and the engagement of a cultural consultant (Vicary & Bishop, 2005) to facilitate both relationship-building and access. This may be vital but is not without risk (Dudgeon, 2000; Garvey, 2007; Oxenham, 2000). The cultural consultant may be precluded from certain areas, relationships and knowledges, or may be bound up in community politics, and is at significant risk of exploitation by practitioners. Nevertheless, if these constraints can be overcome, this is a highly recommended practice. Cultural consultants may be sourced from a variety of places including personal networks and friendships, professional relationships and colleagues, and a network of cultural consultants (Garvey, 2007).

Rationale for culturally competent assessment

Cultural competence is fundamental to good assessment practice. Hays (2008) defined cultural competence as having self-awareness of values and biases, understanding client worldviews, and intervening in a culturally appropriate manner. Cultural competence is a 'set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enables the system, agency or professional to work effectively in cross cultural settings' (Cross et al., 1989). The lack of cultural competence in past practice has been a contributing factor to the overall failure of systems of care for Aboriginal and Torres Islander Strait people (Brown, 2001; Garvey, 2007; Riggs, 2004). Assessment practices are influenced by dominant traditions and 'little has been done to shake up the assessment community despite the development of alternative practices' (Suzuki et al., 2001).

Cultural competence is part of the 'front end loading' that we need to do as principled practitioners (Drew, 2005). Without it, our assessments will be reproductive not transformative, disabling not enabling, disempowering not empowering. Gone (2007) asks practitioners to 'reimagine wellness' in the interests of creating services that 'collaboratively engage and competently incorporate local conceptualizations of emotional experience and expression, prevailing communicative norms, cultural notions of disorder and its treatment and implicit meanings of personhood, social relations and spirituality' (p. 298).

Cultural competence provides the capacity to analyse, reflect on and if necessary name the monocultural tendencies of many service providers (Riggs, 2004). Culturally competent practice is a dynamic reflexive and reflective process of engagement that requires us to step away from the traditional role of objective mirror on people's life-world (Lidz, 2001; Walker & Sonn 2009). It also requires the capacity for critical reflection which recognises that culture is embedded in a wider sociocultural situation. Chapter 12 outlines the tool and techniques for critical reflection and competence and complementary elements to the reflective process of engaging with Indigenous communities as culturally competent practitioners. These involve both a commitment to Aboriginal terms of reference and a critical examination of 'whiteness' (Dudgeon, 2000; Green & Sonn, 2005, 2006; Walker & Sonn 2009). Both promote decolonising practice (Sherwood & Edwards, 2006; Walker & Sonn 2009). Decolonisation is a required response to redress past practices that are, broadly speaking, the product of colonisation and neo- or post-colonisation. The reproduction of Western dominance in practice should no longer be tolerated as a form of secondary colonisation (Green & Sonn, 2005; Green et al., 2007; McCabe, 2007; Sherwood & Edwards, 2006). 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 and Torres Strait Islander people (Walker & Sonn, 2009).

Aboriginal terms of reference

Aboriginal terms of reference are 'a set of principles, core values and processes' that 'acknowledge, derive, validate and promote Aboriginal knowledge and ways of doing things'

(Oxenham, 2002, p. 111). They comprise a set of core values that complement the core principles articulated by Swan and Raphael (1995) guiding the development of the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being 2004–2009*. These principles include:

- the worth and validity of indigenous culture(s)
- the right of expression of Indigenous realities through processes of deconstruction and reconstruction
- self-determination and self-management
- the right of Indigenous groups to work and make decisions within their own cultural terms
- Indigenous control
- positive social change
- social justice
- the recognition and acceptance of Indigenous diversity
- reconciliation of contending interests between Indigenous people
- the worth of the group (Oxenham, 2000, pp. 114–16).

The *National Strategy* expands these core values into the health domain by emphasising, as we have noted throughout this book, that Aboriginal and Torres Strait Islander health is holistic. Sherwood and Edwards (2006) elaborate this by inextricably linking Indigenous wellbeing to obligations to country and culture, noting that ‘a failure to do so brings about a dire consequence to the individual, or their family or communities’ health, wellbeing and the future’ (p. 180).

Notions of whiteness

The second crucial element for positioning the practitioner in relation to Aboriginal and Torres Strait Islander people is the capacity to confront whiteness and the implications of whiteness for engagement with Indigenous people (Dudgeon, 2000, Green & Sonn, 2005, 2006; Green et al., 2007; Walker & Sonn, 2009). Whiteness is socially constructed and functional within particular sociocultural and political circumstances (Green et al., 2007; Walker & Sonn, 2009). Whiteness discourses have the effect of bestowing power, privilege and status on white people on the basis of their particular positions, which may not be a product of merit and in this respect is largely undeserved. Whiteness positions people in unequal power relations and leads to the reproduction of colonising practices that perpetuate marginalisation and oppression. While whiteness is invisible to the whites, the consequences have been endured by Aboriginal and Torres Strait Islander people in Australia for over 200 years. As Green et al. (2007) write: ‘White people do not experience the world through an awareness of racial identity or cultural distinctiveness, but rather experience whiteness and white cultural practices as normative, natural, and universal, therefore invisible’ (p. 396). In Australia, whiteness is a product of particular colonising practices (Riggs, 2004) which influence the shape and form of organisational structures and services that impact on Aboriginal and Torres Strait Islander people. Mental health services render Indigenous culture, ways of knowing and conceptions of mental health invisible. Analysing and reflecting on whiteness discourses and practices makes the influences of whiteness visible to practitioners as a precursor to the enactment of decolonising practice.

This construct and strategies for deconstructing whiteness are explored in detail in Chapter 12. Confronting whiteness is not just a challenge for the non-Indigenous practitioner. Aboriginal and Torres Strait Islander practitioners are also able to be more effective if they understand the implications of whiteness in the agencies in which they work and in the system that tends to reproduce rather than transform mental health practices in Aboriginal

communities. Most Aboriginal and Torres Strait Islander practitioners will almost certainly be working with non-Indigenous colleagues and in agencies that may or may not have responded to the challenges of whiteness and hegemonic practices.

The challenge for all practitioners then, is to move from principle to practice (Tuffin, 2007) and from reflection to action (Green et al., 2007; Tuffin, 2007). It is a form of re-storying or retelling (Green & Sonn, 2005) that can be a powerful imperative for change. Strategies for doing this are discussed in Chapter 9 (Walker & Sonn, 2009).

Guidelines for ethical practice in the assessment

In Australia, the Australian Psychological Society has developed a thorough and clearly articulated set of guidelines for 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*. The guidelines outline a series of principles that should inform practice.

The APS Code of Professional Conduct requires that 'psychologists shall refrain from offering work or advice beyond their professional competence' (Clause IIb). Knowledge of the original, Indigenous cultures of Australia, the psychological functioning and personal psychological needs of people from those cultures, the cultural and other milieu factors that underlie those needs, and ways of applying that knowledge in psychological research with and psychological services for Indigenous people, is essential for professional competence in all research and professional services where Indigenous people are the consumers. Consequently, psychologists who are likely to be involved in such research or service provision have a professional responsibility to obtain such knowledge. Alternatively, they should refrain from such work and refer Indigenous consumers to psychologists who are considered by Indigenous people to be sufficiently knowledgeable in this respect to be able to undertake the research or deliver the services, and who are also otherwise competent to provide the services required.

Mental Health Stay Strong Care Plan

Perhaps one of the most clearly researched and developed models for assessment with Indigenous people is the *Mental Health Stay Strong Care Plan* (Nagel & Thompson, 2006). This comprehensive package of support materials provides a series of culturally appropriate stages of assessment and care planning options for mental health in Indigenous communities. Importantly, the package incorporates an understanding of the holistic nature of Indigenous health and mental health (Nagel & Thompson, 2006). 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.

Mental state examination

Almost all forms of mental health assessment will include some form of mental state examination (MSE). 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, though, these parameters are subject to interpretation that may be culturally biased if not undertaken by culturally competent practitioners (Nagel & Thompson, 2006). In particular, practitioners should avoid overinterpretation 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. In Aboriginal and Torres Strait Islander communities eye contact and posture are particularly important. Affective responses too may be a function of cultural imperatives. For example, anger and resentment in Aboriginal people may be more historical than circumstantial, or indeed some combination of the two. Non-Aboriginal assessors are representatives of the dominant culture and on that account may invoke levels of anger and resentment that are substantially exacerbated in the

context particularly of involuntary review. Language and speech may also vary for reasons other than being solely a function of a person's mental state.

A particular cautionary note should be applied when observing and assessing thought processes and content. Seemingly disjointed, discontented and rambling speech may be a function of language difficulties rather than mental state per se. Similarly, perceptual disorders such as delusions may in fact be intimately related to spirituality and belief systems that are an authentic and legitimate response to mental health issues within a cultural context. Assessment of cognitive functioning and orientation in space and time should be carefully interpreted. Does the person have the knowledge required? For example, asking the person day, dates and times may be as inappropriate as asking for the name of the Prime Minister of the country.

The common thread in all these frameworks is that they are predicated to a greater or lesser extent on the dual lens discussed earlier—understanding Aboriginal terms of reference and confronting whiteness.

GUIDELINES FOR ASSESSMENT PRACTICE

The assessment process includes three related phases: pre-assessment, assessment and post-assessment. All are contingent on a mindful understanding of purposeful critical reflection. The assessment process, intention and practice must be (and be seen to be) culturally secure and decolonising to be genuinely transformative in its implementations and consequences for both the client and for the wider Indigenous community.

Pre-assessment

All practitioners undertaking assessment with Indigenous people must have completed some form of cultural competence, awareness or sensitivity training in the context of Indigenous Mental Health (cf. Westerman, 2004). The pre-assessment phase must also consider aspects of initial engagement and access. Aboriginal psychologist Westerman (1997, 2004) and Torres Strait Islander psychologist Garvey (2007) offer sound summaries of good practice with Aboriginal and Torres Strait Islander clients that include such things as:

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 (Vicary & Andrews, 2001). What are the political ramifications of the assessment, not only for the client but also for the wider indigenous community? Assessment that may have the effect of further exacerbating the pathologisation and marginalisation of Indigenous people should not be undertaken.

Introductions and community access

This may include the use of cultural consultants (Garvey, 2007; Westerman, 2004). It may also include taking the time to become both known and familiar with the community (Westerman, 1997). In regional and remote communities this is particularly important. 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 are all signs of respect, courtesy and cultural competence (Westerman, 1997, 2002, 2004).

The site for assessment

Selecting the site for assessment is crucial, including the risk of misunderstanding that may arise from assessment conducted when the client is separated from country or community, such as prison and hospitals, or other sites that place the client in situations that may exacerbate or create distress (Westerman, 2004).

Negotiating the process of assessment

It is also critical to negotiate the process of assessment such as the number of sessions required and the qualitative and quantitative dimensions of the assessment (Vicary & Andrews, 2001). If quantitative measures are being contemplated, a clear explanation of the range of options and the issues in the administration of such tests, including the limitations, should be provided. The purpose and uses of the assessment must also be explained. It is anticipated that testing will be the exception rather than the norm. Once the initial pre-assessment activities have been undertaken the assessment proper may commence.

Assessment

Aboriginal Terms of Reference Framework

The incorporation of Aboriginal terms of reference 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, not a prescription. It provides an analytic and reflective frame for understanding Indigenous experiences of mental illness. It also includes in a culturally appropriate way models for assessment recommended by DSM IV-TR (2000) and the mental health-related cultural competencies described by Westerman (cited in Garvey, 2007). All these elements must be explored and understood as part of the assessment process. The Royal Australian and New Zealand College of Psychiatrists Indigenous Mental Health Group has developed a ‘Dance of Life’ matrix which identifies some of the issues, gaps in knowledge and solutions to be considered across the physical, psychological, social, cultural and spiritual dimensions (Appendix 14.1). It was devised by and for Aboriginal people as a way of exploring Aboriginal values, experiences and understandings in a systematic and culturally appropriate way consistent with the Aboriginal terms of reference. As the assessment unfolds, the practitioner moves backwards and forwards through these dimensions in pursuit of a detailed and comprehensive understanding of the individual in context. This may also involve extensive consultation with family and other respected community members.

A crucial aspect of the assessment focuses on the ways of doing things. This will include discussion of alternative or traditional healing practices. It will also bring to the discussion approaches to intervention such as medication and therapeutic interventions like counselling. The assessor and the client should fully explore the range of opportunities for effective amelioration of the mental health issues. The *Aboriginal Terms of Reference Assessment 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.

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 (Westerman, 2004). Once again, the practitioner should consider the wider political implications of the assessment.

Intervention strategies

This stage should include a contemplation of traditional healing practices as well as a thorough analysis of the appropriateness of traditional non-Indigenous approaches to intervention. Vicary and Bishop (2005) identify a hierarchy of intervention agents including immediate family, extended family, elders, community healers and so on.

Follow-up, disengagement and closure

Most assessment processes by their nature are short term. However, the practitioner still has a responsibility to ensure that the outcomes of the assessment process have been 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 the cultural consultant if one has been engaged. This form of empathetic engagement is welcomed by Aboriginal people.

The Royal Australian and New Zealand College of Psychiatrists suggests the following reflective questions:

- Has the team you are working with, or other providers working with your client, received cross-cultural education about the meaning of mental health for Aboriginal and Torres Strait Islander Australians?
- 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 Aboriginal Mental Health Worker or cultural consultant?

(<http://indigenous.ranzcp.org/index.php>), accessed 9 November 2008)

MICRO SKILLS

This chapter briefly describes the micro skills for engaging with Australian Indigenous people and communities. More detailed discussion occurs in Chapters 13 and 15 by RANZCP (2008) and Westerman (2004). An understanding of micro skills is increasingly required as part of acquiring cultural competence (Chapter 12). Westerman's article 'Frameworks of working with Aboriginal communities' (1998), provides detailed guidelines for assessment. The key aspects of micro skills that have been identified include:

- 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.
- Non-verbal skills are also very important and include the appropriate use of eye contact, posture and gesture (Westerman, 1997). It is important not to conduct the assessment as a battery of questions. A conversational or yarning approach is more appropriate (Vicary & Bishop, 2005; Westerman, 1997, 2004).
- One of the most important aspects of assessment is to let the person tell you their story; don't get caught up in asking direct questions in order to obtain information for your assessment because this tends to make inaccuracies.
- A nod from the person may not be their answer to the question you're asking but rather an acknowledgment of what you have asked. The clinician or practitioner needs to check if the person has understood what has been said (Westerman, 1998).
- Do your research in regard to communication protocols, such as knowing what questions can and can't be asked and finding out the right person to talk to (Westerman & Wettinger, 1997).

- You need to get to know the client and their community to determine the right way of going about your assessment.
- Do not use technical language as this can lead to misinterpretation; make use of visual aids such as pictures (Westerman, 1998).

Without considering these factors, the potential of providing an inaccurate assessment is increased and this can often lead to misdiagnosis. Furthermore, misdiagnosis serves as an injustice to the client in determining the most appropriate treatment and level of service. Although this process takes time it is by far the most accurate way of obtaining information.

ASSESSMENT IN PERSPECTIVE: 'BRINGING IT ALL TOGETHER'

The fundamental aspects of assessment of Aboriginal mental health have been discussed throughout this chapter. In summary, for accuracy of assessment there are a number of issues to consider:

- Identify your own attitudes, values and beliefs.
- Respect community protocol, i.e. whether there are any ceremonies that may coincide when visiting the community.
- Find out who is the right person to speak with in the community.
- Is it appropriate for you to see this client?
- 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?
- Are the assessment tools appropriate and what factors do I need to consider when interpreting the data?
- Traditional and non-traditional healing practices should be considered when deciding on appropriate intervention, i.e. elders, community healers.

These principles of assessment serve as a guide for clinicians to employ best practice methods. It must be made clear that assessment of Aboriginal people cannot be moulded into a Western framework and that it is not only the individual but also the family and community that play an integral role in assessment and treatment. In summary, the key elements of culturally competent practice and assessment are respect, acknowledgment, understanding and continuous consultation with family, elders, and community.

This chapter has explored the limitations of mental health assessments, which generally fail to contextualise the behaviour and symptoms of Aboriginal and Torres Strait Islander clients within an awareness of their history and experience. Several of the chapters in this book highlight the links between trauma, grief and loss and high level of stress and mental health issues experienced by Aboriginal communities: suicide and suicidal behaviour (Chapter 7); alcohol and substance misuse (Chapter 9); anxiety in young people (Chapter 8); and perinatal mental health (Chapter 16). There is also growing recognition of Trauma Transgenerational Transfer and Post Traumatic Stress Disorder (PTSD) in Indigenous communities due to exposure to a stressful or traumatic experience (see Chapters 10 and 11).

CONCLUSION

Importantly, assessment remains a contradictory and problematic area to help address the magnitude and nature of issues being faced by Aboriginal individuals, families and communities. Given that mental health assessment is the gatekeeping process to mental health service provision, including alternative healing programs and services, it remains an area of significant concern that individuals and communities are not receiving the level of care to redress the impacts of colonisation and the policies that have impacted on Aboriginal and Torres Strait Islander peoples.

Moreover, the low levels of confidence in existing assessment tools for use with Aboriginal and Torres Strait Islander clients means there are fewer assessments undertaken than within the wider population. There are increasing concerns regarding underdiagnosis of PTSD and other mental health issues in Aboriginal and Torres Strait Islander communities. The potential cultural bias and monoculturalism, lack of understanding of Aboriginal culture, pervasive, transgenerational impacts of colonisation upon Aboriginal children, and different conceptions of mental health among Indigenous Australian families and communities about possible cognitive and mental health all interact to make it difficult to find easy solutions.

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. This chapter has suggested a number of ways in which both Aboriginal and non-Aboriginal practitioners are taking up that challenge.

In summary then, assessment is not so much about what you do but how you do it. Culturally competent assessment is a decolonising practice that requires knowledge of the dual lens of Aboriginal terms of reference and the impact of discourses of whiteness on the maintenance of inappropriate service provision that serves to reproduce marginalisation and alienation. It is a culturally situated practice that requires reflexivity. It is a fluid, dynamic process of engagement and relationship-building in the interests of positive outcomes for the client. Properly implemented, it offers the potential for individual and community healing. The assessment process must not only be seen to be culturally competent, it must also be seen to be decolonising in its implementations and consequences. Assessment must be transformative in both intention and practice for both the client and for the wider Indigenous community. Culturally competent assessment offers the promise of a shift from 'discourses of distress' (Gone, 2007) to discourses of hope.

Reflective exercises

- 1 Review the assessment protocols in your agency or agencies you are familiar with. Does the protocol systematically address all the elements of the *Aboriginal Terms of Reference Assessment Framework* described 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 purportedly culture-fair? culture-free? Indigenised? 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 people.

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Appendix 14.1 Dance of Life

Dimensions	Traditional	Historical	Contemporary	Gaps in knowledge	Solutions
Physical	<ul style="list-style-type: none"> • Earth as ‘Mother’, nature as family • Connection to country, source of renewal • Traditional medicine • Traditional diet and activity, “healthy specimens” 	<ul style="list-style-type: none"> • Physical genocide • Dispossession, ‘uprooted’ • Environmental degradation • Rapid change in diet • Incarceration • Institutionalisation • Forced labour • Ill-health, exposure to disease 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Stress, immunity and chronic disease • Grief and mortality • Transgenerational trauma and physical health • Chronic illness and mental health • Complementary healing practices 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Psychological genocide, profound trauma • Abuse • Loss and grief • Extreme powerlessness • Misdiagnosis, Mislabelling, Re-traumatisation 	<ul style="list-style-type: none"> • Place in society • Present trauma, loss, grief • Future uncertainty • Psychological morbidity, illness • Identity issues • Psychological strengths • Apology • International perspective • Exclusion from humanity 	<ul style="list-style-type: none"> • Appropriate diagnostic systems • Treatment options • Culturally valid tools • Appropriate outcomes • Accountability measures • Impact of racism and discrimination • Cultural and spiritual phenomenology • Culture bound syndromes 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Community centred kinship system • Attachment and child rearing • Early autonomy • Country as home, kin • Collective vs individual obligation and reciprocity • Two-way sharing 	<ul style="list-style-type: none"> • Social genocide • Stolen generations • Racism and apartheid • Slave labour 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Family therapies • Children’s needs vs Family • Community outcomes • Systemic barriers 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Origins of life • Dreaming • Belonging, connectivity • Philosophical views • Beliefs, experiences, healing 	<ul style="list-style-type: none"> • Spiritual genocide • Impact of mission life • Imposition of Christianity 	<ul style="list-style-type: none"> • Value of wisdom • Intolerance, Understanding difference • Exclusion from existence 	<ul style="list-style-type: none"> • Spirituality and health • Existential despair 	<ul style="list-style-type: none"> • Central to health of Australia • Healing • Understanding, tolerance, respect • Purpose and future hope
Cultural	<ul style="list-style-type: none"> • Lore/Law • Language • Ceremony • Healing beliefs, expression, experiences 	<ul style="list-style-type: none"> • Cultural genocide • Misinterpretation • Tokenism • Sacrilege 	<ul style="list-style-type: none"> • Cultural clash, two worlds • Cultural mix • Cultural practices, age, gender endurance and resilience, strengths • Cultural knowledge • Cultural grief • Exclusion from custom and consciousness 	<ul style="list-style-type: none"> • Continuum of cultural identity • Diversity of practice and experience • Models of care 	<ul style="list-style-type: none"> • Acceptance • National identity • Compensation • Cultural renaissance, self determination (Indigenous rights) • Indigenous governance • Cultural security • Cultural respect framework • Education, training • Shared learning, collaboration

15



Reviewing Psychiatric Assessment in Remote Aboriginal Communities

Mark Sheldon

EDITORS' INTRODUCTION

This chapter is presented with the kind permission of Dr Mark Sheldon's family. It has been reproduced from Working with Indigenous Australians: A Handbook for Psychologists (Dudgeon, Garvey, & Pickett, 2000).

The chapter is based on the late Dr Sheldon's dissertation, submitted in part fulfilment of the requirements of the Part 2 examination for the Fellowship of the Royal Australian and New Zealand College of Psychiatrists. At the time of writing his dissertation, Mark was Senior Registrar in Psychiatry at the Northern Territory Mental Health Services in Alice Springs.

Even though Mark's work was in psychiatry, much of it is informative for all mental health and wellbeing practitioners intending to work with Aboriginal people, especially in service delivery in the more remote areas of Australia. Mark sought to find alternative ways of working clinically in the cross-cultural setting of traditional and semi-traditional Aboriginal society. He acknowledged that this required a steep learning curve in developing 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 believed he needed to approach all of these issues in a modified way, with considerable reflection on and appraisal of his clinical experiences. He supplemented this process with personal communications with colleagues and explorations of the literature in order to find new modes of working.

*The full text of Mark's dissertation is available online at:
<www.aams.org.au/mark_sheldon/index.htm>.*

COMPLEXITY OF THE ISSUES

In his work with Indigenous people, Sheldon was particularly concerned that the complexity of psychiatric disorders is not properly appreciated. As he indicated:

There is a predominance of psychotic disorders, severe depression often with psychotic features, and co-morbid substance abuse, and, furthermore, there are relatively few cases of anxiety disorder, bipolar disorder, personality disorder or substance abuse/dependence where the abuse/dependence was the sole diagnosis and the presenting problem (p. 14).

He proposed that, with an Indigenous population, there will be a significant number of cases where there is diagnostic doubt. Hospital and community health records show that the usual psychiatric tools of diagnosis, as well as the systems of understanding and treatment, are

relevant to only part of the complexity of the issues with which patients present (Roberts & Pickett, 1998).

Behaviour which is disruptive to others tends to be referred for intervention more than that which involves social withdrawal or purely intrapsychic suffering. There has been the suggestion, documented from camp situations, and seen more recently extended into town environments, that personal suffering tends to be expressed by acting out in a social context to elicit attention and ultimately interventions of care (Coombes et al., 1983). In this way more referrals tend to come via the family than by self-referral.

In contrast to the remote areas, in more urban Aboriginal populations there tends to be less referral for psychosis and more for trauma-related issues, dysthymia and pathological grief. Overall, disorders tend to be referred quite late in their course. For example, severe major depression (with psychotic features and/or gross dysfunction) appears to be referred at a greater rate than mild to moderate depression. Schizophreniform psychosis referred have had florid psychotic symptoms for weeks or months (rather than being referred in prodromal or early subtle stages, as is typically the case in most English-speaking Western societies).

Sheldon states that this may indicate a greater tolerance within the Aboriginal community for disturbed behaviour. It may also indicate that they have a great sense of family duty to care for the disturbed individual. This is especially true for childhood behaviour problems.

In addition, there is also likely to still be an historically based suspicion and fear of having the sick relative taken away. This could delay families seeking help from health services until they absolutely cannot cope any longer. It is also possible that non-Aboriginal professionals may be less able to pick up psychological distress in (traditional) Aboriginal people.

There is the suggestion that mild to moderate depression may present in different ways with different Indigenous clients, for example at times associated with aggression or alcohol abuse. Substance abuse/dependence (and volatile substance sniffing) are seldom referred as the primary problem, but are often seen as co-morbid or precipitating factors.

Somatisation is a common presentation in community clinics. Mental health services rarely become involved.

WORKING WITH OTHERS IN AN ABORIGINAL MENTAL HEALTH CONTEXT

Working with others in an Aboriginal mental health context involves working with a wide variety of people, with a varied range and levels of training and experience, and involving families in the assessment and management of casework. It requires flexibility, willingness to share casework and to delegate responsibility, as well as reciprocal two-way relations between staff. This is especially the case in remote settings. It is also particularly valuable in these situations to work closely with the Aboriginal Mental Health Workers (AMHWs) and the Aboriginal Health Workers (AHWs), who may act as local case managers. They can also be very useful in terms of understanding cultural and contextual aspects of cases. For example, within Aboriginal culture there is a different sense of privacy and boundaries, raising issues of the nature of confidentiality.

MENTAL HEALTH INTERVIEWING

Contacting the community

After arriving in a community, pay respects to the Aboriginal health clinic staff, accompany them to the local council, and take the opportunity to be debriefed on local issues. Take note of issues of concern, progress with mental health matters and other matters that may be relevant to community mental health. You may glean information on mental health issues as well as information relevant to family and individual mental health. You may also find out about issues related to the health service program, local issues of service delivery and its relations to the regional health services.

At this time, make yourself visible and approachable in the community, preferably with the Aboriginal mental health staff. Visit the community store, garage, etc. This provides opportunity for informal referral and for unsolicited information to be provided, for concerns to be raised, and for contacts to be made. Accept invitations to engage in community recreational pursuits. However, in all of these situations, the hat of psychologist is never completely off. Opportunities will be provided for individuals, family members and community people to inform you of matters they consider relevant to your role, to seek informal advice on their understanding and management of mental health issues, and possibly to seek referral.

Negotiating the interview

In negotiating an interview with a client, the setting can include clinic, home, or elsewhere where clients and others feel comfortable and which they consider is appropriate. As indicated by Sheldon, in his experience most patients prefer family to be present. In his work he endeavoured to also give choice to the patient by offering a clinic interview or the opportunity to walk off some distance from the home to do the interview. There needs to be the choice of a private environment. Requests for consultation to be either private or with others should be determined by the client and their request should be respected. The background to the request should be examined as it may have implications for developing appropriate ways of intervention and care.

The home setting is often preferred and has advantages in allowing participation by family, especially for corroborative history, and shared understandings and ways of coping/dealing with the person and the issue (often seen as a family matter). There also needs to be sensitivity to discomfort or selective participation where there is intra-family dispute or concern.

Overall, the client's confidentiality needs to be respected.

Clinical engagement of clients

As clinical engagement proceeds, input from the AMHWs should always be sought. They should be involved at all stages, working as a team with the psychologist as a 'specialist resource person'. Client requests for a confidential interview and privacy of information must be respected and the AMHWs informed of this arrangement. Where AMHWs are not available the AHW may assume this role. It might also be appropriate to liaise with the clinic nurse and involve them in the process. The psychiatrist should always include the remote mental health nurse.

Translation issues are important at this point, involving the AMHW/AHW or possibly the family or others the client may wish to assist. In interviews, clients can often be accompanied by family and others who share the concern and care roles. Their participation needs to be negotiated and clarified with the client to preserve the opportunity for confidential consultation by the client or others. Introduction by a familiar member of staff is important since in Aboriginal culture your relationship to others determines your role and the introduction makes this understood.

It is also necessary to gather from local staff and the family corroborative client history regarding current patterns of behaviour and their development. This must be seen within an appreciation of the current circumstances of the family and community over the generations.

In order to establish reliability of information, it is important to clarify whether the behaviour exhibited in the clinical interview has also occurred in a variety of social settings, and that it is distinctly different to what is described as the client's pre-morbid self.

INTERVIEW TECHNIQUES

Even with considerable experience, one can frequently be perplexed after interviewing an Aboriginal client regarding a presenting issue of concern. The ability to work within situations with a high degree of ambiguity and with often incomplete information is important. In order

to resist imposing one's own understanding on the situation, seeking advice and help from Aboriginal people is essential. According to Sheldon:

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. (p. 26)

Initiating contact and establishing trust

Sheldon talks about his own experience working with Aboriginal people, and makes some practical suggestions for working with what he refers to as the fairly traditional Aboriginal people of the remote communities:

- More often than not some family will be present at the interview. I greet each person with a loose handshake, with arm fully extended so as not to invade personal space, and only fleeting eye contact. Importantly, the hand should not be withdrawn too quickly. I try to greet the elderly first as a sign of respect.
- Seating arrangements, or, more usually, sitting arrangements are important. For the interviews done at a patient's home I ask the patient where they would like to sit and talk. This gives them the option of walking off to sit under a tree if they wish not to talk with family around (sometimes young men prefer this option). However, the concrete veranda adjacent to the house, with the family gathered around, is the usual preference. I try to sit so that I am not directly facing anybody.
- The ideal is to sit side by side with the patient and face in the same direction that he/she is, e.g. with our backs to the house and looking out over the community. This allows some closeness without intimidation, and without the patient feeling that he or she is being stared at. Too much eye contact makes the patient feel as if they are being judged, especially if there are issues related to shame. In everyday interactions between Aboriginal people there is a tendency to talk side by side rather than face to face. However, there is no rigid rule for eye contact. Intuitively one can sense that a certain amount of eye contact is acceptable, based on how much eye contact you are receiving from the patient, the patient's gender and the amount of shame in the content of the material being discussed. As a wandering gaze can give the impression of being disinterested in what the patient is saying, it is appropriate to show an attitude of attentiveness by relatively fixed unobtrusive gaze, such as on the ground or on your hands.
- To gain rapport early in the interview I generally make a lengthy and unhurried description of my role, where I am based, and where I travel to. I highlight any connection I have with people they may know, e.g. the clinic nurse, AHW or District Medical Officer. This lengthy introduction serves firstly to reduce the patient's anxiety as it takes the pressure off them to start talking. Secondly, Aboriginal people need to know your relationships with others before they can decide on their relationship with you. It is not enough to say my name, qualifications and the purpose of the interview (which is all that most White people would need). Aboriginal culture is based on a complex structure of obligations and entitlements based on relationships and kinship networks.

Sheldon describes this process of his 'placing' as then enabling a transferring of the attachment. However, should the group not like you or take a dislike to you, this engagement is unlikely to occur.

- I make it clear that my aim is to provide help within the community and to lower the chance of admission to hospital. Fear of admission, especially involuntary admission, has been a factor in patients and family being reticent to give a frank history. Fearing incarceration, and a loved one being removed from the family, understandably brings out strong emotions in Aboriginal communities given their history of removal and institutionalisation.
- There has been a change in my demeanour in interviews in these settings. In the urban white community a professional distance and a controlled calm air of authority will often give optimal results. This is simply not culturally appropriate in remote Aboriginal communities, where there may be a distrust of external authority figures. Credibility is earned by your acceptance of Aboriginality, willingness to learn Aboriginal ways and humility. In fact, use of humour, often at my own expense, can be disarming and promoting of trust.
- In order to provide a service for Aboriginal people one must develop a relationship first, and to show who you are, not just what you are. This can initially be a discomfoting time for the professional.

Language

In remote areas, according to Sheldon, interviews done in Aboriginal language, even where the patient has a good grasp of English, are likely to produce a more accurate picture of affects, beliefs and internal phenomena. Asking the basic interview questions in Aboriginal language, even with a reply in English, seems to produce more useful results. Interpreters, especially AMHWs/AHWs, are helpful when available, but local language skills vary, as does transfer to English. Local languages can have words for an incredible variety of affect states and behaviours, such as types of anxiety, anger, depression and sadness.

Usually the non-Aboriginal mental health professional attains only limited fluency in Aboriginal languages, and may find, as did Sheldon, that the most useful skill to develop is Aboriginal English.

As a general rule, in all situations simple English should be used. Throwing in too many difficult words at the beginning of an interview can lose the patient's interest. On some occasions in remote areas it is best to start with Aboriginal English in the interviews even though some of the patients are quite fluent in conventional English—especially for the benefit of family members that may be present. It is necessary to find the language that the client and family are comfortable with, and to remain flexible about this. It is important not to give the impression that you are 'talking down' to anyone by being patronising or 'superior', either by jargon or formality. Likewise it is important not to 'go native' by overaffected simplicity, or by presumptuous use of pidgin English.

Taking a history

According to Sheldon, starting with open-ended questions puts too much pressure on the patient to start opening up. More ease is gained by the interviewer doing most of the talking in the early stages. The result of too many open-ended questions early will often be silence or a shrug of the shoulders.

Sheldon also considers that repeated closed questions will only serve to intimidate the patient, who may object to too many worry questions or may simply say 'yes' to the questions to please the interviewer.

Asking about the history of the presenting illness first will be baffling to most Aboriginal people. They may feel that their problems cannot be understood before first understanding the context and their relationships within their family network, community and spirituality, as well

as beliefs they may have about the presenting problem. Failure to do so will lose the patient's confidence in the interview process. Additionally, asking multiple choice questions is not a useful technique in interviewing.

Sheldon summarises the following strategies as ones that he found useful:

- Talk slowly and wait for a considerable time for the patient to consider the question/ statement before he or she may reply. It is the Aboriginal way to consider questions at length before replying. Quick replies can be seen as impolite.
- Commence not with questions but with non-threatening statements, e.g. local observations that might stimulate interest and lead to taking a social history. Then seek to discuss family relationships, skin names and marital history. This is also an opportunity for the family to become involved in the interview.

Over time Sheldon realised that his Westernised emphasis on the individual was impeding progress.

In his efforts to get the patient to talk for him or herself, the family would discuss matters among themselves and answer for the patient. Because the boundaries between individuals within an Aboriginal family are less defined, the 'illness' may, in a sense, be shared by the whole family. There is the belief that mental experiences in general are not private but shared by close relatives, and when sorcery affects an individual it may also affect the 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 mental health worker's observations (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.

The following suggestions are offered by Sheldon:

- 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.
- Delay questions about the history of the presenting illness until well into the interview.
- If there is an AMHW or AHW present, the possibility of involving them could be explored. [However, at the same time, there may be a reluctance to disclose due to their presence. Ask the client privately.]
- Telling a story can be effective, especially when little information is being obtained due to apparent shyness or shame. A hypothetical scenario similar to the patient's can often overcome any shyness or shame and allows the patient to talk more freely without feeling that they are going to be judged. Storytelling is an important part of Aboriginal culture.
- Try to understand the cultural significance of the events in the history. Don't be afraid of showing ignorance by asking questions about such cultural factors; it can be much appreciated by the family when the interviewer asks for help in trying to understand the cultural factors.
- Endeavour to understand the emic¹ view of the illness as well as the etic² view. It is important in the history to include information about predisposing and precipitating

1 Emic relates to, or involves understanding a cultural phenomena from the perspective of one who belongs in the culture being studied.

2 Etic relates to, or involves analysis of cultural phenomena from the perspective of one who does not belong in the culture being studied.

factors as well as retrospective attributions and culturally accepted explanations of the illness and its origins.

- It is important to revisit the social history later in the interview in some detail, especially around sensitive areas (likewise, the developmental history).
- It is important to be patient in these interviews. Often it is the last thing said (to you) that is the most important.

Sensitive topics

Bereavement, the breaking of taboos, ceremonial business, sexuality and fertility, and domestic habits, are all potentially sensitive areas in the interview. The key for the clinician is to firstly be aware of the sensitivities, to assure the patient that you are aware of these, and then seek permission to proceed with the sensitive topic.

Bereavement

Bereavement, known as sorry business, is a very important part of Aboriginal culture. Funerals can involve entire communities and the expression of grief can include self-injury. The grieving relatives may live in a specially designated area, the sorry camp, for a period of time. The relatives may also cut off their hair or wear white pigment on their faces. The community refrains from using the name of the deceased, but can refer to him or her using a special name. People with the same name as the deceased should also be called that special name. Photographs or videos of the deceased may have to be destroyed. It is important for the interviewer that asking about the self-injury (sorry cuts), or other physical manifestations of the grieving, will cause embarrassment. Mentioning the name of the deceased or asking ‘Who has died?’ will also cause distress.

Reasons for the death are sought and this may include sorcery or blaming another individual. Payback is common for the latter case. Consequently there may be anger, fear of payback, fear of further sorcery, etc., in people during time of sorry business.

Ceremonial business

Ceremonial business for initiation of young males into manhood, and for the handing down of gender-specific songs and stories, is a dominant part of cultural life. It is surrounded by very strict taboos, infringement of which can bring payback spearing or death. Understandably, an interview can come to a sudden halt when the issue of ceremonial business comes up, and the patient and family may fear breaking a taboo. What is very beneficial is to ask whether the sudden silence is about ceremonial business, and if so ask how, or if, the interview should proceed. This results in a sense of relief in the patient and family, and improvement in rapport due to a sense of being understood. Usually if male business is to be discussed then females and children should leave the interview setting, and vice versa.

Encroaching on any area that involves taboos or causes the patient to feel judged may result in shame. When shame occurs it can impede the interview process—the patient may get angry about being judged or feel very uncomfortable in the interview. It can be difficult to recognise shame, but it is best to anticipate it and to bring up the issue of shame with the patient before proceeding any further into the sensitive area. For example, it is useful to say, ‘I’m not trying to shame you, but is it OK to talk about these worries?’ Or, ‘I’m not trying to shame you, but it will help me to understand if you can tell me.’ Similarly if there is a block to progress in the interview, then it is useful to ask the patient if they are ‘shamed’ about something.

Sexuality and marital problems

Sexuality, marital problems and infertility, wrong-skin relationships, and questioning about domestic habits are areas which are likely to produce some shame. Ideally the interviewer should be the same sex as the patient when these issues are discussed. The shame can be to the whole family.

MENTAL STATE EXAMINATIONS

According to Sheldon, working in remote Aboriginal communities taught him how much his culture has shaped his perception of mental state. He recognised that there are similarities and differences between Aboriginal and non-Aboriginal culture in how mental disorders are manifest in the mental state. It is sometimes difficult to know what are the sociocultural norms for different expressions of affect and behaviour. There are substantial differences between local cultures, and different aspects of change. These norms change over time. It requires learning about Aboriginal culture, being guided by Aboriginal people, and developing appropriate mental state examination skills. Often it is difficult to pick up subtleties of mental state and more difficult to make confident interpretations of the findings.

Appearance

There is such diversity between communities and difference from the clinician's own likely experience that care must be exercised to avoid stereotypical attributions that can suggest psychological problems. Ultimately the most useful approach is to try to understand the patient's usual level of self-care and appearance, so as to detect any changes which may signify a mental disorder. Seeing the family and relatives in their setting is a good yardstick for this, as is the opinion of the Aboriginal Health Worker.

Self-mutilation that is not based on grief in sorry business usually warrants investigation. It may be occurring after relationship problems involving arguments and conflict, or it may indicate difficulty coping with repeated extended grief due to multiple losses, separation and rejection (especially where there is co-morbid alcohol use). Self-mutilation can occur with poorly controlled bipolar disorder with co-morbid alcohol abuse, but with borderline personality disorder usually only in urban situations with a strong Western component in terms of upbringing.

Behaviour

Shyness is very common and accordingly disinhibited behaviour can be indicative of difficulty—except with children, who, by contrast, tend to be boisterous and uninhibited.

On the one hand there may be unusual culture-specific behaviours, such as that relating to the breaking of taboos, that a community sees as grossly disturbed. It is necessary to have a good grounding in the understanding of Aboriginal culture to judge the appropriateness of (some) behaviour. According to Sheldon, some of the bizarre behaviours that he had witnessed did not appear different from those of Western cultures, e.g. facial grimacing, gait and movement, purposeless arranging of objects, use of a cultural symbol, and so on.

Affect

The problem of cross-cultural assessment of affect and mood is that the emotion terms are socioculturally determined. Earlier assumptions of universal innate expression of (human) emotions have been refined to add more recent developments in anthropological psychology where, although the affect itself may be common, its expression can take on different culturally conditioned forms.

Appearances of low affect in the one-to-one clinical interview may give a wrong impression, perhaps of depression. The flat and restricted affect and blank or non-reactive facial expression may change when the family is present or when the patient is in the camp situation. If not, then a problem is apparent.

If incongruous affect is apparent to the interviewer and others, it may be indicative of psychosis.

Anxiety can be the most difficult of affects to detect, or even to understand its expression in words. White clinicians can underestimate anxiety and emotional distress in traditional Aboriginal people, yet careful study of the Aboriginal languages reveals a surprising array of words and phrases pertaining to different types of anxiety and related somatic phenomena.

Mood

Reports of 'weak spirit' can be a surprisingly reliable indicator of depressed mood. In contrast, Aboriginal English is not adequate to communicate the irritable and elevated mood that one may see in some types of mental disorders, although there may well be in the local language ('cranky' and 'silly' are useful approximations).

Speech and thought form

Referral can be made for 'talking silly', where others consider the client's talk is inappropriate to a concerning degree. Formal thought disorders (including loose associations, word salad, tangentiality) are easily detected if the patient has good English. But if they don't, and they converse more in their own language, then one is reliant on an AMHW/AHW acting as interpreter, to report that the patient is not making sense.

Thought content

Although some Aboriginal clients may be clearly delusional, frequently reliance on family and AMHW/AHW can be crucial. Of more difficulty are beliefs involving Aboriginal spirituality and customs, such as widespread beliefs in remote areas that thoughts and feelings can be shared between closely related individuals in a telepathic way; magical spells can be cast causing ill health or even death; and that the medicine man can cure illness by removal of objects such as bone from the individual's body. Some of the ways these beliefs are expressed may be delusional, others may be culturally acceptable. This can be difficult to establish as the families may tend to adopt the delusional beliefs by association.

The issue to establish is whether the primary symptoms pre-date the culturally based retrospective attributions, which can often be multiple different explanations.

As a reflection of the fact that Aboriginal cultures are in a constant state of flux, many psychotic patients have expressed delusions with very Aboriginal content together with very Western/European content, all in the same episode.

Well-systematised persecutory delusions tended to occur mainly in Aboriginal people who had lived much of their life in more Westernised settings. Often there are phenomena that remain puzzling, and it is a danger that the non-Aboriginal clinician may attempt to label it more to decrease his or her anxieties than to enhance understanding.

Perception

In all cultures, hallucinations may be pathological or culturally based. Getting advice from an AMHW/AHW can be useful in exploring whether the hallucinations make sense in a cultural way, e.g. seeing spirits or birds. Persistent auditory hallucinations are less commonly seen as culturally based and are generally indicative of mental disorder.

Cognition

Ability to assess cognition is hampered by the lack of culturally sensitive assessment tools. The challenge to come up with more culturally appropriate measures is greater in cognitive assessment than in any other component of the mental state examination. According to Sheldon, many assessment tools introduced in training were virtually useless. The concepts of time and place and number are very different, there is no written tradition of knowledge, and general knowledge is of a vastly different domain. In addition, standard assessments of function and activities of daily living (e.g. the DSM IV assessments for dementia) are not appropriate in remote communities where living is more communal. Test developments utilising local knowledge for one part of the country (e.g. North Queensland) are not necessarily applicable to other areas (e.g. Central Australia).

Informant information may be compromised by family not wanting to give embarrassing details of their elder relative's behaviour. The families of sufferers characteristically do not seek help until very late; in the meantime they have been quietly managed by the families.

There is a high incidence of cognitive decline in remote Aboriginal communities because of multiple risk factors: alcohol abuse, petrol sniffing, high incidence of head trauma, CNS infections and poor nutrition.

DIAGNOSIS AND FORMULATION

Relating to his own experiences, Sheldon indicated that having attempted the history-taking and mental state examination in a careful and culturally appropriate way, and having tried to sort out the difference between psychotic phenomena, real precipitants, retrospective attributions and culturally accepted explanations of mental disorder, the process of formulation and diagnosis he followed was the same as that used throughout his training.

Major syndromes

The major syndromes (schizophrenia, major depression, bipolar disorder, dementia) were frequently present and usually easily recognised:

- Even with the obscuring effects of cultural beliefs (i.e. thought-sharing, hallucinations and possession by spirits), *schizophrenia* and *schizophreniform psychosis* could be identified if there was good corroborative history of grossly disturbed behaviour and the community viewing the person as rama (or local words for 'madness').
- Even though it was hard to elicit thought content in *depressive states*, the presence of the biological features of depression would indicate the diagnosis. As in Western culture, there were atypical presentations of depression, somatisation or shame states being examples, but careful collecting of history would usually show a depressive picture to emerge.
- *Dementia* was difficult to distinguish from chronic residual schizophrenia, requiring good longitudinal history.

Sheldon writes that in his experience he found no 'exotic culture-bound syndromes' mentioned for some peoples in the anthropological and ethnopsychiatric literature.

Organicity

Organicity was often a likely factor in many presentations but could be difficult to confirm or exclude because of the difficulty of access to appropriate medical (and neuropsychological) investigations.

Brief psychosis

Brief psychosis with full resolution (often without treatment) and without clear precipitants has been seen and substance use precipitants suspected but not confirmed.

Personality disorder

Personality disorder was a difficult area. According to Sheldon, the more contact the person had with Western culture the more likely these traits would appear.

Sheldon thought there are many Aboriginal people who suffer significant long-standing emotional distress who are difficult to diagnose on Axis 1. These cases don't often get referred to mental health, but the absence of an Axis 1 diagnosis should not preclude them from getting psychological help. The Axis IV diagnosis is more pertinent.

If any cultural explanations are given, there is a danger in writing off or minimising the seriousness of the symptoms diagnostic of psychological disturbances as 'it's all cultural'. As

indicated by Sheldon, too often he came across the dichotomous Western style of thinking ‘is it a real psychosis or is it cultural?’, whereas it was more productive to think of the episode as being both real and cultural. Cultural factors play a part in mental disorders in Western cultures, just as they do within Aboriginal society, but this should not minimise the significance of the disorder. (Nor should the reverse—where there is overdiagnosis of cultural matters as mental disorder.) Ultimately the phenomenology decides the core syndrome, which can have a multitude of different explanations within and between cultures. Culturally accepted explanations can be a mixture of real precipitants (and predisposing and prolonging factors) and retrospective attributions—and a mixture of explanations from both cultures. These may all need attention in the management plan as well as primary attention to any actual mental disorder that may exist.

The challenge was to be culturally attuned enough to pick out the more subtle precipitating, predisposing and prolonging psychosocial factors to have a well-rounded understanding of each case.

Surprisingly, most of the Aboriginal families Sheldon met could quite pragmatically accept a multifactorial explanation for a mental disturbance and accept multimodal management, such as medication for the biological side, seeing a traditional healer for the psychological spiritual side, and mobilising family support for the social side.

MANAGEMENT

Management was nearly always delivered through the family. Their usual wish was for their mentally ill relative to stay, except occasionally where even the tolerance of the family would be exhausted by very difficult or disturbed patients, and the family would make a decision that the patient needed to be taken away, involuntarily if necessary. In deciding whether a patient needed admission or not, Sheldon would be significantly guided by the family’s wishes. However, he would seek to increasingly become involved in the discussion process should the family be underestimating the dangers, especially of suicide. Sometimes respite is an option and a necessity.

In complicated family problems where the family are reasonably functional, management is best handled by calling a family meeting, crystallising what the problems are, and then asking for the family to come up with a solution, with the mental health team acting as facilitator in this process.

Sheldon discusses psycho-education with these families, as ways of increasing their resources of understanding, using storytelling successfully in the remote context. (This was especially necessary with respect to maintenance of medication.)

Psychiatric emergencies are a difficult problem logistically in remote areas, especially where air transport is required. The other difficulty is the infrequency of visits of the psychiatrist to remote communities (typically 2–4 months apart).

EDITORS’ POSTSCRIPT

Since this was written, around Australia further different innovative strategies are being developed. As Sheldon indicates (pp. 10, 13, 18–20, 24, 49), these variously involve AHW and AMHW practitioners in mental health referral and case management support roles. ‘Their role has been of great value and points towards ways of improving mental health service delivery to remote Aboriginal communities’ (p. 19). He sees ‘increased involvement’ for the future (p. 49), especially in regional mental health teams, working together with psychiatry and mental health nursing in servicing local and outstation community clinics, and in employment in regional centres in mainstream and Aboriginal community-controlled health and mental health facilities.

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16

Promoting Perinatal Mental Health Wellness in Aboriginal and Torres Strait Islander Communities



Sue Ferguson-Hill

OVERVIEW

This chapter considers factors relating to perinatal mental health, culture, environmental context, and ways of working with families in this most sensitive of life stages. Perinatal mental health research has ascertained that in the perinatal period women experience increased susceptibility to social and emotional adjustment difficulties, psychological distress, anxiety and mood disorders. The issue of perinatal mental ill health is a major public health problem affecting not only mothers but also their infants, other children in the family, partners, and communities generally.

Protective and risk factors related to perinatal mental health are discussed from the perspective of mother, child and father, along with implications for the wider family and community. Ways of strengthening wellbeing and of recognising and managing perinatal distress and perinatal depression are explored. Cultural considerations in determining the presence of a perinatal disorder in Aboriginal and Torres Strait Islander contexts are highlighted throughout. Current practices and beliefs about recognising and managing signs of distress in a new family are considered, as well as existing strengths in Aboriginal and Torres Strait Islander community contexts which can lead the way in promoting perinatal mental health wellness. The chapter also briefly explores pathways and models of care, screening, and tools of assessment used in the perinatal period.

PERINATAL DEPRESSION

Depression accounts for the greatest burden of disease within all mental illness, and it has been predicted by the World Health Organization that it will be the second highest of all general health problems by the year 2020. Of particular concern and significance is the rate of depression among women (and men) during the perinatal period. Currently there is little information relating to depression and perinatal depression in Aboriginal and Torres Strait Islander communities, though numerous reports demonstrate the complexity of issues impacting on rates of depression in communities. There are indications that perinatal depression is also a significant health issue.

The perinatal period is a unique life stage for women (and men), bringing with it challenges and opportunities with more than one person directly affected if adaptation to the parenting role is impaired, or mental health is negatively affected.

There has been increasing recognition that perinatal mood and anxiety disorders alter a mother's physiological and emotional responses, possibly leading to long-lasting effects on the fetus during the pregnancy, and on the infant, family and community in the postnatal period (*beyondblue*,

2008). The need for comprehensive care provision for mothers and infants in the perinatal period has been identified and now includes screening and assessment to identify women currently experiencing or at increased risk of distress, depression or related functional impairment (beyondblue, 2008). In recent times, the awareness of potential difficulties for fathers has been recognised, with screening for postnatal depression in men becoming more frequent (Matthey, 2008).

A national plan to enhance perinatal mental health wellness

The Australian Government announced in the 2008/09 budget a health initiative for the implementation of a perinatal depression plan to be implemented across Australia over the next five years. The goal is to have available 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 (Yelland et al., 2009).

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 during that time. Actions arising from the research include the development of a national, integrated, coordinated approach to translate the research outcomes into evidence-based policy and practice (*beyondblue*, 2008).

Identifying perinatal issues in Aboriginal and Torres Strait Islander contexts

The development of perinatal screening initiatives in Aboriginal and Torres Strait Islander health contexts is in progress to prevent, detect and manage perinatal mental health problems. Centres such as Aboriginal-controlled Community Health Services and Aboriginal Medical Services provide culturally specific mental health services, and are initiating adaptations to existing screening tools and developing culturally appropriate programs to address the issues. The Western Australian State Perinatal Mental Health Unit is an example of a Department of Health state-based centre with initiatives such as research and education programs based on culturally appropriate service provision for health personnel, including training in the use of the Edinburgh Postnatal Depression Scale (EPDS) in diverse contexts.

Reporting on perinatal mental health

Numerous reports are available about initiatives, strategies, or programs related to perinatal mental health, and maternal and child health, in the Aboriginal and Torres Strait Islander context. Examples include:

- *The beyondblue National Postnatal Depression Program, Prevention and Early Intervention 2001–2005, final report*, June 2005
- *State Perinatal Mental Health Initiative Report 2003–2007*, State Perinatal Mental Health Reference Group and WA Perinatal Mental Health Unit, 2007
- *Aboriginal Perinatal Service Expansion Baseline Evaluation Report*, WA Perinatal Mental Health Unit, February 2008
- *Lessons learnt about strengthening Indigenous families and communities: Stronger Families and Communities Strategy 2000–2004*, Occasional Paper No. 19, 2008.

The reports raise many issues but also highlight the importance of effective communication about perinatal mental health care. Misinterpretation, misunderstanding and miscommunication that occurs when diagnosing, treating and giving care results in negative experiences for the recipients of care and the caregivers (Eley et al., 2006) and require solutions that respect cultural sensitivity, demonstrate cultural competence, and adopt culturally appropriate methods and language related to the perinatal stage of life. Chapters 13, 14 and 15 of this text discuss these issues further.

Scope of the problem

Beyondblue's national depression initiative outlines the scope of the problems arising when there are negative impacts on the wellbeing of families and communities in the perinatal period:

It is now well recognised that vulnerability to psychological distress and disorder is accentuated in the perinatal period not only for the mother, but also her infant, partner and family. Poor maternal mental health can significantly affect the emotional, social, physical, and cognitive development of her child, and is associated with increased incidence of chronic disease. The perinatal phase is critical developmentally, both in terms of the attainment of parenting skills and secure infant attachment. (*beyondblue*, 2008, p. 1)

Role adjustment or mental health disorder?

According to the *beyondblue National Post Natal Depression Research Program*, which screened 40,000 women across Australia, one in seven women who give birth in Australia are affected by postnatal depression. However, questions arise as to whether distress during the perinatal period is related to psychosociology or biology—phase of adjustment to parenthood, or mental health disorder. Buist (2006) notes that nearly 30% of women experience significant adjustment to parenthood difficulties, with the weight of expectation on motherhood creating levels of mental and emotional stress not previously documented. Media images of smiling, relaxed, well-toned, in-control mothers and fathers set an expectation that is difficult to achieve even in well-supported families.

Mental ill health in the perinatal period is a serious public health problem for Australia, affecting mothers, fathers, infants and communities. While the extent of the problem is currently unknown in Aboriginal and Torres Strait Islander communities, the facts identified for the general population demonstrate reasons for concern. For example, approximately 10–13% of pregnant women experience *antenatal depression* and one half of these women will develop postnatal depression (Evans et al., 2001); antenatal anxiety and depression frequently occur together and may lead to postnatal depression and anxiety (WA Perinatal Mental Health Unit, 2007); approximately 50–80% of women will experience postnatal depression or baby 'blues' in the first few days after the birth (*beyondblue*, 2008); *postnatal depression* prevalence is estimated to be 14% in Australia (Milgrom et al., 2005); co-morbid anxiety is reported in postnatal depression in 30–40% of cases (Misri et al., 2000); during the perinatal period the potential consequence of suicide is the equal (with haemorrhage) leading cause of maternal death in Australia (Buist et al., 2005); infanticide is a rare but alarming consequence of severe mental illness (*beyondblue*, 2008).

Further, postnatal depression is frequently unrecognised and untreated (Buist et al., 2005); the incidence of paternal depression ranges from 1.2% to 25.5% in community samples, and from 24% to 50% among men whose partners were experiencing postnatal depression (Goodman, 2004); adolescent mothers are up to three times more likely to experience postnatal depression than older mothers (Swann et al., 2003).

Anxiety and depression are as common in women in the period of time *before* the birth of a baby as that seen postnatally (Buist, 2006). It is estimated that about a third of women will remain depressed over the months following birth, and sometimes for prolonged periods of time. If there is associated drug or alcohol use, domestic violence occurring, or pre-existing mental health problems, the mental health and wellbeing of the woman and her child or children, her partner, and others surrounding her in the community, may be affected.

Fathers may also experience increased rates of dysphoria and depression (Matthey et al., 2000). An integrative review concluded that during the first year after the birth of an infant, the incidence of paternal depression ranged from 1.2% to 25.5% in community samples, and from 24% to 50% among men whose partners were experiencing postnatal depression (Goodman, 2004). The *New South Wales Men's Health Action Plan 2009–2012* supports the *Father-Inclusive*

Practice Framework being developed to align services with the needs of fathers 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.

CONSIDERING PERINATAL STRESS AND DEPRESSION FROM A CROSS-CULTURAL PERSPECTIVE

Differences may exist in the experiences of mental disorders within Aboriginal and Torres Strait Islander contexts. Westerman (2004) reflects on the relevance of 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 significant considerations when managing perinatal mental health. Vicary and Westerman (2004) contend that because mental health problems may show themselves spiritually and culturally, resolution can only be achieved in the same manner. It is to be noted that ‘Aboriginal people ask that workers in community agencies apply an “Aboriginal lens” and consider additional factors and approaches’ when working with Aboriginal people (Mungabareena Aboriginal Corporation and Women’s Health, 2008, p. 2).

Traditional cultural beliefs and practices strengthen wellbeing in the perinatal period

In traditional Aboriginal cultures, birthing and child-rearing practices were strongly related to the land and the plants that provided the necessary elements for rituals relevant to this life stage (Dudgeon & Walker, 2009). Connection to country or ‘homeland’ was, and still is in most Aboriginal communities, an extremely significant feature in ensuring the wellbeing of the mother, the infant, the whole family and the community in general.

In many rural and remote areas in Australia, pregnant women face removal from a partner, family, friends and community, country, and culture for the birth of their children and this may have a significant impact on the wellbeing of Aboriginal and Torres Strait Islander women and their families. Excessive stress, isolation from familiar and nurturing people, surroundings and cultural ways, leads to fear, sadness and loneliness at a critical period. While many urban centres share a philosophy of family-friendly birth environments and provide options for community midwifery services, many women in remote settings face displacement from the familiar, and birthing in the presence of strangers (Hancock, 2007), both significant factors in the creation of high stress levels (Odent, 2002).

Optimal health supports women at the time of birth and, according to Hancock (2007, p. 79), the ‘system of medicalisation and authority [that] has determined [on] removing the Aboriginal woman from her culture and tradition for birthing...’ impacts on health and has not seen corresponding improvement in perinatal statistics to justify the action. Further, ‘Aboriginal women’s preferences, feelings and encounters with the health system as it impacts on them and their family and community lives during pregnancy and after, are poorly understood and appreciated’ (Hancock, 2006, p. 4) with potential for long-lasting impacts on social and emotional wellbeing.

Birthing away from country, from significant family members who would normally nurture, guide and assist the woman, and from traditional and familiar ways of interaction through language and cultural practices may well upset the normal process and rhythm of birth as well as subsequent mother–child interactions and child behaviour and development (Hancock, 2006). Odent (2002) discusses current birth and primal period processes and the

potential for negative impacts on the child's primal health, especially immune system stimulation and the consequent state of wellness. According to Odent, results from scientific experiments about physiological changes and responses when placed under duress have been able to

help us to understand just how much a person's entire capabilities are decreased when they have no control over what happens to them, and can only passively submit. They also help us to understand that the responses of the nervous system, the hormonal system and the immune system should never be dissociated. They form a whole. (2002, p. 7)

In recounting their traditional birth and child-rearing stories to Margaret Stewart (1999), the women of Warmun community in the East Kimberley region of Western Australia highlight 'the importance of safeguarding both the physical and spiritual health of the mother. Adherence to traditional women's Law, and with it the ceremonies and rituals for a healthy mother and baby, is critically important in the eyes of the older women' (p. 6). Werra Werra team members Peggy Patrick, Mona Ramsay and Shirley Purdie share stories indicating the importance of cultural birthing practices:

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...

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. (pp. 6-7)

Life stage: The perinatal period

The available literature assures us that a strong family unit displays signs of being strengthened during this transitional life stage as adjustment followed by adaptation to the new situation of being a parent occurs. From a social-anthropological perspective childbirth is a 'rite of passage', a social transition with a different relationship ensuing between the parents and wider family as they combine to activate a secure environment for infant development and learning (Cox, 1996).

Families are described as a central point 'from which societies derive strength and forge the future' (Cox, 1996, p. 1), highlighting the importance of investment in services and programs to provide families with the supports and assistance required to meet challenges arising in the sensitive perinatal period.

PARENTAL MENTAL HEALTH

Understanding the secure base-safe haven concept, and secure attachment in infants

The first year of a child's life is a critical period in the creation of secure parent-infant attachment and also in the development of neuronal connections in the infant's brain, especially in the area of infant self-regulation of behaviour and emotions (Mustard, 2007). Further, insecure patterns of behaviour in the child may be demonstrated as intergenerational transmission of patterns of insecure attachment (Austin, 2003). 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 (Hoffman et al., 2006). Mother-infant attachment which is strained or lacking may result in a feedback mechanism that exacerbates the woman's depressed mood, reinforcing her feelings of being a poor parent (Goodman, 2004).

What impacts on the development of a secure base?

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. According to Swan and Raphael (1995) and Vicary and Westerman (2004), 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 and personality and adjustment disorders, poor parenting skills, lack of cultural identity, substance misuse, violence, guilt, self-harm and suicidal behaviours.

PROTECTIVE FACTORS PROMOTING PERINATAL MENTAL HEALTH WELLNESS

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 (Luthar, 2006). Protective factors are discussed in detail in Chapter 6. A more effective way of promoting mental health wellness, and enhancing family wellbeing in the perinatal period is to increase a person's, or family's, inner strength, or level of resilience, or coping capacity, through the enhancement of protective factors relevant to the particular family, rather than trying to modify risk factors.

There are many protective factors known to assist management of stressors over a life course and over many generations. The following list, adapted from Ypinazar et al. (2007), summarises examples of protective factors with each defining, influencing, being part of and impacting on, the other.

Protective factors

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
- adequate nutrition.

Infant/child

- healthy infant
- breast fed
- 'easy' temperament
- safe and secure base with positive attention from a supportive, caring mother/family
- strong mother–infant attachment and, where possible, father–infant attachment
- family harmony
- sense of belonging, sense of connectedness
- strong cultural identity and pride.

CAUSES OF PERINATAL MENTAL HEALTH DISORDER

The state of a person's wellbeing is affected by a complex interaction of internal and external factors and is sensitive to stressors mediated by a person's biology, neurochemistry, and psychosocial and environmental factors. Physiologically, alterations in cerebral serotonin and noradrenaline 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 (Buist, 2006).

Risk factors in maternal mental health

Dysfunctional personality styles of some women may become emphasised in the perinatal period as negative emotions and memories of past experiences may be brought to the surface. Memories and problematic behaviours arising from a history of neglect and abuse may be triggered, leading to further problems with mental health disturbance, substance use and, worse, to continuing transgenerational patterns of abuse and neglect of children (Buist, 1998).

Predisposing psychosocial risk factors shown in research studies to be associated with an increased risk of perinatal depression are essential assessment considerations and include 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 (Buist 2006).

However, care needs to be taken to avoid misinterpreting risk factors, or symptoms as representing a depressed state, or a state of illness. Many women experience depressed mood shortly after birth with symptoms that are not severe and that spontaneously resolve within a few days or weeks in a supported environment (Najman et al., 2000). Negative thoughts can be a normal experience after childbirth and reassuring new mothers about this fact may reduce associated feelings of guilt.

Risk factors in paternal mental health

An increase in *couple* mental health illness throughout the first year after the birth of a child is noted, with rates of distress being at the highest point for both partners at one year (Matthey et al., 2000).

Predisposing risk factors for depression in paternal mental health include 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 (Goodman, 2004).

The more risk factors found in the assessment, the greater the chance that the mother, father and family require extra mental health support or intervention in the perinatal period.

CHALLENGES FACED IN THE UNIQUE PERINATAL LIFE STAGE

There are many challenges apparent in the perinatal period including role and stage of life adjustment, personal family and environmental factors, service appropriateness and availability to name a few. Two examples are briefly presented here.

Adolescent parents and perinatal mental health

Understanding the adolescent stage of life provides an opportunity to appreciate the potential for extra pressures and challenges faced by an adolescent mother and her partner and family. The energy and interest in new experiences and learning that adolescents enjoy usually ensures positive interactions with infants. However, if a support system is not readily available, or

parental or child ill health is a concern, or social opportunities for ‘time out’ or for ‘time to be an adolescent’ are scant, there are added stressors imposed on a young family which may impact on perinatal mental health.

The recent Aboriginal Perinatal Service Expansion Baseline Evaluation report from the Western Australian Perinatal Mental Health Unit provides examples of Aboriginal women’s reflections about challenges faced by adolescent mothers when confronted with the realities of motherhood:

‘Young mums isolated socially, missing out. Difficult to get out—leads to depression.’

‘Young mums frightened to seek help, worried about welfare and kids being taken away. Stigma is a big problem.’

‘Mums don’t know they’re depressed, they just know they feel awful.’

‘Many girls don’t recognise symptoms.’

‘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.’

‘Families support mum, try to understand, but may not know anything about depression.’

‘Practical support really needed...’ (Brooks, 2008, pp. 18–22)

Multidisciplinary services incorporating the knowledge and wisdom of Aboriginal Health Workers 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 (Hancock, 2007).

Barriers to service access must be understood in order to determine through collaborative processes ways to overcome them. *beyondblue* (2008) notes that understanding and overcoming barriers is the key to increasing early intervention, in association with routine screening.

DEFINING AND RECOGNISING PERINATAL DEPRESSION

In the first instance, other causes for symptoms that are similar to depression must be considered and ruled out. Anaemia, thyroid dysfunction, having experience of a recent bereavement, and sleep deprivation may present in the same way that depression presents. These may also coexist with depression (*beyondblue*, 2008).

Screening in the perinatal period

In the context of perinatal mental health, screening relates to the identification of anxiety and depressive illness through the use of a validated scale. The EPDS is the screening tool routinely used for predicting and detecting perinatal anxiety and depression and it assists in monitoring anxiety and depression in the perinatal period (Austin, 2003). It is used in conjunction with assessment strategies such as clinical observation, history-taking and physical assessment.

Assessment in the perinatal period

Different health service regions may have their own adapted or preferred tools, which may or may not be validated, in addition to standard assessment tools for determining psychological distress or depression. The Kessler Psychological Distress Scale (K10) is one example. The General Health Questionnaire, Personal Health Questionnaire and *Diagnostic and Statistical manual of mental disorders* (DSM IV) are other tools used in assessment, alongside screening tools such as the EPDS.

Working with the Edinburgh Postnatal Depression Scale

The EPDS was initially developed to screen for postnatal depression in women in the primary care setting. It is a self-report questionnaire and although it appears simple to use, training in administering and scoring the scale is essential, as is giving women (and men) appropriate feedback, understanding its limitations, knowing when referral is required, and having a well-identified referral and care pathway. The EPDS questionnaire is usually administered in the primary care setting by child and family health nurses, midwives and psychologists.

According to Buist et al. (2002), the positive predictive value of the EPDS for clinical depression has a score threshold greater than 12 (i.e. 13 or higher). Like all screening methods, the EPDS does not identify all women with depression and some women with high scores will not be clinically depressed. Identification of women experiencing postnatal distress (i.e. EPDS > 10) may be useful as many may require practical assistance.

It is important that clarification of the EPDS as a screening tool that aids more extensive diagnostic testing for depression (if required) is given to those undertaking the EPDS. Diagnoses of depression should only be made based on a more rigorous psychiatric interview and never based on the EPDS or other such preliminary screening instruments alone (Buist, 2006). Murray et al. (2003) note that some psychologically vulnerable women (and men) who are at particular risk in the perinatal period may self-exclude from the health care system, and therefore miss opportunities for perinatal mental health screening, because of barriers to access, such as inappropriate or unaffordable services and unacceptable care options.

Guidelines for using the EPDS are provided by health services but there are some important points to note: the scale is completed by the person themselves, unless there is limited English or difficulty with reading; the EPDS should always be completed, scored and discussed during a consultation in order to assess the level of immediate support and supervision needed; the EPDS does not provide a diagnosis of postnatal depression, as a screening tool, but can only predict the risk that the person may be experiencing depressive symptoms; notice should be taken of any inconsistencies between the score and any apparent signs or symptoms; high scores on questions 3, 4 and 5 of the EPDS may need further assessment for anxiety; many people with clinical depression experience co-morbid anxiety; anyone who scores 1, 2 or 3 on question 10 (thoughts of self-harm) requires immediate attention and referral (WA Perinatal Mental Health Unit, 2009).

Table 16.1: EPDS scoring outcomes guideline

Women	EPDS score requiring follow-up (probable minor depression)	EPDS score requiring referral to a health professional (probable major depression)	EPDS subscale for anxiety— items 3, 4 and 5 combined score
Antenatal and Postnatal	10 or greater ANY score on question 10 (suicidal thoughts)	13 or greater ANY score on question 10 (suicidal thoughts)	4 or more considered high range but 6 or more shows probable anxiety
Men			
Postnatal	6 or greater ANY score on question 10 (suicidal thoughts)	10 or greater ANY score on question 10 (suicidal thoughts)	4 or more

Source: Adapted from WA Perinatal Mental Health Unit, 2009; Matthey, 2008

Self-harm scoring (Item 10 on the EPDS questionnaire)

If there is any score (i.e. 1, 2 or 3) on the EPDS for self-harm, *consultation with someone more experienced in the mental health area is strongly recommended*. It is also recommended that a suicide risk assessment is explored (see Appendix 16.2). *A suicide risk assessment is not everlasting and therefore reassessment throughout the period of risk is essential*.

Variations to the standard EPDS

Currently, translation of the EPDS into traditional Aboriginal and Torres Strait Islander languages or into Aboriginal English is being explored in different Australian contexts. Different areas of Australia have begun to develop variations to the EPDS for Aboriginal and Torres Strait Islander women and have undertaken research studies to test the adaptations. For example, an adapted EPDS has been trialled in Townsville and Mt Isa with Aboriginal and Torres Strait Islander women and noted to be suitable for some Australian Indigenous women (Campbell et al., 2008). However, Milgrom et al. (2005) report that findings from the Victorian Antenatal Intervention Initiative indicate that Aboriginal and Torres Strait Islander 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.

Cautions

Yelland et al. (2009) caution that not all women (or men) will agree with the correlation of their EPDS score to the reality of their mental health status. Over- or underestimation may occur either because of the interpretation of the questions, or on purpose. As previously pointed out, the EPDS is a guide to be used in conjunction with the history, observation and self-report. As consent for screening is required, the right to decline administration of the formal EPDS is acknowledged.

CHILD ASSESSMENT

The physical, social and emotional wellbeing of children is fundamental to communities experiencing optimal health in the future. It is important to understand that extraordinary stress and perinatal depression places the parent–child relationship at risk because it compromises a child's growth and development.

Assessment of the child involves observation of the two-way interaction (parent to child, and child to parent), and regular assessment of the child's growth and development and behaviours. 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 includes feeding patterns, sleep and settling patterns, interaction and responsiveness, attainment of age-appropriate growth and development trajectory, and general health status. Negative responses to any assessment require review, and if concerns persist, referral to paediatric services.

Possible infant/child outcomes

Perinatal depression adversely affects the mother's physiological responses, creating the potential for impairment of parenting and coping mechanisms. Potential negative impacts on the infant include spontaneous preterm birth (Dayan et al., 2006); impaired mother–infant relationship and cognitive, emotional and behavioural development of the infant (Murray et al., 1999); infant crying and unsettledness (Wurmser et al., 2006); and infant diarrhoeal morbidity (Rahman et al., 2007).

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 (Oates, 1997).

The literature on outcomes in infant and child behaviours where there has been excessive maternal stress, anxiety and depression shows there may be increased infant irritability and poorer neurological scores at birth (Lou et al., 1994), while high maternal anxiety scores in the last trimester of pregnancy may lead to hyperactivity in the child at 4 years of age (O'Connor et al., 2002). Fathers have an important role to play in their child's development; for example, through more frequent physical play. Therefore depression in fathers may lead to more negative interaction, and less interaction with their children, which correlates to pro-social and peer interactional problems for the child later (Dave et al., 2008).

PATHWAYS AND APPROACHES TO PROMOTING PERINATAL MENTAL HEALTH WELLNESS

This section specifically focuses on programs, strategies and initiatives addressing perinatal mental health and reflects observations and conversations with Aboriginal and Torres Strait Islander women over many years of working in community settings as well as recommendations from the literature arising from women's stories of the experience of PND. 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 (Bond 2009).

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 wellbeing (Vicary & Westerman, 2004; Ypinazar et al., 2007). Programs such as 'Strong Women, Strong Babies, Strong Culture' incorporate traditional cultural approaches to parenting and lifestyle, and support pregnant women and their babies throughout the perinatal period.

In respecting the importance of culture and birthing practices, a suggestion for minimising the impact of disconnectedness when birth occurs away from homelands includes offering Aboriginal and Torres Strait Islander women the chance to take the placenta (or part thereof) home for burial, enabling the creation of physical and symbolic links between mother, baby and the homeland (Middleton, 2006).

Programs promoting wellness and wellbeing

The Department of Health and Ageing (1995) point out that any program dealing with trauma (past or present) is beneficial and communities should be encouraged to develop models based on their own cultural context. Workshops such as 'Recreating the Circle' and the model 'We-Al-Li' using the concept of Dadirri—'inner depth listening and quiet still awareness'—and programs such as Rosemary Wanganeen's seven phases of self-healing are suggestions.

The community will determine the appropriateness, timeliness and acceptability of any programs or program content. Examples include traditional healing practices such as bush medicine, traditional ceremonies, song and dance, prayer, and holistic social, emotional, spiritual, and cultural wellbeing practices that are inclusive of all community members—and exercise. Exercise can be an effective way to relieve some forms of depression and is often a neglected strategy for treatment (Blackdog Institute, 2008).

Working in partnerships

The 'Making Two Worlds Work Project' developed by Mungabareena Aboriginal Corporation and Women's Health Victoria provides an example of ways of working in community using stories and art to demonstrate communities and services working together through symbolic interaction.

Working with Aboriginal Health Workers and Aboriginal Mental Health Workers ensures that cultural advice is available. As well as health workers, many communities have Strong Women workers, who provide valuable understandings of cultural and contextual features of cases, as well as language interpretation.

Where perinatal depression has been diagnosed, partnership work will be undertaken with families, child and family health nurses working with the community, community health services, Aboriginal medical services, psychiatrists, and remote area mental health nurses. Community Health and Women's Health services, and local community centres provide community-based programs for women and families which focus on strengthening wellbeing and mental health wellness. Outcomes demonstrate greater understanding of factors impacting on families, and of cultural information exchange.

Antidepressant medication

Decisions about the use of antidepressants in the perinatal period, especially if the woman is breastfeeding, require particular consideration, with review and attention by qualified health personnel. Referral to a doctor is required if there is concern about mental health status in the perinatal period, or, as noted previously, if there is an EPDS reading greater than 12, or any score on question 10 of the EPDS.

Suitable medications and safety considerations in antidepressants prescribed by medical practitioners is an evolving field of research with new information constantly being presented. However, following appropriate referral and assessment in the management of major perinatal depression, and consideration of potential side effects to the mother and her infant (especially if breastfeeding), one of the following examples of medications may be decided upon after consultation with the patient, and family of the person affected:

- selective serotonin reuptake inhibitors (SSRIs) such as Prozac, Zoloft, Cipramil, and Luvox.
- tricyclic antidepressants such as prothiaden.

Signs of withdrawal symptoms must be watched for in the infant (irritability, increased startle reflex, altered sleep) and are potential negative effects of antidepressants when taken by a breastfeeding mother.

CONCLUSION

The emphasis of this chapter has been on promotion of wellbeing and mental health wellness in the perinatal period through prevention and management strategies and initiatives which are holistic in nature and encompass the special worldview of Aboriginal and Torres Strait Islander peoples. Where there is determination of the need for medical management of perinatal mental health illness (through appropriate screening and assessment), collaboration with Aboriginal Health Workers and Aboriginal Mental Health Workers who are recognised as experts in community-relevant knowledge will allow the healing journey for the person affected to be greatly assisted.

Little is known about the incidence and experience of perinatal depression in Aboriginal and Torres Strait Islander women and men, in the perinatal period in particular. Empirical evidence has been presented from the perspective of experienced health workers in metropolitan, rural and remote settings which supports 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 ability to be locally responsive to community needs in order to strengthen perinatal mental health wellness.

Those working in the area of perinatal mental health have a key role to play in promoting wellness, and in detecting and managing threats to a child's secure base.

Reflective exercises

- 1 In considering challenges facing psychiatry, Austin (2003) notes that there are four key clinical questions to guide practice for those working with families in the perinatal period.

Four key clinical questions:

- a. How does becoming a parent (the most challenging developmental phase of life for many people) impact on a new mother or father's mental health?
- b. How does mental illness affect a person's ability to parent adequately?
- c. How does parental mental illness influence parent–infant attachment and the growth and development of infants?
- d. Are we able to minimise negative mental health outcomes for both parents and infants through early detection and appropriate and acceptable intervention for those affected in the perinatal period?

You are invited to reflect on the content of this chapter and answer the questions presented from the perspective of your particular work and geographical context.

- 2 **EPDS practice**

You are invited to turn to Appendix 16.1 and explore the EPDS as a tool of assessment by completing the EPDS based on your own feelings during the *past seven* days. Answer honestly and, when ready, score the answers.

Consider:

- a. How did you feel about the invitation to complete the EPDS? If your response is negative, why did you feel that way?
- b. What factors in your life affected the way you completed the EPDS today?
- c. What was the total score? If greater than 10 it is recommended that you discuss your feelings with a health professional.

A focus of working as a mental health practitioner is providing self-care. If you marked any score on question 10, it is strongly recommended that you discuss this result with a health care provider.

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Appendix 16.1

BLACK DOG INSTITUTE



Self-testing for depression during pregnancy and the postnatal period

Fact Sheet

What this fact sheet covers:

- Self-test (Depression Scale)
- Scoring instructions and results
- Where to get more information.

This fact sheet provides a self-test that can guide you when thinking about any symptoms you may be experiencing.

Please note: While great care has been taken with the development of these self-assessment tools they are not designed to be a substitute for professional clinical advice. Users should always seek the advice of a qualified health care provider with questions regarding their health.

This self-test can also be completed online at: www.blackdoginstitute.org.au

If you want to talk to a health professional about any symptoms you are experiencing, contact your doctor (GP or obstetrician), your midwife, child and family health nurse, psychologist, counsellor, or psychiatrist.

DEPRESSION SCALE

(Also known as the Edinburgh Postnatal Depression Scale -EPDS)*

Instructions:

Please colour in one circle for each question that is the closest to how you have felt in the **PAST SEVEN DAYS**:

<p>1. I have been able to laugh and see the funny side of things:</p> <ul style="list-style-type: none"> <input type="radio"/> As much as I always could <input type="radio"/> Not quite as much now <input type="radio"/> Definitely not as much now <input type="radio"/> Not at all
<p>2. I have looked forward with enjoyment to things:</p> <ul style="list-style-type: none"> <input type="radio"/> As much as I ever did <input type="radio"/> Rather less than I used to <input type="radio"/> Definitely less than I used to <input type="radio"/> Hardly at all
<p>3. I have blamed myself unnecessarily when things went wrong:</p> <ul style="list-style-type: none"> <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, some of the time <input type="radio"/> Not very often <input type="radio"/> No, never
<p>4. I have been anxious or worried for no good reason:</p> <ul style="list-style-type: none"> <input type="radio"/> No, not at all <input type="radio"/> Hardly ever <input type="radio"/> Yes, sometimes <input type="radio"/> Yes, very often

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Page 1 of 5

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BLACK DOG INSTITUTE

Self-testing for depression during pregnancy and the postnatal period

Fact Sheet

5. I have felt scared or panicky for no very good reason:

- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

6. Things have been getting on top of me:

- Yes, most of the time I haven't been able to cope at all
- Yes, sometimes I haven't been coping as well as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping:

- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

8. I have felt sad or miserable:

- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

9. I have been so unhappy that I have been crying:

- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

10. The thought of harming myself has occurred to me:

- Yes, quite often
- Sometimes
- Hardly ever
- Never

NB: If you have had ANY thoughts of harming yourself, please tell your GP or midwife today.

* Cox, Holden & Sagovsky 1987

NB: Please turn over for scoring instructions and results.



BLACK DOG INSTITUTE

Self-testing for depression during pregnancy and the postnatal period

Fact Sheet

Scoring Instructions

To obtain your total score, add up the points for each circle you have filled in.

<p>1. I have been able to laugh and see the funny side of things:</p> <ul style="list-style-type: none"> <input type="radio"/> 0 As much as I always could <input type="radio"/> 1 Not quite as much now <input type="radio"/> 2 Definitely not as much now <input type="radio"/> 3 Not at all
<p>2. I have looked forward with enjoyment to things:</p> <ul style="list-style-type: none"> <input type="radio"/> 0 As much as I ever did <input type="radio"/> 1 Rather less than I used to <input type="radio"/> 2 Definitely less than I used to <input type="radio"/> 3 Hardly at all
<p>3. I have blamed myself unnecessarily when things went wrong:</p> <ul style="list-style-type: none"> <input type="radio"/> 3 Yes, most of the time <input type="radio"/> 2 Yes, some of the time <input type="radio"/> 1 Not very often <input type="radio"/> 0 No, never
<p>4. I have been anxious or worried for no good reason:</p> <ul style="list-style-type: none"> <input type="radio"/> 0 No, not at all <input type="radio"/> 1 Hardly ever <input type="radio"/> 2 Yes, sometimes <input type="radio"/> 3 Yes, very often
<p>5. I have felt scared or panicky for no very good reason:</p> <ul style="list-style-type: none"> <input type="radio"/> 3 Yes, quite a lot <input type="radio"/> 2 Yes, sometimes <input type="radio"/> 1 No, not much <input type="radio"/> 0 No, not at all
<p>6. Things have been getting on top of me:</p> <ul style="list-style-type: none"> <input type="radio"/> 3 Yes, most of the time I haven't been able to cope at all <input type="radio"/> 2 Yes, sometimes I haven't been coping as well as usual <input type="radio"/> 1 No, most of the time I have coped quite well <input type="radio"/> 0 No, I have been coping as well as ever
<p>7. I have been so unhappy that I have had difficulty sleeping:</p> <ul style="list-style-type: none"> <input type="radio"/> 3 Yes, most of the time <input type="radio"/> 2 Yes, sometimes <input type="radio"/> 1 Not very often <input type="radio"/> 0 No, not at all
<p>8. I have felt sad or miserable:</p> <ul style="list-style-type: none"> <input type="radio"/> 3 Yes, most of the time <input type="radio"/> 2 Yes, quite often <input type="radio"/> 1 Not very often <input type="radio"/> 0 No, not at all



Self-testing for depression during pregnancy and the postnatal period

Fact Sheet

9. I have been so unhappy that I have been crying:

- 3 Yes, most of the time
- 2 Yes, quite often
- 1 Only occasionally
- 0 No, never

10. The thought of harming myself has occurred to me:

- 3 Yes, quite often
- 2 Sometimes
- 1 Hardly ever
- 0 Never

NB: If you have had ANY thoughts of harming yourself, please tell your GP or midwife today.

Results

This information is offered as a guide only and not a substitute for seeking professional help. Please discuss your symptoms with your doctor, midwife or nurse if you have any concerns. Remember that the self-test scores apply to the **last seven days**. Use the guide below in relation to your most recent self-test.

Range of Scores

- 0 - 9** When scores are in this range, this may indicate the presence of some symptoms of distress that may be short-lived and are not likely to interfere with day-to-day ability to function at home or at work. However, if these symptoms persist for more than a week or two, you may wish to discuss this with your doctor, midwife or child and family health nurse.
- 10 - 12** Scores within this range indicate presence of symptoms of distress that may be discomforting. You can discuss these with a health professional if you are concerned. We suggest that you repeat the self-test in 1-2 weeks time. If the scores are still within this level, seek further advice.
- 13+** Scores above 13 require further evaluation by a health professional. You may be asked to repeat the self-test and if your score is still within this range, you may be advised to review your results, with the assistance of a mental health professional. Your doctor will be able to advise you about this, and about whether further treatment is needed.

Appendix 16.2: Current suicide risk evaluation

	Sample questions that might be used
Current mood state, or situation	How are you feeling at the moment? What is happening in your life that is causing you distress?
Frequency and intensity of suicidal thoughts	Have you had any thoughts of harming yourself? Of harming your baby? How often do these occur? How long do they last? What is usually happening just before you have these thoughts? Do you feel you can resist the thoughts?
Established plans to self-harm	Have you any plans at the moment to harm yourself? What have you thought about? Do you have the means available to harm yourself, e.g do you own, or have access to a gun? Are final arrangements being considered, e.g have you recently recorded a Will, or said a 'final' goodbye to friends or family?
Past history of suicide attempts	Have you harmed yourself in the past? Have you had thoughts of suicide in the past?
Thoughts, feelings and beliefs that stop the completion of a suicidal act	What stops you from harming yourself?
Openness to other solutions	Would you be willing to talk to someone about your problems? What other options do you see for yourself?
Supports	Who can you talk to about how you are feeling? Who is available to provide some practical assistance?
Substance use	Have you been drinking more alcohol, or taking more drugs lately? How much have you been drinking or using?
Coming events that may increase the suicidal risk	Is there anything coming up in the future that is going to be particularly difficult for you—such as anniversary dates, or family occasions—that will cause you extra stress?
Family history	Has anyone in your family been depressed or had mental health problems?

Part 4:

Working with Specific Groups: Models, Programs and Services



Part 4 presents examples of models and programs for practitioners working with different groups. The models are responses by individuals and groups of people to a perceived need. Some are based on people's personal experiences; others are based on existing models of healing that have been reinterpreted to meet the specific contexts and needs of Aboriginal and Torres Strait Islander people.

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 (Peeters, Ch. 20)



Ngarlu: A Cultural and Spiritual Strengthening Model

Joe Roe

EDITORS' INTRODUCTION

This chapter was written by the late Mr Joseph Roe and has been reproduced from Working with Indigenous Australians: A handbook for psychologists (Dudgeon et al., 2000) with kind permission from his family.

Mr Joseph Roe (Purungu by skin name), is a Karajarri/Yawru man. His people are also from the Broome and Bidyadanga area. He completed a Bachelor of Applied Science in Indigenous Community Health (Mental Health Counselling Specialisation) in 1996. Mr Roe worked in the area of Indigenous mental health for over 10 years including 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.

The Ngarlu model is a highly regarded culturally appropriate way of working with Aboriginal clients to deal with their emotional, spiritual and social problems. It has both practical application and policy impact. For instance, it underpins the current framework for the Western Australian Aboriginal drug and alcohol strategy.

The chapter provides an example of reclaiming cultural ways to meet people's emotional, spiritual, physical, and social needs. When one or more of these needs are not met, people's mental health deteriorates. Poor mental health can result from these wider psychological/social problems, which affects one's Ngarlu. The Ngarlu model may not be generalisable to all situations but the principles could be used to enable other groups to develop their own local healing processes.

NGARLU

Ngarlu is the Karajarri word for defining the place of the inner spirit. This place in our stomach is the centre of our 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. There is a similar term to Ngarlu in many language groups in Australia.

Contained within our Ngarlu are our *Bilyurr* and *Rai*. Bilyurr is our spirit from within, which is in oneness with the physical body. After death the Bilyurr goes on its journey to a special place. Rai is our spirit from the country. The father dreams or sees 'child spirit' that wandered away from the group dwelling place which is called Yadungal. He's now aware that

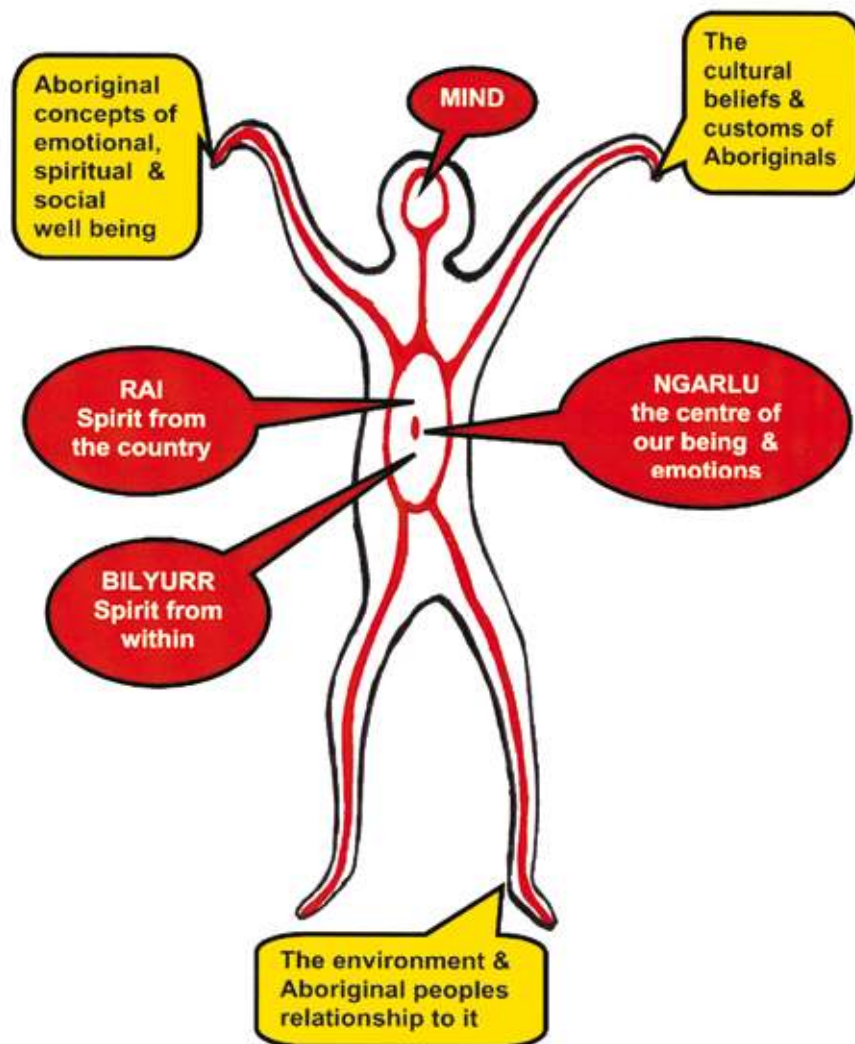
his wife is or will be pregnant and the child's spiritual connection in a form of an animal, fish, plant or a particular area in the land, that will coincide during pregnancy, will be his/her Rai. The physical and spiritual conceptual place of birth becomes the central part of the identity of that person and he also becomes a protector/custodian. When we pass away our Rai (spirit from the country) goes back to the country where it pre-existed and becomes a child spirit again and remains in the group at the Yadangal awaiting another spiritual rebirth.

WORKING WITH NGARLU

Ngarlu has been weakened by the colonisation process, which has led to things like changed lifestyles, dispossession, disempowerment, alcohol and drugs. Ngarlu was what kept people strong and healthy. Ngarlu gave a strong sense of self, where the spirit came from, 'if you feel no good here (pointing to the gut or stomach), then you feel sad or weak'. Ngarlu is more than an intuitive or gut feeling; an Aboriginal person can will himself or herself to die when the Ngarlu has been broken or weakened and is very sorrowful.

Some of the older ones know and understand this. They can connect with and work with it. For the young ones it is part of a cultural loss; they have to be taught it.

A traditional person may say 'not feel too good here', and point to the stomach, referring to Ngarlu. Often this may get misinterpreted as a bellyache when in fact it is indication of a spiritual or emotional problem.



©J.Roc, NWMHS, 2000.

Model 1: Ngarlu Assessment Model

We thought it important to base our workshop on healing—to strengthen the Ngarlu or lian that has been weakened through disempowerment, to make that strong again. This is what has kept the people strong.

This is put in a cultural context with young people. Worldwide, young people have lost their spiritual beliefs and they have nothing to hold onto. We point out to young people to be aware of your Ngarlu—why is it sad, question why you are feeling low, angry. We suppress a lot of feelings, and keep anger and shame down there. We have to get it out, because that has been the Aboriginal way. It is important to work on healing our Ngarlu. The effect of the Stolen Generations and our historical experiences is what has contributed to weakening our Ngarlu. To start to heal, it is important to start in our own Ngarlu, which will help us to deal with our bitterness, anger and sadness.

In Aboriginal culture before, if a person felt bad about another person, they would approach them, express their feelings and get it out, instead of suppressing it. They would clear their Ngarlu. This used to be their strong point when the culture was strong.

In Law time before, the boys would be taken for initiation. If one had a bad feeling for another person he would approach that person and talk to him, even if it meant having a fight. It was important to clear one's Ngarlu before going into that ceremony. Aboriginal people had ways of clearing. If Ngarlu was sore, one should not keep it for too long. White man's way is the other way—take it, tight lipped, keep it down. Our way is to get rid of it quick or it will kill you. It will kill your spirit.

We are trying to work towards this way of healing. Some communities are working with trying to strengthen these cultural ways.

Our approach is about keeping the spirit strong. If one is drinking too much, for example, the spirit falls away, dragging the person away from culture, and cultural responsibility to family, community and country. Other Aboriginal people are independently coming up with awareness of the need for this type of approach: 'Hey that's the thing I'm talkin' about, I'm not the only one talking about it. I can understand better now.' All different groups are coming from the same perspective.

If we deliver this program in a workshop, we focus on Ngarlu. For example, if we are working with Stolen Generations people, we also focus on Ngarlu—on hate, anger and shame.

WORKING WITH MEN: MENTAL HEALTH

My role with Northwest Mental Health Services is to work with men in their recovery from a major psychiatric illness. We are at the stage where we are just starting to implement rehabilitation programs to help instil some practical life skills and assist them in taking responsibility for their illness.

An underlying issue is that society no longer provides Aboriginal men a role to play in the wider community. I run one session for the Kimberley Offenders program for men in prison. This is intended to help them realise that drugs and alcohol are killing our culture; and to talk about taking responsibility, and strengthening our Ngarlu. The aim of the workshop is to ask: 'If your generation, that is you, are in gaol, who is going to talk to the young kids?'

It is hard to get them to look inside their problem. This is very hard even with people in general, but it is especially so with people in prison. They are often at the blaming stage and it is hard to get them to take responsibility. They tend to blame everyone around, but not themselves. They are angry; it is directed outwards.

We trace the process from colonisation, how the violence was internalised, and how it shows now in anger, rage, suicide or taking it out on others, particularly those close to you.

It is hard to get men to talk about their problems. Instead, Aboriginal men often blame their partners. They keep their feelings down rather than express them. They prefer to not talk about it; when it comes out they explode. When visited in prison by support agencies, they

usually don't want to talk about what they've done and how they feel, and when they are released, these feelings all explode out, often against their partners.

This program tries to get them to reflect, to look at themselves, and to accept part of the responsibility. With these types of programs facilitated by senior Aboriginal men, they can be appropriately challenged. Whereas when these types of programs are facilitated by female workers this can be considered culturally inappropriate because they tend to push their views aside, stating that it is not a woman's place to challenge their behaviour, especially if the men have been through traditional law. Part of the empowerment process in supporting men to take back responsibility for their behaviour requires men to facilitate that process. This could be seen as 'men's business' and utilising male Aboriginal workers to deliver these programs will enhance program outcomes.

When culture was strong, young uninitiated men never lived with girls as husband and wife; that wasn't Aboriginal culture. When a young fella turns adolescent, at 13–14 years old, he begins to go through Law. That is his learning time—his initiation—and he is taught about country. Then there is more Law. By the time they take their partners they are nearly 20 years old; that was the proper way. We see young people today doing the reverse, living together, having two to three kids. Often they can't cope any more, and there is domestic violence, substance abuse, and psychological/social problems that can lead to suicide.

Also, in the old times, the skin system controlled who married whom and directed responsibility that was collectively shared by the tribe. The skin system worked well. When there is a breakdown of the skin system, they can just go with anyone, and this causes more problems. In the program we go into regional skin systems, where each person fits, and the personal and collective responsibilities entailed in this.

One should not marry into one's mother's or father's skin group. This protected communities from the effects of genetic closeness. Today with the influence of modern society, especially with the influence of alcohol, people don't care, even to not observing protocols about not talking to one's mother-in-law.

In the proper way culturally, most girls were promised at 14–15 years old to older men. Controls were in place and younger men had to wait. In that time there might be fights for women. Young man supposed to take a wife may be made to wait while an old man may have three to four wives. That is when trouble can begin. He might start running around with others, fighting and so on. The social controls have broken down even in remote communities. In other communities, the Law may be strong, and some have held and been carried through.

CULTURE AND COMMUNITY: DIVERSITY

Mental health workers have to be sensitive to the diversity within the Aboriginal culture and to the people they are working with. Some communities have just about completely lost their culture in the sense of traditional values and practices. It is in those communities one finds more problems, for example family violence, substance abuse, elder abuse and child abuse. In those communities the people are so disempowered and feel so hopeless that they just don't seem to care anymore. In other communities there won't be so much of these problems because their culture is a little stronger.

It is important that even the professionals have to be aware of the sort of community they are dealing with. Because of different impacts of colonisation and the influence of imposed religions, which disregard culture, it appears that where there tends to be the greatest culture loss, there is the highest level of other serious problems. With others, where the language and culture has found some way of being maintained, the situation tends to not be so difficult.

All sorts of psychosocial problems are very complex. Mental illness, suicide, alcohol and drug abuse and sexual abuse are the end results from the ongoing effects of the colonisation process.

TRADITIONAL HEALERS

Sometimes traditional healers can play a significant and at times even a main role in working with patients with mental illness. When this is so, people will generally request it. It can be important to know who is requesting it. Sometimes if it is somebody who has very little actual knowledge of their own culture—someone that lost their culture—it can be a sign that this person may be quite mentally ill. However, within that they may be saying something quite significant that is important for a deeper understanding of their mental and emotional state. In comparison, for the very traditional person from very traditional communities, it's a living part of their belief.

Whether the person comes from an urbanised background is not necessarily an indicator, as sometimes urban Aboriginal people can have strong cultural beliefs. To understand properly we need to take more notice of the cultural background of that client. We need to involve the family so we can work it out together. Practitioners need to be aware of the diversity of Aboriginal people and this needs to be included in the assessment. Acknowledging that some people may ask for a traditional healer needs to be included in the initial treatment process.

What is appropriate for practitioners to do in this situation is not to feel that the Western way is the only way, but to try to work along with this other cultural alternative as well, to work together. Practitioners should contact someone appropriate in the community about it, to seek advice about where they should go from there. Have a talk about it, try to find out and get a bigger picture to work on; the mental state examination can be very narrow, sometimes through not understanding the cultural ways and not including the spiritual concepts of health.

It's best to consult with the team you are working with, including your or the service's cultural reference group. Rather than make an individual decision, discuss it as part of case management. If necessary, an appropriate cultural person will maybe arrange for a mabarn man [traditional healer] to have a look at the patient. Sometimes this is a request from the family who may look for other cultural alternatives before they are satisfied that the person is really mentally ill.

Consulting a mabarn can be an aid to confirming diagnosis, especially in determining whether it is a traditional matter or not. They can be a useful part of the process.

More traditional people have a world-view of Aboriginal things happening to them, but today in this contemporary way, young Aboriginal kids are not knowing this culture. With them it could be a non-cultural issue such as alcohol and drug-related psychosis. Since the 1970s, '80s and '90s there has been more involvement with alcohol and drugs and we are getting more young people with mental illness. There are other things, but drugs are there as well. Without these drugs before, there was not this level of mental illness; maybe excessive drug use has tipped them off the other side. However, additionally a lot of other things may also be happening, like family violence and child abuse.

It is very rarely that we use a mabarn, but we do so if it is to satisfy a client or the client's family. Use them first or in partnership with a psychiatrist and medication. I don't think medication alone is appropriate without considering both the possibility of cultural matters and also that a traumatic thing might have happened to that person. Many traumatic things have happened to Aboriginal people.

Some mabarn men are born with this healing power. There are two ways, healing doesn't always have to be by a mabarn man. An Elder Law man [*Purrku*] who has gained advance traditional knowledge can use his Law powers to heal people as well. People have to be careful of that as well, to heal in some ways one doesn't have to be a mabarn man, and it's important not to call this other one mabarn. Either the Aboriginal mental health worker or the family will organise these matters, not the practitioner. An appropriate Indigenous person will manage it.

The NWMHS team includes a range of mental health professionals, psychiatrists, community mental health nurses, social workers, psychologists, Aboriginal emotional/social/spiritual wellbeing workers and community drug service workers.

COUNSELLING AND NGARLU

Pinikarra Counselling Service was started here because there was only the Aboriginal Visitors Scheme, which was only for people in prison and the lockup. Yet these were the same people who were attempting suicide and getting into distress on the outside as well. We don't get too many men coming to these services, because to them they are not the ones who have psychosocial problems such as domestic violence, drugs and alcohol. To them it doesn't matter. If it does, they don't know where to start.

Looking at the drug and alcohol problem, they need to find out what is causing them to be in that state all the time. They need to find out whether there is something they don't want to remember, or whether they have given up so that alcohol and drug use is a way of escaping these sorts of problems. We find it very hard to get men to come voluntarily to us. But if it is done as part of a court order, then we can talk to them. It takes quite a while and a lot of education to develop their insight and confidence in expressing what is bothering them, why they are angry, and why they are abusing substances.

The Ngarlu approach is to try to look for the source of it. With all this build-up of problems where are you going to start? There is denial of problems, blaming others and everything else, not looking at themselves. It is very hard for men to say: 'I've got an anger problem', or, 'it's my fault', because there is such a history in their lives and in the lives of those before, of terrible treatment and accumulated oppression and trauma.

Through the generations this has been passed down; the message that you're no good, that you are useless/hopeless, and so they give up. The people we are dealing with don't feel good about themselves.

If we have a look at youth suicide, we have to look at the group that is vulnerable—alienated, kicked out of school, and put in a corner feeling they're no good. They start to form into the ones going down that track. Certain kids are just pushed aside, expelled from school for a while. There is no place for them where someone can take a hold of them and try something. Maybe a different sort of education—the fundamentals of life—at least so they feel good about themselves, instead of feeling 'What's the use, I'm going to be put in a corner'.

This leads to a sense of hopelessness, lack of confidence and self-esteem that is also handed down from parent to child. Many young people, especially young Aboriginal males, have turned to alcohol and drugs as a means to create a new form of male identity, one that is thrill-seeking, violent and different to the authority of senior Aboriginal men and white society alike.

TRAINING

Wendy Casey from the Kimberley Drug Service and myself facilitate Cross Cultural Training (Ways of Working Together) for the non-Aboriginal professionals. They find it very hard to see how it will work. First it starts with acknowledging things that have happened to us. For non-Aboriginal people to acknowledge the things that happened to Aboriginal people, for example, when we talk about internalised oppression, they find it difficult to see that as important, instead of just thinking: 'How can I work to empower these young people?'

Finally during the training, the professionals participating might develop good action plans but when they get back to their departments it is hard to implement them. An example was 'sorry day'. The strong reaction of one group was: 'Why should we say sorry?' If you really interpret what sorry means in Aboriginal terms, it can be a grieving; not actually telling people you're sorry about it, but rather sorry time like grieving time. But the media and people in politics misinterpret and distort it and throw out of context of what sorry day is supposed to be. It is really acknowledging what happened. That is part of reconciliation. Sharing the grief means acknowledging the truth and injustice, and then seeking forgiveness. It's not sufficient to just say 'I'm sorry' without acknowledging and working with the other three aspects. We have worked through this for various non-Aboriginal professionals. It means not only bringing back the past even though some find it

very uneasy (because for some it is as if it never happened). It is not about blaming anybody; it is just asking to let us have a look at it together and seek some shared understanding and compassion.

Successful counselling and community development needs to include empowering Aboriginals to bring back their systems of care control and responsibility that once existed. We had it before when Aboriginal society was complete. We are in a state where we are picking these things up, trying to look for the best of both before and now.

RECONCILIATION

Some communities don't feel good about themselves so they are projecting it out on others. For instance, with the land rights/native title situation, people are fighting one another. It is another form of internalised oppression. People are considering more what is in it for them and their family rather than what is there for all of us. It is not caring for others any more. Others who haven't been brought up with that traditional background and with their education may try to stand over the very traditional people as though they themselves are the traditional owners now. There has been a large cultural mix over the generations among Aboriginal people, and a high degree of removal from connections with traditional land, practices and peoples. Many claimed citizenship as non-Aboriginal or identified as being of another culture, but now there is considerable reclaiming of Aboriginal identity, and issues of traditional ownership are raised in this context.

These are some of the realities complicating Aboriginal life and affecting our feelings towards one another and our capacity and willingness to work together. We have to sort out the effects of this ourselves, besides the reconciliation between black and white; it is between black and black as well. There is much infighting, based mostly on the dislocation and the other effects of our past and present treatment by the whites. Apart from reconciliation between black and white, we need to reconcile among ourselves. It is very hard for us to get that to work. For example, we are really all one and shouldn't call one another 'coconuts' (challenging the authenticity of identity) and things like that, but it is difficult when you grow up in it. Also, nepotism in Aboriginal organisations is another problem, a different example of black and black conflict.

For these reasons we run these programs for both our people and for non-Aboriginal people. We need to get our people to see these things as well. We can't just say it's an issue for non-Aboriginal people, because it is a problem for our people too. It is important for both, for reconciliation of black and black as well as black and white.

Internalised oppression is hindering the process of self-determination. It is creating difficulties working together for the self-determination of Aboriginal people as a whole, especially when some people and groups are worried only about themselves and position themselves against others. We should be sorting our own business out and getting together cooperative claims, but people are still divided. Perhaps a cultural centre would facilitate this, as in other regions, where everybody benefits.

When we work with communities, specifically when addressing the alcohol and drugs issue in that context, this type of approach has worked. Participants brainstorm their own ideas and can see what they are capable of. It develops as their action group; it is not we as the facilitators telling them. They explore what can they do to help their youth with drug and alcohol problems. They come out with great ideas and commitment to follow through, such as teaching them culture again, including taking them out and showing them where all the Dreamtime stories about the country relate to. Within that model we then have a look at what the 'contact' history has done. Each of our stories might be a little different but the whole idea is the same and they really understand that. When we present to remote community people, we do it in a way that begins with our skin name, who we are, our identity as an Aboriginal person, and they really open up then.

With the healing model they understand the concept of Ngarlu. They realise their Ngarlu has been weakened and that the task is to find ways to prevent this happening further; ways to protect

it and other positive ways to strengthen it. In this way the whole system is practical, meaningful and powerful. Priority is usually given to working with the family system, to strengthening the family: 'You don't leave your family behind, you help them.' They know about that.

EDITORS' POSTSCRIPT

The Ngarlu model is just one of many approaches worldwide that aims to strengthen and heal the spirit of indigenous peoples.¹ As Hunter (2004) has noted, successful approaches to the heightening of Indigenous wellbeing incorporate a holistic approach, and culturally appropriate therapies. The Ngarlu model is based on cultural beliefs and customs that have sustained Aboriginal and Torres Strait Islander people for centuries. Traditional concepts of emotional, spiritual, and social wellbeing are being rekindled to support social and emotional reconnection. The connectedness that exists in Aboriginal society—to family, kin, the natural world and the universe—is to be found in spirituality.

Reference

Hunter E. (2004). Communication and Indigenous health, *Australian Doctor*, 4 June, 35–42.

¹ See http://www.hosw.com/index.php?option=com_content&view=article&id=3&Itemid=4 for information about the *Healing Our Spirit Worldwide* movement

18



Principled Engagement: Gelganyem Youth and Community Well Being Program

Maria Morgan and Neil Drew

OVERVIEW

In this chapter we outline a model for engagement with remote Aboriginal communities in the East Kimberley. The model has been developed and implemented over the last four years as a partnership between Aboriginal communities and the University of Notre Dame Australia. The engagement model is based on authentic program ownership by the Aboriginal communities to reduce the incidence of youth suicide. The model is holistic, based on a multifaceted wellness framework that includes personal, group and collective wellness addressed directly and indirectly.

A COMMUNITY-OWNED RESPONSE

In the East Kimberley in recent years youth suicide has been endemic. In the small remote community of Oombulgurri there were five deaths of young people by suicide or misadventure between 2005 and 2006 among those prompting a Coroner's Inquiry, which was completed in 2008 (Coroners Act, Ref No: 13/08, 2008). In 2006, the Gelganyem Trust, which comprised the seven Traditional Owner groups of the region, established the Gelganyem Youth and Community Well Being Program as a partnership between the Trust, representing the Traditional Owner groups, and the University of Notre Dame Australia. The Program was designed as a wholly community-owned response to the apparent failure of more conventional interventions to stem the rising tide of youth suicide in the region. The Program receives no government funding and is a grassroots initiative by and for Aboriginal people to respond in a culturally appropriate and innovative manner to a complex and up to now unresolvable concern.

The Program brings together the young people of the community and the young people of the university to live and learn together for sustained periods. The conceptual framework positions the engagement processes as relationship-building based on procedural fairness and inclusion of Aboriginal people within the scope of justice of non-Indigenous mainstream Australian society. The processes of engagement seek opportunities for the development of critical consciousness among young Aboriginal people in pursuit of positive pathways to the future. The outcomes to date suggest that working in partnership with the community on their terms is having positive effects in building local capacity, providing a sense of hope and belief that people are listening and do care. These elements appear to be going some way to addressing some of the underlying issues outlined in the coronial inquiry into deaths of young people in the Kimberley in 2006.

Background to the Gelganyem Youth and Community Well Being Program

Since 2000, the University of Notre Dame has hosted American study abroad students on its Fremantle Campus. As part of their study abroad experience, they attend a cultural awareness program on the Dampier Peninsula north of Broome in Western Australia's North-West. The American students spend five days living and learning with the traditional owners, camping on traditional lands learning about culture, country and the lived experience of Aboriginal people. The trips are organised and hosted by the first author of this chapter and her husband Colin Morgan. To date, over 1000 American students have participated in the Program. In 2006 Colin and Maria reflected on the success of the Program but wondered, 'Where are the Australian students?'

This simple yet profound observation culminated in a series of meetings between the university and community leaders in the East Kimberley to explore ways that young non-Indigenous Australians could engage with Aboriginal people in meaningful ways. There was a belief that the Australian students needed to engage more fully with the complexity of Aboriginal issues in contemporary society. Community leaders identified the issue of youth suicide as a symptom of the more general malaise characterised by a lack of opportunity, of aspiration and of systemic failures to provide sustainable pathways of hope for young Aboriginal people in remote communities. The key issues are discussed in this book. They include the social determinants of Aboriginal and Torres Strait Islander mental health and wellbeing (Chapter 6), and the interplay of the complex reasons surrounding suicide (Chapter 7), substance misuse (Chapter 9) and depression and anxiety among Aboriginal young people (Chapter 8).

The community of Oombulgurri was identified as a place with particularly pressing needs. Oombulgurri, the former Forrest River Mission, is a remote Aboriginal community that mainly comprises members of the Stolen Generations. It is located on the traditional meeting grounds of the Dadaway, an hour and a half by boat from the far northern town of Wyndham. Oombulgurri is also near the site of the Forrest River massacres that occurred in the early part of last century. By some estimates over 50 people were killed in one horrific incident and their bodies burned by authorities in retaliation for the death of a pastoralist killed by an Aboriginal man defending his wife. The bones of those killed were recovered, blessed in the Forrest River Mission Church and interred on the escarpment overlooking the community. A cairn and a large steel cross mark the spot.

The population of Oombulgurri varies from as many as 300 to as few as 25 depending on the time of year and other family, social and cultural circumstances. There is a school, a medical clinic staffed by two nurses, and a police post. The easiest and quickest way in and out of the community is by air from Wyndham at a cost of \$260 per trip of some 15 minutes duration. The community store is supplied by air or by barge at prices that are high even by remote community standards, with the barge costs in excess of \$7000 per trip and air freight by light aircraft over \$1000 per delivery from Kununurra. The community is governed by an elected Community Council advised by a non-Indigenous Government Services Officer. There is almost no meaningful work in Oombulgurri for Aboriginal people and most of the adult population work on the Community Development Employment Program.

In late 2008, Oombulgurri was declared a 'dry' (alcohol-free) community, an outcome of the coroner's report into over 20 deaths of young people by suicide across the Kimberley—several of the suicides taking place by young people from Oombulgurri (Coroner Report, Ref No: 13/08, 2008). Before that time alcohol was freely available in the community and there were regular alcohol-fuelled violent incidents and allegations of child sexual abuse. To date there have been several arrests but no convictions for the alleged abuse.

Initial meetings between university staff and the Community Council in 2006 revealed widespread dissatisfaction with service providers, most without representatives living in the community and providing only fly-in fly-out services. There was also a strong belief that Oombulgurri had been 'forgotten', that 'no-one cares' and that 'they would rather we just went

away' (Meeting Notes). Community leaders identified a range of skill development needs, including suicide prevention, that had been only partially addressed. As one leader poignantly noted, thumping his clenched fist against his chest, 'How can I help my community when my own heart is full of pain?' For example, most spoke in very positive terms about suicide prevention training workshops by a noted Indigenous expert in the field that they had attended the previous year. Almost unanimously they praised the workshop itself, but just as unanimously condemned the lack of follow-up. 'We need to develop confidence. We need someone to walk alongside us as we develop confidence using the skills. The workshop was great but we haven't seen them since' (Meeting Notes).

The preliminary meetings ended with an invitation from the Community Council to the university staff to develop a youth and wellbeing program for students to live and learn alongside the people of Oombulgurri. The first group of students from Notre Dame visited Oombulgurri in July 2006. Since then the Program has expanded to include Wyndham and Warmun, with over 40 students participating in a range of community initiatives.

GELGANYEM YOUTH AND COMMUNITY WELL BEING PROGRAM: FOUNDATIONAL PRINCIPLES

A set of principles was negotiated with the Program's founders that honoured authentic partnership, community ownership and a commitment to practical reconciliation. The overarching goal was to bring the young students of the University of Notre Dame into a relationship with the young people of the community of Oombulgurri so that they can live and learn together in pursuit of positive outcomes. While the Program is a suicide prevention initiative, a decision was taken not to label it as such but rather to adopt a holistic approach to youth and community wellbeing that would, if successful, lead to significantly reduced risk of suicide among the community's young people. The wellness framework at the heart of the initiative is described in more detail below.

The non-negotiable foundations for the Program are:

- that it is wholly owned and directed by the community
- that it is based on unequivocal respect for the cultural and historical rights of the Indigenous people of the region
- that all materials including photography, film and text are wholly owned by the community and only used with permission
- that non-Aboriginal participants only undertake activities at the direction and under the guidance of the Community Council on behalf of the community.

Working in accordance with these foundational principles represents an explicit attempt on behalf of non-Indigenous participants to recognise their power and privilege of whiteness and to work in accordance with Australian Indigenous terms of reference. Both of these conceptual frameworks for understanding Indigenous mental health are discussed in Chapter 9. The articulation of these principles has both symbolic and practical value. Symbolically, it is an unequivocal acknowledgment that the process of colonisation has negatively affected Aboriginal people and robbed them of the capacity to authentically determine their lives. At a practical level it opens a pathway to learning and engagement that is authentically rooted in the Indigenous experience.

The guiding principles include:

- There is a commitment to long-term engagement with the community as an antidote to fly-in fly-out service provision.
- There is a commitment to authentic engagement rather than cultural tourism (student groups live and work in the community for two months of the year and maintain contact and program work in the intervening period).

- Focus on developing enduring and trusting relationships as a precursor to the establishment of sustainable community development programs.
- There is an undertaking for the Indigenous and non-Indigenous participants to ‘walk alongside’ one another in authentic and genuine partnership.
- All projects and activities are negotiated in the community. No external program initiatives are imported or parachuted into the community.
- The Program strives to become part of the ebb and flow of community life rather than providing one-shot interventions.
- People are selected from the university for their heart, spirit (or *Liyarn*) rather than any particular disciplinary background. This is on the basis that, if the right people are selected to participate, then whatever their disciplinary background it will be of value.
- The Program is multilayered, holistic, systemic and integrated. While the student groups establish authentic relationships based on mutual respect and learning, program staff work with community leaders to establish deeper roots in the training and provision of skills to the community leaders.

A commitment to shared and mutual learning

Another key element that is embodied by the foundation of this program is a commitment to shared and mutual learning. This is consistent with the seminal work of Paolo Freire (1972). Shared and mutual learning based on relinquishing (or at least confronting) the disabling impact of whiteness and working in accordance with Aboriginal terms of reference (that is, values, aspirations and ways of being and doing) opens a pathway to critical consciousness-raising. Carlson et al. (2006) elaborate this idea by exploring the stages of critical consciousness as a process of engagement. The principles articulated below exemplify a process that is explicitly designed to explore opportunities for growth through the awakening of critical consciousness. Young Aboriginal and non-Aboriginal people in conversation about the life-worlds of each are part of a long-term commitment to relationship-building that has had a profound capacity to reach a deeper level of understanding. One tangible expression of this is the book *Kids from Cliff Country* (2008), a photographic exploration of what it means to be a young Aboriginal person growing up in the East Kimberley. Young Aboriginal photographers worked alongside the students of the university to tell the story of their lives in images and text. Before the publication of the book a photographic exhibition was held in Wyndham attended by over 100 Aboriginal and non-Aboriginal people. The exhibition then travelled to Kununurra and several other communities in the East Kimberley. Processes like this seek practical reconciliation through emancipatory education and liberation (Burton & Kagan, 2005; Freire, 1972, 1994).

How the Program works

The Program is process-focused, not outcome-focused. There is a strong belief that if the project honours a process of principled engagement, the outcomes may not be entirely predictable but they will certainly be better than they would otherwise be. The Program is also based on the recognition that it is just one of a constellation of potentially positive approaches to suicide prevention.

Preparation

The Program is essentially quite simple. Students at the University of Notre Dame make a written application to participate in the Youth and Community Wellbeing Program. All applicants must provide an expression of interest and explain why they wish to travel to the East Kimberley. All applicants are interviewed to assess their suitability. The criteria are those identified by the community. Key to the selection process is an evaluation of the spirit or heart of the applicant. The indicators of heart and spirit are rooted in an assessment of insight into the Indigenous experience, whiteness and Indigenous terms of reference (Oxenham, 2000). All successful applicants enrol in a unit for academic credit (though if they prefer they may travel as university

volunteers but must still complete the preparatory classes). Topics covered in the unit include the history of colonisation, the history of East Kimberley Aboriginal communities, Aboriginal and Torres Strait Islander health inequalities, suicide in Aboriginal communities, principled practice in community engagement, micro-skills for culturally appropriate communication, and self-care. All classes are premised on a commitment to cultural competence, a concept that is explored in Chapter 9.

Entry to the community

Once the group arrives in the community they are greeted by the community council or other Indigenous representative groups and formally welcomed. The community orientation includes the protocols for conduct including photography and restrictions on movement (into culturally sensitive areas, for example). A further meeting with community leaders is held to plan the program of activities for the month. As mentioned earlier, all activities are negotiated with the community leaders and usually involve the visiting group matching themselves to the ebb and flow of community life. In recent years these activities have included:

- women's group activities
- men's group activities
- vacation care for the younger children
- the establishment of a cultural and historical centre
- outdoor activities—swimming, fishing, hunting
- family fun days
- photographing and scientific naming of bush plants and animals
- storytelling about the experience of being a young Aboriginal person in the Kimberley using still photography and film.

Participation in the 'everyday' is crucial to the success of the Program. The students provide much-needed capacity in a setting that is natural and well known to the children and young people of the community. Up to 15 students travel to two or three communities, adding 450 labour days to the community in the month that they are there (up to 900 days a year). This is a significant practical contribution and is the vehicle for relationship-building and shared learning.

These activities represent an opportunity for the local Aboriginal children and young people to share their knowledge and insight into being a young person in a remote community. Many of the young people have not learned the value of their knowledge and experience, and sharing with non-Indigenous people in a non-threatening setting where there is genuine interest in their ideas and lives builds their self-confidence and assurance.

While the engagement of young people is the most visible aspect of the Program, staff also engage with community leaders to develop the scaffolding for the future establishment of sustainable community support programs and structures. This is a longer-term goal and continues to gain momentum. Programs under development include:

- community capacity training in counselling and community support. The goal is to identify and support the natural helpers in the community to respond to needs as they arise
- development of a trauma response capability to assist the community to deal with the unrelenting cycle of grief and loss
- community capacity-building training (governance, administration)
- youth leadership and community service training.

These programs are being developed in consultation with community leaders and add capacity to existing initiatives identified as priorities or areas of interest within the community.

Leaving the community

At the conclusion of each trip a report is provided to the community leaders and plans for ongoing cooperation are developed. The report and future plans are an important component of the process as they guide the ongoing activities of the university staff in preparation for subsequent trips. They also serve to clarify the reciprocal arrangements. Community members often travel to Perth and are hosted or spend time with the university staff and students. The purpose proposed and actual benefits or outcomes of each trip are also formally reported to the Gelganyem Trust

Funding

This is a very low-cost, high-productivity program. The entire program to date has cost less than \$60,000 a year for the equivalent of over 900 labour days in crude quantitative terms or over 900 days of high-quality engagement between Indigenous and non-Indigenous young people in qualitative terms. To date the Program has been wholly funded by the Gelganyem Trust on a cost recovery basis. The university makes an in-kind contribution of staff and facilities. For the past two years students have made a voluntary \$500 contribution to program expenses. The university derives no income from the Program. External funding is being sought, and community leaders are adamant that any funding must be consistent with the foundations and principles of the Program. The Program must remain wholly community-owned, and the outcomes must be consistent with community aspirations rather than solely the expectations of the funding body (these often do not match).

Evaluation of the Program

At the request of Aboriginal community leaders the Program is not formally evaluated. Community leaders commented that they have been 'researched' in the past and they and their communities have received little or no benefit. This is consistent with the literature on the overburden of research in Aboriginal communities (Dunbar & Scrimgeour, 2006; Fredericks, 2008; Smith, 1999). Instead we have engaged in a process of reflective, community-based participatory evaluation as a potentially effective and empowering process to ensure Indigenous determination of their futures (Walker et al., 2003). As Haviland (2004) writes:

Participatory evaluation is a process through which people involved at various levels of a project engage in ongoing evaluation of the project and its effects. The focus of participatory evaluation is to actively engage those who the project is for in all aspects of the evaluation process—sharing control of planning, undertaking, analysing and applying learning from an evaluation process. (p. 1)

Participatory evaluation is a 'formal, reflective process [that communities can undertake] for their own development and empowerment' (Patton, 2002, p. 183). A continual cycle of reflection in action of the Program is undertaken during the trips in consultation with community leaders to ensure that we are working in ways that are consistent with the Program's goals and principles. Program reports to community and the Gelganyem Trust document the quantitative achievements (activities and participation) as well as presenting the less tangible qualitative outcomes such as the trust and relationship-building, self-reported pride and confidence that develops through photography and short film productions. In addition, we receive and document feedback from key stakeholders. For example, a police officer in Wyndham has provided written confirmation that they have observed a measurable drop in incidents involving young people while the university groups are in the community. The Gelganyem Trust also seeks, independently of the Program staff, reports from the host communities. Based on the written and verbal reports provided to the Trust, funding is approved for the following year.

In addition to the reflective, community-based participatory evaluation, the university students provide feedback on their experience. They are required to keep a reflective journal and on their return to Perth a debriefing and reflection session is held on the Program experience.

This includes a critique of the Program preparation, conduct and outcomes from their perspective. This information is used to refine the processes of engaging and preparing students to work in the community. Based on the feedback by the students, in 2009 the Youth and Community Well Being Program was awarded an Australian Teaching and Learning Council Citation for Excellence in Student Learning.

The Wellness Framework

The Gelganyem Youth and Community Well Being Program is consistent with the definition and holistic understandings of Aboriginal and Torres Strait health and mental health discussed throughout this book. The Youth and Community Well Being Program is based on a model of wellness initially developed by Prilleltensky and his colleagues in Canada (Nelson & Prilleltensky, 2005; Prilleltensky & Nelson, 2002). The model we have developed in partnership and extensive consultation with the Oombulgurri community is premised on the notion that wellness should be understood at the personal (individual), group (relational) and collective (societal) level. Generally, non-Aboriginal understandings of wellness tend to focus on the personal and group levels but have largely ignored the collective. In this respect Prilleltensky and Nelson's approach to wellness is highly appropriate and consistent with Aboriginal and Torres Strait Islander definitions and understandings of health and mental health. The key to collective wellness is social justice, a quality largely denied Aboriginal people since colonisation. Importantly, as noted throughout this book, many of the mental health issues confronting Indigenous people can be traced to the failure to enact social justice.

As discussed further in the next section, the Youth and Community Well Being Program is a genuine and explicit attempt to reposition Aboriginal people within the scope of justice of the wider Australian society. Excluding Aboriginal people from the scope of justice (also known as the 'moral envelope') has had profound, and arguably genocidal, consequences. Our wellness model is an expanded one that includes a holistic belief that our work must address the many complex determinants that impact directly and indirectly on issues such as suicide. Not only is suicide an issue of wellness (personal, relational and collective), it is also a consequence of failures both direct and indirect, as discussed in Chapters 3 and 7. The Program is designed as a long-term sustainable response to address personal, relational and collective wellness in direct and indirect ways (Table 18.1).

Table 18.1: The Gelganyem Wellness Model

	Personal	Relational	Collective
Direct (Micro-skills)	Counselling skills Outreach Empowerment programs	Community capacity- building Community skills audits Leadership development Interagency liaison Community participation and engagement	Governance training Prevention programs (such as suicide prevention) Training in Law and human rights Community education Social action
Indirect (Macro-skills)	Understanding and changing social and public policy Promoting social justice through procedural and distributive fairness Law and international rights.	Trust building in interagency relationships Building a sense of community Promoting democratic participation Community resilience- building	Advocacy training Spirituality and cultural reconnection

Note: Activities listed in each cell are indicative, not prescriptive or exhaustive (or mutually exclusive). They change and evolve as part of the iterative program processes.

Principled practice in pursuit of wellness

The philosophy underpinning the Gelganyem Wellness Model is the need to engage in principled practice. Principled practice is an approach to relationship-building with Aboriginal people that locates trust at the heart of any successful long-term engagement process. Given the history of colonisation and their contemporary circumstances of disadvantage, Aboriginal people on the whole do not trust, and are right not to trust, non-Indigenous service providers. There is ample evidence to suggest that non-Indigenous health and social service providers often do not or cannot provide services in a culturally appropriate and respectful manner. In the past policy-makers' and program providers' intentions, while notionally benevolent, have had profoundly negative consequences for Aboriginal people. As Chapters 2, 3 and 6 demonstrate, there is substantial evidence of the continuing effects of prejudice and racism in program and service delivery upon almost every social, health, economic and environmental indicator. As we have also seen from the Northern Territory Intervention, this is not an historical artefact. Indeed, commenting on the recent death of Mr Ward, who died from extreme heat exposure while being transported in custody in Western Australia in 2008, the coroner, Alistair Hope, said it was inconceivable that such a thing could happen in a society that calls itself civilised. Yet it did. And it continues to happen. So for any long-term success there must be mutual trust based on genuine/authentic and principled practice/engagement on the part of all practitioners working with Aboriginal and Torres strait people as individuals, family groups and communities.

Principled practice is based on the premise that enacting justice builds trust (Drew, 2005, 2006; Drew & Bishop, 2002). More particularly, enacting procedural fairness builds trust. Social justice is a complex idea that is often simplistically associated with the distribution of resources. Defining social justice is difficult. Our favourite definition of justice is that it is 'like a greased pig—it squeals loudly but is hard to catch' (unknown author cited in Tornblom, 1992). We favour the idea that social justice is not a universally understood or accepted idea, that it is a social construction, and that it means different things to different people in different circumstances (Drew & Bishop, 2002; Hodgetts et al., 2010). The analogy of the greased pig resonates with many Aboriginal people we have worked with as they strive for the elusive ideal of justice for themselves and their family. We also differentiate the philosophical notions of what justice ought to be from the social psychological understanding of the *lived experience* of justice (or more correctly in many cases) injustice.

If people receive less than they feel they are entitled to then they feel that the outcomes are unjust. However, the focus on the distribution of resources has been perhaps the greatest red herring in the pursuit of social justice for Indigenous people in Australia (and for that matter for Indigenous people in many jurisdictions throughout the world). A focus on distributive fairness has fuelled the rise of neo-racist rhetoric dressed up as 'equality and fairness for all'. The perception that Aboriginal people receive a disproportionately large share of resources relative to their number led directly to the ascendancy of Pauline Hanson, the Australia First and One Nation movements. And many Aboriginal people and organisations have also been seduced by the lure of distributive fairness. Our point here is to elaborate the idea of social justice beyond solely distributive fairness. We are not suggesting that distributive fairness is unimportant but that there are other deeper levels of justice that provide an important and often neglected facet of the Australian Indigenous experience.

In essence, the distribution of resources is not nearly as important as how (and to whom) those resources are distributed. This is the heart of principled practice. Principled practice argues that procedural fairness (the fairness of the way that resources are distributed) is much more important than the distribution itself. Perceptions of procedural fairness are associated with increased trust and confidence. In other words, if people feel that the distribution of resources is decided by a fair process then they are much more likely to perceive the allocation of resources as fair. Procedural fairness also speaks directly to how people develop a robust identity. If we feel that we have been treated in a procedurally fair manner we develop a strong sense of self and feel included in reigning social structures. Failure to be treated in a procedurally fair manner

leads to perceptions of exclusion, marginalisation and oppression. Procedural fairness tells us something of what the authorities think about us. Perhaps the most important and durable finding to emerge on procedural fairness is that perceptions of procedural fairness enhance trust and confidence in people and authoritative institutions (Tyler, 2000, 2006; Tyler & Degoey, 1995, Tyler & Lind, 1992). Trust and confidence also legitimises authoritative structures (Okimoto & Tyler, 2007; Sutton et al., 2008; Tyler, 2004; Wenzel, 2006). In a climate where trust in authoritative institutions is uniformly low, this is a crucial observation. It suggests that attending to procedural fairness is fundamentally important. Perceptions of procedural fairness tell us something about our position in the group, about our standing and status.

There are some pretty basic rules for deciding whether something is procedurally fair or not. While they may mean different things to different people they seem to be durable across time, circumstance and culture. They include:

Knowledge of procedures: In order to evaluate a procedure people must have knowledge of how procedures are enacted.

Accurate information: Procedures should be based on accurate information.

Recognition of people's rights and dignity: Procedures should recognise individual rights and dignity.

Ease and efficiency: Where possible procedures should be easy to understand and quick.

Consistency: Procedures should be consistent across people and groups and on different occasions.

Unbiased: Procedures should be seen to be unbiased.

Correctability: Procedures should have adequate provisions for correcting bad decisions.

Ethicality: Procedures should conform to acceptable standards of moral, ethical and legal behaviour.

Representativeness: Procedures should ensure that the voices of all relevant subgroups have the opportunity to be heard (Lind & Tyler, 1988; Tyler, 1989, 1994; Tyler & Lind, 1992).

It is clear that many of the processes for determining outcomes for Aboriginal people do not honour these basic principles for procedural fairness. But that is not all. There is another dimension of the Aboriginal experience of justice that they share with other disenfranchised, marginalised and oppressed groups throughout the world.

For many people, not only are they denied justice but they are seen not to be deserving of fair treatment. In Opatow's (1990, 1993, 1994, 2001, 2008) terms they are positioned by those in authority to be outside the *scope of justice*. If justice is denied, the consequences can be profound for those unjustly treated. When justice is not only denied but also not considered necessary the consequences can be unfathomable and unspeakably dire. Hitler's treatment of Jews, gypsies and those with disabilities during the Second World War is an almost unbelievable example of exclusion from the scope of justice. Placing these people outside the scope of justice enabled death camps and gas ovens to operate at capacity for several years until six million people had been exterminated. There are other extreme examples: Rwanda, the former Yugoslavia and so on. Some examples are very close to home. Australian Aboriginal people were classified with the flora and fauna until quite late last century.

People outside our scope of justice are seen to be undeserving. When we place them outside our scope of justice we legitimise our failure to treat them according to the same standards of justice we afford to those within our scope of justice. Overt violations of the standards of justice that apply to those within our scope of justice do not evoke the same levels of guilt, anger, or outrage when applied to those positioned outside the scope of justice. Those outside the scope of justice are perceived as 'nonentities, expendable, undeserving' (Opatow, 1993, p. 72). It turns out to be surprisingly easy to place people or groups outside the scope of justice. There are a number of delegitimising strategies that can be invoked. Most include the use of language and the media to create a public perception that enables people to be treated unfairly with apparent impunity.

The media construct and in turn are constructed by and in society. They both reflect and create social 'reality'. There is considerable evidence that the views we take of particular groups

are reflected and reinforced by the media. The media undeniably possess considerable power to influence and indeed create public opinion. Media accounts privilege some stories (or versions of stories) over others (Tuffin & Frewin, 2007). These accounts serve interested parties. The media have been used to promote social and political debates in ways that delegitimise some groups in society and consequently position them outside our scope of justice. Once delegitimised, they are easy prey for actions that serve to further marginalise and oppress.

For example, media stories about refugees marginalise them and position them as less deserving by dehumanising them (Esses et al., 2008). At the height of the 'boat people' crisis refugees were referred to in the press as 'queue jumpers', 'aliens' or 'illegals'. Such language served to place them outside the scope of justice of mainstream Australian society. Once that was achieved it was easy to gain widespread public acceptance for detaining them offshore, some for many years in an apparent violation of international law. In Australia, the delegitimation of refugees has served both the media (to sell papers) and the government interests (to shore up flawed ideologies and policy).

Aboriginal people have similarly been delegitimised in public debate. The Northern Territory Intervention is an example of a misrepresentation of the findings of the *Little Children are Sacred* report that was designed to delegitimise Aboriginal people and served as the catalyst for the 'invasion' of Northern Territory communities and the suspension of the Race Discrimination Act by the Howard government (Altman & Hinkson, 2007). This allowed the government authorities to engage in behaviour that would be considered reprehensible if perpetrated on any other sector of society. Media representations of Aboriginal people are generally negative, characterising them as shiftless, lazy, alcohol-sodden, undeserving beneficiaries of the Australian welfare system.

In Oombulgurri, there was a disgraceful and inaccurate media campaign to paint the community in this light. This blinkered all-or-nothing approach failed to acknowledge (indeed, explicitly ignored) the work of many dedicated and extraordinary people in the community. The Gelganyem Program was initiated, developed and implemented by Aboriginal leaders of the East Kimberley long before the media brought it to the attention of middle Australia. When approached by one of the authors of this chapter providing information about the positive community initiatives, a reporter stated unapologetically, 'That's not the story we are telling at the moment'. One male community leader resignedly commented after the media campaign had gathered momentum: 'It's hard enough to walk down the street as a blackfella...now people look at me as a blackfella who is abusing his children.'

Principled practice focuses on honouring and seeking procedural fairness in engagement with Indigenous people and communities and strives to enact processes that ensure that Aboriginal people are included in the scope of justice of Australian society. Principled practice is a reflective process that builds trust and confidence in the relationship. Honouring these principles demonstrates authentic mutual respect as an antidote to the experience of the community leader above and many more like him.

The Gelganyem Youth and Community Well Being Program: Key learnings

The Gelganyem Youth and Community Well Being Program exemplifies a process of engagement to prevent youth suicide that is based on a holistic conception of mental health and wellbeing, is culturally competent, and arises from clearly articulated whole-of-community processes to enact procedural fairness and moral inclusion of Aboriginal people. In essence, whatever we do does not matter nearly as much as how we do it.

Over the past few years we have made a commitment at all times to ensure that our practice:

- is guided by authentic ownership and commitment by Indigenous people
- respects and is accountable to Indigenous terms of reference

- is cognisant of and addresses the implicit power and privilege of whiteness in favour of Indigenous terms of reference
- strives to enhance wellness holistically at all levels: personal, relational and collective; directly and indirectly
- strives to, and is accountable for, the inclusion of Indigenous people in the scope of justice of the wider Australian society
- honours and is accountable to the principles of procedural fairness
- strives for long-term enduring, trusting and sustainable relationships
- provides opportunities for developing critical consciousness about the experience of Aboriginal people in Australia.

There have been no deaths by suicide in Oombulgurri since the Program began, but it would be unfounded and overconfident to claim that this is solely attributable to the Program. We view the Program as a grain of sand that will be added to other grains of sand until a tipping point is reached. We hope that as we strive for that crucial and sought-after tipping point for the future of Aboriginal Australia that the Gelganyem Youth and Community Well Being Program represents a model for principled engagement, which will have had a positive impact.

Reflective exercises

- 1 Draw up a matrix based on the Gelganyem Wellness Framework introduced in this chapter (Table 18.1). Try to fill in as many cells with examples from your workplace (or a service or agency you are familiar with). How many cells could you fill? Is your workplace (or service) concerned with direct or indirect service at the individual, group or collective levels? What are the implications of your analysis for understanding your agency in relation to holistic mental health service delivery? What opportunities exist for your workplace to expand its operation to be more holistic in its service delivery?
- 2 Think about your workplace (or agencies that you are familiar with that work with Indigenous people). Do the policies and practices for engaging with Indigenous people embody the principles of procedural fairness? If not, how can you identify and challenge these policies and practices to enhance trust and confidence?
- 3 In your work, identify instances of the way that Indigenous people are delegitimised. How can you challenge these delegitimising strategies to enhance the likelihood of Indigenous people being included in the scope of justice?
- 4 The Northern Territory Intervention is an example of delegitimation that enabled among other things the quarantining of welfare and the suspension of the Race Discrimination Act. Can you think of other examples where delegitimation has led to behaviours and actions that would not be tolerated in non-Indigenous society?
- 5 Read your local newspaper for accounts of Indigenous issues. Examine the language being used. Is the story a positive or a negative one? Does the reporter use any delegitimising strategies to position the reader to think about the issues in a particular way?

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19

Dealing with Loss, Grief and Trauma: Seven Phases to Healing



Rosemary Wanganeen

The more extensive a man's knowledge of what has been done, the greater will be his power of knowing what to do. (Benjamin Disraeli)

We know we cannot live in the past but the past lives with us. (Charles Perkins)

OVERVIEW

This chapter describes the potential of a holistic loss and grief mode, Seven Phases to Healing, to heal anger, rage and violence and empower people who see and find themselves as victims. This model of self-healing and spiritual reconnection provides a basis for elements related to counselling processes. It is based on five years of personal life experiences and over 15 years in professional practice. The culmination was the development of a healing centre and a counselling model that focuses on assisting people to understand and take personal ownership of their healing journey. Drawing on this deeply personal experience, this chapter emphasises the importance of positive self-healing and each person's responsibility for this.

GRIEF AND LOSS AND THE LEGACY OF COLONIAL HISTORY

Research has shown that mental health problems and distress are prevalent among Aboriginal and Torres Strait Islander peoples. A study by McKendrick et al. (1992) reported that over 50% of 112 randomly selected Aboriginal participants could be described as having a mental disorder, with a further 16% reporting at least 10 non-specific psychiatric symptoms, including depression and substance abuse. Within the sample, 49% had been separated from both parents by the age of 14 and a further 19% 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 (1991) study, based on a sample of 530 Aboriginal people in South Australia, 31% had been separated from parents before age 14. The absence of a father and of traditional Aboriginal teachings was found to be significantly linked with attempted suicide and mental disorder. Hunter (1994) 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. 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.

Raphael and Swan (1998) 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. The extended family structures of Aboriginal peoples mean that individuals have more exposure to bereavements, trauma and loss than non-Indigenous peoples. It has been argued that these experiences are likely to lead to higher levels of mental health problems, in particular depression and symptoms of posttraumatic stress (Raphael & Swan, 1998). Recent work has focused on both intergenerational (Danieli, 1998), and chronic personal experiences of traumatisation that may cause anxiety disorders. 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 (Raphael & Swan, 1998). Given findings such as these, it is not surprising that Indigenous Australians experience high levels of mental illness. In this respect, Sansbury (1999) noted that 25% 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% more likely to commit suicide than non-Aboriginal males; and that more than 63% of Aboriginal people presenting to Aboriginal medical services have a significant level of distress, principally depression. However, for a long time I have observed that we've got medical centres all over the place. They can't be separated like that. The physical body will heal once we heal our spirit from all of our past pains, traumas and tragedies. We've got to look at the whole thing holistically.

Definitions and scope of grief and loss

What is loss?

- Loss has two categories: recognised or that which can be seen, and unrecognised or that which cannot be seen.
- Loss is experienced by all that is living: Mother Earth, human beings, animals and fauna and flora.
- Losses are a natural part of being a human learning how to grieve and evolve.

What is grief?

- There are two categories of grief: healthy and toxic.
- Whatever two categories of grief are being experienced at any given time generate live energy that appears to be invisible, but it becomes visible when it causes the physical body to pressurise at dangerously high levels. Grief generates dangerously high levels when left suppressed and unresolved for long periods. Imagine a pressure cooker not able to release the steam from its spout because there's a serious blockage—the laws of nature predict that the pressure cooker will explode. Similarly, the laws of nature will cause the physical body to pressurise because this live energy has now accumulated enough power to begin the process of dismantling healthy cells and thus cause disease. As the pressure cooker explodes, so does the physical body explode into disease; this becomes more of a reality if it is toxic grief.
- Healthy grief is when someone is consciously aware of honouring its process.
- Toxic grief evolves when it is suppressed in the long term. The person is unconscious and suppresses it.
- It is seen, felt and heard via storytelling across and down the generations (ancestral), eventually compounding and complicating contemporary descendants' grief.

The characteristics of loss and grief

- They are holistic and do not shame or blame but rather assist accountability and responsibility for self-healing.
- They are holistic and realign and/or solidify all seven humanities to the innate instincts.
- They do not discriminate.

- There's much more to it than death and dying.
- If addressed, they can support the recovery of mental illnesses.

The seven humanities: A human being has seven humanities: mental, emotional, physical, spiritual, sexual, cultural, social.

A MODEL OF HEALING

The Seven Phases to Healing model aims to heal toxic anger, rage and violence, and depression and suicidal thoughts, thereby leading to empowering people who see and find themselves as victims. The model was developed from my own experiences at a women's shelter when I was at my rock bottom, and the only way out was to heal, in the first instance, all my anger, rage and violence. I needed to find out where I came from to be so angry, so full of rage and at times, so violent! So yes, I was a victim but I was a perpetrator of family violence: I was mentally, emotionally and physically abusive to my children; alcohol only served to fuel my anger, rage and violence. I draw on my story to show the benefits of using grieving as a ladder to get out of this black hole. When I began, I had no name for all this stuff; but I know I could have ended up with some form of mental illness without my personal healing processes.

This holistic approach to loss and grief assists clients to deal with suppressed unresolved grief and has enormous potential to be the missing link to healing mental illnesses in the Aboriginal community. Just as healing oneself is all in the timing, it's all in the timing for finding new approaches to a new model of healing grief; it's important for Western civilisation and all its health systems to understand that mental illnesses are derivatives of intergenerational (ancestral) suppressed unresolved grief and that there are two forms of grief, healthy and toxic, as outlined above. Intergenerational suppressed unresolved grief has been compounded and complicated by the suppressed unresolved grief of our contemporaries, as was my experience. It seems to me this phenomenon occurs when children see, feel and hear their carers tell stories: it's all a part of being human to tell these stories with emotion.

It's been my observation growing up biculturally that mental illnesses have become extremely sensitive and deadly diseases, but I have also observed that they seem to be elusive diseases from the perspective of Western medicine. I believe I didn't end up with a mental illness because I found my innate human instincts. During the first few years, these instincts had me unconsciously seeing, feeling and hearing my ancestors communicate to me that everything was going to be all right. Over the five years from 1987 to 1992, I somehow came to know that I was going to be OK going through all this stuff; but this is not to say I didn't experience my highs and lows of anger, rage and violence. Similarly, I had highs and lows of sadness, depression and suicidal thoughts.

In 1992 while in the Pitjantjaratjara lands reconnecting with my ancestors, I designed what became Phase One. Phase One evolved so that eventually the Seven Phases to healing myself was conceived. But still I had no idea that I was going to use it to develop a specialised holistic approach to healing loss and grief. It wasn't until 1993 that I had a very broad design of what the Seven Phases to Healing would unpack.

In 1994, I completed a loss and grief course that enabled me to finally put a name to all 'this stuff' called loss and suppressed unresolved grief. My grieving processes saw me grow out of being a childish frightened victim to an empowered adult. Although the course opened my consciousness to seeing, feeling and hearing that there's 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 much more. By 1994, I had developed and described the seven phases to include:

- Phase One: Contemporary adult major grief reaction
- Phase Two: Identifying childhood and adolescent multiple losses and suppressed unresolved grief

- Phase Three: Ancestral losses and suppressed unresolved grief. Aboriginal and European physical experiences and emotional legacies
- Phase Four: Identifying ancient Aboriginal and European grieving ceremonies/ activities for physical expression
- Phase Five: Identifying ancient Aboriginal and European grieving ceremonies/ activities for spiritual expression
- Phase Six: Contemporary loss and grief healing centres for practical ceremonies/ activities—physical expression
- Phase Seven: Contemporary loss and grief healing centres for practical ceremonies/ activities—spiritual expression.

In order to validate the Seven Phases, I use my own personal experiences. I want to explain that it is a holistic system, and I do not want to depersonalise this approach as a system. While it is important that the process of healing grief is seen as an experience that is unique to the individual—real, uncomfortable and confronting, I believe that it is a powerful healing model with processes that can be used to address the intergenerational suppressed unresolved grief of other individuals, their families, their communities, a race, a nation.

The *Seven Phases to Healing Using Loss and Grief* figure below is an adapted version of the original model:

PARTS	PHASES
1) The Past	5 Traditional cultural grieving processes—spiritually based.
	4 Traditional cultural grieving processes—socially based.
	3 Ancestral losses and their unresolved grief begins: Invasions experienced by Indigenous European culture 388 BC; and by Aboriginal Australians through experiences of 1788 and since.
	2 Contemporary child/teenage losses: contemporary losses.
2) The Present	1 Contemporary adult major grief reaction experiences of major social and health problems.
3) The Future	6 Develop traditional/contemporary grieving programs—spiritually based.
	7 Develop traditional/contemporary grieving programs—socially based.
<p>Phases 1—3 are categorised as losses, which ultimately amount to grief-fear.</p> <p>CATEGORY 1 losses are recognised losses <i>that can be seen with the naked eye</i>—death/removal from family/abuse: mental, emotional, spiritual, physical, cultural and sexual/loss of traditional grieving process.</p> <p>CATEGORY 2 losses are categorised as losses <i>that cannot be seen with the naked eye</i>—sense of identities; mother, father, sister, brother, cultural, granddaughter, grandson/power/confidence/self-esteem/dreams/ hopes/intelligence/safety/self-respect/love.</p> <p>Phases 4—5 are categorised as powerful, structured culture which ultimately amounts to <i>innate instincts</i>. Innate instincts are what have maintained traditional culture.</p> <p>Phases 6—7 are categorised as <i>innate instincts</i> that can be reclaimed using loss and grief processes.</p>	

Phase One: Contemporary adult major grief reaction

Contemporary adult major grief reaction in adulthood, such as I experienced, would more than likely be called a nervous breakdown by the medical profession.

Such a major grief reaction occurred in 1987 in Sydney in a women's shelter—I was disfigured, bruised and battered yet again. I have no idea how I got here, how I came to be a part of three violent relationships and other mentally and emotionally abusive relationships. How is it that I have been both the victim and the perpetrator of domestic violence? Yes, I'm a wife, a mother, a woman, a colleague and yet on leaving the women's shelter I'm traumatised as I realise I don't know who the hell I am. I feel only half a person; it feels like my spirit had split from my physical body, giving me the sensation that I'm only half a person. I continue with depression and having suicidal thoughts. While I know intellectually that I am an Aboriginal person, emotionally and spiritually I do not *feel* a *Nunga* (a South Australian word for Aboriginal people); I didn't know then how different it is to feel my 'Nunganess' mentally, emotionally and spiritually compared to knowing intellectually that I was a Nunga. Holistically, I felt inept inside, then I realised that the lack of my Nunga identity had me experiencing my life with a lot of deep-seated shame. I had lost faith and trust in myself. In order to figure out how I ended up in this emotional whirlpool a 'voice' told me to go back into my past: this terrified the hell out of me. All my adult life I had been conditioned to stay away from the past, 'what's happened has happened, you can't change it so just move on', yet as I am sitting here at 3 a.m. with tears streaming down my face, I know that it is time to feel the fear of my past and do it anyway. The depth of my emotional whirlpool became what I now call my rock bottom: not knowing the names of my adult and childhood major loss experiences and unresolved grief emotions. I'm uncontrollably catapulted back into my childhood/adolescent years.

So, a question came from unpacking Phase One and it was this: 'How the hell did I end up like this?'

Summary of Phase One:

As a health practitioner/counsellor (or even other family member) it is useful to be aware that:

- The individual has to reach what they consider to be their rock bottom.
- When the timing is right and with the right support, they'll pose their own question: How the hell did I end up like this?
- With the right support, they need assistance to feel their childhood/teenage grief-fears when they revisit childhood/adolescent years to find their major loss experiences and suppressed unresolved grief emotions.

Phase Two: Contemporary child/teenage losses

To illustrate the various elements in this phase, I draw on my own life experiences and memories. This phase involves recognising major losses that can be seen and then unpacking these *Loss experiences* as outlined in Table 19.1, column 1; column 2 involves naming the *Forms of abuse*; the third column involves connecting with the *Innate emotions* that we are born with. Depending on the individual's life experiences within their family environment, their communities, their cultural background(s) and the nation they are raised in, these innate emotions have the potential to become affirmed incrementally—these are losses that cannot be seen. Correspondingly, depending on the individual's life experiences within their family environment, their communities, their cultural background(s) and the nation they are raised in, these innate emotions can be extinguished

incrementally and I call them *Emotional legacies* as outlined in column 4. Column 5 is the *Age in which loss experiences occurred in childhood/adolescence*.

Table 19.1: Loss of Innate Emotions model

Loss experiences (visible)	Form of abuse	Innate emotion (what I had)	Emotional legacies (not visible)	age
Teacher told me and classmates that I was a dummy. I felt her wrath.	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 2.5 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 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

As outlined above, these major loss experiences took place when I was from 7 to 16 years of age and they became my childhood/adolescent experiences. It is now my theory that these experiences do not constitute an inner child (in the singular) as is commonly referred to. By experiencing these multiple childhood experiences at these ages, they become collectively what I call multiple inner children. My multiple children had unresolved childhood grief and anger that grew into rage and violence as an adult. Growing up with all these eight inner children inside me, as outlined above, they developed personalities in their own right. They had their childlike major grief reactions when they sensed they could or would be exposed to experiencing degrees of emotional legacies throughout their adulthood; for example, love from someone who could inspire happiness by doing or saying something that inspired dreams and/or hopes for the future, like marriage/children/careers. Sometimes these childlike major grief reactions would be experienced as covert or overt tantrums as they went into a state of panic to rescue adult me from an adult intimate relationship. This would make sure that I, the adult Rosemary, didn't fall in love with a view to staying in love, or get too familiar or too loving or too happy with someone or something that I could get pleasure and happiness from.

From 18 to 38 years of age, these experiences constantly reminded me, the adult Rosemary, of what happened to all of us in our childhood/adolescent years; love and happiness leads to major recognised and unrecognised losses that cause us to go head first into a major grief reaction yet again. So when the timing was right, they would implement the sabotage pattern, on my behalf—I actually had no control over them. So, why risk experiencing love and happiness again? It's like putting your hand into a fire knowing you're risking getting severely burnt, blistered and scarred.

This would then have the adult Rosemary sabotaging/rejecting/detaching from someone or something sooner rather than later.

I refer to this phenomenon as the inner children's interpretation. It helps a child make sense of being violated holistically or in part; or of their whole family as they experience numerous major recognised and unrecognised losses and numerous grief emotions engulf them like a tsunami—there's no stopping the grief emotions from coming in.

For thousands of generations, Western civilisations suppressed grieving processes and so as each new generation became a part of the human race they were conditioned to suppress their grief in isolation. This was an intergenerational phenomenon for Western civilisation. So it makes sense for a child who has been and still is being raised in Western civilisation to continue this phenomenon in the 21st century. (This is not to shame or blame but it is imperative that we include First Inhabitants of any continent who experienced an invasion/colonisation by Western civilisation.)

These experiences collectively became inner children residing inside us; they are a collection of individual loss and grief reaction memories frozen in time. The intensity of a major grief reaction experienced by a child or adolescent will be determined by the following two things: What are the material object/s lost? and Which human being was lost? Furthermore, the intensity of the grief reaction can be measured according to how holistically attached a person is to the loss.

Here I was, 30 something, and I still did not know what really happened to me as a kid and not just what happened to me as an individual child. But what were the political explanations and what was the law that allowed me to be taken into the welfare?

Throughout this phase, my mental thought processes:

- Seemingly out of control (couldn't shut them up); always in a state of questioning significant memories or a contemporary behaviour possibly linked to childhood or adolescent or early adulthood.
- *What* happened? *Where* did it happen? *When* did it happen? *How* did it happen? *Why* did it happen?
- *Who* did it? Mental thoughts of suicide plan in my head.

My emotions:

- In and out of anger, rage, violence; in and out of sadness, depression; emotional suicidal thoughts (plan in my head).

Question:

Who the hell gave someone the right to take me away from my family?

Summary of Phase 2:

As a health practitioner/counsellor (or even other family member) we need to be aware that:

- To maintain holistic wellbeing, it's imperative we give ourselves and others permission to unpack our/their childhood loss experiences and find where grief was stifled and suppressed.
- Once someone understands what happened to them as a child, with many inner children, they can surrender them to who they are becoming as a mature adult.
- 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.

Phase Three: Invasions/colonisations

As a 12-year-old student in a class full of non-Aboriginal students, a history teacher told us that Aboriginal people were savages when Captain Cook arrived in Sydney! I recall her telling this story with such malice. What follows is the power of storytelling when it's heavily wrapped in emotional grief anger; for me I immediately felt the shame for my Ancestors and sorrow for them. Under my breath I whispered to myself: 'Oh no, shame job! How could my ancestors do that to those poor people?' I never forgot the way she said it and how I internalised my feelings of shame as it engulfed me in the classroom. This was the moment that I lost my innate emotion called 'pride' and replaced it with an emotional legacy call 'shame'.

So, for 20 years I unconsciously accumulated my childhood/adolescent and early adult emotional legacies. But they began magnifying in 1987 and reached their culmination in December 1991. It was as if something detonated emotionally inside my head and heart. The detonation blew up this stockpile of grief and fear that had been generated by the accumulation of all my emotional legacies and living a life under these emotional legacies that sometimes coerced me into living unhealthy lifestyles (mild to medium to extreme unhealthy lifestyles will be determined by what we have experienced in any given moment, day, month or year).

Phase Three focuses on understanding features of European history, where the origins of suppressed unresolved grief are deeply rooted and are the causes of major social and health issues in contemporary Aboriginal Australia.

Growing up biculturally in non-Aboriginal society, I have seen, felt and continue to hear that sadness over the other grief emotions is a weakness. It's been a long-term intergenerational practice not to show sadness, and of course this has implications for the physical body. When grief-sadness (as with any other grief emotion) is suppressed, it begins to build up, which leads to the manifestation of grief-depression; still suppressed, it manifests into suicidal thoughts and for many, if it's still suppressed, they succeed in committing suicide.

Ironically, sometimes when the individual's suppressed child's grief-anger is suppressed in adulthood, they may enter the workforce and take on senior positions with subordinates working under them. This has been Western culture for centuries; again it resembles a triangle where the superior is at the top and the subordinates line up below and feel so powerless because they have been raised from within a culture that observes grieving as a weakness. In my experience, they need to have superiors above them, or believe they have no alternative. The three concepts have been endured transgenerationally since people came to this continent with their bible clutched in one hand and a deadly weapon and diseases in the other. Once I really got my head around the truth of 1788, I found that there were three forms of warfare executed across Australia: outright warfare, disease warfare and psychological warfare.

With 20 years' experiences of unpacking and developing a holistic approach to a loss and grief model, I have come to the conclusion that a grief-stricken human being carries the unresolved grief of their ancestors; we then unconsciously weave the combined toxic grief into the fabric of our contemporary life experiences that they have endured as numerous major losses that are both recognised and unrecognised. What I found here is the following: a child is generally victimised by an adult perpetrator, but when that child's grief remains unresolved, it's just a matter of time before the child victim becomes a perpetrator in their own right.

This has potential for an adult perpetrator not being able to see, feel and hear when another human being is becoming a victim of theirs. The perpetrator is stuck in their grief emotions (more likely grief anger, rage and violence) holistically because the perpetrator is experiencing high levels of grief energy that is a contributing factor to a numbness of their own. Suppressed unresolved grief has the ability to generate revenge, manifesting into grief anger, rage and/or violence; human beings' grief-revenge can manifest in individuals, families, communities, a race of people, a nation.

It's been extremely interesting to observe how many non-Aboriginal Australians find it in their hearts to celebrate and acknowledge celebrations of Australia Day and Anzac Day without a serious and meaningful questioning and acknowledgment of the truth behind them. How do we as contemporary human beings gain knowledge about what happened to our ancient and/or contemporary ancestors and their culture? For thousands of years humanity has used storytelling (in Western culture, the written language, art, dance and songs, and the media).

Throughout this phase, my mental thought processes:

- Seemingly out of control (couldn't shut them up), always in a state of questioning significant memories or a contemporary behaviour possibly linked to adolescence or early adulthood.
 - Childhood (what the teacher/classmates told me)
 - Teacher who told lies about my Ancestors/history
- *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 anger and rage; in and out of sadness; depression.

Question:

Well, if my ancestors weren't savages, what sort of people were they?

Summary of Phase Three:

As a health practitioner /counsellor (or even other family member) you need to be aware that:

- Suppressed unresolved grief in victims of historical and contemporary recognised and unrecognised losses are more likely to convert their grief energy into grief behaviours associated with anger, rage and violence, thereby becoming perpetrators as individuals, as a family, as a community, as a race, as a nation.

- A perpetrator's suppressed unresolved grief has more than likely been learnt in childhood and therefore is more likely to pass it on to their children as learnt behaviours, hence becoming intergenerational.
- A perpetrator's suppressed unresolved grief is likely to be affirmed in the extended family, in the community, and through societal conditioning, as a race of people, as a nation, hence becoming intergenerational.
- Suppressed unresolved grief from ancient times gets passed across and down the generations into contemporary time.
- Many from Western civilisations in contemporary times still internalise and suppress their grief, guilt and anger on behalf of their ancestors, causing grief denial for what was inflicted upon the First Inhabitants. Many from Western civilisations in contemporary times have internalised and suppressed grief-guilt, and still do.
- Anger, rage and violence by non-Aboriginal ancestors cause grief denial for what was inflicted on Aboriginal ancestors whose ancestors were First Inhabitants, centuries ago.
- Denial of the truth about invasions around the world only serves to sustain grief-fears of an individual, a family, a community, a society, a race of people, a nation.
- A perpetrator can be an individual, a family, a community, a society, a race of people, a nation.
- Every human being as an individual, as a family, as a community, as a society, as a race of people, as a nation of people has a story to tell of severe, recognised and unrecognised losses; and their grief predominately remains suppressed and unresolved.
- It is crucial to teach history from a loss and grief perspective.
- Humanity has come a long way but still has some way to go.

Phases Four and Five: Traditional culture

I was fortunate to have a very spiritual experience to demonstrate that some 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 back to my teacher who, unbeknown to her, gave it to me. 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. It wasn't until I unpacked this part of my history and had such a powerful experience that I deeply reattached to my Nunga identity without any more shame or blame. Similarly, I attached to my ancestors with love, honour and respect. Correspondingly, my faith and trust in them was reclaimed and they are here with me and it has only solidified over the years. I have never experienced such a deep love, faith or trust for any human beings as I have towards them today.

Throughout researching this phase, I discovered many things about traditional culture and because I have never lived or studied traditional culture, my research is what I would describe as broadly abstract, other than what I experienced above. In December 1992, when I moved to Adelaide, the concept of setting up the Sacred Site Within Healing Centre was conceived.

During this phase, my mental thought processes:

- Became more responsive and not reactive when I thought about what my teacher/classmates told me. Thinking more about her experiences and the system she was raised in that enabled her to teach such lies about my ancestors and history.
- For the teacher: *What* happened to her? *Where* did it happen to her? *When* did it happen to her? *How* did it happen to her? *Why* did it happen to her? *Who* taught her?

My emotions:

- Fluctuated between sadness, understanding, low levels of anger and empathy and forgiveness for non-Aboriginal Australia and their history—they committed anger and violence from what had happened to them in ancient European times.

Summary of Phases Four and Five:

- It is critical to teach the next generations how to address and overcome major social and health issues using loss and grief as an individual, a family, a community, a race of people, a nation.
- It is crucial for humanity to use loss and grief to understand human civilisation—to know where we have come from, to know where we are going.
- I have the ability to forgive my ancestors for not fighting back to keep our culture.
- Our ancestors did not have the numbers, let alone resources, to keep our culture intact.
- Aboriginal Australians were spiritually evolved to the highest order.
- Contemporary Aboriginal Australians can reclaim the ability to become spiritually evolved again.
- Aboriginal Australians developed strategies that were structured to maintain relationships with each other, nature, Mother Earth.
- It is crucial for practitioners/services to support people who report hearing voices, or seeing and feeling things that aren't tangible or who have an association with the supernatural/spiritual, as this may be part of the process of self-healing.

Phase One—Full circle: The present

It is important to understand not just the psychological effects that are experienced by Aboriginal children and teenagers as they grow up in a society dominated by non-Aboriginal systems delivered predominantly by non-Aboriginal service providers. It's also imperative to understand that when an individual is or feels powerless in their emotional legacy and they are in a grief-stricken state they can make choices from that place of grief-fear. Grief-fear is a byproduct of intergenerational unresolved grief that has compounded and complicated contemporary unresolved grief, and individuals can be forced into, seduced and/or coerced into unhealthy lifestyles and grief behaviours as a consequence.

So here I am, having done the full circle. Over a five-year period, virtually single-handed, I committed myself to expressing my toxic grief-fears for my contemporary losses and that of my ancestors. I could not have done it any other way because throughout my grieving processes I lived in grief-fear of mainstream services because it was non-Aboriginal people who delivered those services, predominantly. My grief-fears were based on what I was experiencing was my fault; I was afraid I would experience racially motivated comments or behaviours within the services; I would be made to feel less; and these fears of what would happen I had already experienced, just as I have outlined. I lived in grief-fear most of my teenage and adult life.

After 22 years, this is what I believe I know about humanity: holistic loss and grief and mental illness. I say this from first-hand experience and not formal research to back up the following statements:

Humanity

- There is not a race of people who have not experienced some form of invasion and the invaders called it settlement and or colonisation.
- There is not a race of people who have healed as a contemporary race of people to break the cycle for future generations whereby major social and health issues don't exist.

Holistic approaches to loss and grief

- I have not totally reclaimed my grief-fears whereby I can see, feel and hear that I am totally safe in my own country. I need to believe that's yet to come. This fear is a derivative of Australian history that has been passed across and down the generations of both Aboriginal and non-Aboriginal families via storytelling. As a consequence of Australian history, my personal grief-fears came from living the psychological warfare.
- It's important to acknowledge that not all grief is toxic. When a person experiences healthy grief, they have become conscious that loss and grief are a natural part of a human being's life experiences, and they can do this because they have healed their toxic grief and they know the difference.
- It would be in the best interest of health services, providers and the patient/client to develop and implement a holistic approach to grieving programs that's accessible and that's culturally appropriate.
- Public, systemic and workplace racism has been and can be perpetrated by an individual, a family, a community, an institution, a race of people, a nation
- My informal research on racist beliefs, concepts, understandings and practices tells me that they come out of ancient European culture and have become intergenerational, suppressed, unresolved grief-fear of multiple losses; the individual, family, etc. become fearful of feeling any form of grief emotions and so take their grief-fear out on the minority. The word 'racist' or 'racism' may not have been used in ancient European cultures but the concepts and practices have found their way into contemporary Western society and are still being used by an individual, a family, a community, an institution, a race of people, a nation to keep minorities away from all forms of wealth of a nation. Keep in mind that genocide was a systemic practice across Australia.

Mental illness/es

I don't believe there is a disease that should be called mental illness. This name is maintaining the Western cultural beliefs, concepts, understandings and practices that have been passed across the generations and down the generations in the field of health/science since the time of the ancient Greeks. The human being was never meant to be dissected as it has been throughout Western civilisation. Table 19.2 shows how the Western system dissects an individual as they seek assistance when they are in poor health, when all that is wrong with them is that they are grieving.

Table 19.2: The Western dissection of an individual

Mental	Psychiatry: the study of medicine which deals with the diagnosis and treatment of mental disorders
Physical	Medicine: the study of diseases and ways of maintaining and restoring health
Emotion	Psychology: the branch of science which studies consciousness and behaviours
Sexual	Psychiatry, psychology, medicine

Spiritual	Theology: the study of divinity or religious doctrines, such as the characteristics of a god or gods in relation to man and the universe
Cultural	Anthropology: the study of origins and development of mankind
Social	Sociology: the study of social behaviours especially in relation to the development or changing of societies and social institutions.

- A mental illness by any other name is suppressed unresolved grief and can be processed using loss and grief as a holistic model because it has more potential to restore and realign the seven humanities of the whole person.
- Traditional Aboriginal culture had forms of psychology; for example, in the Kurna traditional culture the word used is *Tanka Manninendi*,¹ meaning 'to alter the mind for the better'. So we must ask: If Western civilisation across Europe had all forms of mental illnesses, severe to mild, throughout all classes of their society before, during and after 1788 and on arrival of the First Fleet, is there a record of mental illness as they knew of it recorded about traditional Aboriginal people?
- Today, there's enough evidence to show there was a difference between Eastern and Western Europeans' cultural beliefs, concepts, understandings and practices compared with Kurna traditional Aboriginal cultural beliefs, concepts, understandings and practices. Some people believe the East and West were culturally violent whereas Kurna was culturally in relationship with everything and everybody. It's my hypothesis that traditional Kurna people were able to maintain cultural relationships because they intellectually understood that grieving processes expressed toxic grief energy that secured their seven humanities to their innate human instincts.
- Using holistic intelligence to interpret and recognise experiences as cultural beliefs, concepts, understandings and practices enables people to work with the voices and visitations of the supernatural or extraordinary.

During Phase One, my mental thought processes:

- Are extremely responsive and very rarely do I react to any situation.
- I process any racially motivated behaviour as grief-fear of the person who is perpetrating it—not to shame or blame them but I see, feel and hear their grief-fears.
- I feel the fear and do what I have to do to achieve my dreams, hopes and expectations as a human being who happens to be a woman and an Aboriginal person.

My emotions:

- Fluctuate between low levels of anger, sadness, understanding, empathy and forgiveness for where Western civilisation has come from to become who they became.
- I choose not to experience substance abuse but rather to live a healthy lifestyle.
- I had no fear in creating my own future, using my life experiences to become a businesswoman; I had no fear of getting out of poverty (a mortgage).

Summary of Phase One:

- It is crucial to teach the next generations how to address and overcome major social and health issues using loss and grief to heal and restore one's humanity to an individual, a family, a community, a race of people, a nation.

¹ Bi-Cultural Awareness Training Manual, It Takes an Individual to Nurse a Nation Back to Health. Tanka Manninendi was given to me by Lewis O'Brien, a Kurna Elder.

- I use loss and grief to understand human civilisation better, to know where humanity has come from to know why we impose inhuman grief behaviours upon each other.
- There is no mental illness, just intergenerational suppressed unresolved grief that has compounded and complicated contemporary Aboriginal Australian societies.
- There is no mental illness, just intergenerational suppressed unresolved grief that has compounded and complicated contemporary non-Aboriginal Australian societies.
- For people there are four categories of loss: traditional culture, contemporary losses, recognised losses that can be seen, unrecognised losses that cannot be seen.
- Loss and grief impacts upon but heals relationships: individuals, families, communities, race, nations, humanity, Mother Earth.
- Loss and grief are toxic when left suppressed and unresolved; they generate dangerously high levels of live energy. Toxic grief is a pressure cooker over the heat with a blocked spout—it's dangerous and will explode. Toxic grief is experienced by an individual, a family, a community, a nation, a race of people, humanity. Families grieve as individuals. Men grieve differently from women. Women grieve differently from men. Children grieve differently from adults and from other children.²
- Ten common grief emotions: Anger—anger, rage to violence (male perpetrators); Shock—disbelief, denial, numbness; Panic—panic attacks; Apathy—lack of energy, submissive aggressive behaviour (female victims); Depression (mental illnesses); Guilt—“if only” stage; Physical illness (diseased body); Emotional release—need to cry; Hope and readjustment—forgiveness.
- *Victim to perpetrator/perpetrator to victim*: until healing is completely processed, a grief-stricken human being can oscillate between being a victim one day and a perpetrator the next—it's like observing two people doing a waltz with each other: they have a propensity to seek each other out because their inner children recognise the victim and/or perpetrator characteristics from experiencing their parents waltzing around with each other, in their childhood.
- *Reactive trigger*: this is an indicator that the grief emotions are still suppressed and unresolved in relation to a particular major loss; it triggers memories and the triggers can be ignited by sight, smell, taste, hearing, touch, feeling, dreams; by intergenerational addictive triggers (alcohol, gambling); and by compounded and complicated contemporary addictive triggers (alcohol, gambling, etc.). This form of trigger is a pathway to ascertaining what could be the multiple major loss/es, and where the grief is still suppressed and unresolved in relation to these loss/es.
- *Responsive trigger*: this is an indicator that the loss/es don't cause the reactive to ignite, which means the grief is resolving or resolved.
- *All in the timing*: healing as an individual, a family, a community, an institution, a race of people, and a nation - is all in the timing.
- *Distorts*: toxic grief distorts the past, the present and the future; healthy grief inspires one to use the past and the present to help humanity reconnect to each other and to nature.
- *Inner children's interpretation*: to make sense of major losses in a child's life they will give their experiences an interpretation.
- *Gender grief*: it's been my observation that males are conditioned to adopt grief-anger; women are conditioned to adopt grief-apathy. I believe this is why we statistically see males who perpetrate (grief-anger to rage to violence) family violence and females who take on the role of victim (grief-apathy) and develop submissive aggressive behaviours.
- *Discounting*: discount the self—‘I can't do it.’ Discount others—‘What would they know?’ Discount situations—‘Well, it happened 200 years ago’ or ‘They died 30 years ago’. Either way, ‘get over it’.

² Bereavement Educational Services Model from my course in 1994.

- *Forgiveness*: loss and grief must reclaim forgiveness! Forgiveness is available at the *end* of the grieving journey; it's not the immediate solution. To acquire and sustain lifelong health and wealth organically and holistically, forgiveness is always available—it's all in the timing. Forgiveness is for the self, others and nature; it is intergenerational and it is for contemporaries. It is a choice. Realigning the seven humanities enables forgiveness to reach its full potential:

Forgiveness is an important part of resolving grief and moving on in healing ... Many people get stuck in anger because of an unwillingness to forgive—to let go. Forgiveness is to cancel all demands, expectations and conditions ... if we continue to hang on to anger and not forgive, we tend to become bitter and we are the losers. We are the one that suffers, not the person we chose not to forgive. Quite often the person that we are angry at does not know of our anger or they are dead. Forgiveness does not excuse the behavior, does not negate the wrong; it is an acknowledgement of what has happened; a choice has been made. Forgiveness does not mean forgetting. (Bereavement Educational Services)

Phases Six and Seven: The future

Phases Six and Seven are about the future. During these phases, innate instincts are reclaimed using loss and grief processes/activities for an individual/family/community. During these phases, and where appropriate, we need to develop traditional and/or contemporary grieving activities/ceremonies. Herein lies the power to break the cycle of grief-fears and the grief behaviours that accompanies them.

Phase Six involves the development of traditional and contemporary grieving programs that are spiritually based. In this way you can make your connection to your spirit and to our spiritual ancestors. The Seven Phases to Healing is one such program.

Phase Seven involves the development of traditional and contemporary grieving programs that are socially based. During this phase, we express the built-up grief energy out of the physical body. The Seven Phases to Healing is one such program.

In broad terms, when an individual, a family, a community, a particular cultural group, a nation of people experience the Seven Phases they will invariably experience AIRRFI.

AIRRFI: Six steps to healing grief

AIRRFI is the acronym for Awareness, Identify, Reclaim, Reconcile, Forgive, Inspire. AIRRFI are the six steps that became an ongoing process for me.

Journeying throughout the Seven Phases, the suffering was horrendous. I don't recall experiencing AIRRFI at a conscious level. As I had little or no contact with counsellors or professionals, out of fear of being judged and criticised for getting myself into my situation, I identified some years ago that I experienced the AIRRFI process within these Seven Phases instinctively. I had endured my rock bottom and instinctively knew I was ready, willing and able to climb out of what I had become; I was submissive, aggressive, angry, full of rage, violent, and had thoughts of suicide.

Step 1—Awareness. This first step slowly opened my consciousness, enabling me to fully understand that 'there's nothing wrong with me, I'm "only" grieving'—it was an 'ah ah' moment. This first step explains what, where, when, how and why loss and grief became my missing link to understanding my major social and health problems.

Step 2—Identify. This stage cleared a pathway where I was able to identify and name what, where, when, how and why numerous recognised and unrecognised losses occurred for my ancestors. I was able to apply the same processes for me as one of their contemporary descendants. It was also the stage where I married together these same two categories of major losses with my trapped suppressed unresolved grief emotions.

Step 3—Reclaim. During this stage, I had to presuppose what my ancestors must have endured as a starting point to reclaiming, where possible, their recognised and unrecognised losses; I had to put myself through my contemporary grieving ceremonies/activities on their behalf. I was also compelled to apply comparable contemporary grieving ceremonies/activities on my own behalf throughout my adulthood as we were never able to grieve throughout my childhood/adolescent years. By and large, these steps eventually led to me reclaiming my innate human instincts from grief-fear.

Step 4—Reconciling. The first three steps were physically enduring and exhausting since my physical body had been accumulating dangerously high levels of grief energy. So, expressing the build-up of this dangerously high level of grief energy prepares my physical body to embrace my human spirit; they both readied themselves for a powerful spiritual and physical reconciliation. When my human spirit reconciled with my physical body, this primed me holistically as a human being to become spiritually evolved. Becoming spiritually evolved supported me to rise above the day-to-day surroundings of a grief-stricken physical world of human beings—here is where I found my holistic wellbeing, passion and life's purpose.

It is my belief, concept, understanding and experience that the actual reconciliation occurred when my seven humanities slowly realigned themselves with my innate human instincts, and it's this phenomenon that enabled me as a human being to begin the process of spiritually forgiving. Forgiveness belongs under the umbrella of loss and grief and sadly it has been misappropriated in other areas of society. Forgiving both categories of perpetrators for what happened to my ancestors when they experienced their major invasion led to subsequent losses for the following generations and their contemporaries in the 21st century. Forgiveness is not to forget what's happened or to excuse perpetrating toxic grief behaviours upon humanity, but I was acknowledging that I had hit my rock bottom and my suppressed unresolved grief became detrimental not just to myself but my family and the next generation.

Step 5—Forgive. Spiritually forgiving the European ancestors became necessary for those who were transported in 1788 to this continent; spiritual forgiveness had to be applied to my contemporary family and non-family perpetrators. When I was spiritually prepared to forgive the perpetrators of all forms of abusive and violent grief behaviours, I become responsible for breaking my cycle of perpetrating abuse in my lifetime, in my personal life. Using loss and grief as a health model, I optimistically hope that future generations in a workplace setting or in their personal life will be able to take responsibility for their social and emotional wellbeing by choosing not to impose their personal and/or professional grief-fears upon humanity.

Step 6—Inspiration. This step enabled me to find my wellbeing holistically. In my opinion, the individual who has achieved their true purpose is the person who will be able to keep all forms of unhealthy social and health problems at bay: mental illness, diseases, addictions, etc.

CONCLUSION

This chapter has proposed that it is important to recognise 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 and community wellbeing. It has drawn on the comprehensive programs and individual counselling models offered through the Australian Institute for Loss and Grief that explore the major losses and unresolved grief that have been passed down from generation to generation.

Grief is defined as a deep sorrow or suffering and a natural reaction to losing something or someone precious to us. This grief arises from individual as well as collective traumatic loss. To really heal, people need to reconnect with the sacred site that resides within the body, which many call the spirit. While this chapter recognises the shared history of invasion and colonisation experienced by Aboriginal people, it also stresses the

diversity of historical influences and geography and the need for programs to be developed in accordance with these diverse needs and circumstances. It proposes an alternative way of viewing and dealing with mental illnesses and the need for holistic loss and grief programs to be available for individuals, families, communities, as a race of people and as a nation to access without any fear or favour. As long as adults continue suppressing their grief emotions out of shame, blame and fear they will not know how to nurture children in any family or workplace loss and grief situation.

Reflective exercises

- 1 If childhood grief remains unresolved, all of us carry our suppressed unresolved grief into our teens and into our adulthood. It is important for our own healing to recognise our own suppressed unresolved grief in order to be empathetic and to be able to work effectively to assist others to heal their grief and trauma. This exercise is useful for all practitioners in developing cultural competence and critically reflecting on their own level of resilience.

Think about an instance where you have experienced a major loss and you're confident that the grief is still unresolved today. Consider whether these were associated with any form of loss pertaining to abuse and how you feel about this experience today. I've inserted one of my loss models as an example.

To apply this model to yourself, begin by identifying a time when you felt very confident in yourself or when you used to feel safe or trusting. Ask yourself why you tend to feel unsafe around a certain gender and/or situation now?

Innate emotion (what I had before the abuse)	Scale 1–10	Identify the experience where loss of innate emotion originated	Emotional legacies (not visible)	Scale 1–5
Safety	9	Sexually abused at 11 years of age	Unsafe	2
Trusting	8	Sexually abused at 11 years of age	Distrusting	
INNATE HUMAN INSTINCTS INTACT (Collectively)			GRIEF-FEAR (Collectively)	

- 2 As you complete this process, try to articulate the thought processes and emotions that you experienced in dealing with the situation at the time, and any questions it raised for you.
- 3 This chapter focuses on the importance of positive self healing. Reflect on Indigenous cultural aspects that may impact on self healing.

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The Marumali Program: An Aboriginal Model of Healing

Lorraine Peeters

Grappling with issues of identity is central to our healing... To us, the Stolen Generation is a social and emotional issue, not a mental health issue. In the first instance, we need access to services and counsellors trained to support us to heal and reconnect with ourselves, our families and communities, rather than psychiatrists or the mental health system. We are not saying we will never need mental health services, we are just saying our issues need to be seen as social and emotional issues first, and the bulk of our support should come from the social and emotional wellbeing sector. (Peeters, 2008, p. 298).

OVERVIEW

This chapter provides an example of a social and emotional wellbeing program, the Marumali Journey of Healing, which was developed *by* Aboriginal people, *for* Aboriginal people in response to an identified need. The program aims to ‘increase the quality of support available for survivors of removal policies.’ The Marumali Journey of Healing is grounded in Aboriginal knowledge systems and is truly holistic in its approach: historical, social, cultural and spiritual factors at an individual, family and community level are integrated throughout the healing journey. The diversity of Aboriginal ways of being is respected and a central concept is that clients must be in control their own healing journeys. The development and implementation of the Marumali Program followed correct consultation processes and protocols and has been endorsed as best practice in this field of work. 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 non-Indigenous mental health practitioners to work in partnership with Indigenous counsellors.

REMOVAL OF ABORIGINAL CHILDREN AND ITS IMPACT

There is one particular blight on the history of this country that has had devastating and far-reaching consequences for its Indigenous inhabitants: the deliberate and systematic removal of Aboriginal and Torres Strait Islander children from their families and their placement in church or state-run institutions, or with non-Indigenous families. It is generally accepted that between 1910 and 1970, when forcible removal was at its peak, most families lost at least one child.

The effects of removal were not confined to the children taken away. Each removal left a legacy of fear, loss and grief in its wake. All Aboriginal and Torres Strait Islander families

and communities were affected, and because of the deeply connected nature of Indigenous relationships, these effects have been transmitted from one generation to the next.

Evidence of the negative effects of removal policies and practices began to emerge through studies such as the Royal Commission into Aboriginal Deaths in Custody (1987), which found that out of the 99 deaths investigated, almost half (43) were people who were separated from their families as children. The *Ways Forward* report on Aboriginal and Torres Strait Islander mental health released in 1995 identified the need for specialised counselling to deal with the 'longstanding, past or profound, continuous and multiple traumatic experiences' associated with separation (Swan & Raphael, 1995, p. 49). A growing awareness of the extent and impact of removal of Aboriginal children led to a national Human Rights and Equal Opportunity Commission Inquiry conducted to 'trace the past laws, practices and policies which resulted in the separation of Aboriginal and Torres Strait Islander children from their families by compulsion, duress or undue influence, and the effects of those laws, practices and policies' (HREOC, 1997, p. 2).

Hundreds of people gave evidence of the profound and lasting physical and emotional problems that followed removal: anxiety, depression, suicide, violence, delinquency, alcohol and substance abuse. Most reported a pervasive sense of loss around identity, culture, family and community and, without a parental role model, many had trouble raising their own children. The wider Indigenous population reported high levels of anger, powerlessness, lack of purpose and a distrust of government, police and officials as a result of children being removed.

The inquiry resulted in the release of the *Bringing Them Home* report (1997) which brought about widespread recognition of the need to heal and reintegrate those individuals, families and communities affected by removal policies. The Marumali Program supports a number of the report's recommendations related to this need.

The *Bringing Them Home* report concluded that removal policies were in breach of the international prohibition on racial discrimination and amounted to a 'gross violation of human rights'. It made 54 recommendations to help repair the damage caused by the forcible removal of Aboriginal children from their families (HREOC, 1997). The report did not use the term 'Stolen Generations', preferring 'the forcible removal of indigenous children from their families'. Recommendations included the need for counselling to support those subject to forcible removal as well as Link-Up services to reunite Aboriginal people with their families.

The dedication of an annual National Sorry Day is a reminder to all Australians of the links between the political and social issues of reconciliation and self-determination and the mental health and social and emotional wellbeing of Aboriginal people. The Australian Government's Apology to the Stolen Generations on 13 February 2008 has potential therapeutic benefit as well as contributing to reconciliation.

The Marumali Program

Marumali is a Kamilaroi word meaning 'to heal' or 'put back together'. The aim of the Marumali Program is to increase the quality of support available for survivors of removal policies undertaking their healing journey. The Marumali model of healing is unique, original and unparalleled. While based on the healing of one individual, it offers an effective framework, structure and process which supports the healing of all survivors, 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 Circle of Healing model acknowledges that reconnecting with Aboriginal spirituality is a core healing tool to overcome the grief and loss experienced by Aboriginal people from past government removal practices (Peeters & Kelly, 1999). The Marumali Circle 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. 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. The Marumali Program was identified as an example of best practice in the *Bringing Them Home* report Evaluation (Wilczynski et al., 2007).

An overview of the development of the Marumali Program

Ten years ago, as an Aboriginal woman removed and institutionalised at age four, I developed a model of healing for survivors of the Stolen Generations. Frustrated by the lack of appropriate support to heal from my own experiences, I developed a model by documenting my own healing journey over the five years from 1994 to 1999.

This healing model was presented for the first time as an invited keynote address at the NSW Aboriginal Mental Health Conference held in Sydney in 1999. The support I received was strong and instantaneous. The conference audience requested that the model of healing and body of work be 'copyrighted, published and circulated within Aboriginal communities, Link-up organizations and Aboriginal Community Controlled Health Organisations, to enhance the healing process for Aboriginal people' (Peeters & Kelly, 1999, p. 139).

In response, I developed a five-day training workshop for Indigenous counsellors with my daughter, Shaan Gerrard, which was subsequently reviewed and endorsed by Professor Beverly Raphael (co-author of *Ways Forward*) as being safe, effective and ethical to use with Stolen Generations survivors (Letter of support, 2000). The program was piloted with funding from the Department of Health and Ageing. The Department of Health and Ageing contracted an external evaluator to assess the pilot workshop, which was delivered to experienced Link-Up workers. Further funding was dependent on achieving a positive evaluation. This was achieved and OATSIH supported the Marumali Program to train Indigenous counsellors employed in Aboriginal Community Controlled Health settings for a number of years.

Very few services were funded as an outcome of *Bringing Them Home*. Bringing Them Home counsellors, more Link-Up services and the training provided by the Marumali Program were some of the main strategies to be funded in response to this report. The Marumali Program harmonises with and underpins the work of Link-Up organisations and Bringing Them Home counsellors. The program has been endorsed by Link-Up organisations and the National Aboriginal Community Controlled Health Organisation (NACCHO) as an appropriate model to use with Stolen Generations survivors. More recently, the Marumali Program was identified as an example of 'best practice' in the Bringing Them Home evaluation conducted in 2007 (Wilczynski et al., 2007).

The Marumali Program is designed to equip counsellors with the skills they need to aid Aboriginal people who are suffering from grief and trauma as a result of separation. An important aspect of the training is to respect the rights of the survivors of the removal policies and to allow them to control the pace, direction and outcome of their own healing journey. The program provides a basis for identifying and understanding common symptoms of longstanding trauma 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. 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 the healing journey. Training provided under the Marumali Journey of Healing is designed to empower Aboriginal counsellors to take the lead in this area of work. All participants in the counsellor training are required to have had previous formal training or work experience as counsellors.

The workshops have trained more than 1000 Aboriginal workers and counsellors to assist their brothers and sisters to find their way home to themselves, their families and communities. The program has also been successfully implemented with groups of survivors and Indigenous people in corrections facilities. The overwhelming majority (93%) of

workshop evaluations have rated the Marumali training as ‘excellent’. Many have identified it as a ‘life-changing’ experience.

The strengths of the Marumali Program are:

- It was developed by an Aboriginal survivor for Aboriginal survivors.
- It is a healing program, rather than a ‘therapy’ or a ‘treatment’.
- It is culturally appropriate for those who were removed.
- It is culturally appropriate for the families and communities they were removed from.
- It respects the autonomy and strength of survivors.
- It offers a clear path forward for survivors, regardless of how they were removed or what has happened since.
- It allows survivors to set the pace, rate and direction of their healing journey.
- It is holistic, and includes the spiritual dimensions of healing.
- It addresses the transgenerational effects of removal.

HEALING AND RECOVERY FOR THE STOLEN GENERATIONS

The ‘Stolen Generations’ refers to the many thousands of Aboriginal children who were deliberately and systematically removed from their families using ‘laws, policies and practices which relied on compulsion, duress or undue influence otherwise known as “forcible removal”’ (HREOC, 1997, p. 5).

Removal took many forms and differed from region to region. It has had devastating consequences on all Aboriginal families and communities, not just the children who were removed. While those of us who were removed have had a chance to tell our stories, the families and communities we were removed from have not, and their pain has yet to be acknowledged.

It is worth noting that no studies have ever been done on the psychological effects of what happened to us, and a so-called ‘body of evidence’ still does not exist for mental health clinicians and others to draw on. Our trauma has been compounded by the widespread denial about what actually happened, and this has included mental health practitioners. 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 that left us feeling that our pain had no meaning and made no sense. The *Bringing Them Home* report noted the lack of culturally appropriate mental health services, and how this gave rise to ‘critical problems relating to misdiagnosis, consequent inappropriate treatment, or failure to treat altogether’ (HREOC, 1997, p. 321).

Out of necessity, we were forced 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. We are now a strong group of survivors, with clear views about what needs to happen to support other survivors to heal. We have learnt the hard way—by trial and error—and we ask that our views are heard and our knowledge respected. No other group has experienced what we did at the hands of governments and their agencies. For many reasons, we are a unique group with unique healing needs.

I have learned some things from facilitating over 100 five-day workshops throughout Australia for a number of years with more than 1000 Aboriginal workers from all walks of life, groups of survivors themselves, and inmates in jail. When questioned, all Aboriginal people already ‘know’ how removal would affect us as Aboriginal children, what our struggles would be when we were growing up, and some of the difficulties we would face when and if we tried to make our way home to ourselves, to our families, cultures and communities. If they can sit there, as Aboriginal people, and think, well if this happened to me, I would feel this way or that way, then it reassures me that the struggles we face as survivors are ‘normal human reactions’ to extremely damaging events. I always ask the same questions of a group

and I am amazed at how similar the responses have been for each of the 100 workshops. If our experiences have caused us to suffer from mental illnesses, why is it that other Aboriginal people are able to predict the ins and outs of what we will go through? This is an important point. A core belief of the Marumali Program is that when they embark on a healing journey removed people are experiencing normal human distress and suffering in response to what they went through, rather than showing symptoms of mental illnesses or disorders.

The Marumali concept of healing differs in this regard from other consumer-driven or Western models of recovery. Our journey of healing is one of recovering our culture and identity as Aboriginal people, not one of recovering from a mental illness. Healing involves mind, body, spirit, 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.

THE EFFECTS OF REMOVAL: DISCONNECTION

Although the means of removal may have varied (the main ones being institutions, fostering and adoption), 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 subject 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.

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 OK 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 acts.

The Marumali Program provides an overview of the healing journey and how it might unfold, identifies the core issues that need to be addressed at each stage, the risks associated with these issues and how to anticipate and manage the risks throughout the journey to ensure safe passage for the survivor.

The Marumali model is only a guide though, and each journey will be as different as the experiences of removal were. 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 journey may include learning about removal policies; making sense of the 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, spirit; reclaiming our spiritual heritage; working through issues of blame; retracing our steps; looking at what has been taken, left behind or unlearned; stripping away some of the mainstream values implanted by others, and replacing them with relearned Aboriginal values. Some may choose to reject their Aboriginality altogether, and that is OK 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.

No two healing journeys will be alike. 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. I cannot overstate the importance of recognising the removed person as the specialist of their own

healing, and the need to ensure that they are able to control what happens, and when, as well as what does not happen.

THE CRITICAL NEED FOR ABORIGINAL COUNSELLORS

The overview of the healing journey above should help to explain why we need Aboriginal counsellors as guides to our healing. The support and information we need is not taught in universities and cannot be obtained from non-Indigenous people, no matter how 'culturally competent' they are. It can be a barrier to our healing process if a non-Aboriginal counsellor dabbles in core issues for our recovery, such as our Aboriginal identity or reclaiming our 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 have become involved during our stage of crisis, they should look for removal in our history, and if they find this, they should aim to refer us as soon as possible to Aboriginal Bringing Them Home counsellors. If they are unable to refer us immediately, this should occur by the time we are ready to start reclaiming some of what we have lost (stage three of the Marumali journey). Link-Up workers are trained and highly skilled in cultural and spiritual matters and the delicate consultations required to reconnect us with our Aboriginal families and communities. For this reason, no journey should be embarked on without the involvement of Link-Up workers at key stages of the journey.

CONCLUSION

What happened to us as Aboriginal people was unprecedented. Our identity as Aboriginal people, our culture, our land, our mothers, families and communities, were forcibly and often brutally removed from us as little children. We were systematically punished for being ourselves, until we learned to act like non-Aboriginal people. Often the process of removal was designed to prevent us from ever finding our way home and also to prevent our families from being able to find us. Then, as a nation we went on to pretend that this never happened, right up until last year, when Prime Minister Rudd made the Apology to the Stolen Generations. The truth about what happened to us can no longer be denied.

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. As a result, when this happened we thought we were going mad. We have had to work out what was happening to us and how to deal with it ourselves. We feel we know what we are doing now and invite Aboriginal counsellors to learn from us, since we have much to share. We also invite non-Aboriginal mental health practitioners to work with us and to support us to do this healing work, but in a way that allows us to determine how much is done and in what way. We, the first generation removed, are elders now, and we ask that you listen quietly to us, to learn from what we have to say. We do not want to raise our voices or strain to get your attention. The silence has been broken now and we will talk if you will listen.

Reflective exercises

Throughout this text, students and mental health and wellbeing practitioners/counsellors are asked to reflect on their privilege, their whiteness, their discipline. Some of 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:

- 1 What if this had happened to you or your children?
- 2 How would you have felt then?

- 3 How would you feel now?
- 4 This chapter provides a particular perspective on the impact of Stolen Generations on Aboriginal and Torres Strait Islander Mental Health. Discuss these perspectives and your thoughts on this issue.

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21



Mental Health Programs and Services

Compiled by Gina Milgate

OVERVIEW

A number of organisations offer support to people who are dealing with issues that affect their social and emotional wellbeing.

This chapter lists mental health services and programs that provide specific assistance for Aboriginal and Torres Strait Islander people and the practitioners who work with them. There are different programs and services for different groups and types of mental health issues. The information has been supplied by the organisations or has been gleaned from their websites. The services listed in this chapter are not the only ones available but the chapter does provide a starting point for people looking for information or a place to go.

Please consult the websites of each organisation (provided below) to find more information about their programs and services, and links to other relevant sites.

1 *beyondblue: The National Depression Initiative*

Short description of core business

beyondblue is a national, independent, not-for-profit organisation working to address issues associated with depression, anxiety and related substance misuse disorders in Australia. The organisation is a bipartisan initiative of the Australian, state and territory governments and has a key goal of raising community awareness about depression and reducing stigma associated with the illness. *beyondblue* works in partnership with health services, schools, workplaces, universities, media and community organisations, as well as people living with depression, to bring together their expertise around depression.

beyondblue's five priorities are:

- 1 increasing community awareness of depression, anxiety and related substance misuse disorders and addressing associated stigma
- 2 providing people living with depression and their carers with information on the illness and effective treatment options and promoting their needs and experiences with policy-makers and healthcare service providers
- 3 developing depression prevention and early intervention programs
- 4 improving training and support on depression for GPs and other healthcare professionals
- 5 initiating and supporting depression-related research.

Programs and services relating to Indigenous mental health

Relevant programs and activities include:

- the NT Aboriginal Mental Health Worker Program ‘Working Both Ways’
- ‘Ngaripirriga’ajirri’, an early intervention for children and parents on the Tiwi Islands
- developing Aboriginal Mental Health First Aid Standards
- supporting action research into ‘Indigenous Men’s Sheds’
- working with Hip Hop performers to take mental health messages to young Indigenous people
- developing health professional training online with the Royal Australian and New Zealand College of Psychiatrists.

Other relevant information

beyondblue has strong reciprocal partnerships with a wide range of organisations. Partner relationships are invaluable for the delivery of *beyondblue*’s information and program objectives and for addressing shared goals.

Website: <www.beyondblue.org.au>

2 headspace

Short description of core business

headspace is Australia’s National Youth Mental Health Foundation. The *headspace* mission is to deliver improvements in the mental health, social wellbeing and economic participation of young Australians aged 12–25. To this end, *headspace* aims to be the focal point for youth mental health issues across the country. This includes providing funding to improve services for young people who may be experiencing mental health and/or drug and alcohol issues and the latest information about these important health matters for young people.

headspace is aiming to achieve this through funded *headspace* services located in each state and territory in Australia. These services provide an entry point for young people to access a broad range of services that are available in their local community. All services have a focus on providing a more integrated service response.

Programs and services relating to Indigenous Mental Health

headspace seeks to deliver improvements in the mental health, social wellbeing and economic participation of young Australians aged 12–25, including Indigenous young people. To this end, *headspace* sites are located all over Australia, giving Indigenous and non-Indigenous youth access to mental health services designed specifically for them. Sites are described thus:

- a youth-friendly, community-based health service for young people and their families
- a place where young people can receive help for health, education, work, mental health and alcohol and other drug issues
- staffed by a range of workers including doctors/GPs, psychiatrists, mental health workers (psychologists, social workers, occupational therapists, nurses), and other workers (youth workers and alcohol and other drug workers, vocational) who have specific expertise in working with young people
- a confidential low-cost or free service dependent on situation
- a locally run initiative established by organisations that understand the community
- a place where young people and families are encouraged to become involved.

Other relevant information

With mental health being the single biggest health issue facing young Australians, developing services that are responsive and able to offer early treatment is essential. The current mental health system is not resourced to deal with young people who have mild to moderate mental

health issues. This often means that young people do not obtain timely treatment or they have difficulty finding a service that can respond to their needs.

Delays in obtaining a service are also caused because young people do not necessarily know the best place to seek assistance. Young people are most likely to talk to friends or family members as the first step in their help-seeking journey. These key people are often also unsure how to find best possible support options for their friends or children. As Australia's National Youth Mental Health Foundation, *headspace* is tackling the issues that stand in the way of young people's access to accessible and appropriate health services.

Website: <www.headspace.org.au/>

3 Kids Helpline

Short description of core business

Kids Helpline is a free, 24-hour counselling service for young people aged 5–25 years. Counselling is offered by phone, email and over the web. *Kids Helpline* counsellors are fully qualified professionals who undergo additional accredited training at *Kids Helpline*.

Kids Helpline exists to assist children and young people to develop strategies and skills that enable them to more effectively manage their own lives.

Kids Helpline is a service of BoysTown.

Programs and services relating to Indigenous mental health

In 2007, *Kids Helpline* initiated an Indigenous project with the aim of increasing the access of Indigenous callers and improving the delivery of services to Indigenous children and young people.

This project involved:

- counselling training to improve response and intervention techniques to Indigenous children and young people in culturally sensitive ways
- building and enhancing relationships and networks with Aboriginal groups and communities
- consulting with Indigenous young people to raise awareness of the service and better target the service to meet the needs of young Indigenous people.

During 2008, *Kids Helpline* responded to 1562 contacts from Indigenous children and young people aged 5–25 years. Nearly one in every 20 contacts received is from Aboriginal and Torres Strait Islanders.

Other relevant information

The five most common reasons for which Indigenous young people seek help are the same as for their non-Indigenous peers (family relationships, peer relationships, partner relationships, bullying and violence). However, the other issues concerning this group vary considerably with higher rates of family relationships, homelessness, grief, drug and alcohol use and violence.

Of greatest concern is the increased proportion of counselling sessions about health-related issues, especially mental health, which has proportionally increased sixfold over the past four years, along with emotional issues, especially emotional/behavioural management, which proportionally has almost doubled since 2005.

Website: <www.kidshelp.com.au>

4 Mental Health First Aid Training and Research Program

Short description of core business

In 2000, Betty Kitchener and Professor Tony Jorm began writing a mental health first aid (MHFA) manual and an accompanying course, with the aim of improving the mental

health literacy of members of the Australian community. Since then, the *MHFA Training and Research Program* has been developed, evaluated and disseminated nationally and internationally. The philosophy behind this Program is that mental health crises, such as suicidal and self-harming actions, may be avoided through early intervention with people developing mental disorders. If crises do arise, then members of the public can take action to reduce the harms that could result.

The MHFA program has developed specialised MHFA courses. In early 2005, three culturally and linguistically modified MHFA courses were launched for Croatian, Vietnamese and Italian communities in Australia. In early 2007, two more specialised MHFA courses were launched, an Aboriginal and Torres Strait Island MHFA course for urban and rural aboriginal community members, and a Youth MHFA course suitable for adults working with adolescents.

Since April 2005, the MHFA Program has been under the auspices of the ORYGEN Research Centre at the University of Melbourne.

Programs and services relating to Indigenous Mental Health

In 2007, the *Mental Health First Aid for Aboriginal and Torres Strait Islander Program* was launched. This culturally relevant version of the MHFA course runs for 14 hours. Instructors in this course are Aboriginal people with training and experience working with Aboriginal people with mental health problems. Instructors complete a five-day Instructor Training course before teaching the materials in their own communities.

Len Kanowski has developed the course materials with a team of Aboriginal and non-Aboriginal people and with extensive input from stakeholders in Aboriginal mental health. The materials include DVDs developed by and with Aboriginal people, and a manual containing information that has been tailored to the needs of Aboriginal people, particularly those living in rural and regional areas.

In addition, guidelines for providing MHFA to Aboriginal people have been developed by the team. These guidelines were developed using the consensus of a team of Aboriginal people who have training and experience in treating Aboriginal people with mental health problems. At present, the following guidelines are complete and available on the MHFA website <www.mhfa.com.au/Guidelines.shtml>:

- MHFA Guidelines for Australian Aboriginal and Torres Strait Islander Peoples—Cultural Considerations
- MHFA Guidelines for Australian Aboriginal and Torres Strait Islander Peoples—Depression
- MHFA Guidelines for Australian Aboriginal and Torres Strait Islander Peoples—Psychosis
- MHFA Guidelines for Australian Aboriginal and Torres Strait Islander Peoples—Suicide
- MHFA Guidelines for Australian Aboriginal and Torres Strait Islander Peoples—Trauma and Loss
- MHFA Guidelines for Australian Aboriginal and Torres Strait Islander Peoples—Problem drinking.

These guidelines may be accessed and used by members of the public, and their content will continue to guide the development of the program. They can be freely printed and distributed for non-profit purposes as long as they are not altered and the copyright notice remains intact.

Other relevant information

Those who have completed MHFA courses have been very positive about the knowledge and skills they have acquired. Course participants have been very varied, including teachers, police, nurses, case managers, support workers, social welfare staff, employment agency staff, personnel staff, members of the general public, and staff from many Australian and local government departments.

The mainstream MHFA course has been thoroughly evaluated using randomised controlled trials and a qualitative study and been found to be effective at improving the course participants' knowledge of mental disorders, reducing stigma, and increasing the amount of help provided to others. To disseminate the course, MHFA instructors are trained from across Australia to conduct the 12-hour MHFA course autonomously in their local region. Instructors work for NGOs (e.g., Red Cross, Lifeline, Relationships Australia), social welfare services (e.g. employment, housing), local area health services, places of employment, or as private practitioners. In view of the innovation and quality of the Program, it has won a number of prizes and has spread to a number of other countries, including Scotland, Canada, Hong Kong, Singapore, New Zealand and the USA.

Website: <www.mhfa.com.au>

5 *MindMatters*

Short description core business

MindMatters is a national mental health initiative for secondary schools funded by the Australian Government Department of Health and Ageing and implemented by Principals Australia (formerly APAPDC).

MindMatters uses a whole-school approach to mental health promotion based on the principles of the World Health Organization's Global School Health Initiative and the Australian National Health Promoting Schools Framework.

MindMatters aims to:

- embed promotion, prevention and early intervention activities for mental health and wellbeing in Australian secondary schools
- enhance the development of school environments where young people feel safe, valued, engaged and purposeful
- develop the social and emotional skills required to meet life's challenges
- help school communities create a climate of positive mental health and wellbeing
- develop strategies to enable a continuum of support for students with additional needs in relation to mental health and wellbeing
- enable schools to collaborate better with families and the health sector.

Programs and services relating to Indigenous mental health

MindMatters has a range of school environment and community-based resources and activities relating to Aboriginal and Torres Strait Islander Mental Health Promotion, including the following:

- *The Community Matters Resource Booklet* offers schools professional support and development to enhance and implement whole-school approaches to diversity, with a specific location for young Indigenous Australian students, their families and their communities.
- *Professional development activities: MindMatters Level (1) and Level (2) workshops* are offered nationally to support the use of the resource, within the school and external community environments.
- *Communities Do Matter* is a significant *MindMatters* activity aimed at developing an Aboriginal and Torres Strait Islander whole-of-community development approach for engaging and strategically aligning external-to-school community resources, agencies and members to become active facilitators with schools to progress and sustain the health and wellbeing activities generated.

Communities Do Matter activities and support are provided for:

- Aboriginal and Torres Strait Islander young people (Feeling Deadly not Shame)
- their parents and caregivers (Community Yarning)
- Aboriginal and Torres Strait Islander education workers (Professional Development)
- community leaders seminar (Consultation Seminar)
- community agencies professional development (Professional Development).

Other relevant information

MindMatters has a Mental Health Links page with direct links to several relevant sites, and a page with Indigenous and transcultural links.

Website: <www.mindmatters.edu.au>

6 Gatekeeper Training Program

The Gatekeeper Suicide Prevention Training Unit at the Telethon Institute for Child Health Research provides the *Gatekeeper Training Program*.

Gatekeeper training is based on the premise that individuals at risk of suicide come into contact with a range of community people who have the capacity to direct them towards help. The Gatekeeper training is based on a biopsychological model of suicide: that suicide has many causes and is based on a lifetime of risk factors. The amount of time or emphasis on particular modules depends on the identified training needs of participants.

The purpose of Gatekeeper training is not to train people to act as counsellors but rather to raise awareness of people at risk and refer for professional treatment. This linkage to professional help is fundamental to the success of Gatekeeper training as a suicide prevention strategy.

Further information is available on the Gatekeeper Training website of the Telethon Institute for Child Health Research.

Website: <www.ichr.uwa.edu.au/preventing-suicide/prevention/gatekeeper>

7 Indigenous Psychological Services

Indigenous Psychological Services (IPS) is a private company founded in late 1998 by Dr Tracy Westerman, an Indigenous psychologist originally from the north-west of Western Australia. She is of the Nyamal people from Port Hedland and Marble Bar area. Dr Westerman developed IPS primarily to address the inequities that exist for Indigenous people in relation to appropriate levels of access to specialist and culturally specific mental health and psychological services.

Indigenous Psychological Services provides a range of services including whole-of-community intervention programs such as Whole of Community Suicide Prevention Forums and Trauma Management in Aboriginal Communities.

Website: <www.indigenouspsychservices.com.au>

8 Australian Integrated Mental Health Initiative in the Northern Territory

The *Australian Integrated Mental Health Initiative in the Northern Territory* (AIMHI NT) has been working with people in both remote and urban areas to learn more about the experience of Indigenous people with mental illness. AIMHI has studied the journey of Aboriginal people through mental health services, and explored strategies to facilitate the journey of clients and their carers from community to primary care to specialist mental health services and home again.

Website: <www.craah.org.au/research_program_areas/downloads/SE63AIMHIFact_Sheet-0308.pdf>

9 Other programs and services

A range of community-based mental health and wellbeing programs and initiatives for Aboriginal and Torres Strait Islander people are available. Most of these programs are listed on the Australian Indigenous HealthInfoNet website.

The HealthInfoNet is a 'one-stop info-shop' that aims to contribute to closing the gap in health between Indigenous and other Australians by informing practice and policy in Indigenous health by making research and other knowledge readily accessible. The HealthInfoNet website also supports 'yarning places' (electronic networks) that encourage information-sharing and collaboration among people working in health and related sectors.

The HealthInfoNet website provides a specific Indigenous social and emotional wellbeing web resource for people working, studying or interested in addressing issues that influence the social and emotional wellbeing (including mental health) of Aboriginal and Torres Strait Islander peoples. Programs listed here include ones that address issues presented in chapters in this book.

Websites:

<www.healthinfonet.ecu.edu.au>

<www.healthinfonet.ecu.edu.au/other-health-conditions/mental-health>

‘Designed for practitioners and mental health workers, as well as students training to be mental health workers, I am confident that the publication of *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* marks a watershed in the treatment of Indigenous mental health issues.’

Tom Calma

Aboriginal and Torres Strait Islander Social Justice Commissioner

‘Embracing the principles and practices in this textbook will help the health workforce play its part in achieving the commitment by the Australian Government and the state and territory governments to closing the life expectancy gap between Indigenous and non-Indigenous Australians within a generation.’

The Hon Warren Snowdon MP

Minister for Indigenous Health, Rural and Regional Health & Regional Services Delivery

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