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Community Consultations for the Development of an Empowerment, Healing and Leadership Program for Aboriginal people living in the Kimberley, Western Australia

FINAL RESEARCH REPORT

March 2012

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THE UNIVERSITY OF WESTERN AUSTRALIA



UWA School of Indigenous Studies



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Community Consultations for the Development of an
Empowerment, Healing and Leadership Program for
Aboriginal people living in the Kimberley, Western Australia

FINAL RESEARCH REPORT

March 2012

Pat Dudgeon, Kathleen Cox, Divina D'Anna, Cheryl Dunkley,
Katherine Hams, Kerrie Kelly, Clair Scrine and Roz Walker

Aboriginal & Torres Strait Islander viewers are advised this report may contain images of or information on deceased persons.



The Development of an Aboriginal Empowerment, Healing and Leadership Program in the Kimberley, Western Australia was funded by the Australian Government Department of Health and Ageing.

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FOREWORD

I welcome the publication of the Hear Our Voices as an important contribution to the Aboriginal and Torres Strait Islander suicide prevention, not only for Aboriginal communities in the Kimberley but for other parts of Australia too. This Project was initiated in response to the high number of suicides in the Kimberley, northern Western Australia over more than ten years.

The outcomes of this Project underscore the importance to develop a culturally appropriate and locally responsive empowerment, healing and leadership strategies. The objectives are to restore the social and emotional wellbeing of communities thereby preventing further traumatic events from occurring as a result of community distress and suicide. This also enables communities to regain their resilience and to provide an environment that supports the recovery and healing of community members.

This Project is unusual and innovative in that it utilises traditional western academic approaches through formal literature and best practice research with the concept of community empowerment, ownership and leadership. The Project sought the views of community members in Broome, Halls Creek and Beagle Bay in the Kimberley region on the need for a dedicated new Aboriginal-led empowerment, healing and leadership program. Knowledge was gained through these extensive community consultations, as well as a national review of literature and programs concerning empowerment, leadership and healing. The Project showed that where consultations took place, there was an overwhelming consensus that there is a real need to support individuals to change their lives. People spoke of needing to “build self first” and to “make ourselves strong” and to focus on “rebuilding family”. Aboriginal people said they wanted to learn how to talk to one another again, to share and care for one another and to praise those who do good things for themselves and their communities.

The Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group, of which I am Chair, is currently working with the Menzies School of Health Research to develop Australia’s first national Aboriginal and Torres Strait Islander Suicide Prevention Strategy. Projects such as Hear our Voice will inform our work and hopefully inspire others in Aboriginal and Torres Strait Islander communities to develop their own empowerment initiatives. I look forward to the outcomes of the national roll-out of this project with great anticipation.



Dr Tom Calma
AO, HonDLitt CDU, HonDSc Curtin,

THE TEAM



Professor Pat Dudgeon is from Bardi and Giga people of the Kimberley in Western Australia. Her family is the Gregory/Mungets. She was the first Aboriginal psychologist to graduate in Australia and has made outstanding contributions to Indigenous psychology and higher education. She was the Head of the Centre for Aboriginal Studies at Curtin University, for some 19 years. She works for the School of Indigenous Studies at UWA and is also a researcher with the Telethon Institute of Child Health Research. Pat has always worked in ways that empower and develop other Aboriginal people. Pat is the Project Manager for the Empowerment, Healing and Leadership Project.



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. She has taught extensively at undergraduate and graduate levels in Aboriginal community management and development and health. She has worked in Aboriginal education in teaching, curriculum development, academic co-ordination, research and evaluation. Roz is a Senior Research Fellow at the Centre for Research Excellence in Aboriginal Health and Wellbeing at the Telethon Institute of Child Health Research. She has extensive experience in translating research into policy and practice. Roz is the Senior Researcher for the Empowerment, Healing and Leadership Project.



Cheryl Dunkley is the Research Officer and Administrative Officer for this project. She works with the University of Western Australia and for the Centre for Research Excellence in Aboriginal Health and Wellbeing at the Telethon Institute for Child Health Research. She has a Bachelor of Business and spent much of her career working for Universities within the human resource sector. Cheryl has strong connections with the Kimberley having married into the Dudgeon family, who are descendents of the Munget family of the Bardi people.



Divina D'Anna is a community consultant on this project and was born and raised in Broome and the surrounding area. She lived all her life in the Kimberley from Broome to Wyndham and Kununurra. She has always worked with Kimberley Aboriginal people whether it be through her work with Notre Dame University (5 years) or the Kimberley Land Council (8 years). Divina is passionate about her people feeling empowered to enrich their own lives in their own ways whether it be wanting to be the prime minister or just to have a happy and healthy life for themselves and their children.

THE TEAM



Kathleen Cox is a local business woman whose ancestry connects her to the East and West Kimberley regions of Western Australia. She is a Bard, Gija, Nygkina, Nimanburr and Baniol woman who is passionate about Cultural Tourism and advocates strongly for the homelands movement of her people (going back to country). Kathleen has a wide range of working history across various areas. She is passionate about working with her people specifically with women and youth. She is always looking for new opportunities on different ways on how her people can become empowered so they can take control of their own destiny, lead their people towards their own autonomy and develop viable and sustainable communities in which they live.



Dr Clair Scrine is a Senior Research Officer at the Kulunga Research Network at the Telethon Institute for Child Health Research. Clair joined Kulunga in 2006 and has been a member of a number of project teams involving research and evaluation with a number of Aboriginal communities and organisations in the Pilbara, East Kimberly, Wheatbelt, South West and Perth Metro regions. 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).



Katherine Hams is currently the Executive Manager of the Regional Social Emotional Wellbeing Workforce Support Unit for the Kimberley Aboriginal Medical Service Council. She is an Indigenous Mental Health Professional and has worked as a teacher, counsellor and trainer. With more than eight years of management experience in mental health services, Katherine has extensive clinical experience, particularly in Aboriginal communities. Her interests include developing strong recognition and positive promotion of mental health, establishing a stronger link to holistic health, advising on providing culturally specific mental health service and supporting stronger linkages between state mental health services and community based and primary health care providers. Katherine is a member of the WA Mental Health Advisory council, Kimberley Aboriginal Mental Health Planning Forum.



Kerrie Kelly is a non-Indigenous psychologist who has been mentored to become culturally competent in the area of Aboriginal and Torres Strait Islander social and emotional wellbeing (SEWB). For more than a decade, Kerrie has collaborated with Aboriginal and Torres Strait Islander colleagues to develop and deliver a range of innovative products, models and services to meet the social and emotional wellbeing needs of individuals, families and communities.

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- Photos in this report, cover and project related documents were kindly made available by Kathleen Cox, of Goombaragin Eco Retreat.
- The watermark artwork throughout this report was kindly made available by artist, Elaine Cox.
- We also thank and acknowledge Rita Markwell for her excellent final editing of this report.
- Finally thanks are extended to the Department of Indigenous Affairs, Western Australia for the Kimberley maps in the appendices and to Jeff Murray for creating the original map, which is modified for use in this report.

The thing to remember is that this isn't just about suicide; there are so many other real day to day issues that affect our liarn (feelings) which makes our hearts and heads get sick. And when we get sick we don't feel well. The people all too often overlook these signs because somehow these signs have become part of everyday life, which in reality it should not be like that.

(Kathleen Cox, Community Consultant, Goombaragin, Dampier Peninsula, Kimberley, WA)



ACKNOWLEDGEMENTS



Elaine Cox: A Mungit Story

The veins of the Mungit clan group bloodline runs strong. Their nyamini (maternal grandmother) came from the East Kimberley, the Kija people. Their jamoo (maternal grandfather) was a Bard man who lived with his mother in Pender Bay on the Dampier Peninsula north of Broome in the West Kimberley. Their union was very special because fresh water stories were brought to saltwater country. They brought the land and sea together and passed on their cultural traditions and stories of hunting and gathering to their children.

This painting describes the seasonal nomadic life of the Mungit people. The women and children collect magabala (bush banana) and the men hunt for baarni (goanna) which represents the land. The aarli (fish) is caught using bunjoorrd (fish poison root) around fish traps made from rocks and represents the saltwater.

The old people told us that we must care for the country – and in turn, the land, sea and country will care and provide for us. It is a symbiotic relationship where one is connected to the other.

Today our Mungit family are strong people. We work to help and lead our families and people ensuring that everyone feels good and strong in their liarn (feelings) so they can live life, be happy and feel safe.

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EXECUTIVE SUMMARY



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1 EXECUTIVE SUMMARY

This research Project was initiated in response to the high number of suicides in the Kimberley, northern Western Australia over more than ten years, which sadly, has only worsened in the past 12 months.

Between 1999 and 2006, there were 96 Aboriginal suicide deaths in the Kimberley, an average of one suicide per month over that period. According to the Kimberley Aboriginal Medical Services Council, between October 2010 and September 2011 there were 36 Aboriginal suicides in the Kimberley. As with other jurisdictions, death had been brought about almost exclusively by hanging.

In the Kimberley, suicide and self-inflicted injuries combined have been identified as the third most common cause of avoidable mortality for Aboriginal people in 1997 – 2007. Suicide accounts for twice the mortality burden compared to alcohol-related mortality.

This period of time coincided with increased investment and policy experimentation by Governments following the dismantling of ATSIC. However investment and effort has not always been well targeted or implemented. In his inquest, Coroner Alastair Hope found that 'government agencies receive \$1.2 billion funding annually but only five per cent of the expenditure was spent on Aboriginal people on the ground' (Quoted in Hansard, Tuesday, 26 February 2008). The WA Special Advisor on Indigenous Affairs, Lieutenant General John Sanderson, has also commented that 'programs appear fractured, random and lacking in continuity, with intentions confused and transitory' (Sanderson, 2007, p6).

The extraordinarily high rates of suicide and other social and emotional wellbeing problems in Aboriginal communities are commonly attributed to a complex set of factors which not only includes disadvantage and risk factors shared by the non-Indigenous population, but also a broader set of social, economic and historic determinants that impact on Aboriginal social and emotional wellbeing and mental health. These risk factors are in addition to, rather than instead of the mainstream notions/ determinants of wellbeing like health, education, income and housing.



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Identifying the risk and protective factors that contribute to the social and emotional wellbeing of Aboriginal communities, and its opposite, community distress and suicide, requires an in-depth knowledge of the historic, cultural and economic risk factors at play in each community and are best known and understood by community residents themselves. Furthermore, while external change agents might be able to catalyze action or help to create spaces for people to undertake a change process, empowerment can occur only as communities create their own momentum, gain their own skills, and advocate for their own changes.

With this in mind, the Project sought the views of community members in Broome, Halls Creek and Beagle Bay in the Kimberley region on the need for a dedicated new Aboriginal-led empowerment, healing and leadership program. The main aim of this Project was to develop such a program in the Kimberley that could be flexible enough to meet local circumstances while upholding some of the best practices understood in research. Knowledge was gained through extensive community consultation, as well as a national review of literature and programs concerning empowerment, leadership and healing.

Across the three communities where consultations took place, there was an overwhelming consensus that there is a real need to support individuals to change their lives.

People spoke of needing to “build self first” and to “make ourselves strong” and to focus on “rebuilding family”. Respondents said they wanted to learn how to talk to one another again, to share and care for one another and to praise those who do good things for themselves and their communities. Of particular note was the high level of concern and urgency for the need to focus on young people who, it was felt, have lost their sense of connection to and respect for their culture, their family and themselves.

The consultation process also confirmed the need to ensure individual and community readiness to commence any type of healing and empowerment program. There was a concern that those in most need of such a course, especially young people, would be unable and unwilling to participate. The community consultations, literature and program review demonstrated that to be effective, programs needed to be culturally-based and incorporate traditional elements. This includes employing local people to work on interventions and training them in community development skills.

In response, this Report recommends some very practical steps to develop an Aboriginal led Empowerment, Healing and Leadership program in the Kimberley region. It begins with a community readiness/preparation phase and continues all the way to nationally accredited training for local people who are prepared to lead change on a family and community level.

In the 2011 Budget, the Australian Government has committed to working with the States and Territories to develop a new *Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework* in 2012. In addition, the Australian Government is supporting an Aboriginal and Torres Strait Islander-led process to develop a National Indigenous Suicide Prevention Strategy. This Report underlines the interconnectedness of these initiatives, the importance of long-term bipartisan support from governments for these policies, as well as the scale and urgency of need.





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1.1 Key Findings

The Key Findings of this Project are that:

- Some of the most important influences on positive social and emotional wellbeing and mental health are opportunities that enable people to exercise control over their lives, to use their skills, to engage in supportive social interactions and to be able to set goals and experience a variety of opportunities (WHO, 2004).
- The underlying principle of all community development and empowerment approaches is that only solutions driven from within a 'risk community' will ultimately be successful in reducing community-based risk conditions. Ensuring that the community drives the process is the most important factor if community outcomes are to be achieved (Mitchell, 2000).
- In Australia, we have yet to see the development of a comprehensive body of knowledge that identifies the domains of Aboriginal social and emotional wellbeing or the range of risk and protective factors within domains, so that the former can be minimised and the latter can be maximised to enhance community wellbeing and resilience.
- Empowerment and healing strategies that enable people to take greater control over their life and responsibility for their situation; to become strong culturally and spiritually and establish more equitable power relations, are effective ways of addressing suicide risk factors.
- Fostering a secure sense of personal and cultural identity is a powerful protective factor against the threat of self-harm, especially for young Aboriginal people.
- Apart from historical influences, there are a range of social and economic determinants contributing to community distress and suicides in the Kimberley region, for example a lack of access to primary health care, extreme overcrowding, socio-economic disadvantage and poverty.
- Stressful life events also contribute to this heightened vulnerability – for example stress related to the discriminatory effects of government services and systems such as incarceration of family members, contact with the child protection system and child and family safety issues, as well as alcohol use and abuse.
- A perception that governments may have unwittingly contributed to high levels of community distress and suicides in the Kimberley over the past decade due to constant changes in governments, senior personnel and ministers and ongoing changes in policy direction in the absence of a national policy framework on social and emotional wellbeing and evidence base of 'what's working' to guide investment; resulting in a lack of long term funding commitments for programs and basic services required to attain and maintain Aboriginal health and wellbeing; poor governance and accountability, and an overstated confidence in bureaucracy and an understated confidence in community initiatives.
- Also, a perception that well-meaning attempts by the three levels of governments to resolve community distress and reduce suicide by removing responsibility and in some instances, preventing communities from taking charge of their own lives, may have increased risk of suicide while simultaneously undermining protective factors such as Aboriginal governance and cultural stability. This is likely to have increased psychological distress and risk across communities and particularly among those deemed to be vulnerable or 'at risk'.



Empowerment programs are instrumental in resourcing Aboriginal people to develop their understanding of the underlying causes of their poor social and emotional wellbeing and ways to tackle those issues. As such, healing, empowerment and leadership programs are:

1. An effective way to address the alarming rates of suicide in many Aboriginal communities;
 2. A means of supporting people to be in a position where they are capable of taking on further training leading to employment and leadership positions; and
 3. Facilitating community empowerment and responsibility leading to better governance, safety and leadership within these communities.
- There is a high level of need in the Aboriginal communities of Broome, Beagle Bay and Halls Creek (and indeed across the Kimberley) for a range of culturally appropriate and locally responsive empowerment, healing and leadership programs and strategies.
 - Across the three communities where consultations took place, there was an overwhelming consensus that there is a real need to support individuals to change their lives. People spoke of needing to “build self first” and to “make ourselves strong”; to focus on ‘rebuilding family’ and ‘learning to be good parents and role models’. Respondents said they wanted to learn how to talk to one another again, to share and care for one another and to praise those who do good things for themselves and their communities.

Of particular note was the high level of concern and urgency for the need to focus on young people who, it was felt, have lost their sense of connection to and respect for their culture, their family and themselves.

Programs need to address empowerment in different ways, for different groups and in multiple settings, to accommodate differing levels of need and community, family and individual readiness.

- There is a real need for preparatory workshops that facilitate people’s readiness to start and continue on their healing journey.
- This Report highlights substantial evidence to show that the Family Wellbeing program, which was initiated by Aboriginal people, has suitability as an approach to healing and empowerment that is able to accommodate a range of different cultural contexts, circumstances and needs and educational aspirations.
- Programs need to be culturally-based and incorporate traditional elements into their content and teaching, learning and healing processes. This includes employing local people to work on interventions and training them in community development skills and processes.
- The support and engagement of community members throughout the design, implementation and evaluation of programs and any related materials is another critical factor in the effectiveness of programs.
- These types of programs and strategies also require a long-term approach involving regular group discussions, interviews, critical reflection and feedback to promote and assess individual progress.
- There is a need for new programs to work in with the many existing agencies and services that are doing good work with small target groups such as youth, mothers, elders in order to ‘join the dots’, ‘value add’ to these programs and strengthen the overall effectiveness.

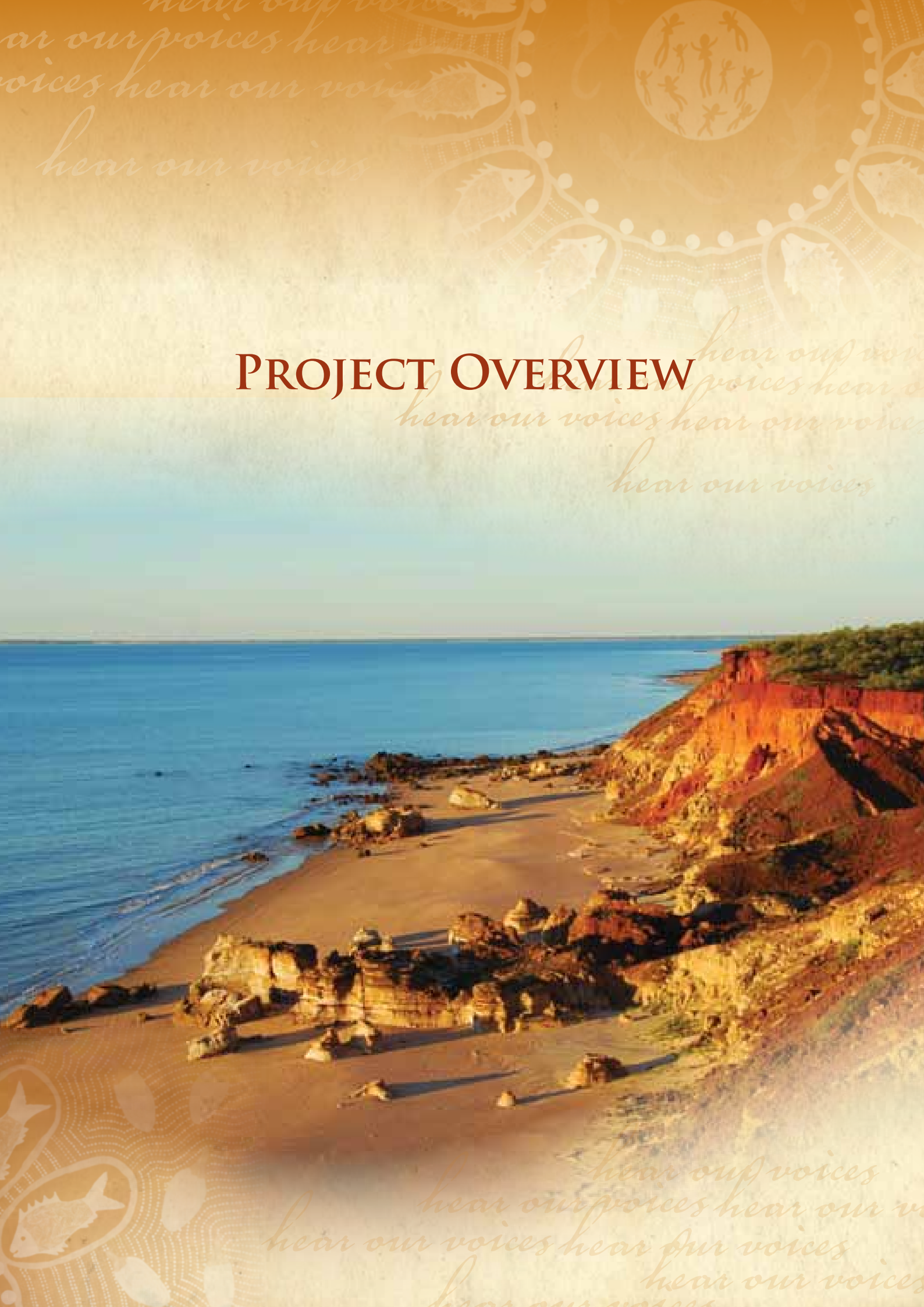


1.2 Key Recommendations

The following recommendations are based on the key findings from the literature and program reviews, and the community consultation. It is recommended that:

1. Funding is provided for the development of (both accredited and non-accredited) programs that are more targeted, locally and culturally responsive and suitable for delivery to a range of groups in Beagle Bay, Halls Creek and Broome, and such programs are extended broadly across the Kimberley over time;
2. Funding is provided for delivery of preparatory workshops to build individual and community readiness for healing and leadership;
3. Programs are developed (and funded) in a way that facilitates a long-term approach, including feedback and evaluation to assess effectiveness and ensure the content and delivery process is responsive to people's needs;
4. Non accredited courses are given legitimacy for what they can deliver in their own right to people in terms of learning outcomes and individual/community empowerment and positive transformation;
5. Development of culturally appropriate 'train the trainer' programs are provided for local people to become empowerment course facilitators and support personnel for the ongoing delivery of workshops and courses;
6. Processes are established to identify and provide support to existing mentors within the communities to increase the capacity of those on their healing journey to support others (including use of Elders and those in the communities who have already completed programs i.e. the FaHCSIA Leadership program, Family Wellbeing and other relevant programs);
7. Learning pathways are mapped and processes established to identify and support individuals in each of these communities to undertake further training in community development skills and processes (such as those offered through the Centre for Aboriginal Studies at Curtin University, Notre Dame University and TAFE);
8. Specific programs and activities are developed that work with young people to improve their self-esteem, and/or readiness to take on other empowerment and leadership courses;
9. Future programs and stakeholders work in an integrated manner with existing programs and services to avoid duplication and ensure they are adding to current processes;
10. A local advisory/action group is established to work with the project team to identify where and how existing support services could increase the scope of their work to empowerment and healing initiatives;
11. Any program ensures the provision of a culturally safe environment for participants including basic health and safety and shared respect, shared meaning, shared knowledge and experience (with access to skilled counsellors if required);
12. Policy makers, service providers and funding groups adopt an enabling role where they support flexibility, creativity, action learning, innovation and diversity.





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PROJECT OVERVIEW

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2 PROJECT OVERVIEW

2.1 How the Project came about

The idea of this project came about with the double suicide of two of our family members late last year in Broome, Kimberley, Western Australia 2010. Our families were devastated and we felt that there were no professional support mechanisms in place to immediately help us, comfort us, other than our own families and friends getting together supporting each other. The only close support we found was to engage in our Catholic faith and participated in a nine day Novena with the support of the local priest from the Broome Parish, Father Ernesto. We were fortunate to have a strong extended family and the rosary each night provided an opportunity for us to come together each evening to pray, grieve, to plan the funeral and to be together as a family.

We were aware that the suicide rates for the Kimberley were appalling. This was not the first family members we had lost to suicide and sadly it proved not to be the last either. We sat down and talked about what we could have done to save the lives of our loved ones? We asked ourselves, what was missing? Despite the range of existing programs out there, why are our people still killing themselves? It just doesn't make any sense!

With the understanding that the government is spending millions of dollars into the Kimberley through health, youth and mental health programs it appears that these terrible statistics continue to rise. We felt that there has to be something else that was needed to be done to fill in some of the gaps! Not reinvent or reproduce programs; but develop something creative, real and meaningful that would value add to existing programs and that was flexible. It was then the idea came about that we should try and do something different and start from the beginning. That we should go back, start from deep within ourselves and ask ourselves why are we here, how can I love and support my family, love and respect myself, my community and be committed to my workplace and the people within it.

What can we do that would help me better understand myself?

The conversations then led to how can we celebrate and promote life and empower ourselves to make good, real and solid decisions for ourselves to make the positive changes so that in-turn can give us the tools to self-heal and become leaders within our families and communities that need us the most. With these ideas it was decided that we should get involved in the development of programs that will give us those necessary skills whereby we can build upon our existing strengths and weaknesses and work on empowering and healing ourselves in the first instance. But it was very important that we talked with other people in the community as well. We wanted to know if this was a good idea and would it be something that they could relate to and if so, how would we develop a program that suited them. Our consultations have shown that others do indeed share our idea that empowerment, learning to self-heal and becoming grassroots leaders for our people might be one answer – the strategy needed to make a change in us as individuals, families and communities.

Kathleen Cox, 2011. Community Consultant for the Research Project.



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2.2 Project Goals and Objectives

This Project's long-term goal is to strengthen Aboriginal peoples' social and emotional wellbeing by working to enhance the capability and capacity of Aboriginal people to take charge of their lives and strengthen their communities.

The Project objectives were to:

- Bring together lessons from available research and existing programs on the importance of leadership, empowerment and healing to enhance Aboriginal peoples' social and emotional wellbeing;
- Identify the level of need for empowerment, healing and leadership programs for different groups in three communities across the Kimberley region through community consultation;
- Define community-based understandings of leadership, empowerment and healing, and determine how this would be translated into a community-based program through community consultation;
- Develop the foundations for culturally appropriate and responsive non-accredited community based programs as well as accredited training to empower Aboriginal people in the Kimberley; and
- Identify and negotiate with potential stakeholders for further phases of the study to work in an integrated manner and to avoid duplication.

2.3 Project Outputs

The Project involved delivery of a range of outputs:

- This final Research Report.
- A research and policy brief that highlighted the key findings arising from the research, and the implications for policy makers and relevant stakeholders.
- Community consultations in three sites: Broome, Beagle Bay and Halls Creek.
- A community feedback brief that reported the findings of the consultations, literature and program reviews to the community in an appropriate and relevant way.
- A community feedback forum to provide community members and stakeholders



opportunities to provide comments to the findings presented.

- Convening a national advisory group to advise on the findings of the consultation and literature and program reviews.
- Arranging a policy and practice forum in Perth to present the findings of the consultations, literature and program reviews.
- Developing an accredited training continuum consistent with community needs. This included:

1. Examining the viability of developing workshops as a preparatory element that prepares community members for enrolment into the accredited courses; and

2. Negotiating with the Kimberley Aboriginal Medical Services Council Regional Centre for Social and Emotional Wellbeing (a Registered Training Organisation) to develop an accreditation process for the skill sets delivered by any future courses.



2.4 Project Partners

The Project was funded by the Australian Government Department of Health and Ageing. The partners involved in undertaking the Project and preparing this Final Research Report included:

- The National Health and Medical Research Council's (NHMRC) Centre for Research Excellence Aboriginal Health and Wellbeing at the Telethon Institute of Child Health Research;
- The School of Indigenous Studies at the University of Western Australia; and
- The Regional Centre for Social and Emotional and Wellbeing at the Kimberley Aboriginal Medical Services Council, Western Australia.

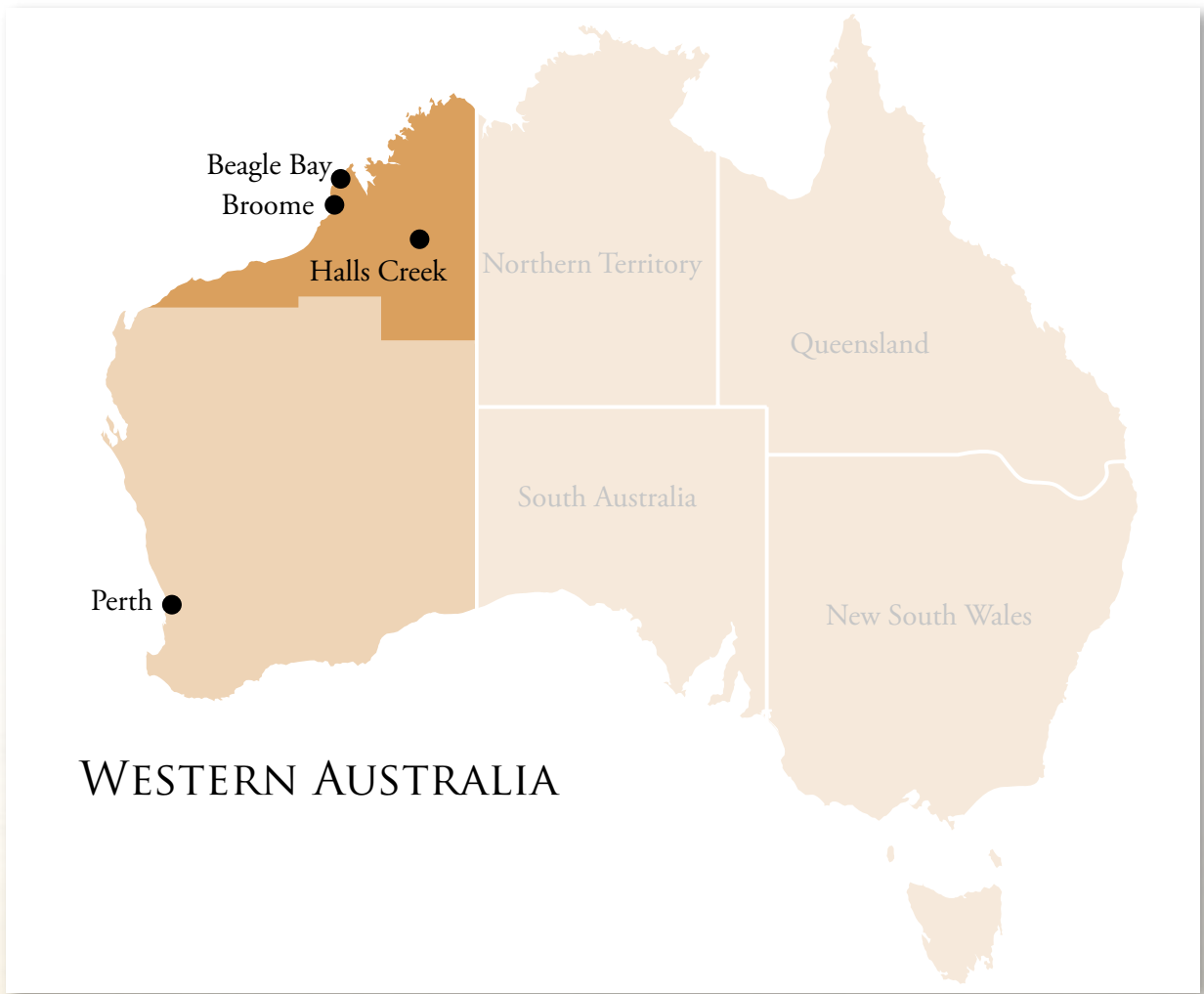
2.5. Understanding the Kimberley Region

The Kimberley Region is located in the far north of Western Australia and has a diverse mix of population and industry. Due to its large size (nearly twice the size of Victoria) and small and dispersed population, there are significant challenges to service delivery in this region. There are about 35,000 people, with nearly half living in Broome and more than 200 small Aboriginal communities. Compared to the rest of Western Australia, the Kimberley region has the highest proportion of Aboriginal people (46% or 15,632 people) and the greatest number of remote Aboriginal communities (ABS, 2006). The Aboriginal population is much younger than the non-Aboriginal population, with nearly half (44%) aged under 20 years old (Ibid).

The major towns in the Kimberley region are Broome, Derby, Fitzroy Crossing, Halls Creek, Kununurra and Wyndham.

Aboriginal people constitute 97% of the Halls Creek Shire, 76% of the Derby-West Kimberley Shire, 42% of the Wyndham-East Kimberley Shire and 30% of the Broome Shire (ABS, 2006). All locations are classified as being in very remote Australia (ABS, 2011).

Aboriginal communities are mainly clustered along the coastline between Broome and Derby, along the Gibb River and around the town of Fitzroy Crossing. Communities such as Kalumburu, Oombulgurri, Mulan, Wirrimanu (Balgo), Kundat Djaru (Ringer's Soak), Ardyaloon (One Arm Point), Lombadina/Djarindjin, Beagle Bay and communities along the Gibb River Road are frequently inaccessible by road during wet seasons (October/November to March/April). There are 30 Aboriginal languages spoken across the region. A list of these groups is provided in Appendix 1. A detailed map of the communities in the area is provided in Appendix 2.

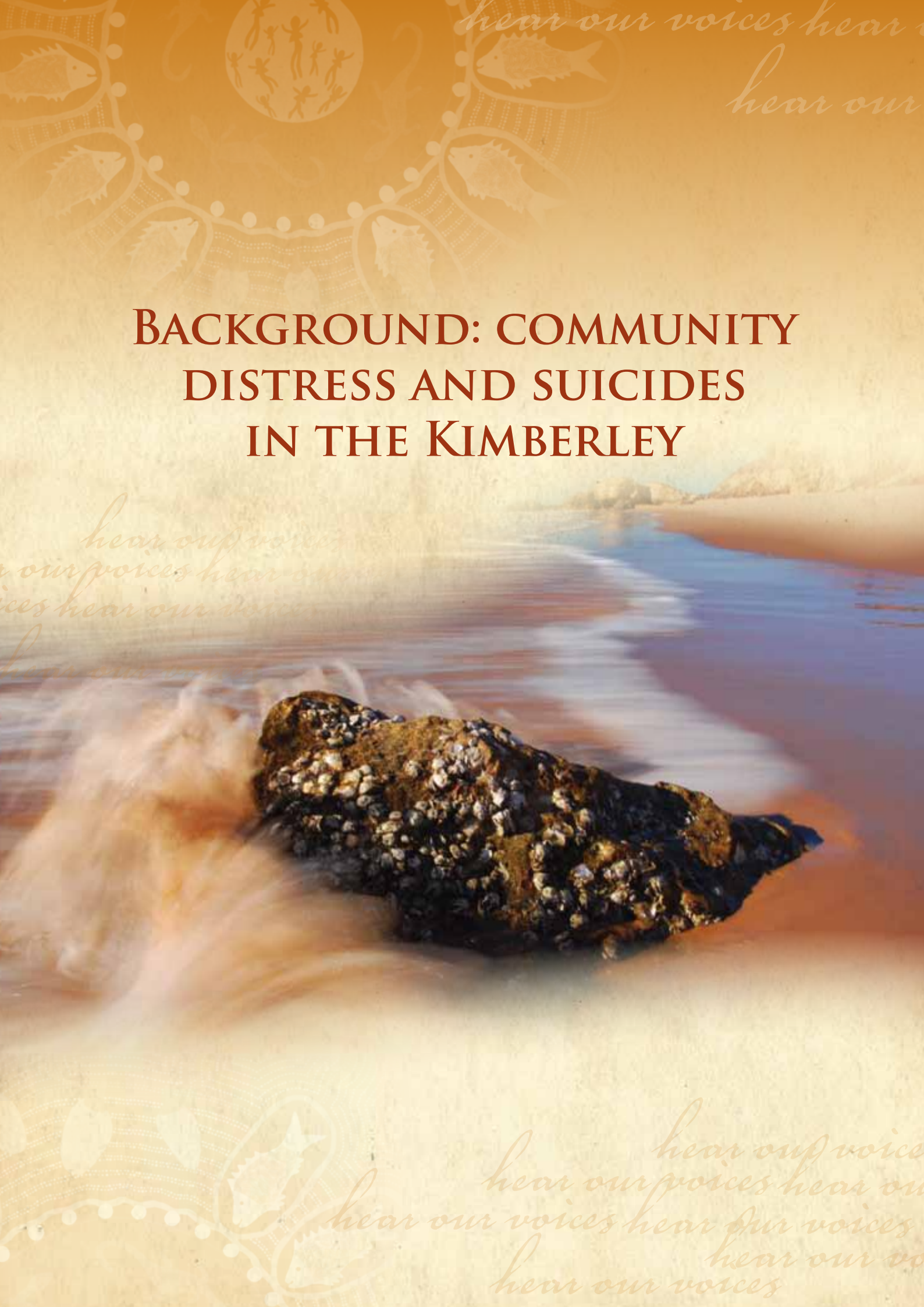


The Kimberley region and the three sites of consultation undertaken in the Project.

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**BACKGROUND: COMMUNITY
DISTRESS AND SUICIDES
IN THE KIMBERLEY**

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3 BACKGROUND: COMMUNITY DISTRESS AND SUICIDES IN THE KIMBERLEY

We need to identify with ourselves. We need more self worth - gain greater self esteem. We need to make ourselves strong first. We as a community need to recognise people that have done good for themselves and the community and give praise and recognition (Participant, Broome Community Consultation Workshop, 2011).

3.1 Suicide in Western Australia

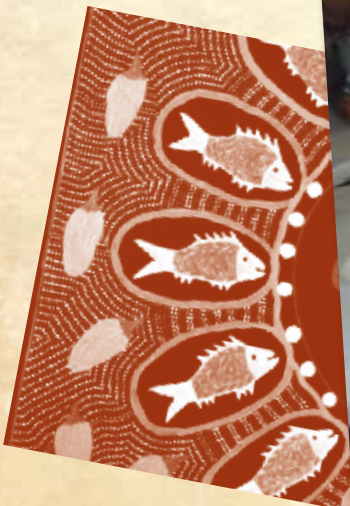
Aboriginal male suicides in Western Australia were reported to have decreased from 70 people per 100,000 population in 1998 to 38 people per 100,000 in 2002. However, the numbers of suicides were 2.8 times more than expected for Aboriginal males and 1.9 times more than expected for Aboriginal females (Lenferna de la Motte, 2007).

Across Western Australia, during the period 2004 to 2008, the Aboriginal suicide rate was 31 per 100,000 population. This was triple the non-Indigenous rate (10.7) in Western Australia and higher than the national rates of 23.8 for Aboriginal and Torres Strait Islander people and 9.9 for others (ABS, 2008).

In 2008, there were a total of 103 Indigenous suicide deaths nationally, with 29 of these occurring in Western Australia. The Western Australian suicides constituted 28% of the total number of Indigenous suicides for the year, even though Aboriginal people in Western Australia form just 14% of the total Indigenous population. It therefore appears that Aboriginal people across Western Australia are at higher risk of suicide, rather than just those in the Kimberley.

In the Kimberley suicide and self-inflicted injuries combined has been identified as the third most common cause of avoidable mortality for Aboriginal people with 67 deaths between 1997 and 2007, representing 9% of avoidable mortality (Western Australia Department of Health, 2011). Suicide and self-inflicted injuries is identified as the second more common cause of preventable mortality for non-Aboriginal people in the Kimberley region, with 28 deaths representing 13% of the burden of avoidable mortality. Suicide therefore accounts for twice the mortality burden compared to alcohol-related mortality.

In the Kimberley, during the five-year period 2002 – 2006 there were 171 Aboriginal people admitted for self-inflicted harm (an average of 17 admissions per year), a rate similar to non-Aboriginal people in the region and the rest of the state (Ibid). The Western Australian Child Health Survey conducted during 2000 – 2001, which included a Kimberley sample, reported that 9% of females and 4% of males had attempted suicide in the past 12 months (De Maio et al, 2005).



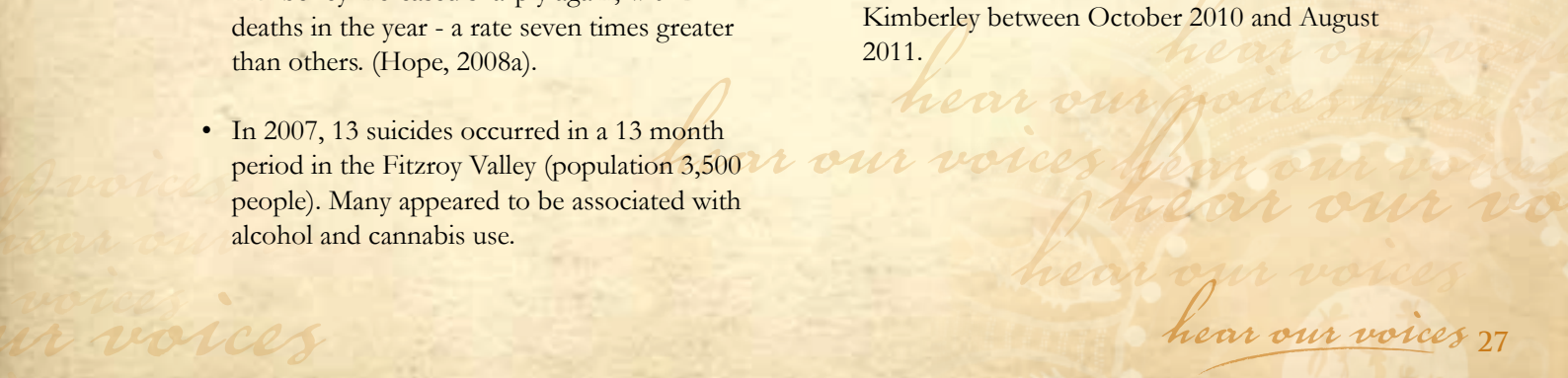
The survey found that having low self-esteem, friends who had attempted suicide, exposure to family violence, and exposure to racism, were each independently associated with suicidal ideation (Ibid).

Due to the method and frequency of national data collection on suicides, there is a significant time lag in receiving current information. The timeline below includes more recent data from other sources.

3.2 Timeline: Community Distress and Suicide in the Kimberley region

The Kimberley region began receiving national attention when Aboriginal suicide rates increased dramatically in 2006. However, this was not a new phenomenon. In 2000, a study revealed the suicide rate for Aboriginal males from 1986 to 1997 was 37 per 100,000 population - double the rate for all males in Western Australia (Hillman et al, 2000). The Kimberley Aboriginal population is just 15,632. As described below, the traumatic nature of about 100 suicides in as many months has had a devastating impact on the population and cannot be overstated, as waves and clusters moved from community to community.

- Between 1999 and 2006, there were 96 Aboriginal suicide deaths in the Kimberley, an average of one suicide per month over a period of seven years. The suicide rate during this period was four times that of non-Aboriginal people in the region (Western Australian Suicide Prevention Strategy 2009 – 2013, 2009).
- In 2004, the Coroner investigated three suicide deaths associated with petrol sniffing in Balgo in 2002, and the services provided by government agencies.
- In 2006, the number of suicides in the Kimberley increased sharply again, with 21 deaths in the year - a rate seven times greater than others. (Hope, 2008a).
- In 2007, 13 suicides occurred in a 13 month period in the Fitzroy Valley (population 3,500 people). Many appeared to be associated with alcohol and cannabis use.
- In 2008, a Coronial Inquiry conducted by Alastair Hope examined 22 alcohol and drug related deaths that had occurred in the Fitzroy Valley, 2000 – 2007 and the underlying reasons for the high death rates. The Coroner found 17 of the deaths were suicides, which had followed the consumption of alcohol and/or cannabis in the period immediately prior to death. He reported ‘the very high numbers of Aboriginal suicides in the Kimberley result from the fact that many people are ‘very unhappy and live in unsatisfactory and distressing conditions’ (Hope 2008a, p16).
- The Coroner reported there had been an average of one Aboriginal suicide per month in the Kimberley in the nine-year period 1999-2006. This was reported as 100 suicides in 100 months (Hope, 2008a).
- In 2008, a second Coroner’s Inquest was held into five suicide deaths that occurred in Oombulgurri between March 2005 and April 2006 (Hope, 2008b).
- In February 2011, the media reported there had been nine Aboriginal suicides in nine weeks in the Kimberley, since December (The Australian, February 28, 2011).
- In April 2011, more suicides were reported in Derby and Kununurra. Eleven suicides had been recorded since December, together with many failed attempts and self-harm episodes.
- In August 2011, there were three suicides on three successive nights in Derby. At least six young people had taken their lives in Derby since the start of the year (West Australian, August 4, 2011).
- In October 2011, Australian Government officials told a Senate Estimates hearing that the Standby Suicide Bereavement Service reported a total of 23 deaths by suicide in the Kimberley between October 2010 and August 2011.



- In October 2011, the State Coroner investigated five suicides associated with petrol sniffing in Balgo (450 population). Mr Hope said in his findings that although the suicide rate among Kimberley Aboriginal people was 6.25 times higher than that of the general WA population, it was 100 times higher in Balgo (Sydney Morning Herald, October 22, 2011).
- According to the Kimberley Aboriginal Medical Services Council, between October 2010 and September 2011 there were 36 Aboriginal suicides in the Kimberley (compared to two for the non-Aboriginal population during the same period), a rate 182 times that of others. As with other jurisdictions, death had been brought about almost exclusively by hanging. There is increasing alarm about the rise of suicide among young women (17 of the 36), from a baseline of nil in the Kimberley in 2000.

3.3 Timeline of Aboriginal Led Initiatives to Address Community Distress and Suicide in the Kimberley.

Below is a timeline of Aboriginal led initiatives to address community distress and suicides in the Kimberley.

1997:

The Yiriman Project was an unfunded project developed by Elders in the Fitzroy Valley who were concerned about local young people struggling with substance abuse, contact with the justice system, self-harm and suicide. They saw the need for a place where youth could separate themselves from negative influences and reconnect with their culture in remote and culturally significant places. Funding was not obtained until 2001. From 2004, programs were also delivered for young women. The Kimberley Aboriginal Law and Culture Centre (KALACC) auspices the Yiriman Project.

In response to representation from Aboriginal community organizations, the WA Ministerial Advisory Group on Youth Suicide engaged in consultations with Aboriginal communities and

agencies during 1996 and 1997. This resulted in a set of recommendations for *Across Government Policy and Programs for Preventing Suicide among Aboriginal Youth in Western Australia*. The strategy was not funded or implemented.

The Kimberley Aboriginal Youth Suicide Prevention Project *Choose Life 1998–1999* took place in collaboration with the Kimberley Aboriginal Medical Services Council (KAMSC).

1999:

KAMSC developed a Certificate IV in Social and Emotional Wellbeing; and conducted research to explore trauma experienced by young people and its relationship to suicide and self-harming behaviours in the Kimberley.

2000:

KAMSC published the following reports:

1. *Choose life: A Report on the Findings and Recommendations of the Kimberley Prevention of Youth Suicide Project* carried out by the KAMSC sponsored Kimberley Youth Project Team March-June 1999 (Ralph, Murray and Hamaguchi, 2000).
2. *True Words - Real Life: A Study of the Social and Emotional Wellbeing of Young People in the Kimberley: Plain Language Report on the Preliminary Findings From Choose Life Project 1998–1999* (Ralph, Murray and Hamaguchi, 2000). This report was widely disseminated across the Kimberley and a shift in thinking was seen, with service providers (mental health, education, justice) starting to talk in terms of trauma rather than depression as the main cause of suicide in the region (Ralph et al, 2006).

The Western Australian Aboriginal Child Health Survey (WAACHS) was undertaken 2000–2001 across Western Australia to describe and define the health and wellbeing of Western Australian Aboriginal and Torres Strait Islander children and young people aged 0–17 years. The study included Broome, Derby, Fitzroy Crossing, Halls Creek and reported that 9% of females and 4% of males had attempted suicide in the past 12 months (De Maio et al, 2005).



The study found those with a high score on the Strengths and Difficulties Questionnaire, low self-esteem, friends who had attempted suicide, and exposure to family violence and racism were most at risk of suicide ideation (Ibid).

2001:

The Aboriginal Suicide Prevention Steering Committee developed a briefing paper titled *Working Together: Recommendations for Cross-Government and Intersectoral Universal Prevention Initiatives to Promote Wellbeing and Resilience and to Reduce Self-harm and Suicide Among Aboriginal Youth*, which was presented to the then Minister for Indigenous Affairs and to a succession of Government Agencies and enquiries over the next decade.

The paper found:

The current situation results in services that all too often are neither locally owned nor appropriate, delivered by personnel with no local status. The Fitzroy Valley needs locally designed service models for locally owned and delivered services, which draw on local cultural knowledge and which use with discernment 'evidence-based' interventions (Aboriginal Suicide Prevention Steering Committee, 2001, p8).

2002:

A young Aboriginal woman approached the KAMSC Regional Centre for Social and Emotional Well Being and requested that someone 'do something' about sexual abuse in communities (Ralph et al, 2006). As a result approximately 80 women attended a Peninsula Women's Bush Meeting (Beagle Bay, One Arm Point, Lombadina, Djarindjin, Broome) which focused on sexual abuse. The women formed a group Oorang Arl Arl Jugarda Bowra to stop child sexual abuse in their communities. The slogan was *Child Sexual Abuse is Not a Part of Our Culture. A We're Not Gammin* sexual assault and child sexual abuse kit was developed, and a Rally Against Child Sexual Abuse was held at Beagle Bay (Ralph et al, 2006).



2004:

A Derby community committee Jayida Burru formed to coordinate the multitude of non-government and government services in the community.

In a submission to the Senate Select Committee on the Administration of Indigenous Affairs, Wunan Regional Council in Kununurra proposed a 3-tiered regional council to overcome disadvantage in the Kimberley, stating:

To overcome our situation we need to become more assertive in defining a way forward – we need to take responsibility for setting the goals that will make the most difference to our communities and identify strategies that will achieve these goals.

The Kimberley Aboriginal Medical Services Council (KAMSC) Social and Emotional Wellbeing Unit developed an Advanced Diploma in Social and Emotional Wellbeing to follow their existing course 'Introduction to Counselling and Factors Impacting on Mental Health.' The Advanced Diploma was developed to address increased needs in the region.

2005:

KAMSC Social and Emotional Wellbeing Unit worked with community women to develop an *All Children Have Rights Pamphlet* and A3 Poster to prevent child abuse.

2006:

The Kimberley Aboriginal Medical Services Council (KAMSC) Social and Emotional Wellbeing Unit developed the *Live Life, Stay Solid* Social and Emotional Wellbeing campaign and funding was obtained for a two year project to provide 'one off' 2 day training programs to towns and communities within the Kimberley.

2007:

A group of Aboriginal women from the Marninwarntikura Women's Resource Centre in Fitzroy Crossing called for an enquiry into the high number of suicides in the Fitzroy Valley and began a successful campaign to ban the sale of full-strength takeaway alcohol in their community. June Oscar explained on Newslines Radio:



We had attended 50 funerals in our community and we had witnessed the burials of people who had committed suicide and we had 13 suicides in 13 months. The period before that, the whole community was in discussions for many many years. Men, senior men, senior women, young people, you know several generations were raising this issue at many different points. So I think the community had had enough discussion locally and that it needed some decisive action and so the women felt that, well if anyone's going to do it, it had to be the women

(Newslines Radio, October 5, 2009).

From May, it became possible for communities in WA to approach the Minister to request a restricted area under section 175(1a) of the Liquor Control Act 1988. This enabled the Governor, on the recommendation of the Minister, to declare a restricted area. Regulations made it an offence to sell, supply, possess or bring liquor into these communities.

In Kununurra:

The Ord Valley Aboriginal Health Service (OVAHS) obtained funding to provide Social and Emotional Wellbeing counsellors. KAMSC provided intensive 2-week training on-site for the new staff before it was opened.

At Fitzroy Crossing:

The Yiriman youth diversion program won a silver medal in the National Drug and Alcohol Awards. Since 2008 funding has been provided to suicide prevention elements of the program through the Australian Government's National Suicide Prevention Program.

At Balgo:

- The Balgo Women's Group held a Women's Law Camp to discuss social and emotional wellbeing issues and began fund-raising to provide services.
- The Palyalatju Marpanpa Health Committee at initiated a youth service to provide counseling, support, advocacy and youth activities, but was unable to attract government funding. Obtained funding from St John Of God Hospital and Caritas Australia, with a 5% contribution from the WA Government.
- The Coordinator of this service won the WA Youth Sector Worker of the Year Award from the Youth Affairs Council of WA in 2008.
- The Balgo community invited CAYLUS Youth Link-Up (based in Alice Springs) and other agencies to meet to consider how to respond to petrol sniffing.
- The Kimberley Aboriginal Medical Services Council (KAMSC) in Broome:
Led a consortium in a tender to establish a 'headspace' Community Youth Service based in Broome to provide mental health response and intervention services for 12-25 year olds in the Kimberley.
- KAMSC Social and Emotional Wellbeing Regional Training Centre launched the *Live Life, Stay Solid* Social and Emotional Wellbeing campaign, which included a CD.

- KAMSC Social and Emotional Wellbeing Regional Training Centre received a grant to conduct youth suicide prevention training throughout the Kimberley. A Suicide Prevention and Response Training Package was delivered in Derby, Beagle Bay, Bidadanga and Djarindjin. KAMSC also contracted a consultant to produce a resource for teachers and parents to use when a child discloses experiences of child sexual abuse.

In Broome:

The Saints, in partnership with Men's Outreach Service, established the Alive and Kicking Goals program aimed at raising awareness of suicide among young Aboriginal men in Broome. The suicide prevention peer education project takes an innovative approach to tackle the inadequate provision of mental health services to youth at risk in the Kimberley. It aims to prevent self-harm and suicidal behaviours by enhancing protective factors.





Garnduwa Indigenous sport and recreation body for sport and recreation in the Kimberley: has delivered an annual 4-day Garnduwa Remote Communities Sporting and Cultural Festival each year since 1992. Other programs include *Kickstart* program for the AFL and *Be Active* program.

The Gelganyem Trust, which comprised the seven *Traditional Owner* groups of the Argyle Diamond Mine region, established the Gelganyem Youth and Community Well Being Program and funding was obtained for a two year project to provide 'one off' 2 day training programs to towns and communities within the Kimberley.

2008:

The Saints, in partnership with Men's Outreach Service, established the Alive and Kicking Goals program aimed at raising awareness of suicide among young Aboriginal men in Broome. The suicide prevention peer education project takes an innovative approach to tackle the inadequate provision of mental health services to youth at risk in the Kimberley. It aims to prevent self-harm and suicidal behaviours by enhancing protective factors.

Hon Robyn McSweeney moved an unsuccessful motion that the house considers as a matter of urgency the serious lack of ministerial accountability exposed by Coroner Alastair Hope in the record of investigation into death by suicide of 22 people in the Kimberley region of

Western Australia: 'government agencies receive \$1.2 billion funding annually but *only five per cent of the expenditure was spent on Aboriginal people on the ground*' (Emphasis added. Extract from Hansard, Tuesday, 26 February 2008).

2009:

CEO June Oscar and Chair Emily Carter, of Marninwarntikura Women's Resource Centre in Fitzroy Crossing travelled to New York with the Human Rights Commission to share the journey of the alcohol restrictions with the United Nations:

Alcohol restrictions in themselves are not the answer to all the problems in the community and were never intended to be. Their purpose was always to create a breathing space from the trauma and chaos of death, violence and fear; a breathing space in which to think and plan strategically

(June Oscar, Marninwarntikura Women's Resource Centre, Fitzroy Crossing, 2009).

At Fitzroy Crossing:

The Kimberley Aboriginal Law and Culture Centre (KALACC) developed a proposal for COAG to fund the 'Kimberley Regional Indigenous Youth Alcohol and Drug Diversion Program through the *Yiriman* Project. The Program was being funded with philanthropic donations.

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In its submission to the Senate Affairs Inquiry into Suicide, KALACC stated:

The State of Western Australia in the 2009/2010 will spend a total of \$2.0 billion on the following three agencies: Police, Prisons and Courts. Some of that money will be spent on consulting Aboriginal people but virtually none of that money will be spent on empowering Aboriginal people to develop and implement community - based and community - owned initiatives

(KALACC, 2009, p3).

The Fitzroy Futures Forum – made up of the Marninwarntikura Women’s Resource Centre, Marra Worra Worra Aboriginal Corporation, Nindilingarri Cultural Health Service and the Kimberley Aboriginal Law and Culture Centre – developed and released a framework for universal strategies to prevent suicide in the Fitzroy Valley which was in line with the LIFE Framework, titled *Community-Owned Approaches to Social Recovery – Overcoming Suicidal Despair in the Fitzroy Valley*. The strategy was not funded.

Aboriginal communities in the Fitzroy Valley invited the George Institute for Global Health to work with them on their project: *Overcoming Foetal Alcohol Spectrum Disorder and Early Life Trauma in the Fitzroy Valley: A Community Initiative*. This has become the Marulu - Lililwan Project where a group of experts in Indigenous health, pediatric medicine, human rights advocacy, child protection and a production company are progressing the strategy, which will include two films to raise awareness of FASD.

A separate Ord Valley Aboriginal Health Service Foetal alcohol spectrum disorders program was launched targeting the population of Kununurra. This was funded by local Aboriginal people through the Miriwung Gajerrong Ord Enhancement Scheme and delivered through the Ord Valley Aboriginal Health Service (OVAHS).

In Kununurra:

OVAHS was granted Commonwealth funding for a mental health nurse (\$130,000) and a psychologist (\$230,000) but was unable to accept either, due to an inability to house them.

In Halls Creek:

Children are experiencing trauma and emotional upheaval in their personal lives and for some kids it's on a daily basis. It's just not a good environment for kids to be brought up in ... because kids see the misery all the time and experience it as well. One Aboriginal lady in the Kimberley, and she's right, describes it as our kids are now showing emotional signs similar to kids from war-torn countries.

(Doreen Green, The West Australian, 2009)



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In response to lobbying by the Halls Creek Alcohol Management Group, led by local Elder, Mrs Doreen Green, the Director of Liquor Licensing announced that alcohol restrictions in relation to full strength alcohol from take-away outlets would be instigated in Halls Creek for an indefinite period. Mrs Doreen Green was recognized for her efforts to have alcohol restrictions put in place, winning an Australian Human Rights Commission certificate for her persistence and tireless campaigning with the Halls Creek Alcohol Management group for alcohol restrictions. She was further recognized by induction in the WA Women's Hall of Fame (Perth Now, January 17, 2011).

Inaugural Ngayuru Waaringarrem Halls Creek Music Festival 2010 took place. An alcohol, smoke and drug free event promoting messages about community unity such as *Respect Yourself - Respect Your Culture, It's Not OK to Stay Away.*

At Beagle Bay:

The Billard Blank Page Summit is held. A local family who had lost two sons to suicide organised an emergency summit near Beagle Bay. Now an annual event known as the Blank Page Summit, the summit allows Aboriginal people in the Kimberley to sit down with representatives from State government, Federal Government and community agencies to talk about key issues affecting their local communities. Funding was provided in 2010/11 to the Billard Learning Centre through the National Suicide Prevention Program to facilitate field trips and community consultations with the Balgo Community with the view to holding a summit-like event in the community in 2012.

Billard's three key messages in its call for action were:

1. Creating suicide-proof communities;
2. Training families to be families; and
3. Healing and self-care through staged support.



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2011:

Liquor restrictions are in operation in Derby, Fitzroy Crossing, Halls Creek, Kununurra and Wyndham, Pandanus Park and Looma under Section 64 of the *Liquor Control Act 1988*. The remote communities of Oombulgurri, Jigalong and Wangkatjungka are 'dry' communities under Section 175 of the *Liquor Control Act 1988*.

Labor MP, Tom Stephens who lobbied for the 2007 coronial inquest into suicides in the Kimberley, said governments have rewarded ineffective Perth-based agencies with funds at the expense of successful Aboriginal-led organisations. Despite evidence of success, Aboriginal-led health and cultural organisations that aimed to close the gap had been treated 'woefully' by governments (The Australian Newspaper, Feb 28, 2011).

The Kimberley Aboriginal Medical Services Council (KAMSC) received \$800,000 for four Community Coordinators to work in the region for 12 months to develop plans to suicide-proof communities (Australian Newspaper, April 30, 2011).

There were suicides on three successive nights in Derby during August. 300 residents and government agency representatives gathered at Derby's Civic Centre for an emotional crisis meeting to take action against the rising tide of suicides in the town (West Australian, August 4, 2011). WA Police, Department for Child Protection, Derby Aboriginal Health Service, Shire of Derby West Kimberley, WA Country Health, Department of Indigenous Affairs and KinWay have invited the community to air concerns in a bid to stem the tide of death. In August, a Coronial Inquest examines four

suicide deaths associated with petrol sniffing in Balgo during 2008-2009. Petrol sniffing had ceased in Balgo 12 months ago. Billard leaders were invited by community elders to host a summit-like gathering at Balgo.

The Education and Health Standing Committee tabled its report: *Alcohol Restrictions in the Kimberley – A Window of Opportunity for Improved Health, Education, Housing and Employment*. The report recommended that the Yiriman project be funded to provide regional services.





3.4 Timeline of Government Policies and Responses to Community Distress and Suicide in the Kimberley

1996:

In 1996, the WA Youth Suicide Advisory Committee expanded its scope to include suicide prevention in young Indigenous populations. The proposal was initiated out of the need to formulate relevant community responses to suicidal behaviour and other adverse outcomes that required urgent attention within WA's Indigenous communities. Using a preventative approach, 'local action plans' would help to build community capacity within Aboriginal communities to strengthen the governance, management, leadership and cohesion. The policy was endorsed as State policy by Cabinet in late 1997.

1998:

In 1998, a WA Aboriginal Suicide Prevention Steering Committee was established. The policy was launched by the WA Minister for Health in February 1998, but was not implemented due to a change of government.

1999:

The National Suicide Prevention Strategy 1999 – 2003 began. The Kimberly Primary Health Care Plan Steering Committee (which included Aboriginal people and agencies) noted Aboriginal people who committed suicide did not have major psychiatric conditions and that suicide prevention strategies in the Kimberley required a community development response supported by Aboriginal community controlled organizations (Kimberly Primary Health Care Plan Steering Committee, 1999).

2000:

In 2000, COAG endorsed an Indigenous affairs approach to guide service delivery based on partnerships and shared responsibilities with Indigenous communities, program flexibility and improved coordination between Government agencies.

2001:

In 2001, the WA Government announced the Gordon Inquiry to examine the response by Government agencies to complaints of family violence and child abuse in Aboriginal communities. This was prompted by a coronial inquest into the death of a 15 year old Aboriginal girl at the Swan Valley Nyoongar Community in 1999.

2002:

In 2002, COAG announced ten trial sites for a 'whole of government' approach to Indigenous affairs based on partnerships and shared responsibilities with Indigenous communities program flexibility and coordination between Government agencies, with a focus on local communities and outcomes. This included an East Kimberley COAG Trial Site that was established to address disadvantage by improving the coordination and implementation of State and Commonwealth Government services in Balgo, Billiluna, Mulan, Ringers Soak and Yagga Yagga. A Regional Reference Group was formed to develop a Munjurla Scoping Study and Joint Action Plan. Later a newspaper reported, "of \$1.3 million allocated to the COAG trial in the Far-East Kimberley region of Western Australia, only \$327,000 was spent on Aboriginal people and programs over two-and-a-half years. The rest of the money was spent on salaries, travel and other related administrative expenses of the Department of Transport and Regional Services, which administers the program. (The Age, September 15, 2005).

The report of the Gordon Inquiry was produced, *Putting the Picture Together: Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities*. The Western Australian Government released its Action plan for addressing family violence and child abuse in Aboriginal Communities (the

Gordon Action Plan). The implementation of the Gordon Action Plan formed part of the WA Government's contribution to the East Kimberley COAG trial site. More than 120 initiatives were to be implemented by 15 agencies.

2003:

In 2003, the 'Communities in Crisis' policy was established as a strategic initiative to address crisis in nominated discrete Indigenous communities in a whole of government manner. Crisis was defined as 'suffering from intolerable levels of alcohol, substance and child abuse, violence and high rates of suicide and self-harm'. In communities declared a 'Community in Crisis', the Commonwealth and State Governments worked together to:

- Stabilise the community (e.g. family violence, substance abuse, corruption)
- Re-establish basic services
- Develop local plans of action
- Build governance, capacity and leadership
- Help communities engage with government

Balgo was declared a 'Community In Crisis' by the Australian Government following a spate of self-harm and suicide attempts. The Wirrimanu Aboriginal Corporation was placed in administration and State and community-based agencies formed a local response group to advocate for resources to tackle disadvantage at Balgo, Mulan, Billiluna and Ringers Soak (the Katjunga region).

2004:

Kalumburu was declared a 'Community In Crisis' (the 2002 Gordon Inquiry had identified it as a community in acute need). A 'whole of Government – all of community' strategy was implemented.

The Australian Government abolished ATSIC and transferred responsibility for ATSIC-ATSIS programs and services to mainstream agencies from 1 July. A National Indigenous Council was formed to provide expert advice to a Ministerial Taskforce on Indigenous Affairs. The Australian Government established an Office of Indigenous Policy Coordination and Indigenous Coordination

Centres replaced ATSI Regional Offices around Australia to facilitate coordination of service provision to Indigenous communities.

2005:

Beagle Bay was declared a 'Community in Crisis' following a collapse of community governance (Beagle Bay Community Council was unable to hold constitutionally valid elections as a result of on-going tensions between members of the Stolen Generations and Native Title Claimants resident in the community).

An evaluation of the Gordon Action Plan found the central reporting and monitoring of the Action Plan were inadequate. Basic information such as total number of initiatives, number implemented, estimated expenditure or anticipated completion dates was not available.

The Petrol Sniffing Strategy Eight Point Plan was announced by the Australian Government. The Kimberley was one of four priority zones for implementation of the strategy (Opal fuel).

2006:

The Bilateral Agreement on Indigenous Affairs 2006-2010 was signed by the State of Western Australia and the Commonwealth of Australia. The Agreement established an agreed framework and priorities for intergovernmental cooperation and enhanced effort in Indigenous affairs. The Agreement had six key outcome areas and a number of specific joint initiatives as well as establishing processes for further work on key issues such as community governance, responding to communities in crisis and future service delivery to remote communities.

The COAG measure, *Addressing Violence and Child Abuse in Indigenous Communities – Drug and Alcohol Treatment and Rehabilitation Services for Indigenous Australians in Remote and Regional Communities* was announced.

Between February and July of 2006, the Halls Creek *Engaging Families* trial was implemented involving 30 Parenting Payment recipients, with two aims: to increase participation in job-oriented activities among Parenting Payment recipients

with children at Halls Creek School; and to encourage those parents to try to make their children attend school regularly.

2007:

As part of the COAG Action Plan On Mental Health 2006-2011 the Australian Government provided \$3.2 million to the Kimberley Division of General Practice received to deliver Mental Health Services in Rural & Remote Areas (June 2007 – August 2011). Information about services delivered to Aboriginal people and communities is not available.

The Drug and Alcohol Office of Western Australia commissioned the University of Notre Dame to independently evaluate the impacts of the alcohol restrictions in the Kimberley.

Several people in Kulumburu and Halls Creek were charged with sexual abuse offences. The Australian Government announced a package for Kimberley Aboriginal communities, which includes \$7 million for a Family Violence Service hub to deliver counselling and other assistance, about \$1.6 million for education programs, and up to \$1 million for a Child Care Services Hub to be based at Halls Creek (Sydney Morning Herald, September 26, 2007).

The Commonwealth Government announced funding for the *8 Point Plan* anti-petrol sniffing strategy, which included strengthening and supporting communities, better policing, establishing treatment and respite facilities, providing alternative activities for young people and supporting the roll-out of unleaded Opal fuel.

Minister Hockey through Indigenous Business Australia commissioned the Irving Report which showed that Leedel Trust, an Aboriginal company formed with government support to manage the ownership of key enterprises in Fitzroy Crossing, including the Inn and supermarket had \$8 million in assets and sold more than \$4 million in alcohol annually from the Crossing Inn and had not transferred a cent to those it was set up to help 18 years previously.

2008:

The Australian Parliament formally apologized to Australia's Indigenous Peoples, and in particular members of the Stolen Generations, for past injustices.

COAG agreed to a number of ambitious targets to Close the Gap in Indigenous disadvantage and agreed on new public reporting frameworks for new expenditure. This included \$5.5 billion of investment for remote Indigenous housing.

The WA Education and Health Standing Committee recommended the Kimberley Yiriman Project be supported and used as a model for other regions. No additional funding was provided.

Eighty Aboriginal parents in Kununurra, Halls Creek and Balgo who sought financial assistance from Centrelink twice in a short time frame agreed to be interviewed, placed on voluntary income management and given a Basic Card.

2009:

The Australian Government announced \$26.6 million over four years to establish a new Aboriginal and Torres Strait Islander Healing Foundation to provide grants for community healing projects and strategically invest in research, training and education related to healing.

Under the COAG *National Action Plan On Mental Health 2009-2010* Mental Health First Aid Training was delivered nationally to ancillary workers (drivers, receptionists) in Aboriginal Community Controlled Health Services to help detect and refer those with a mental illness.



'Voluntary' income management and Basic Cards were extended to Derby, Fitzroy Crossing, Kalumburu, Oombulgurri and Beagle Bay.

Kalumburu was no longer designated as a 'Community in Crisis'.

Through COAG, the *Remote Service Delivery* initiative begins to bring services and infrastructure in 29 Indigenous communities and regions across Australia up to a standard expected in other Australian communities of a similar size. The Kimberley is host to four sites: Beagle Bay, the Bardi Jawi lands, Halls Creek and Fitzroy Crossing. A Remote Services Coordinator General is appointed to monitor and report twice a year on progress in the delivery of infrastructure and services, community by community.

Western Australia's Commissioner for Children, Michelle Scott, expressed disbelief at the lack of services in Fitzroy Crossing, where pediatricians estimate at least a quarter of children were affected by fetal alcohol spectrum disorder.

2010:

The WA Government appointed a Mental Health Commissioner, Eddie Bartnik.

Burdekin Youth In Action (Broome) Indigenous Hip Hop Projects West Kimberley Community Workshops. Indigenous Hip Hop Projects Community Workshops aim to engage young people in remote communities using a prevention and early intervention approach to facilitate social change. IHHP use the energy and enthusiasm of hip hop music, dance, and safe-talk to address crime prevention and promote community safety.

The report, *Halls Creek Alcohol Restriction Report: An Evaluation of the Effects of a Restriction on Take-away Alcohol Relating to Measurable Health and Social Outcomes, Community Perceptions and Behaviours After a 12 Month Period* by Kinnane, Golson, Henderson-Yates & Melbourne (2010) is released and this recommends that:

- There need to be back-up services in place from the start when bringing alcohol restrictions into place
- A full-time mental health worker in Halls Creek is required in light of the increased presentations of mental illness.



- Government needs to invest in counsellors in Halls Creek as the levels of suicide and suicide attempts are unacceptable.
- A 24-hour counselling service is required.
- A renal dialysis unit in Halls Creek would mean people did not have to travel to Broome.
- There ought to be regular reviews of the impacts of the restrictions by service providers so that they are monitoring and responding to changes in their areas of responsibility.

2011:

February. Another 9 suicides were reported since December. North West Mental Health Service is overwhelmed, with 300 clients already on its books and about 300 new referrals. WA Mental Health Minister Helen Morton described the spike in suicides as a Kimberley-wide tragedy and crisis. She said an emergency response had been put in place and health services would receive extra funding for more counsellors and other staff. In the long term, she said, a suicide-prevention strategy would focus on prevention. The strategy, which had been delayed and would now be fast-tracked, will see \$850,000 spent in the Kimberley in 2011 (Australian Newspaper, February 28, 2011).

North West Mental Health calls for specialists, more workers on the ground, massive investment to address the grave shortfall in indigenous housing. "This is larger scale than a cluster, bigger than anyone can respond to at the moment," said one NWMH figure.

The Consultation Paper, *WA Mental Health Towards 2020* was released. A significant gap identified in the paper was: 'the importance of prioritising engagement with the spectrum

of Aboriginal service agencies and with local Aboriginal communities'.
The WA Mental Health Minister, Helen Morton announced \$1.3 million to fast-track the housing and employment of four Local Community Coordinators to help Kimberley communities develop action plans to help reduce suicide. State-wide arrangements to implement the policy are:

- Centrecare has been contracted to increase awareness, coordinate training, research and evaluation of suicide prevention strategies across WA.
- A Network Coordinator will engage communities and outline how they can implement the Strategy.
- An Agency Coordinator will engage government, non-government and corporate agencies to establish organisation wide suicide prevention strategies.
- Local Community Coordinators will support local communities to map existing suicide prevention activities and determine need for future initiatives. These will be documented in Community Action Plans.
- Community Action Plans recommended by Centrecare will be approved by the Ministerial Council for Suicide Prevention.
- Edith Cowan University will conduct the research and evaluation components of the Strategy.

In Kununurra, police have listed 25 at-risk individuals who have threatened or attempted suicide in the recent past.

The WA government's emergency response to the high rate of suicides was to provide \$560,000 for extra counsellors and other staff. (Australian Newspaper, April 30, 2011).

April: The Australian Government announced a Kimberley Suicide Prevention Initiative:

- BOAB Health Services in Broome (formerly Kimberley Divisions of General Practice) was provided with \$490,000 to deliver an Access to Allied Psychological Services (ATAPS) program to Aboriginal people who have attempted or are at risk of suicide.
- \$280,000 was provided to the Australian Psychological Society to deliver Indigenous specific, culturally appropriate suicide prevention training for mental health professionals in the Kimberley (Australian Government Department of Health and Ageing Fact Sheet, 2011).

The Australian Government also announces it will allocate up to \$6 million over four years for targeted suicide prevention interventions in Indigenous communities nationwide, making Indigenous communities the first priority under the \$22.6 million *Supporting Communities to Reduce Risk of Suicide* component of the National *Taking Action to Tackle Suicide* package.



August: The State Coroner began an Inquest on site in Balgo to examine 5 suicides associated with petrol sniffing. The Kimberley Mental Health and Drug Service told the court that the ‘tyranny of distance’ means its officers only get to make six weekly visits to Balgo for the year (West Australian, August 4, 2011).

September: Extra Federal Government money to address the growing suicide toll in the Kimberley has been tied up in red tape instead of improving mental health services on the ground, the Opposition claims. A spokeswoman for Mental Health Minister Mark Butler said the Government was taking immediate action to tackle suicide in the Kimberley. She said the Kimberley Division of General Practice had its funding increased 216 per cent to \$779,000 in 2011-12 to improve access to suicide prevention and mental health services (West Australian Newspaper, September 5, 2011).

October: Coroner hands down findings of Balgo inquest. Senate Estimates: The Standby Suicide Bereavement Service reported a total of 23 deaths by suicide in the Kimberley between October 2010 and August 2011. The Western Australian Government established a Cabinet Standing Committee on Indigenous Affairs (the Committee) to provide leadership and accountability in service delivery to government in Indigenous Affairs. The Committee provides policy directions, sets priorities and outcome targets, monitor and report on the State Government’s performance to reduce Indigenous disadvantage in Western Australia.

December: The Western Australian Mental Health Minister Helen Morton announces the State-wide Specialist Aboriginal Mental Health Service (SSAMHS), a unique partnership program sourcing community knowledge of mental health issues and delivery of services from the Kimberley Aboriginal Medical Services Council (KAMSC) and the WA Country Health Service (WACHS) to address severe and persistent mental illnesses such as bi-polar and schizophrenia affecting Aboriginal people across WA. The Mental Health Commission will fund 12 positions

across the Kimberley to improve access to mental health assessment, treatment and support services, better co-ordination of care, including access to the support of elders and traditional healers and the provision to support Aboriginal people in custody or presenting for parole.

3.5 Capacity of the Health System to Intervene to Address Community Distress and Suicide in the Kimberley

Many of the risk and protective factors that impact on Aboriginal social and emotional wellbeing and mental health lie outside the ambit of the health and mental health systems, in sectors that impact on the daily lives of individuals and communities (ie the social determinants). Rather than preventing suicide, the role of the health system is early intervention, to address problems as they develop in those identified as vulnerable.

Psychological distress and any indication of suicidality in the previous 12 months are accepted indicators of ‘need’ for primary mental health care services, such as the new services developed and delivered during the life of the COAG Mental Health Action Plan 2006-2011: Better Access, ATAPS, Headspace and the Mental Health Services in Rural and Remote Areas program (Harris et al, 2009). Even though twice as many Aboriginal and Torres Strait Islander people experience serious psychological distress (32%) compared to non-Indigenous Australians (17%) (ABS and AIHW 2010), very few Aboriginal communities have gained access to primary mental health care services since the new primary mental health services have been delivered almost exclusively through Divisions of General Practice. Aboriginal Community Controlled Health Services have yet to be included as service providers or fund holders for primary mental health services delivered under the COAG Mental Health Action Plan 2006-2011.

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As well-meaning as the professions, health services, and government bureaucracies are, they are inevitably driven by their own professional, governmental or commercial paradigms and, in some cases, self-interest. (McBride in Price & Considine, 2008 p. 121).

Comprehensive Primary Health Care in the Kimberley

Aboriginal Community Controlled Health Organisations employ GPs and generalist health staff to provide social and emotional wellbeing services as part of holistic health care. There are seven Aboriginal Community Controlled Health Services in remote areas of the Kimberley. Each service provides outreach health care to surrounding communities.

- Broome Regional Aboriginal Medical Service;
- Ord Valley Aboriginal Health Service in Kununurra;
- Yura Yungi Aboriginal Medical Service Aboriginal Corporation in Halls Creek;
- Derby Aboriginal Health Service;
- Nindilingarri Cultural Health Services in Fitzroy Crossing;
- Palyalatju Maparnpa Health Committee in Wirrimanu (Balgo); and
- Jurruggk Aboriginal Health Service Aboriginal Corporation serving the Gibb River Road area.

Aboriginal Health Workers are the backbone of Aboriginal Community Controlled Health services. Bringing Them Home counsellors are available in Derby, Kununurra and Halls Creek to support members of the Stolen Generations and a Link Up service is available in Broome. OVAHS has been funded to provide additional SEWB services.

Yagarrbulanjin Mental Health Support Group was established and incorporated in 1998 to assist Aboriginal carers and families living with mental illness in the Broome area. The Yagarrbulanjin Mental Health Support group negotiated a rooming-in service in the Broome hospital for children with mental illness. The facility was used by families to monitor the person affected by mental illness. Without it, the person affected

would have been flown to Perth as the Broome hospital did not have the facility to monitor people with mental illness. The Kimberley Aboriginal Medical Services Council provides a Social and Emotional Wellbeing Regional Training Centre and delivers SEWB education throughout the region from its base in Broome. Two Aboriginal organisations in the Kimberley offer Sobering Up Services and alcohol rehabilitation programs: Milliya Rumurra in Broome and Ngnowar-Aerwah in Wyndham.

Mainstream Primary Mental Health System

In order to access primary mental health care services, Aboriginal people need to express / display their psychological distress to a GP, who will then either treat them themselves with 6 therapeutic sessions, or generate a GP Mental Health Treatment Plan to refer them to providers of Medicare subsidised mental health care services for 6 sessions of 'focused psychological strategies' or treatments by a Clinical Psychologist. It is therefore of concern that there are only 9 GP practices in the Kimberley, with a total of 72 GPs providing services, and an estimated shortage of 20.6 FTE GPs in order to meet the needs of the population (Roach et al, 2006). The lack of availability of GPs in remote areas of the Kimberley is reflected in the low uptake of Medicare funded GP mental health treatment plans in 2009-2010.

There were a total of 611 GP attendances for mental health treatments in the Kimberley, representing a rate of 17 attendances per 1,000 population (WA Department of Health, 2011) This rate is lower than the national average of 21.5 per 1,000 population for remote areas - itself a figure already 60% lower than in capital cities (; Perkins et al, 2010). Even if General Practitioners and mental health care providers were geographically accessible to Kimberley Aboriginal communities, the lack of cultural competence in non-Indigenous service providers creates an additional barrier to effective service provision within a social and emotional wellbeing framework.

To access primary mental health care services, Aboriginal people need to express or display their psychological distress to a GP, who will then either

treat them themselves, or generate a GP Mental Health Treatment Plan to refer them to providers of Medicare subsidised mental health care services. It is therefore of concern that there are only 9 GP practices in the Kimberley, with a total of 72 GPs providing services. The only private practice GP service in the Kimberley is located in Broome with an overall shortage of 20.6 FTE GPs identified in the Kimberley (Roach et al, 2006). The lack of availability of GPs in remote areas of the Kimberley is reflected in the low uptake of Medicare funded GP mental health treatment plans in 2009-2010. There were a total of 611 GP attendances for mental health treatments in the Kimberley. This represented a rate of 17 attendances per 1,000 population, a rate lower than the national average for remote areas: 21.5 per 1,000 population (WA Department of Health, 2011).

Outside of Broome, GPs are employed as District Medical Officers by WA Country Health Services - some with rights to private practice. Currently, the WA Country Health Service Kimberley has vacant District Medical Officer positions at Broome, Derby, Kununurra, Fitzroy Crossing and Halls Creek Hospitals. The turnover rate for health staff in the Kimberley is 60%, with 300% turnover of doctors and a rate of 350% for nurses. A turnover rate of this magnitude requires 50 nurses to be employed each year to fill the 15 nursing positions in Fitzroy Crossing (Hope, 2008).

In 2007, the Commonwealth Government funded the Kimberley Division of General Practice to provide low cost or free ATAPS services to disadvantaged people in remote areas, especially Aboriginal people and those in remote areas otherwise unable to access support for high prevalence disorders such as anxiety and depression in remote areas (last round of ATAPS roll-out). Aboriginal uptake of these services has yet to be reported. The Kimberley Primary Care Sustainability Planning Group 2008-2030 criticised the new MBS mental health referral program introduced in 2007 as lacking



coordination with other agencies and relying on too few psychologists to provide support, providing only outreach services and the program needed to be better tailored to suit the needs of Indigenous people.

In 2008, the WA Country Health Service gave evidence at the Coroner's Inquiry that the turnover rate for health staff in the Kimberley was 60%. In Fitzroy Crossing, medical and nursing turnover were 300% and 350% respectively, and it was necessary to employ around 50 nurses each year to fill the 15 nursing positions in Fitzroy Crossing (Hope, 2008).

In 2011, the Commonwealth Department of Health and Ageing funded the Kimberley Division of General Practice to employ two clinicians to provide intensive support to Aboriginal people identified as being suicidal, at risk of suicide, have self-harmed or attempted suicide, using GP Mental Health Treatment Plans to refer patients to approved providers of mental health care services. While the number of sessions is unlimited, it is expected they will be conducted in a short period of time (1-2 months).

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To support this initiative, the Commonwealth Department of Health and Ageing funded the Australian Psychological Society to adapt its ATAPS Specialist Services for Consumers at Risk of Suicide training package to prepare the two clinicians to work in the Kimberley cultural context.

Specialist Mental Health Services

People with a mental illness are at a higher risk of suicide than the general population and some mental health disorders, such as mood, anxiety and schizophrenia-spectrum disorders are independent risk factors for suicidal behavior. Co-morbid psychiatric disorders are commonly found in those with alcohol use disorders.

In Western Australia over the past 21 years, 35% of men and 60% of women who completed suicide had suffered from a diagnosed psychiatric disorder in the preceding 12 months. Disorders included depressive disorders, schizophrenia, substance misuse and personality and other adjustment disorders. Over a third had been admitted to hospital for psychiatric treatment at some time in their lives (WA Suicide Prevention Policy, 2010).

The Coroner investigating 22 suicide deaths in the Kimberley in 2006 noted the majority did not have a diagnosed mental illness and did not receive any clinical mental health services prior to their deaths (Hope, 2008a; Kimberley Mental Health & Drug Service, 2009).

Numerous government reports have highlighted the chronic under-resourcing of mental health services in the Kimberley region and the inability of mental health services to intervene unless the patient presents on site to seek help from clinicians – usually mental health nurses (Price & Considine, 2008).

One in 15 adults (6.9%) in the Kimberley reported they had used a mental health care service such as a psychiatrist, psychologist or counselor in the last 12 months (WA Department of Health, 2011).

Involuntary patients under the *Mental Health Act 1996* (risk of harm to self or others) are referred to Graylands Hospital in Perth, although the inability of the Graylands facility to effectively treat Indigenous patients from the Kimberley has also been noted (Ibid).

Rooming-in facilities for voluntary patients are provided in Broome, Kununurra and Derby. Rooming-in units are opened when required and staffed by mental health nurses and assisted by a family member or friend of the patient (Gordon, 2002). Carers dealing with episodic cases are routinely referred to the police for assistance (Price & Considine, 2008).

Those with serious mental illnesses needing to travel to regional towns such as Broome to access services are usually required to fend for themselves and find accommodation in backpackers or sleep in the bush on the edges of town (Price & Considine, 2008).



In December 2011, the Western Australian Mental Health Minister Helen Morton announced a State-wide Specialist Aboriginal Mental Health Service (SSAMHS) to address severe and persistent mental illnesses such as bi-polar and schizophrenia affecting Aboriginal people across WA. The Mental Health Commission will fund 12 positions across the Kimberley to improve access to mental health assessment, treatment and support services, better co-ordination of care, including access to the support of elders and traditional healers and the provision to support Aboriginal people in custody or presenting for parole. (Clinician.net.au, 2011). An additional 12 FTE (4 through KAMSC with 2 for Derby and 2 for Balgo); and 8 WACHS with 3 for Broome, 2 each in Kununurra and Fitzroy Crossing, and 1 for Halls Creek with further expansion of the Halls Creek service.

The Australian Government also funds a community based support program for people living with acute mental illness in Broome and West Kimberley through the Personal Helpers and Mentors Scheme.

Suicide Postvention in the Kimberley

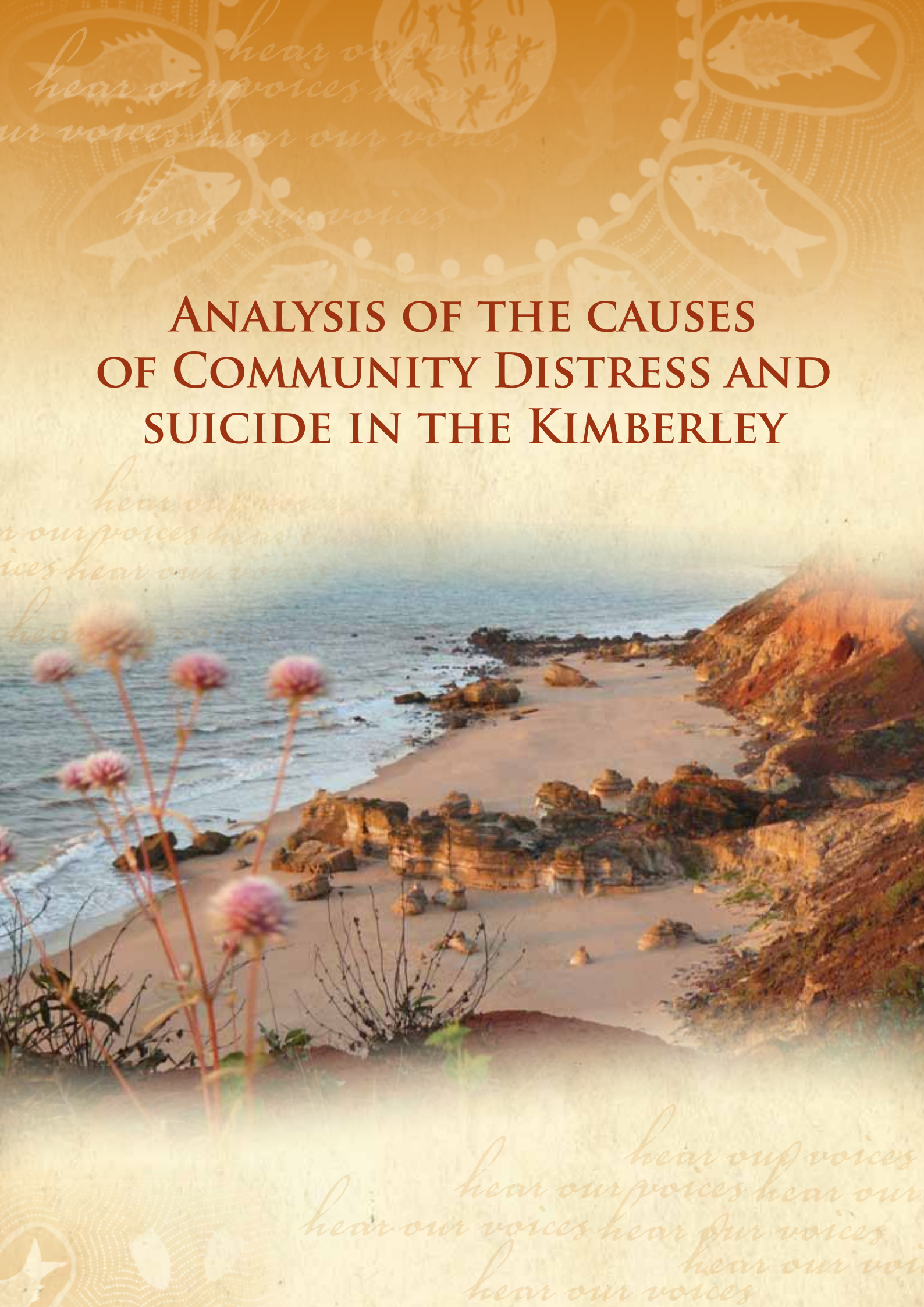
The small and close knit nature of Indigenous communities means every suicide has a widespread impact with ripples of loss, grief and mourning extending throughout the community and beyond - particularly where communities are highly interconnected. This can create layers of increased risk within affected communities during the grieving period, and in some situations

a 'suicide cluster' can form. The nature of suicide clusters mean they can unfold over time and alongside existing relationship networks, further compounding and extending the grief, loss and distress experienced by the survivors of suicide (i.e. the families and communities (Ugle, Glaskin, Dudgeon & Hillman, 2009).

Anglicare WA has been funded by the Australian Government to provide a StandBy Response Service to those bereaved by suicide, including Aboriginal people. StandBy is a 24 hour community based active suicide postvention program based on that developed by Anglicare's United Synergies Ltd in Tewantin, Queensland. The service is based on non-Indigenous research that shows those who know someone who has died by suicide are at greater risk of suicide themselves (with an average of 6 people affected by each suicide). StandBy Kimberley staff are located in Broome (Anglicare Broome) and Kununurra (Anglicare Kununurra).

In 2011, StandBy Kimberley won the LIFE Award in the category of Healthy Communities in recognition that 'through their support, initiatives and the provision of their culturally appropriate education programs StandBy have made immeasurable contributions to suicide prevention and post-vention in one the most suicide affected regions of the country'.





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ANALYSIS OF THE CAUSES OF COMMUNITY DISTRESS AND SUICIDE IN THE KIMBERLEY

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4 ANALYSIS OF THE CAUSES OF COMMUNITY DISTRESS AND SUICIDE IN THE KIMBERLEY

*The common factor in suicide and other forms of self-harm is distress... People kill themselves when they feel trapped within an intolerable intensity of psychological pain. Suicide is the escape from intolerable pain when all other avenues of flight are perceived to be blocked. The question which must be asked is: why do so many Aboriginal persons in the Kimberley feel an **intolerable intensity of psychological pain**?* (Emphasis added, Coroner Alastair Hope pp. 9-10, 2008).

It is a story of colonisation; the threat of losing our cultural authority to manage our societies; and the despair that has come from that disempowerment. It is a story of grief and trauma and the continued pain of living with grog, drug and violence. It is a story that academics and journalists write about us as though we are victims of history that we can do nothing about. And within their stories about us is an acceptance that the paternal hand of government will determine the nature of our welfare and even the nature of our rights. I want to tell a different story. It is about how Aboriginal people can be the authors of our stories and not passive and powerless subjects in stories told and written by others (Oscar, 2009).

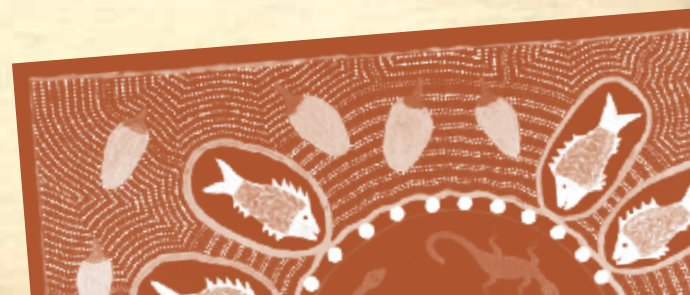
4.1 Analysis Using a Social and Emotional Wellbeing Framework

The extraordinarily high rates of suicide among Aboriginal and Torres Strait Islander people are commonly attributed to a complex set of factors which not only includes disadvantage and risk factors shared by the non-Indigenous population, but also a broader set of social, economic and historic determinants that impact on Aboriginal social and emotional wellbeing and mental health.

The absence of a comprehensive national Aboriginal mental health plan or suicide prevention policy to date has meant that Aboriginal populations and communities have missed the opportunity to implement strategies to restore social and emotional wellbeing at community level (however that community is defined). Being perennially identified as an 'at-risk' group within the broader mainstream population has resulted in the repeated delivery of selective or indicated strategies, where only small pockets of the most vulnerable receive short-term support. Multiple short-term projects which reach small numbers will not achieve the critical balance required to restore social and emotional wellbeing across the Aboriginal population. Universal prevention strategies, which promote strong, resilient communities and focus on restoring social and emotional wellbeing are needed. This needs to be done in such a way that each language group/nation and/or community is supported to achieve the goal of restoring social and emotional wellbeing at individual, family and community levels.

'Social and emotional wellbeing problems' have been described by Aboriginal people as '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).

Conversely, factors that strengthen and protect Aboriginal social and emotional wellbeing have been identified as: connection to land, culture, spirituality, ancestry and family and community. These factors serve as a unique reservoir of resilience in the face of prolonged adversity, and have helped to moderate the impact of the array of stressful circumstances on the social and emotional wellbeing of individuals, families and communities. The first step to restoring the social and emotional wellbeing of each community requires focus and attention to identify the risk and protective factors impacting on each domain of social and emotional wellbeing.



Preventative health approaches work to increase *protective factors* and reduce *risk factors* using universal, selected and targeted interventions:

- *Universal prevention strategies* promote strong, resilient communities and focus on improving the mental health of the population.
- *Selective prevention strategies* target at risk groups such as Aboriginal youth, children of parents who have suicided or had a substance abuse problem and/or children growing up with domestic violence.
- *Early treatment strategies* involve the early recognition and response to people who are currently at risk of suicide.
- *Relapse prevention and longer term treatment strategies* aim to prevent recurring suicidal behaviour and hospitalisation by engaging with people who are at chronic risk of suicide or who repetitively self-harm.

Within each of these categories, strategies which focus on constellations of risk and protective factors are likely to be most effective. The Aboriginal social and emotional wellbeing framework not only supports this activity in a way that respects and restores cultural integrity, but also serves as a resource to a range of social and emotional wellbeing problems, for example suicide, substance abuse, family violence.

Working to strengthen the domains of social and emotional wellbeing is therefore likely to result in a reduction, if not eradication, of a range of social and emotional wellbeing problems in each community. In contrast, the non-Indigenous preference to focus on individualistic explanations and treatments for problems often means the contributions of structural and systemic inequities are ignored.

Remote Aboriginal communities in the Kimberley have a range of additional stressors or risk factors which lie in the social determinants, such as entrenched poverty, crowded housing and high levels of preventable morbidity and mortality which also need to be accommodated into suicide prevention strategies. Risk factors are also likely to include cultural dimensions, such as those relating to 'country', elders, ancestors and cultural practices.

Identifying the risk and protective factors contributing to the social and emotional wellbeing of the community, and its opposite, community distress and suicide, therefore requires an in-depth knowledge of the historic, cultural and economic risk factors at play in each community. These are best known and understood by community residents themselves.

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This is critical where the social determinants of community distress and suicide have historical roots which have contributed to a sense of powerlessness at an individual, family and community level. Solutions brought in by outsiders cannot address the risk factors or harness the protective factors which lie within each community within the domains of social and emotional wellbeing.

It cannot be assumed that the risk and protective factors for community distress and suicide are the same across language groups and communities in the Kimberley, or that these are shared in equal proportions by each community. The diversity of language groups, the cultural accommodations made to support shared occupancy of communities, the historical experiences of colonisation and the risk and protective factors these pose all prevent findings from one community being generalized to others. Protective factors such as connection to land, culture, spirituality, ancestry, family and community, will also vary from community to community, and within communities and family groups.

Effective leadership and the ability to motivate and encourage people to embark on a journey of recovery is key to achieving effective outcomes. It is clear that leaders have emerged within each community in the decade of struggle to prevent further suicides in Kimberley communities. This is likely to have been driven by high levels of community distress in response to the suicides. While psychological distress can serve as a powerful drive to action, it can also be accompanied by a sense of powerlessness and being overwhelmed by events.

Given that there has been a suicide a month for more than a decade in the Kimberley region, there is an urgent need to support Elders, leaders and young people in each community to effectively identify and manage their own distress so that empowerment and healing can effectively progress beyond the crisis response phase.

Aboriginal psychologist, Pat Dudgeon has drawn attention to the process whereby oppression and abuse are internalised by those who are oppressed and abused. Individuals need to be given opportunities to heal, in parallel to strategies that promote community recovery (Dudgeon et al, 1997). Community leaders need to be supported and strengthened in their efforts to facilitate community recovery and to form partnerships with external stakeholders necessary to challenge and overcome entrenched disadvantage.

4.2 Risk factors to Aboriginal Social and Emotional Wellbeing in the Kimberley

Historical influences

Studies have shown that the social disadvantage and health issues confronting Indigenous people internationally tend to be complex, historical and include many interacting social determinants, including exclusion, discrimination and marginalisation (Marmot, 2005). For instance, in parts of the Kimberley, the lives of Aboriginal people have been profoundly influenced by missions and the pastoral industry. In the 1960s, families were forced off stations into town centres, and found themselves excluded from country, unemployed and subject to unrelenting discrimination, powerlessness and poverty. It is worth noting that the introduction of alcohol to Kimberley Aboriginal people coincided with the forced relocation to towns in the 1960's.

Evidence from analysis of 20 years of census data regarding the relative socioeconomic status of Aboriginal people in the Kimberley compared to Indigenous people elsewhere in Australia, indicates outcomes in the Kimberley are amongst the most disadvantaged in the nation (Taylor, 2009). Across the Kimberley, 12,753 people live in census collection districts with SEIFA Index of Relative Socioeconomic Disadvantage scores in the lowest 10 percentile in Australia (Wood et al, 2011).

Access to adequate community infrastructure

Providing the community infrastructure required attaining and maintaining health and wellbeing (housing, water supply, sewerage, roads, and community buildings) is likely to have a powerful impact on preventable morbidity and mortality in the Kimberley, including suicide.

A series of reports have linked infrastructure to social and emotional wellbeing. For instance, the shift in government policy towards self-determination has lacked consistent administrative or political engagement with Aboriginal organisations in Western Australia (Department of Indigenous Affairs, 2005) and the community infrastructure required for Aboriginal communities in the Kimberley to attain or maintain their health or social and emotional wellbeing has never been established (Hope, 2008). When giving evidence to the 2007 Coronial Inquiry into the Kimberley suicides, Professor Sven Silburn, from the Ministerial Council for Suicide Prevention, likened living conditions in remote Aboriginal communities to those in Mozambique (West Australian, 2007). In 2008, the State Coroner Alistair Hope revealed 'a complete lack of leadership in the response by government to the disaster of Aboriginal living conditions' for the persistence of 'appallingly bad' living conditions in Aboriginal communities in the Kimberley (Billard Summit, 2009, p.17).

Hope drew attention to the \$1.2 billion allocated to address Aboriginal disadvantage in WA every year (via 16 Ministers and 22 government agencies) and to reports produced by the Western Australia Government Indigenous Implementation Board, which found funds were being allocated to the various departments without any mechanisms in place to monitor how they were spent or whether any outcomes were achieved. The apparent inability of the WA Government to address Aboriginal disadvantage in remote areas, led Lieutenant General John Sanderson - appointed by the Western Australia Government as Special Advisor of Indigenous Affairs in 2006 and then Chair of the Indigenous Implementation Board in 2009 - to claim that the poverty, violence, and lack of education and health services in remote areas met the criteria for

a 'failed state, bereft of government that works' (Weekend Australian, July 26, 2008).

Lack of support for community governance, initiative and cultural stability. While external change agents might be able to catalyze action or help to create spaces for people to undertake a change process, empowerment can occur only as communities create their own momentum, gain their own skills, and advocate for their own changes.

Strategies which successfully reduced alcohol use/abuse in the Fitzroy Valley were driven by a group of Aboriginal women: 'the women at Fitzroy Crossing undertook to address the problem themselves and came up with a solution, and then the State got behind them with the alcohol restrictions' (Education and Health Standing Committee, 2011, p6).

While governments strongly espouse the goal of working in partnership with communities, there is ample evidence in this Report's background materials to show there is a lack of knowledge or skill about how to put this goal into practice. At other times there may be a reluctance to share decision-making power and resources beyond the comfortable confines of bureaucracy and government systems. Some examples include:

- Repeated scenarios of money being spent on consulting with communities to develop detailed strategies to deal with suicide that then gather dust on shelves (see 3.3)
- Highly commended community programs like the Yiriman Project struggling for years to obtain Government support (see 3.3)
- In his inquest, Coroner Alastair Hope found that 'government agencies receive \$1.2 billion funding annually but only five per cent of the expenditure was spent on Aboriginal people on the ground' (Quote from Hansard, Tuesday, 26 February 2008).

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In evidence to the Education and Health Standing Committee, ex-government minister Mr Ernie Bridge, noted that government actions to date have ‘dismantled’ the traditional governance models that Aboriginal communities are based upon, and that communities are bearing the consequences of this:

Governments have led a charge towards dismantling the cultural authority of the Indigenous population. Governments have gone around for a number of years and effectively disenfranchised elders. They have looked at the young educated Aboriginal as the person who should give an opinion. They have ignored the elderly person who sits there quietly loaded with wisdom but being ignored. We are feeling the brunt of that now. We have got to retrieve the importance of the elders (Education and Health Standing Committee, 2011, p. 30).

- The East Kimberley COAG Trial (2002-2006) where \$327 000 of \$1.3 million was spent on Aboriginal people and programs. The rest of the money was spent on salaries, travel and other administrative expenses of the Australian Government Department administering the trial. (see 3.4)
- The fact that high levels of suicide in Aboriginal communities in the Kimberley continue unabated despite a plethora of Government policy announcements in recent years.

The failure to adopt a consultative or community development approach to social and emotional wellbeing strategies can at times unwittingly serve to increase psychological distress and its accompanying risk factors - suicide ideation and a sense of powerlessness. This notion is supported by Canadian research into discrepancies in suicide rates between Canadian Indigenous communities, which led to an exploration of the effect of ‘cultural stability’ on suicide rates (Chandler, 2008). Communities which sought a measure of self-governance and to actively preserve and rehabilitate their cultural values had suicide rates that were remarkably lower than communities where this did not exist. Communities with ties to their cultural past and collective futures, and which sought to control their own destiny were identified as powerful protective factors against youth suicide in Indigenous communities (Ibid).

Nonetheless, Kimberley communities have continued to show strong and persistent leadership throughout the crisis – the Fitzroy Valley women’s campaign to ban alcohol is one example in point. Communities have also been extraordinarily resourceful in obtaining the funding and other resources required to implement these programs in the face of Government inaction or refusal to support the initiatives. The poor performance of government responses compared to Aboriginal leadership drew comment from the Special Advisor on Indigenous Affairs:

This sort of strategic leadership is not readily apparent in current public sector activities... programs appear fractured, random and lacking in continuity, with intentions confused and transitory (Sanderson, 2007, p. 6).

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Social Determinants of Community Distress and Suicide in the Kimberley

Around the world, those who are poorest have the poorest health (WHO, 2008). Where people are in the social hierarchy will affect the conditions in which they grow, learn, live, work and age, their vulnerability to ill health and the consequences of becoming ill. Health disparities are the fruit of social determinants and link to the gaps in the quality of health and health care across particular groups in society. The Aboriginal population in the Kimberley has the highest death rates and lowest life expectancy in the nation (ABS, 2008). In regional and remote areas of Western Australia during 2003 – 2007, those living in the most disadvantaged areas died as a result of conditions usually managed in primary health settings (amenable mortality) at twice (115 per 100,000) the rate of those living in least disadvantaged areas (57 per 100,000) (PHIDU, 2011). Aboriginal rates of acute illnesses, chronic illness and preventable deaths in the Kimberley are currently 2.5 that of others in Western Australia. Aboriginal hospitalisation rates in the Kimberley are five times that of others (Western Australia Government, 2011). In 2008 – 2009, nearly half of all Aboriginal admissions to hospital (44%) could have been avoided if effective treatment had been provided in the primary health care sector – a rate four times that of others (10%) (Western Australia Department of Health, 2011).

If you look around, you will not see people between the ages of 30 and 70, because they are all dead. They have died from heart disease and diabetes and kidney failure, not from alcohol. I do not see chronic cirrhotic livers at this hospital. I see people with the worst renal failure you could ever imagine, with the most poorly managed diabetes you could imagine, with cholesterol and heart disease that are out of this world (Dr Ralph Chapman, Acting Senior Medical Officer, Fitzroy Valley Health Services, Agency, WA Country Health Service in evidence to the Education and Health Standing Committee, 2011, p76).

Action Area 5 of the Western Australian Suicide Prevention Strategy 2011 – 2013 attributes high levels of Aboriginal suicide directly to the disadvantage faced by many Aboriginal people, exacerbated by broader underlying social, economic and health issues that have impacted on every dimension of Aboriginal life (Western Australian Government, 2010). It is widely acknowledged that risk and protective factors leading to high rates of Aboriginal suicide in the Kimberley are outside of the capacity of the mental health system to address.

Numerous studies around the world have also documented a social gradient in relation to suicide (Page et al, 2007). In Australia, an examination of suicide rates among young Australian males between 1979 – 2004 (during Australia's 'suicide epidemic') showed rates peaked in 1997 – 1998, before beginning to decline dramatically, giving a much lower national rate overall. However, closer examination has revealed the declines were restricted to cities and large regional centres, while rates in Remote Australia continued to increase, from 38.8 in 1999 to 47.9 per 100,000 in 2004. The regional differences were mediated by socio-economic factors, with declines experienced in middle and high socioeconomic status (SES) groups, while rates continued to increase in low SES groups. As a result, the gap between suicide rates in urban and remote Australia is the largest it has been for 25 years (Page et al, 2007). The report *Western Australia: A Suicide Prevention Strategy* shows that across Western Australia, suicide rates are highest among disadvantaged socio-economic groups (2009). The Kimberley has the highest suicide rate in the State and one of the highest in Australia (Commonwealth of Australia, 2008).

The rapid economic growth associated with the resource boom in Western Australia is deepening the inequity gap between Aboriginal and non-Aboriginal people in the Kimberley, with those not involved in the mining industry struggling to keep up with higher living costs. The unemployment rate for Indigenous people nationally is three times the rate for other Australians (SCRGSP, 2009). The median individual weekly income for the Kimberley region in 2009 was between \$160-\$199 for Aboriginal people and \$500-\$599 for others.

The average number of dependents for income earners was nine for Aboriginal employees and .5 for others (Ibid).

The acute lack of housing in the Kimberley has been identified as a key determinant of distress and suicide and a major limiting factor to rolling out new programs to address Aboriginal health and social and emotional wellbeing issues such as suicide (Hope, 2008). The private rental market varies according to the 'two-speed economy' driven by the resource boom in Western Australia. In July 2011, the average rent for a 3 bed-roomed house in Derby was \$1,000 - \$2000 per week and the median rent in Broome was \$545 per week. In 2010, the waiting list for public housing in Broome, Derby, Halls Creek and Fitzroy Crossing was 1,100 with a waiting time of three to four years. When investigating suicide deaths in the Kimberly in 2008, the State Coroner found 'the quality of housing in which many Aboriginal people live...is relevant to the high levels of distress and dissatisfaction felt by the Aboriginal people and is a factor in the high suicide rates' (2008, p16).

The social determinants of health are not just the circumstances in which people are born, grow up, live, work and age, but also include the health systems that are available (WHO 2008). Adverse conditions arising from the social determinants such as child neglect, violence, discrimination, poverty and lack of access to education and appropriate health and mental health services can have a significant impact on mental health and suicide (WHO, 2004).

Nationally, twice as many Aboriginal and Torres Strait Islander people experience serious psychological distress (32%) compared to non-Indigenous Australians (17%) (ABS and AIHW, 2010). This statistic has direct relevance to the high rate of Aboriginal suicide across the nation, as well as in the Kimberley. Aboriginal people participating in the National Aboriginal and Torres Strait Islander Health Survey (ABS, 2004) were tested using a 5-item Kessler scale to measure psychological distress. It should be noted that high scores on the 10-item Kessler scale (i.e. indicating serious psychological distress) have been shown to strongly predict suicide ideation in the general population.

While information about psychological distress in country Western Australia is not available, if serious psychological distress in the Kimberley reflected the national rate, then it is highly likely that one in three Kimberley Aboriginal people have considered suicide in the past month. When serious psychological distress and increased risk of suicide ideation exists among 30% of people in any community, this can easily translate to increased risk at a community level and distress can quickly become community distress (Kelly, Dudgeon, Gee and Glaskin, 2009). This risk is further heightened in remote and isolated communities, and amplified again by the interconnected nature of remote Aboriginal communities.

Serious psychological distress among Aboriginal and Torres Strait Islander people tends to be correlated with higher exposure to the stressful life events associated with the social determinants including death of family members, serious illness, accidents, and incarceration of family members. There is much to suggest that the Australian governments' commitment to 'harnessing the mainstream' to address factors associated with Indigenous disadvantage has served to entrench this disadvantage through disproportionately high levels of: reporting, investigations and substantiations of neglect and abuse of children; avoidable morbidity and mortality due to poor quality primary health care; excessive incarceration of those who use alcohol; and barriers to early intervention in the primary mental health system, due to poor understanding of Indigenous concepts of social and emotional wellbeing (Kelly, Dudgeon et al, 2009). An examination of data from national collections in relation to these issues revealed a picture of entrenched disadvantage, with a failure of governments to adequately address disadvantage on the one hand and high levels of State intrusion into Indigenous lives on the other. For example, rather than creating new opportunities for recovery or building on strengths, those suffering psychological distress, using alcohol or struggling to deal with mental health issues appeared to be at increased risk of being subject to a range of punitive rather than supportive interventions, such as incarceration and removal of children (Kelly, Dudgeon et al, 2009).



Nationally, Indigenous adults are 14 times more likely than others to be imprisoned (SCRGSP, 2009). The arrest rate for the Kimberley was 364 per 1,000 Aboriginal people and 24 per 1,000 others. In 2009-2010 the Aboriginal imprisonment rate was 4,293 per 100,000 population compared to 168 per 100,000 others (SCRGSP, 2009). Aboriginal people in Western Australia were 25 times more likely to be jailed, compared to others (Ibid).

The Western Australian rate of detention of Aboriginal youth aged 10 to 17 years old is also the highest in the nation. In 2008 – 2009, Aboriginal people aged 10 to 17 years old were detained in juvenile detention at a rate of 641 per 100,000 compared to a rate of 14 other young people (SCRGHSP, 2011). This was 44 times the rate for non-Aboriginal young people in Western Australia and 1.7 times higher than the national rate (371) (Ibid).

Nationally, Aboriginal and Torres Strait Islander families are over-represented in the child protection system, with 11,451 children on care and protection orders in 2009-2010 (SCRGSP, 2009). The national rate of care and protection orders per 1,000 children aged 0–17 years was 48.3 for Indigenous children and 5.4 for other children (Ibid). In Western Australia, the rate for care and protection orders was 41.6 per 1,000 Aboriginal children, compared to 4.1 other children (Ibid).

Nationally, families who come into contact with the child protection system tend to share common characteristics: low incomes; reliance on pensions and benefits; alcohol and substance abuse; psychiatric disability, and a family history of domestic violence (Department of Human Services, 2002; The Allen Consulting Group, 2008).

Aboriginal and Torres Strait Islander families are also over-represented in these categories, therefore making them more likely to come into contact with the child protection system.

During 2009 – 2010, substantiations of neglect were more common among Aboriginal and Torres Strait Islander families, while the least common category was substantiations for sexual abuse (lower rates than non-Indigenous families) (SCRGSP, 2011). In 2006, research conducted in the Kimberley with 167 Aboriginal young people aged 12 – 25 years reported only 5% of the Aboriginal participants and 7% of non-Aboriginal adolescents reported sexual abuse (Ralph et al, 2006). One year later however, it was reported in national media that 12 men in Halls Creek and Kalumburu were charged with over 139 offences of alleged child sex crimes (The Age, July 13, 2007).

In his presentation at the Billard Summit Blank Page Summit in 2009, State Coroner Alastair Hope shared information about risk factors from the Coroner's Database, which have triggered suicides mainly related to relationship breakdowns and arguments or family disputes. On some occasions, investigations revealed different causes for the death such as past sexual abuse and family breakdown. Mr Hope noted that factors responsible for suicide can be complex and difficult to identify.

We need to support families with drinking and alcohol problems. Our kids are being exposed to this every day...their education is about how to keep drinking. Little kids are being sworn at and abused, learning this life style and become this themselves. It is a cycle that needs to stop (Participant, Broome Community Consultation).



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Community Distress and Alcohol Use / Abuse in the Kimberley

Alcohol use and suicide are intimately linked, but they are both complex phenomena, springing from a multitude of factors and the relationship remains poorly understood. Pompei and colleagues, in a broad overview which examined the relationship, found that alcohol use, particularly heavy use and alcohol dependence, is associated with suicide in three ways: i) alcohol, through its disinhibiting effects, is related to suicide attempts and completions; ii) individuals with alcohol use disorders are at an increased risk of suicide when compared to the population at large; and iii) at the population level, alcohol consumption is correlated with the suicide rate (Pompili et al, 2010).

Alcohol is often used as self-medication for depression and anxiety and some authors have hypothesized that once a decision to attempt suicide has been made, alcohol may be incorporated into the suicide plan in order to gain courage, numb fears or anesthetize the pain of dying (Ibid). The literature does not support the notion that a state of drunkenness alone can lead to a decision to commit suicide. Rather, it is more likely that using alcohol to ease distress has negative rather than beneficial effects, making suicide more likely (Pompili et al, 2010). Alcohol therefore is neither a necessary nor sufficient condition for suicide, but may be regarded as a contributing factor.

Across Western Australia, between 1986 – 2005, positive blood alcohol readings were present in 41% of men and 27% of women who completed suicide (WA Suicide Prevention Policy, 2010).

In the Kimberley between 1997 – 2007, suicide and self-inflicted injury was the second most common cause of preventable death for all males (14%), followed by alcohol related disease (6%) (Carlose et al, 2011).

More Aboriginal people do not drink alcohol when compared to other Australians. Nationally, more than half (53%) of Indigenous respondents to the National Aboriginal Torres Strait Islander Health Survey (NATSIHS) 2004-05 reported they had not drunk any alcohol in the previous week, compared to 36% other Australians (SCRGSP, 2009). Among those who drank alcohol, drinking at rates likely to lead to long-term problems (long-term risky/high risk alcohol consumption) were similar for Indigenous and non-Indigenous people (13 – 15%). However, Indigenous adults were twice as likely to report binge-drinking (i.e. drink alcohol at short-term risky/high risk levels) at least once a week over the previous 12 months.

Interestingly, the proportion of Aboriginal people in the Kimberley who reported drinking at levels that would put them at risk of either short-term or long-term harm were not statistically significantly different when compared to the rest of the State. The low or equivalent rates of 'alcoholics' in the Kimberley was supported by medical personnel giving evidence before the Education and Health Standing Committee in 2011: 'People who drink to excess every day [alcoholics] will get liver cirrhosis. We do not get the numbers that you might expect given the vast quantity of alcohol consumed' (Dr David Atkinson, Acting Medical Director/Medical Educator, Kimberley Aboriginal Medical Services Council in evidence to the Education and Health Standing Committee, 2011, p17).

At the same time, the disproportionate impact of the small number of heavy drinkers on their broader family group has been identified by a number of stakeholders, including community leaders who led the drive for alcohol restrictions:

The ones who drink are a small group, but the impact is devastating. We are the ones who live with the violence, the suicides...

(June Oscar, Marninwarntikura Women's Resource Centre, 2009).

Nationally, hospitalisation rates for alcohol-related conditions (cancers, cirrhosis, alcoholism, stroke, falls, self-inflicted harm, road injuries, falls, assaults and child abuse, ischemic heart disease) were higher for Indigenous people compared to others in 2006-07 (Ibid). During the period 1997 – 2006, the number of Aboriginal admissions for alcohol-related conditions in the Kimberley was five times greater than others in the region (Xiao et al, 2008). However, rather than diseases that characterised alcoholism, the most common reason for Aboriginal alcohol-related admissions was assault, with admissions being 1.7 more common than the rest of the State. At the same time, it should be noted that non-Aboriginal admissions for assault in the Kimberley were four times greater than the State average.

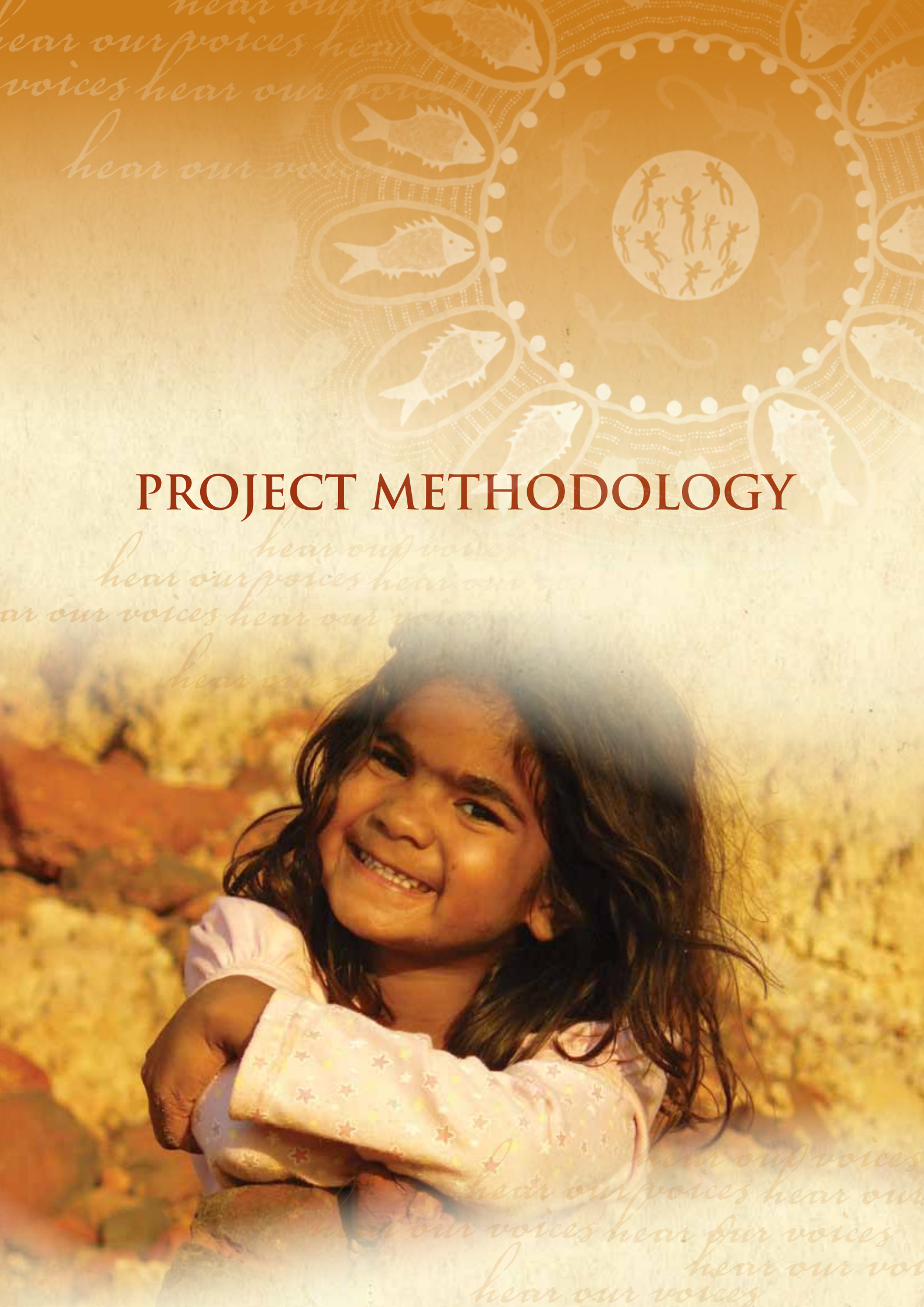
Both Aboriginal and non-Aboriginal people in the Kimberley are admitted to hospital for alcohol-related conditions at higher rates than the rest of the State. Compared to the State average, the overall rate of alcohol-related hospitalisations during 2002-2006 were three times higher in Broome, five times higher in Derby-West Kimberley, seven times higher in Halls Creek and four times higher in Wyndham-East Kimberley (Xiao et al, 2008b).

During the ten-year period 1997 – 2006, 92 Aboriginal people in the Kimberley died from conditions attributed to alcohol use (39 of these were attributed to alcohol related injuries) (Xiao et al, 2008b). This was similar to the State Aboriginal alcohol-related death rate (Ibid). Alcohol-related disease has been identified as the fourth most common cause of avoidable mortality among Aboriginal people in the Kimberley, with 50 deaths between 1997 – 2007 representing 6.8% of avoidable deaths.

Between 1996 – 2005, Aboriginal hospitalisations for other drug use in the Kimberley were the same as the State rate: 2.3 per 1,000 population (Western Australia Government, 2011).



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PROJECT METHODOLOGY

5

PROJECT METHODOLOGY

The Project has involved consulting with three communities in the Kimberley to identify the ways in which an empowerment, healing and leadership program could empower Aboriginal people to deal with many of the issues that underlie community distress and suicide.

It originated out of a desire to assist these communities who have asked for more resources to support them to take charge of their lives and strengthen their families.

The Project employed two highly skilled Aboriginal professional community consultants from the Kimberley who had worked extensively with various community groups across many areas, and who were experienced in community consultation, and were knowledgeable about cultural issues in the three areas. They are well regarded throughout the Indigenous and non-Indigenous community.

Consultation took place with individuals, families, communities and relevant stakeholders in Broome, Beagle Bay and Halls Creek; representing a variety of different language groups with different community histories. These communities were also identified as suitable to the Project's objectives because of their diverse geographical locations.



5.1 Research Approach

The Project was community driven using an inclusive, participatory action research process which:

...involves all relevant parties in actively examining together current action (which they experience as problematic) in order to change and improve it. They do this by critically reflecting on the historical, political, cultural, economic, geographic and other contexts, which make sense of it. ... Participatory action research is not just research, which is hoped that will be followed by action. It is action, which is researched, changed and re-researched, within the research process by participants. Nor is it simply an exotic variant of consultation. Instead, it aims to be active co-research, by and for those to be helped. Nor can it be used by one group of people to get another group of people to do what is thought best for them - whether that is to implement a central policy or an organisational or service change. Instead it tries to be a genuinely democratic or non-coercive process whereby those to be helped, determine the purposes and outcomes of their own inquiry (Wadsworth, 1998).

In Indigenous Australia, there are concerns about research as continuing the process of colonisation in determining and owning knowledge about Indigenous peoples (Moreton-Robinson, 2000; Oxenham, 1999; Rigney, 2001; Nakata, 1997). These concerns have highlighted how research is inextricably linked with European colonisation. Many Indigenous scholars such as Smith (1999) are concerned with how western systems of knowledge have denigrated and distorted the cultures of the colonised.

This Project was concerned with cultural reclamation and required Aboriginal people and experiences as a centrally important inclusion. Participatory action research has been widely promoted as an empowering and effective way in working with Indigenous people in achieving better outcomes in a range of factors such as health, education and community building. Conventional research practices in many contexts have been perceived as ineffective and disempowering. (Kemmis & McTaggart, 2003).

Participatory action research is defined as ‘... inquiry by ordinary people acting as researchers to explore questions in their own lives, recognise their resources, and produce knowledge, and take action to overcome inequalities, often in solidarity with external supporters’ (Dickson, 2000 in Wenitong et al, 2004, p. 5).

This Project used a methodology that ‘gives voice’ to Aboriginal people and is aimed at empowering oppressed groups. Participatory action research intends to be participatory, cyclic, qualitative and reflective. This involves participants as research partners in the research process and participant’s experiences and knowledges are critical.

Participatory action research emphasises developing self-reflexive critical awareness, is concerned about power and powerlessness, and is connected to social action. Participatory action research is also concerned with valuing and validating the knowledge and lived experiences of oppressed groups. This approach is based on the premise that people are experts about their own lives and cultures. It has two objectives; (a) to produce knowledge and action that is directly useful to a group of people and (b) to empower people to reconstruct their own knowledges leading to empowerment and social change. (Bacon, Mendez & Brown, 2005; Radermacher & Sonn, 2007). This method includes the research participants in ‘all the thinking and decision making that generates, designs, manages and draws conclusions from the research’ (Reason, 1994, p. 325). It can ensure a transformative process is facilitated with real and concrete outcomes for participants.

5.2 Data Collection

A qualitative research process was utilised in the collection of data. Qualitative methods facilitate an understanding of the complexity of people’s experiences and circumstances and allow participants to tell their story. A series of workshops, focus groups and one-on-one interviews were completed in each of the three project areas. In total, 78 people were consulted across the three areas including some from 14 different agencies. The consultation included men, women, elderly and young people (15 -25

years) to ensure future programs and strategies cater for different community group members and differing levels of need. Although a majority of participants were Aboriginal, non-Aboriginal people were also included as part of the consultations where they worked in stakeholder services and programs.

In the workshops and focus groups participants were asked to explore the question – *What do we need to do to make ourselves, our families, and our communities stronger?*

To answer the questions, the focus groups involved a lengthy brainstorming session exploring:

- what participants understood about empowerment, healing and leadership;
- what the concepts of empowerment, healing and leadership meant to them; and
- what people believed was required for an effective healing journey, to become empowered and to be a good leader.

The workshops and focus groups identified what type of courses would be required to meet the needs of the community and the more specific details of the program’s content, including the types of topics that should be addressed and the best way to have the course/units delivered.

The one-to-one interviews also followed the same format of questions.

A thematic analysis was conducted whereby the information gathered from all sources was grouped into meaningful themes. Emerging themes provided powerful and meaningful messages. The collection of information or the collective voice of the Aboriginal people builds a strong perspective to the issues facing Aboriginal people. This information when viewed alongside the literature review clearly provides a way forward, articulating what the issues are and how these need to be addressed in culturally appropriate ways that enable Aboriginal people to take control of their own destinies.

A community feedback forum was held in Broome to check that the findings were right and reflect the issues raised in the consultations. An accessible, Community Brief was prepared and distributed (See Appendix 3: Community Brief). It was also important to disseminate the findings of the Project to the broader Aboriginal community and to those responsible for policy. At the conclusion of the Project a public forum was held at the Telethon Institute of Child Health Research in Perth where the outcomes were presented to Aboriginal leaders, senior government policy officers and researchers (See Appendix 4: Policy and Research Brief). At the same time, a national advisory committee was convened to discuss the Project findings and possible ways forward. This was well attended and commitments have been made to continue the committee when the empowerment program (s) are implemented. Membership included a number of Indigenous and non-Indigenous experts in the field and representatives from the three empowerment programs from Adelaide, Alice Springs and Cairns. See Appendix 5 for the full membership list.

5.3 Literature Review

Researchers from the Telethon Institute of Child Health Research undertook a comprehensive review and analysis of some of the key literature and theory on healing, empowerment and leadership. The review examined a range of research, both in Australian and international contexts, to identify conceptions of empowerment, healing, and leadership; why these concepts are considered effective in addressing the trauma and dysfunction experienced by Aboriginal communities; and in what ways they build esteem, capacity and improve people's social and emotional health and wellbeing.

5.4 Program Review

A review of relevant programs in Australia was the third element to the research Project. The specific focus involved identifying some of the current healing, empowerment and leadership programs in Australia to examine their application and understanding of these

concepts; their aims and objectives and to what extent they are effective in achieving them. A number of different programs, evaluations and studies were documented. In addition, the review sought to understand what programs or aspects of programs are working to facilitate greater individual and community wellbeing to compile a set of core elements critical to the effectiveness of healing, empowerment and leadership programs and program delivery in diverse Aboriginal contexts.

The program review also comprised site visits by researchers on the project. Visits were undertaken to Cairns, Adelaide and Alice Springs where three different applications of the Aboriginal Family Wellbeing (AFWB) Program are being implemented to consider the program's effectiveness in meeting diverse community needs.

5.5 Community Consultations

The two local Aboriginal community consultants were employed to:

- consult with the target communities to determine the community members and service stakeholders who should be involved in the focus groups, interviews and the program development;
- work with the community to identify relevant issues surrounding community-based understandings of leadership, empowerment and healing and provide advice as to how these could be translated into a community-based program;
- identify potential stakeholders for further phases of the project to work in an integrated manner and to avoid duplication; and
- report project developments and findings back to the community and stakeholders to ensure maximum community engagement and ownership of the project.

5.6 Community and Stakeholder Recruitment

A key factor in engaging the community was the involvement and employment of two local community consultants. Their local knowledge and networks, in addition to existing relationships that other team members had with the communities, was critical to the successful completion of the community consultation process. The Project team and community consultants developed lists of government and private agencies, local groups and individuals in the community to advise them in person email and mail of the forthcoming workshop. In the days leading up to the community consultation meeting, various community members were contacted and reminded of the meeting and asked to confirm their attendance.

A series of workshops/focus groups and one-to-one interviews were then conducted. The community consultants were able to advise about the appropriate times for workshops – a critical matter given that communities are inundated with other commitments and cultural events. As well as the targeted invitations, flyers were also posted in major community outlets prior to the workshops, to allow any other interested community member the opportunity to attend or to contact the consultants for more information and input by individual/group interview. A Fact Sheet was also prepared to inform the community participants about members of the Project Team. See attached Flyer in Appendix 6 and Fact Sheet in Appendix 7.

5.7 Profile of Consultations Completed

The collection of data was obtained through focus group discussions with stakeholders and one on one individual interviews. Information was gathered from the collection of data from 14 different agencies offering various other activities to address the social emotional wellbeing in the community and individual participants from a wide range of gender, age and competency.

A majority of the participants were Aboriginal people. There was good diversity in both the gender and ages of participants. There were a majority of women participants overall. Although efforts were made to ensure age representation the largest age group were in the 35 – 50 years old group. There are several reasons for the majority of female representation. Women felt it was their role as mother and carer of the family to address family and community issues that are impacting them as individuals and their families.

Majority of males also supported this notion of the female role in the family. The men that did attend identified a perception of their diminishing role as a males and the impact this role has on the issues facing individuals and families. The men that attended also felt excluded from addressing family issues and wanted to become more involved as a male and also as a father of the community.

Table 1: List of Number and Type of Participants

Location	Individuals	Stakeholders
Beagle Bay	18	2
Halls Creek	15	5
Broome	45	7
	78	14

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Figure 1: Female and Male Participants

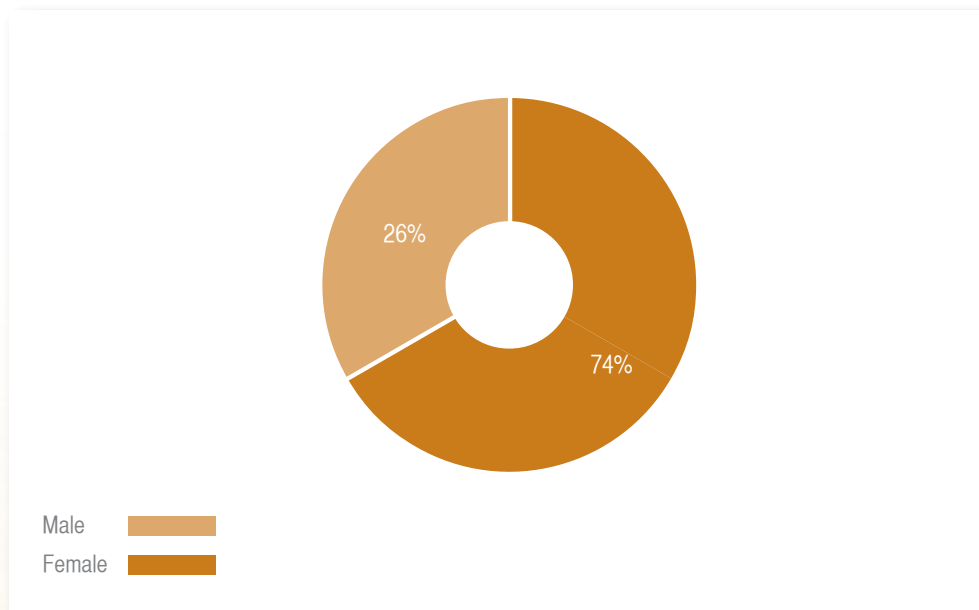
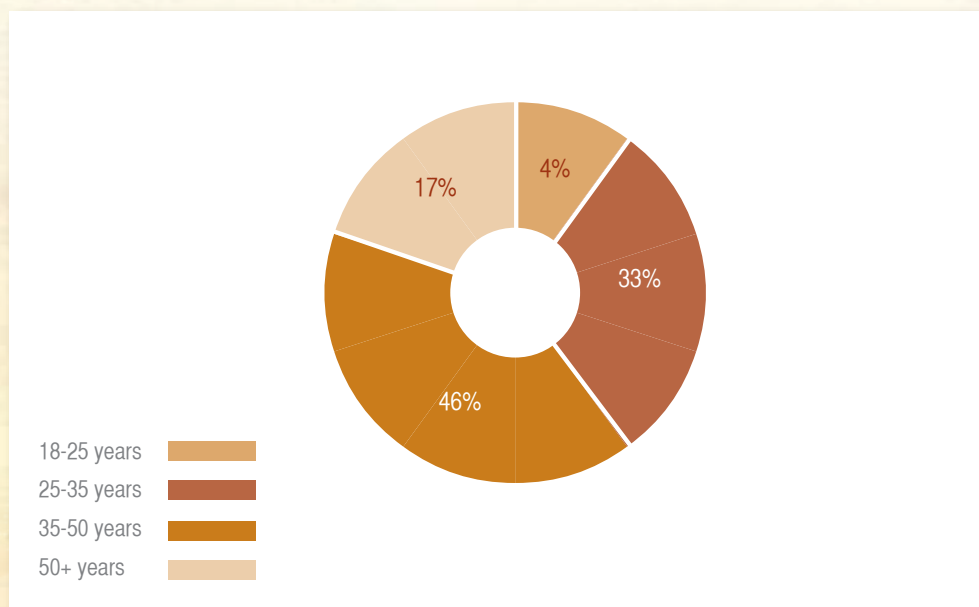
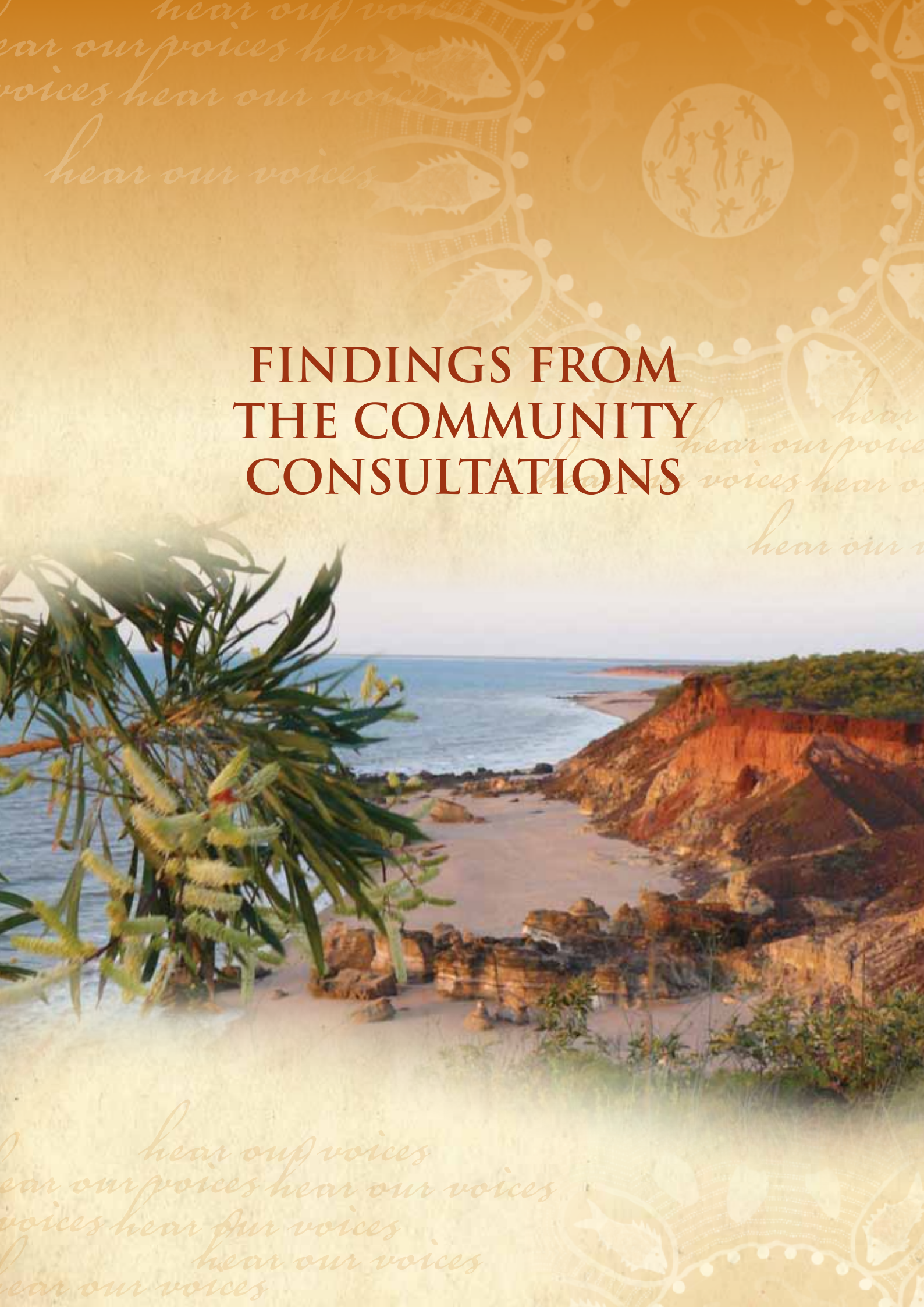


Figure 2: Age of Participants





FINDINGS FROM THE COMMUNITY CONSULTATIONS

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6

FINDINGS FROM THE COMMUNITY CONSULTATIONS

6.1 Summary of Responses to the Focus Questions

What do we need to do to make ourselves, our families, and our communities stronger?

People said:

We need to “build self first”, identify with ourselves. We need more self worth. We need to make ourselves strong and find our inner strengths.

We need role models from our own backyards.

No more shame factor.

We want to get it right in families. We need to feel the love of families, need to feel good about sharing, don't hide things from family. Keep in touch with families. Make families aware to care and communicate with each other.

We need to learn how to talk to one another again, to share and care for one another and to praise and credit to those who do good things for themselves and for others.

We need to feel and be a part of our community. Have a sense of belonging, have cultural identity.

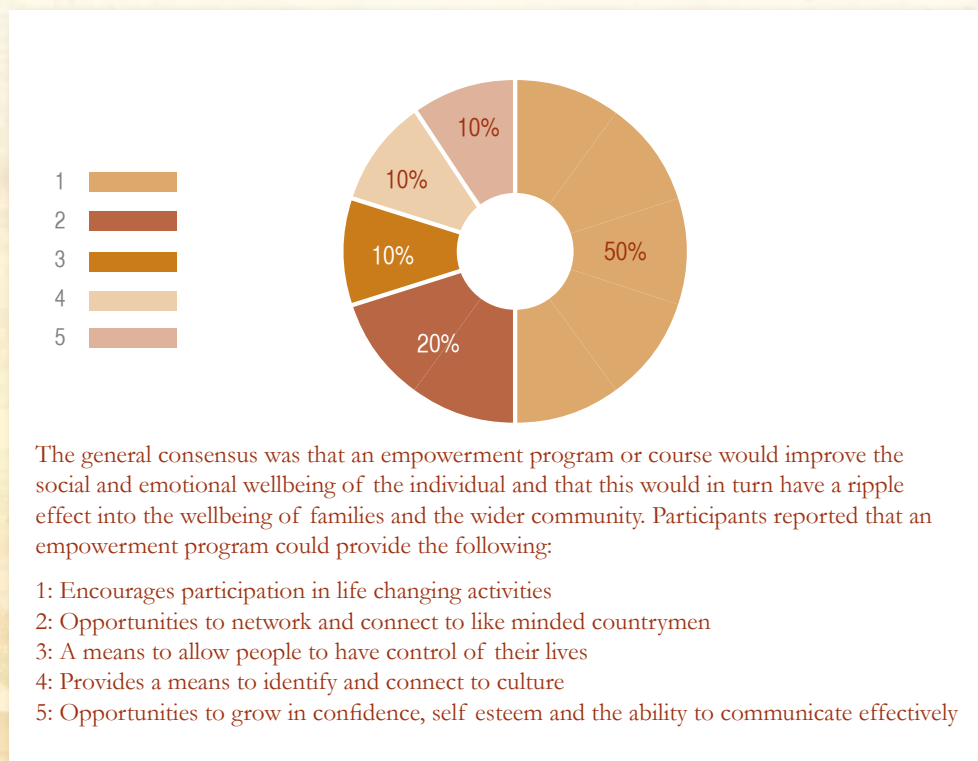
Help us to become good parents and set good examples for our children. We really want to be good parents.

We need to heal by getting back to country and keeping culture strong.

We need to help our young people who don't respect their family, their culture or themselves.

We need to learn how to deal with grief and trauma to break the cycle of pain in our families.

Figure 3: How Would an Empowerment Program Help You?



What does healing, empowerment and leadership mean to community?

People defined healing as:

A spiritual understanding of self, identity, love, belonging, family, security, hurt, heartache, good times, laughter and our connection to land. Having hope and finding acceptance based on love and respect, of understanding of ourselves, our supports and being able to tell “our” stories.

Becoming empowered is how we can start to deal with the pain and grief and then help others and our community.

What do people want in a program?

People said they wanted:

Flexibility

Programs that meet different individual needs and the different priorities of the local community

Mentors and support at a local level

Practical, visual and hands-on courses

Employ and train local people including a mentorship program

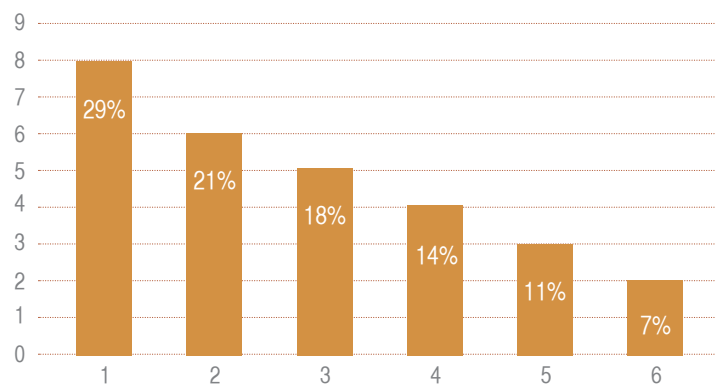
Programs that have the support of the community

Goal setting, motivation and organisational skills to achieve goals

Culturally based programs that go back to country and use the knowledge of our elders

Different options and pathways that meet different capacity and stages of readiness for healing and change

Figure 4: Barriers To Empowerment



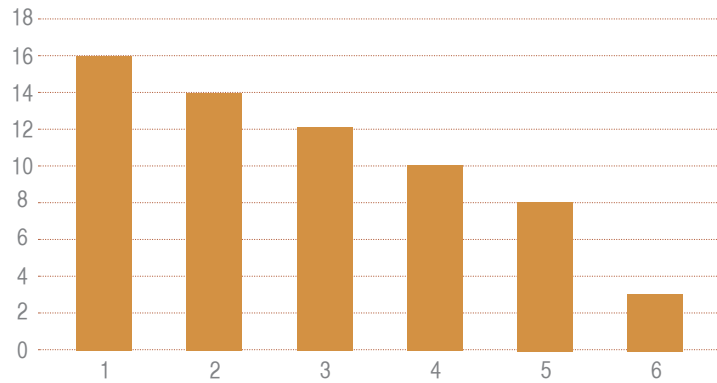
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|-----------------------|------------------------------|
| 1: Lack of Confidence | 4: Motivation to Participate |
| 2: Shame | 5: Drug and Alcohol Issues |
| 3: Jealousy | 6: Finance |

Comments:

The collection of information about barriers to empowerment was limited as a result of it not being a part of the interview questions. The outcomes of this information was only gathered through general conversations when these issues arose. Barriers recorded in conversation were tallied to obtain an understanding of the significance of each barrier. Shame and jealousy issues were common barriers from remote community conversations such as from Beagle Bay and Halls Creek.

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Figure 5: Program Enablers

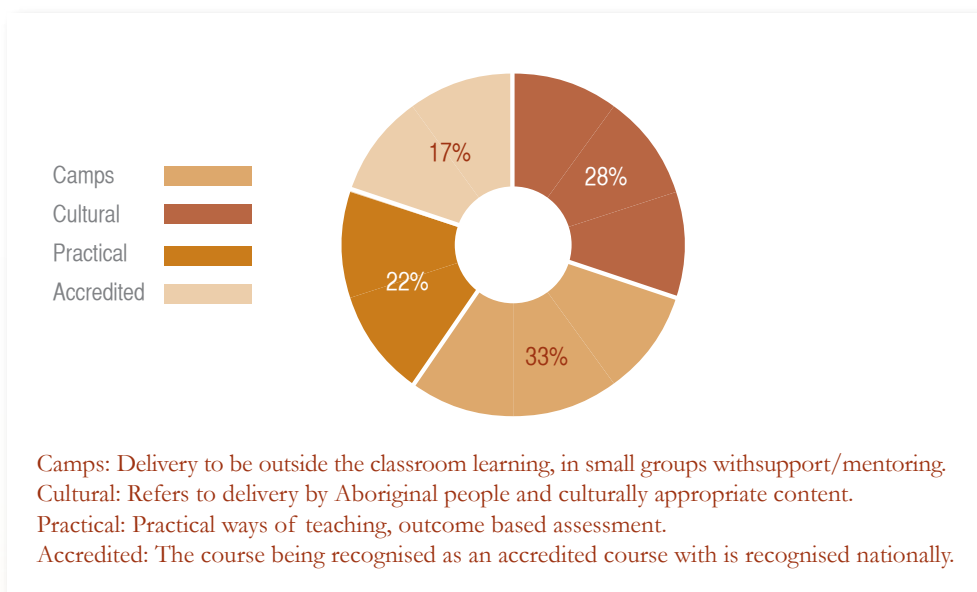


- 1: Flexible and creative delivery with 2 to 3 day session per week
- 2: Back to country in small groups (meaning not always in the classroom)
- 3: Mentors and support
- 4: Content practical, visual and relevant to issues
- 5: Delivery by local people
- 6: Workplace delivery so we can be paid while we train

The issues above indicate particular course delivery elements that participants thought were important. The most important indicator for successful delivery was flexibility. This is based on the understanding that Aboriginal people need to still meet other cultural and social obligations in their lives while undertaking a course. This issue is also an indicator identified in other successful courses that have already been run in the community such as the Sisters of St John of God – Counselling Course.



Figure 6: Importance of Design and Delivery



The focus groups also identified what type of courses would be required to meet the needs of the community, including the types of topics that should be addressed and the best way to have an empowerment course or units of sets of skills delivered.

First and foremost people wanted the content to be practical, visual and relevant to issues in people's lives and the local area. All three groups agreed that programs need to be:

- *local, focus on community issues and aspirations, cross generations, bring young ones and elders together, maintain cultural, connect to country, language based be for individuals, family and community*
- *delivered around key community happenings, events, and with key group activities.*

The consensus is each of the areas was for a method of program delivery that involved small groups of around six participants. The teaching method and environment was an important consideration with people wanting both a classroom setting as well as other methods such as on country, camps, with activities that are more hands-on and about real life situations, and with the use visual learning aids and outcome based assessment rather than too much theory. Several participants suggested that the sessions should be short (no more than half a day) and use simple language. Others felt it was less a time issue but more important to capture people's interest.

Flexibility was another critical aspect in what participants prioritized as important in successful course delivery. Several people made the point that Aboriginal people have many other cultural and social commitments in their lives, and it is only through ensuring flexibility in a program that they would be able to firstly commit to and secondly, to complete such a program. The recommended components of any empowerment, healing and leadership program included:

- Goal setting
- Self development (self-esteem, confidence building, positive attitudes, motivation)
- Anger and conflict management skills
- Communications and relationship skills

- Addressing the use of alcohol and drugs
- Building resilience
- Support and mentorship training
- Building cultural identity

The consultation process confirmed the need to ensure individual and community readiness to commence any type of healing and empowerment program. The general view was that this type of program was going to have the best results with people who knew they wanted to change their situation, develop themselves and had a desire for self-improvement. There was a concern that those in most need of such a course, especially young people, might be unable and unwilling to participate.

The consultation process identified the need to ensure and support people's readiness for change so they can effectively undertake a fully accredited program. From the consultations with community members and stakeholder representatives it is clear that a series of preparatory workshops should be offered to assist with people's readiness to undertake further study and training including an accredited healing, empowerment and leadership course. It is anticipated that some participants might not go onto the accredited course but that positive learning outcomes and individual/community empowerment will be gained from the workshops in any case.

6.2 Key Messages from Broome, Halls Creek and Beagle Bay

Each group of participants had a slightly different set of messages and priorities based on that community's experiences.

Broome participants

The Broome community group was fully aware of the problems and issues facing their community, but they felt helpless in addressing the issues. The Broome community had a strong sense of ownership of their issues and spoke of needing to be empowered to help themselves in a way that they know is culturally appropriate and sensitive to their needs. They spoke of developing role models 'from their own backyard' that the whole community knew and respected; role models

that they could turn to for advice and help. They named barriers to personal empowerment as a lack of identity, self worth, and self-esteem. They felt very strongly about 'getting it right' in families, as families are the core of individual and cultural realities.

It appears that being located in an urban centre where more facilities and infrastructure are provided has had an influence to a greater understanding of what it would take to make their community strong.

There was a strong belief that 'working upstream' from suicide needed to happen to reduce the escalating suicide epidemic in the Kimberley. The majority of the group felt there was a break down in families where children are growing up with the wrong message about how to conduct their lives and how to have a good healthy life. Participants felt that young adults have little respect for parents or themselves: 'Our young adults have no good role models, direction or mentors to guide them in the right direction'. Participants felt that because youth leave the family with little respect for themselves and others, social problems like drugs and alcohol become a part of their lives and so the vicious cycle goes on. A clear message from this community consultation was about the need for culturally appropriate parenting skills.

A statement demonstrating this was, 'Help us to become good parents and set good examples for our children. We really want to be good parents'. There were strong passions to making a positive difference in the future of the community. This was grounded in community members needing to take responsibility and be skilled to have the confidence and knowledge to make changes. Participants articulated clearly what skills should be in a course that is appropriate to their needs. The other strong message was that the course or readiness program should have ongoing mentorship or coaching as an integral part.



This would be to provide personal encouragement and assistance for people in addressing the many issues Aboriginal families face trying to better themselves and their communities.

Participants felt that mentorship should include home visits that there are some families that don't feel comfortable going to organisations to seek help. These home support visits would create opportunities for individuals to participate in family discussions about the many issues affecting their families and themselves as individuals.

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It was also seen as a positive to address obstacles for the old people (senior family members) who have disabilities and mobility problems to participate as well. It was also noted that this way of providing support might not suit all families but this was raised with a sense of nostalgia of the old days where informal home visits provided foundations for good building relationships between family members and the supporting persons. This is why flexibility is important in strategies that aim to address issues that confront Aboriginal people.

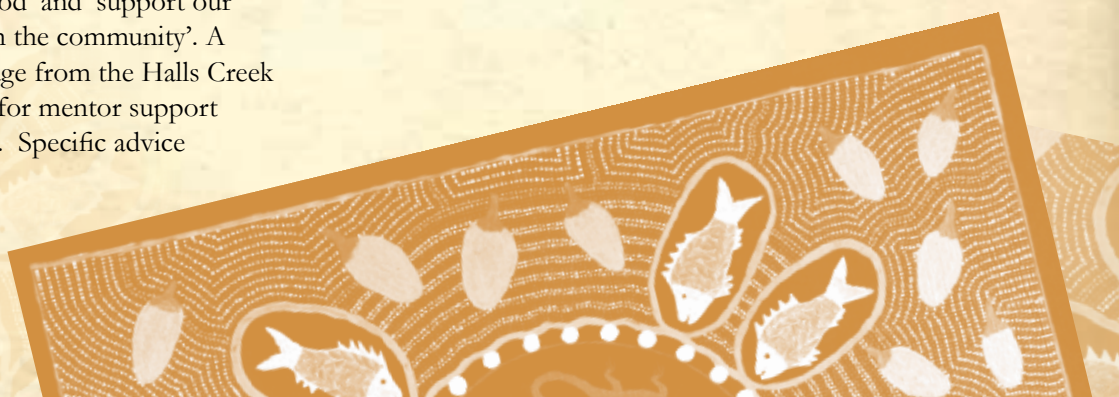
Halls Creek participants

The participants in Halls Creek had a slightly different perspective on what was needed to make people, families and communities strong. Participant's views on an empowerment, healing and leadership program was more about healing the individual and addressing personal barriers such as being able to address 'shame' and jealousy. Recognition of community members and their skills and value was clearly articulated: 'Stay at home mums with good parenting skills should be recognised' and 'valuing our old people and appreciating the knowledge and culture'. Supporting both genders was seen to be important: 'We need to support each other, even the men that do good' and 'support our men in our homes and in the community'. A strong and unique message from the Halls Creek consultation was a need for mentor support throughout the program. Specific advice

about the course delivery strongly advocated a community approach to education - taking the program to the people, rather than the people to the program, which is the usual situation. The community also needs to be involved in school education and education that starts at home, teaching life skills. There were suggestions about attaching such a program to CDEP payments. One of the big issues for the community was actually enabling the community to participate. Participation in itself appears for this community a signification achievement and many people were perceived to lack motivation for change: 'Be positive each morning and get up and tell yourself that life is good'.

People defined empowerment as:

Being a knowledge holder, being focussed, confident, to be leaders, to take control of any situation, believing in yourself and being a problem solver. Being active, having respect for yourself and others, accepting challengers, having motivation, caring for yourself, family and people, speaking out and having the confidence and being strong and having goals. Having any income as the more income you have, the more choices you have and the more choices gives you more power over your life. (Halls Creek Consultations).



Beagle Bay participants

The outcomes of the community consultations in Beagle Bay focussed more on skills that needed to be available for the community to improve the social and emotional wellbeing of the individual. This would in turn have a ripple effect on the well being of the family and wider community. A program should encourage participation in life changing activities. It should provide a means to identify and connect to culture, to help oneself and to take control of one's life. Also a program should provide opportunities to network and connect to like-minded 'countrymen' (people). There are a couple of CDEP (Community Development and Employment Program) programs being undertaken that encourages community members, especially younger people, to participate in activities ranging from women's groups, child care, health and beauty, building, horticulture and building and construction. These activities should be opportunities to grow in confidence and self-esteem, and opportunities to provide people the ability to communicate effectively. Ultimately a program/course should be delivered by local people and should be part of workplace training so that participants have an income while they undertake the program.

6.3 Community Comments on Existing Support Services

Gaps in Appropriate Social and Emotional Wellbeing Services

The majority of stakeholder representatives identified gaps in current levels of service delivery, especially to people experiencing psychological distress. These gaps included a lack of after-hours services when people in crisis need it most, especially those considered at high risk of attempting suicide. Anecdotal evidence highlights the extent to which suicides take place at night. (In a recent community meeting women talked of being afraid to go to sleep at night for fear their children would take their own lives through the night.) Very few organisations are currently offering after-hours contact with individuals or even phone services and those that did provide a phone number were deemed useless as they required people to have money to make

the call. Often those in crisis do not have credit on their mobile phone, assuming they have a mobile phone. The provision of only a telephone number was also criticised because it assumes that in a moment of crisis people are able to reach out for help, feel comfortable making such a phone call, and can remember the 1800 number to ring. The consensus was that there needs to be identified Aboriginal community leaders, mentors/coaches in the community or a network of community people who are trained and easily accessible to such individuals in the community.

More Proactive Approaches Required from Services and Agencies

Many individuals in the three communities were clear in their views that stakeholder agencies should be notified by police of an incident affecting a family and the appropriate agencies should be proactive and go out and approach the family as soon as possible, to offer support and counselling when the families are ready to seek help. It was felt that just knowing that there is someone else there and that you are not alone is comforting.



One family who had experienced the loss of two family members in a matter of days of each other stated that they ‘were shocked that there was no-one to assist them in their loss, and they had to rely on each other to provide support when everyone was caught in their own grief’.

Burden of Meeting Funding Criteria

There was also a view that many organisations start off with good intentions and great ambitions to help the community address community issues impacting on individual and family social and emotional wellbeing, but government policy and regulations to meet contractual obligations to access further funding impedes the desired outcomes and the approach of such programs.

Stakeholder representatives expressed frustration at the need to meet government funding criteria, which is not always aligned with addressing community issues and community priorities. There was a sense of government’s focus being the need to ‘tick all the right boxes’ for reporting requirements and future funding.

Stakeholder representatives were frustrated by the amount of time spent on internal human resources, administration and financial obligations rather than hands on, face to face time in the field and developing effective programs that address the real issues. Many individuals in stakeholder organisations felt disappointed that they are not making enough of a difference and that the skills, manpower and government assistance to implement such a program is missing.



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FINDINGS FROM THE LITERATURE REVIEW

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FINDINGS FROM THE LITERATURE REVIEW

7.1 *The Meaning of Empowerment*

The term and concept of empowerment has beginnings in the civil rights and women's movements of the social action ideology of the 1960s and the self-help ideology of the 1970s (Fredericks, 2009, p.7). Influential theorist of critical pedagogy Paulo Freire was one of the leaders in community empowerment and liberation (1970). In here, the first step in the process of empowerment is the raising of critical conscious where oppressed groups of people can gain an in-depth understanding of the causes of their problems and how the people and the causes are embedded within the social and political structures in which they live. In this concept, empowerment becomes the vehicle for people to take action against the oppressive elements in one's lives, to place challenges before themselves, to their own internalised powerlessness, and to develop opportunities to gain a sense of control within their lives, including the environments in which they live.

Wallerstein and Bernstein (1988) drawing on the work of Freire (1970) explored empowerment within the context of community and community development and applied it to health education. Empowerment is described as:

... a social action process that promotes participation of people, organisations, and communities in gaining control over their lives in their community and larger society. With this perspective, empowerment is not characterised as achieving power to dominate others, but rather to act with others to effect change (1988, p. 380).

The literature on empowerment describes it in terms of a range of essential elements or set of beliefs and attitudes identified with becoming or being empowered. These include:

- Self-worth;
- Hope;
- Choice;
- Autonomy;
- Identity and efficacy;
- Improved perceptions of self-worth;
- Empathy and perceived ability to help others;
- The ability to analyse problems;
- A belief in one's ability to exert control over life circumstances; and
- A sense of coherence about one's place in the world (Caber, 1999; Wallenstein, 1992, 2006; Zimmerman, 2000).

There are particular skills and knowledge required for people to empower themselves. These include emotional control, and reflective, analytic, communication and decision-making skills (Haswell et al., 2010; Whiteside, 2011). When empowerment outcomes have been achieved – the focus is on some element of change or transformation having taken place. Often it is where people have a sense of greater choice in their decision-making and behaviour (Feeney, 2009; Kabeer, 1999; Wallerstein, 1992, 2006; White & Epston, 1989).

Group or community empowerment can include stronger social networks and community participation in organisational decision-making; perceptions of increased support and community connectedness; and the ability to reach consensus on goal-oriented strategies. Community empowerment has also been described as a process that progresses along a dynamic continuum: individual empowerment; small groups; community organisation; partnerships; and political action (Baum, 2002; Wallerstein, 1992). Structural empowerment is understood as referring to actual improvements in environmental or health conditions, evidenced by changes in systems, public policy and the community's ability to acquire resources to create healthier environments (Wallerstein, 1992).

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From a community development perspective, empowerment strategies are understood as a means for disadvantaged communities to challenge control and social injustice by uncovering the mechanisms of control, the institutional or structural barriers, the cultural norms and social biases. In so doing, people are able to challenge internalized oppression and to develop new representations of reality. 'Empowerment can be seen as a dynamic interplay between gaining greater internal control or capacity (personal transformation/ psychological empowerment) and overcoming external structural barriers to accessing resources (community or institutional transformations)' (Wallerstein, 2006, p.18). Wallerstein advocates for an approach that engages people 'through a group dialogue process in identifying their problems; in critically assessing the social, historical, and cultural roots of their problems; and in developing action strategies to change their personal and social lives' (1992, p. 203).

These understandings and models of empowerment support the relevance of empowerment as a concept and healing strategy for Aboriginal people, specifically as means of redressing the damage and trauma experienced from a history of social injustices.

7.2 Aboriginal Perspectives on Empowerment, Healing and Leadership

Discussions about Aboriginal healing and empowerment are relatively recent in the literature. While there are many definitions of health and healing, there is a general acceptance that the concept of healing for Aboriginal people is itself specific to the experiences of Aboriginal people and differs considerably to many Western worldviews of healing as individual treatment modes. National consultations undertaken by the Aboriginal and Torres Strait Islander Healing Foundation in *Voices from the Campfires* (2009) found that Aboriginal participants saw healing as a spiritual journey that requires initiatives to assist in the recovery from trauma and addiction, and reconnection to the family, community and culture.



Healing was described as:

...holistic and involves physical, social, emotional, mental, environmental, and spiritual well being. It is also a journey that can take considerable time and can be painful. It is about bringing feelings of despair out into the open, having your pain recognised, and in turn, recognising the pain of others. It is a therapeutic dialogue with people who are listening. It is about following your own personal journey but also seeing how it fits into the collective story of Aboriginal and Torres Strait Islander trauma (2009, p.11).

Linda Archibald (2006) whose comparative analysis examined decolonisation and Aboriginal healing in the United States, New Zealand, Australia and Greenland stated:

The experience of being colonized involves loss—of culture, language, land, resources, political autonomy, religious freedom and, often, personal autonomy. These losses may have a direct relationship to the poor health, social and economic status of Aboriginal people. Understanding the need for personal and collective healing from this perspective points to a way of healing, one that combines the sociopolitical work involved in decolonization with the more personal therapeutic healing journey (2006, p.5).

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Holistic approaches are important aspects to Aboriginal perspectives on healing. McEwan and Tsey (2009) state that the essence of holism as it is used in Indigenous Australian health discourse, refers to 'the interconnectedness of life's dimensions' (2009, p.14). This sense of interconnectedness is also the best way of describing Aboriginal conceptions of healing, empowerment and leadership where they are understood as part of one continuum. Programs designed to foster empowerment are increasingly recognized as an effective way that Aboriginal people can begin the healing journey and, by becoming empowered, can continue that journey where they are able to lead and assist others in their own healing.

For many authors empowerment is described as a process of healing that involves Aboriginal people coming to terms with the past and present situations and dealing with the pain. They describe healing through empowerment as a process of 'decolonisation' and redressing the ongoing inequality experienced by Aboriginal people and communities (Archibald, 2006; Feeney, 2009; Laliberte et al., 2009; Pearson, 2000; Robertson, 2000; Tsey et al., 2005a, 2009; Wanganeen, 2010).

One of the important aspects to the effectiveness of empowerment as a health strategy for Aboriginal people is that it fits with a strengths-based approach to addressing health issues.

This type of approach focuses on Aboriginal peoples' inherent strengths not their deficits; works with Aboriginal people rather than a 'top down' approach; and assumes that Aboriginal people are best placed to identify the issues in their community and the ways to address them (McCalman, 2006).

Those who promote the concept of empowerment are especially critical of programs and strategies that assume Aboriginal people and communities lack the tools or ability to address their own issues. Many authors such as McCalman propose that health professionals and policy makers continue to assume that best practice health interventions with Aboriginal people depend entirely on 'the ingenuity, expertise and generosity of the outsider' (2006). This has led to repeated mistakes in 'fixing up' problems for Indigenous peoples rather than 'harnessing and supporting those strengths from within' (2006).

Findings from the Empowerment Research Program

The Empowerment Research Program (ERP) at James Cook University has developed a theoretical model of the elements and attributes of empowerment for Aboriginal Australians who complete Stage One of the Certificate II in Family Wellbeing Counselling training (Whiteside et al., 2011).



These include the presence of particular beliefs and attitudes. Primary among these beliefs and attitudes were autonomy, responsibility, and optimism; self-esteem and pride; belief in God; and strong personal values, including respect and acceptance, forgiveness, and compassion.

Through the research of the ERP, the benefits of the Certificate II in Family Wellbeing (FWB) Counselling Training Program have been able to be tracked and assessed over the longer term. A summary of self reported changes by FWB program participants reflect the range of outcomes and manifestations that empowerment can take such as:

- improved communication skills with loved ones, including family, particularly with children;
- empathy, especially thinking about how other members of the family or community might feel;
- establishing a vision for the future and recognising personal potential, for example: formulating career or educational goals;
- thinking more about fundamental values such as trust, courage, hope and honesty and their influence in our lives;
- seeing ways of connecting with the past and tradition, finding new forms for expressing spirituality and new pathways for healing; and
- a better ability to critically reflect on oneself and one's life journey (Mayo et al., 2009, p.2).

Some participants also talked of a renewed sense of calm in their lives and not getting angry as often as they did before completing the program. The research of the ERP supports the view that the strength and effectiveness of empowerment programs such as the Family Wellbeing program, comes from people gaining control over their lives. They note that the key ingredients in this 'control factor' for Aboriginal people are capacity for hope, empathy, a sense of connectedness and respectful communication with loved ones (McEwan & Tsey, 2008, p.2). Tsey notes that many participants who at the start told stories of feeling disempowered, 'permanently stuck' in their current situation, and overwhelmed by their problems, later began to tell stories about themselves which often reflected strong values-based positive attitudes and beliefs about



life. As he notes, 'such changes are remarkable given the significant structural barriers many of the participants faced' (2008, p.16). Of particular significance is the fact that the personal empowerment and change experienced by participants had a lasting impact on themselves and on those around them.

The research of the ERP has identified that the dominant theme from the data on the Family Wellbeing programs is **that the most critically important aspect to empowerment is change in self**. This change starts with the participants 'clarifying and/or redefining their values and norms regarding right and wrong behaviour. This enables them to create boundaries and be able to say 'no' to people, which was identified as critically important in facilitating the process of changes in self. As participants went through this process of personal transformation, they built up their self-esteem and self-confidence, and were able to create safer and happier home environments for themselves and their families (Tsey, 2008a, p.17).

7.3 Empowerment to Address Risk Factors for Community Distress and Suicide

The importance of a strong sense of self and cultural renewal to a person's social and emotional wellbeing is the central tenet of the extensive research of Canadian psychologist Michael Chandler. In his original research (with Christopher Lalonde) the devastating effects of Aboriginal people's cultural loss and disempowerment are made especially clear (1998). Seeking to understand why some Indigenous communities had suicide rates 800 times the national average, while in others suicide was essentially unknown, the effect of 'cultural stability' was explored, firstly using data from 1987 to 1992 and then again with data from 1993-2000 (2008). Measures of 'cultural stability' were developed that took into account of communities' differential efforts to preserve and rehabilitate their cultures including factors such as the active pursuit of land claims, the takeover of social service management, and investments in cultural activities, most of which were regarded as measures of assertions of self-government (1998). The authors compared suicide rates in communities defined as more culturally stable or enacting more to preserve and rehabilitate their cultures, with rates in communities where there was less cultural stability, if any. It was found that there a range of poor outcomes in Aboriginal communities including high rates of suicide, especially among Indigenous youth, where there was a lack of cultural preservation, stability and, in effect, empowerment.

One of the key findings was the importance of fostering a secure sense of personal and cultural identity as a necessary protective factor against the threat of self-harm. As the authors state 'without some sense of personal (not to mention cultural) continuity, it would appear, life is easily cheapened, and the possibility of suicide becomes a live option' (2008, p.70).

Lack of continuity and identity seemingly has the greatest impact on young Aboriginal people:

In the best of circumstances, one's culture can be counted on to provide young people a measure of sameness while in the business of outgrowing childish ways. If instead, one's culture is marginalized, or vandalized, or turned into a laughingstock; and if (because of colonization or decolonization or globalization) the familiar and trustworthy ways of one's community are criminalized, legislated out of existence, or otherwise assimilated beyond easy recognition, then woe be upon those transiting toward maturity, and for whom otherwise customary ways and means of warranting one's personal persistence often no longer suffice. This is the fate, we argue, of many Indigenous youth around the world. Their culture of origin no longer computes, and their key to paradise is turned into a parking lot. The predictable consequence of such personal and cultural losses is often disillusionment, lassitude, substance abuse, self injury and self-appointed death at an early age (Chandler & Lalonde, 2008, p.70).

7.4 The Protective Power of Good Community Leadership and Governance

Good community leadership and governance is well recognised as a primary element in successful communities, while failures in community governance have been associated with catastrophic social dysfunction. For all Indigenous people, including women, empowerment and leadership is critical in the development of positive social and emotional wellbeing for individuals and the community. Studies from North America have shown that good governance and cultural preservation develop healthy communities (Sullivan, 2007).



The Aboriginal concept of leadership is particular to Aboriginal cultural values and experiences. Indigenous leadership is based on traditional values, knowledge, laws, kinship systems, and extended family relations (Calliou, 2008). Peters-Little (2001) notes that Aboriginal people's notions of leadership often clash with non-Aboriginal or mainstream concepts of leadership, and 'that conflict will always arise when Aboriginal people are expected to conform to the latter' (2001, p.189). The literature shows that the qualities of strong Indigenous leaders mirror those listed as arising from an effective empowerment and healing program. These include: respect for culture, self-awareness and confidence, integrity and wisdom, good negotiation skills, enthusiastic and inspirational, good communication skills and a sense of humour and adaptability (Reconciliation Australia, 2010).

A central aspect to Aboriginal people's empowerment and healing journey is being able to be in a position to influence others around them - in their families and communities. In so doing they can provide supportive networks to each other to maintain and strengthen their empowerment and contribute to community wellbeing and shared values. Many authors support the necessary and inseparable links between the individual, the family and the collective (Tsey, 2008a).

In their examination of best practices in Aboriginal community development and leadership, Canadian authors Cynthia Wesley-Esquimaux and Brian Calliou (2010) describe the process in the following way:

A community-centered, strength-based approach, deeply rooted in traditional practice works as it aims to strengthen leadership and social organization among community members who interact regularly and share institutions of social life. Strengthened social organization is, in turn, a means to enhance the ability of community members to engage in collective problem solving, to improve self-sufficiency and efficacy, bolster internal control, and to make the community a desirable place to live. Such changes benefit individual and family functioning (2010, p.18).



When there are good leaders, communities can be truly empowered and self-governing (Calliou, 2008). This is important when considering empowerment, leadership and the role of Aboriginal women, where gender equality and addressing the gendered impact of human rights violations is central to restoring the equality, cultural renewal, self determination and social and emotional wellbeing of Aboriginal people and communities.

Aboriginal Women's Empowerment and Leadership for Healing

Aboriginal women's empowerment and leadership plays an important role in Aboriginal healing (Dudgeon & Walker, 2010; Fredericks, 2009; Kabeer, 1999; Redbird, 1995). The Native Women's Association of Canada states that a culturally relevant gender-based analysis is required in the discourse on empowerment to allow for Aboriginal ways of understanding gender and the central roles of women in the healing and empowerment of Aboriginal men, families and communities. Kabeer (1999) states a crucial outcome of empowerment is evidence of sustainable gains in women's position and exercise of power (1999). Similarly, from their extensive studies on what mitigates against youth suicide in Aboriginal communities in Canada, Chandler and Lalonde (1998, 2008) found that promoting women in positions of leadership was one of the critical factors identified in those communities identified as culturally stable and where there were no youth suicides and low numbers of adult suicide rates (2008, p.25).



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In the Australian context, some authors talk of the need for healing journeys to specifically address the disproportionately high levels of violence against Indigenous girls and women when addressing the legacy of trauma impacting on Aboriginal people. Such violence is seen by some authors as part of the legacy of colonialism and associated social conditions including marginalization, dispossession, poverty, and discriminatory social institutions which empowerment strategies are seeking to redress (Fredericks 2010; Robertson 2000). Others make the important point that women must be active participants in the processes of gaining agency and control, rather than just recipients of such change (Malhotra, 2002).

Bronwyn Fredericks (2010) states that an important aspect to Aboriginal women's empowerment is Aboriginal women themselves defining what empowerment might mean to them (2010, p.55). She argues that 're-empowerment' must be seen as an act of Aboriginal women's healing and resistance to the on-going processes and impacts of colonization. She adds that re-empowerment also implies 'rebuilding and reviving Aboriginal women's spiritual and cultural practices accompanied by healing' (2010, p.550).

7.5 Critical elements for Effective Aboriginal Empowerment Programs

Analysis of the literature on healing, empowerment and leadership including a range of programs and services undertaken with Aboriginal people, confirms that no single approach or program can be made applicable across all communities.

Linda Archibald warns of the danger in assuming that healing programs working well in one context can be successfully transported to an entirely different social, cultural or political context (2006a, p.9). However, some common factors seemingly central to the effectiveness and longevity of many of these programs can and have been identified.

Some of these common elements refer to the particulars of the project itself, whereas others involve pre-existing resources in and around the community.

- These include: trusting, respectful partnerships between Aboriginal community members and external resource people, agencies and providers;
- the availability of external resource people who can provide information about health problems and possible action strategies, as well as stimulate critical reflection; and,
- adequate resources within and outside the community to buy equipment, offer transport to participants and conduct project monitoring and ongoing evaluation (Campbell et al., 2007).

Other factors identified within much of the literature (including International literature) and program reviews and discussed in more detail below include:

- a community's readiness for change;
- community members owning and defining their problems and designing the solutions;
- supporting local involvement including employing local people and training them in relevant skills and processes;
- culturally appropriate and locally based programs;
- ensuring the role of elders; and
- program structures ensuring sustainability and ongoing support.



In evaluating the Family Wellbeing Program, McEwan and Tsey (2008) note its capacity to provide participants with paths to healing that both engaged their creativity and intellect. The content of the FWB program and the flexible approach it takes has enabled it to be a program with capacity for translation across different settings. It also draws heavily on a wide range of cultural traditions which has also meant it has proved highly adaptable. Its focus on culture, including spirituality, as part of the healing process is also crucial to its success with Aboriginal people because it approaches these important factors as a 'living, dynamic personal and social resource' (McEwan & Tsey, 2008, p.20). Other factors inherent to the design and delivery of the Family Wellbeing program have also been identified by the Empowerment Research Project (ERP) as critical to the program's effectiveness. These include:

- the use of the Aboriginal survival experiences of course facilitators and students as the main learning resource;
- a holistic approach and a focus at the three levels of empowerment advocated by Wallerstein, namely the individual and the broader social environment – the family, community, workplace and broader society;
- a focus on teaching analytical skills (to assess elements or domains of life);
- mastery training (to cultivate co-ordination of the different domains);
- transformation (to encourage reorganisation of the personality around a different set of values);
- meditation (to facilitate exploration of the superconscious); and,
- relational techniques (to foster more openness and better communication with others.

Sustainability

The issue of sustainability to ensure a long term approach is also well documented by the ERP which identified it as important to the effectiveness of empowerment and healing outcomes. The ERP researchers found that the program coordinators and participants associated with the Family Wellbeing program have all identified that the process of empowerment is lengthy, taking years to achieve change beyond the individual level.

It is for this reason that they insist empowerment programs require a structure (and funding) that facilitates a long-term approach involving regular group discussions, interviews, critical reflection and feedback to promote and assess empowerment (Tsey, 2008a; Whiteside et al., 2011).

Employing and training local Aboriginal people

Another critical success factor for many programs, including the Family Wellbeing program, was employing local people to work on interventions and training them in community development skills and processes. The Family Wellbeing program is designed to use the Aboriginal survival experiences of course facilitators and students as the main learning resource. Evaluations of the course have identified this as one of its strengths. Participants have reported that the use of local facilitators' personal experience as a basis for learning was helpful because it created awareness that 'the facilitators had had issues to deal with in their own lives' (Tsey & Every, 2000, p.511).

The literature notes that use of local staff and ensuring a majority of Aboriginal staff on healing projects was deemed the most suitable approach. The advantages can include familiarity with the culture, knowledge of the history of removal and having the lived experience of the cultural reality and the grief (Koolmatrie & Williams, 2000). It also notes that staff and assistants involved in healing need to be confident, skilled and well supported to be able to address the complexity of problems involved (Silburn et al., 2010, p.101). Silburn et al note the urgent need for community-based workers trained in mental health and counselling methods. Similarly, Darryl Henry has highlighted the need for specialist training for Aboriginal people delivered in their communities and which adapts psychological and psychiatric methods for use with Aboriginal people (cited by Silburn et al., 2010, p.101).



Inclusion of Elders

International literature detailing programs working with victims of family violence in Aboriginal communities notes the significant role of individual Elders, Councils of Elders and Elders' groups. Elders played high-profile roles in projects by guiding and informing, exerting their authority, doing their own research and acting as project officers, as well as by being key speakers, cultural educators and mentors for younger leaders.

Brown and Languedoc (2004) identify the importance of incorporating teachings by Elders into programs through cultural techniques such as 'sharing circles' or ceremonies, as an important part of the healing process. The authors suggest 'the roles of Elders as spiritual leaders and teachers reinforced the path clients have embarked on for self-understanding and change' (2004, p.481).

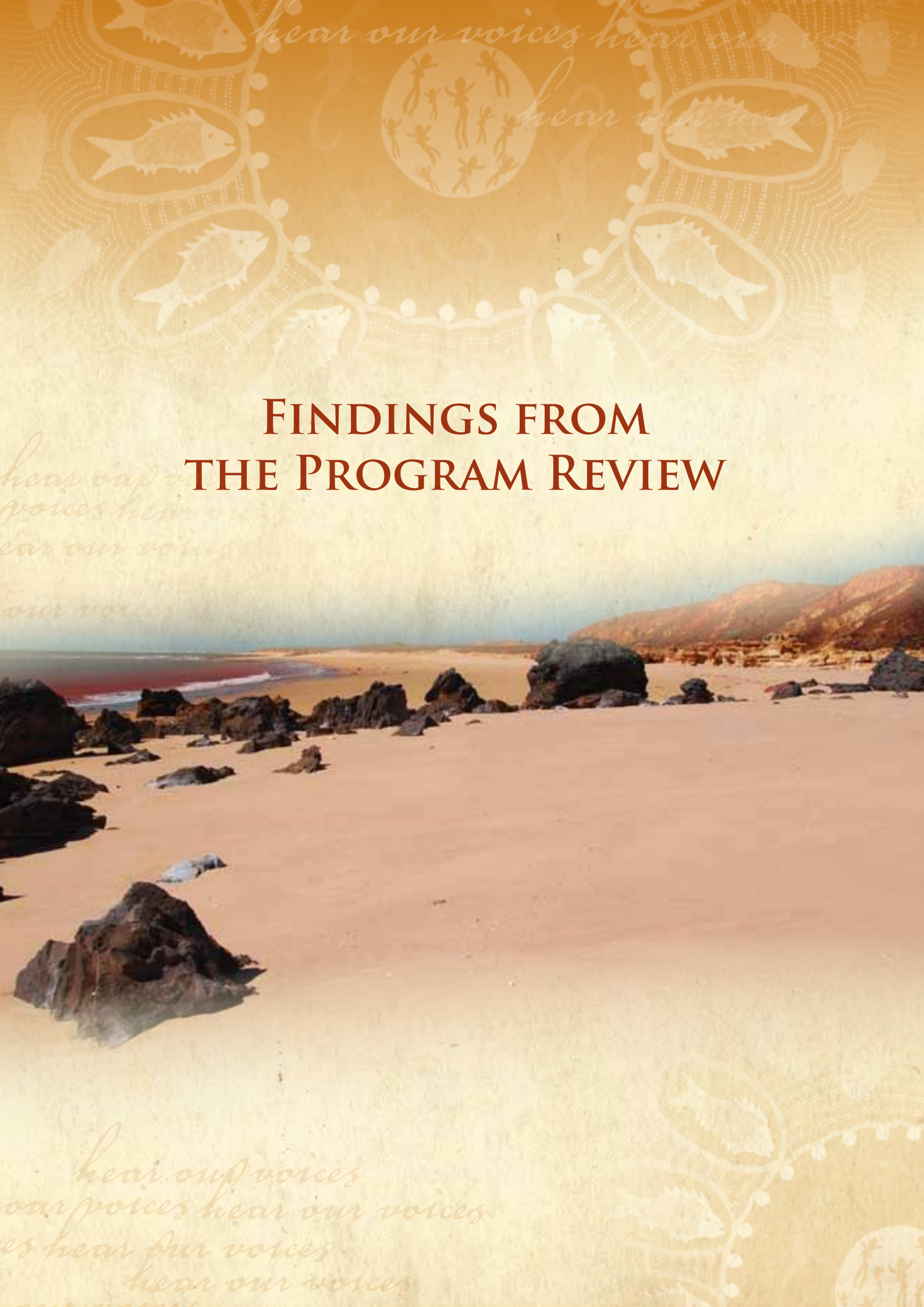
This trend is also evident in the Australian context, where numerous programs, ranging from those dealing with criminal and community justice issues to those tackling violence and substance abuse in Aboriginal communities have recognized the importance of incorporating the cultural authority of Elders (Memmot et al., 2006). The inclusion of Elders in the Port Augusta Aboriginal Families' project's activities and advisory group was identified as a crucial aspect to the effectiveness and acceptance of the program by Aboriginal participants (McCallum, 2001, 15).

Ensuring community readiness for change

One of the critical elements to an effective healing and empowerment program was the readiness of individuals and communities to embark upon such a journey. This readiness includes ensuring people are physically and emotionally able to participate in a program. Authors described the need for an environment that is conducive to healing practices flourishing.

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FINDINGS FROM THE PROGRAM REVIEW

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8

FINDINGS FROM THE PROGRAM REVIEW

8.1 Programs Designed and Delivered by Government Agencies/Services

The specific focus of the program review was to identify some of the current healing, empowerment and leadership programs in Australia to assess their effectiveness, suitability, flexibility to be adapted and transferred to other Aboriginal contexts. This required an examination of relevant programs application and understanding of these concepts, (healing, empowerment and leadership); their aims and objectives, and to ascertain to what extent they are effective in achieving them. A number of different programs, evaluations and studies are documented.

The first section examines two programs that have been designed by government agencies and services including the Aboriginal Families Project in Port Augusta, South Australia and the Aboriginal Family and Community Healing (AFCH) Program and the Family Wellbeing Program (FWB).

Port Augusta Aboriginal Families Project, South Australia

The Aboriginal Families Project in Port Augusta is a service for Aboriginal people and families who are experiencing multiple problems, many of which can be traced back to forced separation of family members. Many of these families have been involved with numerous agencies over a long period of time. It was recognised that for a range of complex reasons, families experiencing multiple problems are generally extremely difficult to engage, and resource-intensive for all agencies with which they may be involved. It was also apparent that more-of-the-same interventions would not be useful in attempting to facilitate change for these families. Instead, this service aimed to apply the principles of empowerment,

participation and partnership, in a creative way which fits this particular client group in this specific setting; that is, Aboriginal families in Port Augusta.

Project outcomes include breaking the cross-generational cycle that began with these disruptions. Families are given the opportunity to identify their own goals and staff work on the principles of empowerment, partnership and collaboration to ensure the process is in line with the family's wishes. Success stories include preventing the need for children to be placed in alternative care, repayment of debts, the return of children to the education system, stability in accommodation for the family and discharging of criminal justice orders. An Elders' group provides guidance and support to the project. While no details were provided on the treatment method, it appears to be based on a combination of practical interventions, support and empowerment (McCallum, 2001).

An evaluation of the program identified a number of positive aspects to the program and its impact on participants (McCallum, 2001). It noted the clear and articulated vision and a series of defined principles of the program including being overseen by Aboriginal people for Aboriginal families (staffed primarily by Aboriginal people, and operates under the guidance of a committee of Elders); the flexibility to work with clients' needs at a pace they can cope with; a sense of the families being in control of the process; and, doing things differently from how they have been done before to enable creativity, and to indicate to families and agencies that this program is a new way of working (McCallum, 2001, p.9). The evaluation highlighted the effectiveness of the program in approaching deep underlying personal issues, such as rejection by mothers, grief and loss, and domestic and family violence as the cause of so much of people's instability associated with debt, housing and child care. It noted that resolution of these deeper issues enables people to face their day-to-day problems (McCallum, 2001, p.8). It concluded that the vision and principles, which guide the intervention, are effective because they provide the framework for families to address the problems facing them. This resulted in

families managing for longer periods of time and requiring less assistance in coping with problems than they did when they started with the Project (McCallum, 2001, 15).

Aboriginal Family and Community Healing (AFCH) Program, Adelaide, SA

The aim of this program was to develop effective responses to family violence within Aboriginal families and communities in a northern metropolitan region of Adelaide. The Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) contracted the South Australian Department of Health's Central Northern Adelaide Health Service to develop and implement an AFCH Program through its primary health care Aboriginal outreach services.

This program worked with Aboriginal men, women and youth to promote effective responses to family violence. It focuses on substance misuse and social and emotional wellbeing at the family and community level (Kowanako et al., 2009). The program started from an understanding that family violence occurs within a historical context that has resulted in ongoing trauma, loss and unresolved grief, alcohol and drug abuse and a range of other health and well being problems and issues, including violence.

The AFCH Program comprised a complex range of programs, partnerships and activities that provided holistic and culturally appropriate strategies to enhance the safety and wellbeing of Aboriginal families and communities. The program objectives were to: build community capacity to support 'safe families'; equip Aboriginal people with the skills for effective communication and conflict resolution; support families in crisis; build capacity of mainstream agencies and services within the region; and workforce development. Strategies included establishing men's and women's groups, sharing knowledge within the safety of the group to enable people to learn to trust again, and providing counselling, role modelling, having older and younger people together in the group, respectful communication, and a combination of formal and informal learning.



An evaluation undertaken by researchers at Flinders University found a range of beneficial impacts on Aboriginal clients, families and community. It observed that the strengths of the program and key to its effectiveness were:

- evidence based design;
- holistic approach;
- clinical focus; committed staff; inter-agency/sectoral linkages;
- provision of peer support and mentoring; and
- Aboriginal cultural focus and long-term vision of the process of healing (Kowanako et al., 2009).

It reported that clients and workers were unanimous in their enthusiastic support for the program. Program participants reported that they gained communication and conflict resolution skills enabling them to address the reasons for and consequences of family violence.

The holistic approach of the AFCH Program was regarded by all involved as essential in addressing the social, cultural, spiritual, emotional and physical dimensions of wellbeing of the individual in the context of family and community. Having older and younger people together in the groups was also seen as a positive by both workers and clients, as younger people tended to be more open, whereas older people could offer insights and solutions based on experience. The groups were an important aspect of the program. For instance, male participants reported that the men's group became an important part of their lives because it provided them companionship, fun, a reason to 'get out of the house' and a way of learning new skills. Others talked of changed relationships with



family members since attending the group. The group provided a venue for the men to discuss issues and problems that they would not be able to talk about anywhere else. Several commented that it taught them to 'go home and listen'. The evaluation noted that participants learned about conflict resolution, consideration of others and how to be patient (Kowanako et al., 2008).

The results of this program were such that it was identified and highlighted as an effective strategy against Aboriginal family violence by the Productivity Commission in its *Overcoming Indigenous Disadvantage, Key Indicators* report (2009). That said, funding and organisational support has not continued for this program although it is known to be effective and is highly valued by the community.

8. 2 Programs Designed and Delivered by Aboriginal People

This section examines several programs designed by Aboriginal people that operate within a social and emotional wellbeing framework, which is considered essential if cultural integrity is to be restored. The programs include, Maramuli; Red Dust Program; and Yarrabah Family Life Promotion Program.

Marumali Journey of Healing

The Marumali Journey of Healing was developed by Aunty Lorraine Peeters, a survivor of the Stolen Generations. It is a healing program, rather than a 'therapy' or a 'treatment' and respects the

autonomy and strength of survivors and includes the spiritual dimensions of healing. It operates within the social and emotional wellbeing framework advocated by Aboriginal and Torres Strait Islander people in the SEWB Framework 2006 - 2010.

The word 'marumali' is a Kamilaroi word, which means 'to heal' or 'put back together'. The aim of the program is to 'increase the quality of support available to survivors of removal policies (Stolen Generations)' (Peeters, 2010).

The model offers an effective framework, structure and process to support the healing of survivors regardless of whether they were removed to institutional care, foster care or adoptive families. The Journey of Healing seeks to reconnect those who were removed to family, community, land, language and ancestors. It affirms that 'disconnection is the disease, reconnection is the cure'.

The Marumali Journey of Healing is a common model of healing used in Australian Government Health funded services, such as Bringing Them Home counsellors and Link-up programs. The program has also been successfully delivered in Victorian prisons since 2002, with over 20 workshops delivered to 250 prisoners. Since 2000, more than 120 workshops have been delivered to more than 1,200 participants: the majority of whom have been Aboriginal and Torres Strait Islander people working to support survivors of forcible removal policies (Stolen Generations).

Marumali Journey of Healing workshop is an accredited unit of competency (HLTAHW402A) 'Assess and support client's social and emotional well being' in the nationally endorsed Health Training Package HLT44007 Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care (Community Care) - Social and Emotional Wellbeing.

Red Dust Healing

Red Dust Healing is a cultural healing program developed by two experienced Indigenous workers who, through their own journeys of self-discovery, understand the importance of unpacking the issues in men's lives to address what lies at the heart of their problems. The program is delivered through group sessions and individual case management and support systems. The aim of the program is to give Aboriginal men an understanding of identity, to equip them with self evaluation skills, to develop future role models and fathers, and to restore family relationships.

The program seeks to facilitate the healing and rehabilitation of Indigenous offenders and those at risk of offending by providing them with a useful paradigm to understand how much of their behaviour may be addressed within the broader context of colonisation, oppression and identity. Furthermore, it aims to equip participants with the tools to break the cycle of intergenerational disadvantage. It is a unique example of an Indigenous-run initiative that aims to equip Indigenous men with the skills to reassert their Aboriginal identity, responsibilities and roles in the context of their relationships in a post-colonial society.

The Red Dust Healing program deals with areas considered significant to healing including; identity; family roles and structure; relationships; Elders roles; men's business; Indigenous history and the impacts of colonialism; drug and alcohol use; family violence; grief and loss; stress and mental health issues; anger management; education and employment; housing issues; and community contribution and governance.

The cultural and therapeutic elements are strengthened by practical case management and support systems to place the gains made from healing in a socially sustainable context. Each participant develops an individual case plan that will help continue the healing work. The case-plans follow on from the specific issues identified by participants during the workshops and set out goals for participants for when they return to their families and communities. Participants are matched up with a buddy from their area to assist in case-plan completion and the directors of the program then follow-up with participants via phone and also face-to-face meetings where possible.

Red Dust Healing has been provided to a wide range of participants, including young people in juvenile detention, high school students and men's groups. Red Dust Healing has also been adapted for delivery to doctors, police and legal practitioners to increase cultural awareness and explain healing from an Aboriginal perspective. The program uses simple but effective tools that 'target the heart, not the head' – and this is its strength, according to the directors of the program and past-participants (Cull, 2009).



Part of increasing the sustainability and reach of the Red Dust Healing program is the training component of the program. Participants are encouraged to become trainers so they can run the program in their own communities and provide mentor support to other participants. This training requires that individuals attend two blocks of program. The first assists the participants to deal with their own healing issues and familiarise themselves with the program. The second session involves participants taking a more active role in the program as mentors and co-facilitators under the supervision of Tom Powell and Randal Ross. Participants are left with all the program content and materials and can access additional support from Tom Powell as required. This training is increasing the number of people who are able to access the program. For instance, an Aboriginal Liaison Officer from Lismore Police (NSW) has since participated in the training and has now run the program in the local high school.

Over 1250 people have now officially completed different stages of the program with some outstanding results. Participant feedback has shown some powerful positive outcomes. An assessment of the program states that 'participants did not simply benefit from the program, but had come to believe in its capacity to equip Indigenous men and their families with the tools to reassume their roles and responsibilities as proud Aboriginal people' (Cull, 2009, p.60).

Yarrabah Family Life Promotion Program, Yarrabah Queensland

In the mid-1990s the Yarrabah people were traumatised by the number of suicides in their community that mostly involved men. Deaths occurred almost on a weekly basis and the Yarrabah Health Services (Gurriny Yealamucka) turned to the community to identify the causes and to develop some social and emotional intervention strategies such as a crisis intervention group and a Family Life Promotion Program. The mission statement of the program was:

To use a Community Development Suicide Prevention Model to heal individuals, promote family life, support, encourage, develop, improve and empower the people of Yarrabah to help reduce the suicides and attempted suicides in the community. To develop a locally owned culturally relevant Primary Health Care & Treatment Model such as Intervention, Prevention & Postvention to encourage individuals and families to move to a more healthy lifestyle, spiritually, physically, mentally and emotionally so to create a more socially acceptable environment (cited in Hunter et al., 2001, p.60).

The Yarrabah Family Life Promotion program in Queensland, established in 1995, subsequently developed a successful set of strategies for suicide prevention, intervention, aftercare and life promotion. Specific strategies implemented under the Program included:

- (a) a Men's Group to create supportive environments for men to play their rightful roles as fathers, husbands, brothers, uncles, grandfathers, elders, and traditional owners; and
- (b) education and training programs for individuals and families to empower them with the knowledge, skills and understanding, to deal with the suicide problem from a holistic healing perspective.

In their research of the community's response to the high rates of suicide, Ernest Hunter et al. noted that the Yarrabah community identified the reclamation of 'spirit' or responding to the experience of hopelessness, as fundamental to the achievement of health improvement. The community reported that what comes with 'healing the spirit' is 'self-determination, the opportunity to be the author of one's destiny and to take responsibility for one's life' (Hunter et al., 2001, p.77). They note the success of the program is the effective community empowerment and engagement it facilitated, rather than any specific outcomes with regard to suicides. As the authors note, 'it is the process undertaken by Yarrabah in defining its own responses and solutions, rather than the specific initiative that emerged at the end of that process, that are important' (2001, p.64).



Since 2000, the Family Wellbeing empowerment program has been operating in Yarrabah. Gurriny Yealamucka staff members are being trained as Family Wellbeing facilitators and are successfully conducting the program for a number of community groups (McEwan & Tsey, 2009).

The Family Wellbeing Program, South Australia

Some of the most effective healing and empowerment programs in Australia have arisen through the dissemination of the Family Wellbeing Program (FWB) that was developed by Aboriginal people in South Australia. The Family Wellbeing Program began as an Aboriginal led group program in 1998 to respond to social and emotional wellbeing problems such as suicide and family violence in the Riverland area of South Australia. The architects of the program were survivors of the Stolen Generations, who despite past traumatic experiences appeared to have actualised their potential in life (Tsey & Every, 2000). As one architect of FWB stated, the question we were asking ourselves is, 'How did we survive? If we can understand how we survived then we can help others' (Tsey, 2008a, p.6).

Reflection on their own experiences and consultation with others in their communities became the basis of the Family Wellbeing program. However, the program authors drew from an array of theory and resources, ranging from Eastern knowledge traditions to mainstream Western psychology (Whiteside, 2010). Certificates I and II in Family Wellbeing Counselling were developed, gained national

accreditation and have been successfully delivered across Australia including Alice Springs, Yarrabah, Cairns, Hope Vale, Whyalla and Tasmania. The program takes the form of a structured but flexible 5-stage program. Each stage consists of 30 hours of group learning, exploring themes of life balance, wisdom, and values; physical, mental, emotional, and spiritual needs; understanding and enhancing relationships; dealing with grief and loss, violence, and abuse; and processes of healing and change. The first stage provides an introduction to these concepts as a basis for personal understanding and change that is supported in subsequent stages. Each of the five stages is delivered as either a thirty-hour, stand-alone workshop (complete in a block) or as a series of weekly meetings. Completion of all five stages of the program provides participants with a nationally accredited qualification in counselling (Haswell et al., 2010).

This Project has identified that empowerment, healing and leadership programs can be an effective way for Aboriginal people to address the social inequality and relative powerlessness that are considered major factors in their disadvantage and key social determinants of health. The focus of these programs on mentoring, restoring family relationships, enhancing parenting roles and communication skills, means they are also proving particularly effective in restoring a family's ability to support and nurture its young people, which is a major factor in youth social and emotional wellbeing and suicide.

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APPENDICES



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10 APPENDICES

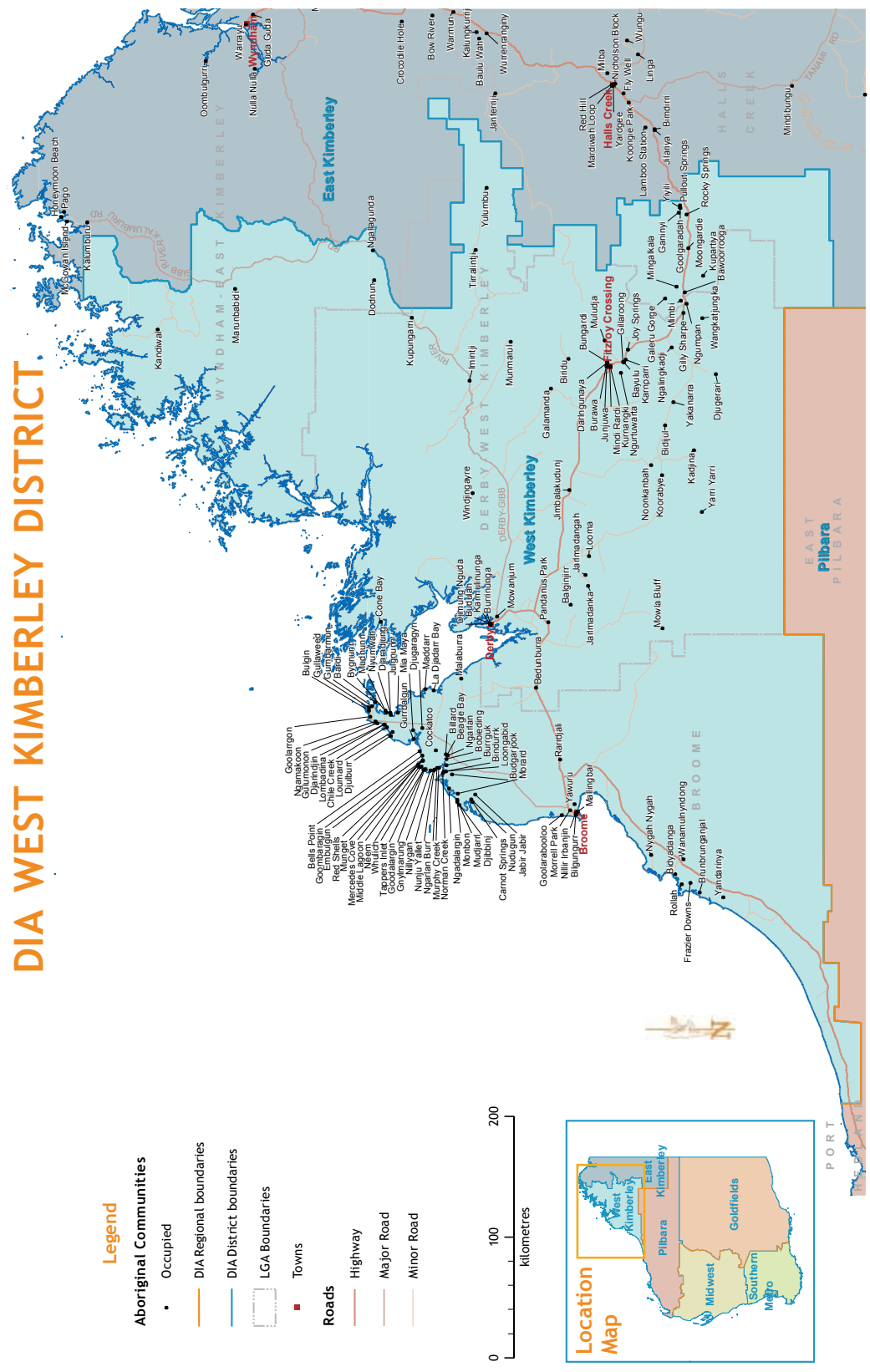
Appendix 1

Traditional language groups: the 27 traditional language groups within the Kimberley Region are listed below.

- Jukin (Broome area)
- Yawuru (area south of Jukin)
- Ngumbarl (area north-west of Jukun)
- Jabirrabirri (Cape Baskerville area)
- Nyul Nyul (area north of Jabirrabirri)
- Bardi (Lombardina, Cape Leveque area)
- Djawi (islands in King Sound)
- Nimanburu (King Sound area)
- Nyikina (Derby, Looma, Noonkanbah, Fitzroy Crossing area)
- Warwa (King Sound area)
- Unggarangi (area north-west of Warwa)
- Umida (Koolan Island area)
- Unggumi (area east of Warwa)
- Punuba (Fitzroy River area)
- Gooniyandi (south-east of Punuba)
- Worla (King Leopold Ranges, Durack Range area)
- Ngarinyin (Drysdale River area)
- Worora (Augustus Island, Collier Bay, Prince Regent River area)
- Wunambul (Bonaparte Archipelago, Bigge Island area)
- Gamberre (Cape Bougainville, Kalumburu area)
- Miwa (Cape Londonderry area)
- Kwini (area south-east of Miwa)
- Yijji (area south-east of Kwini)
- Doolboong (Wyndham, Ord river area)
- Kadjerong (area east of Doolboong)
- Miriwoong (Kununurra, Lake Argyle area)
- Kija (Lake Argyle, Turkey Creek area)

Appendix 2: Detailed Map of the Communities in the Area

DIA WEST KIMBERLEY DISTRICT



Based on information provided by and with the permission of the Western Australian Land Information Authority (2010).
Aboriginal Communities © DIA May 2010

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Appendix 3: Community Brief



Developing an Innovative, Culturally Responsive Healing, Empowerment and Leadership Program for Aboriginal people living in the Kimberley Region of Western Australia

COMMUNITY FEEDBACK

Where did we go ?

The consultation was undertaken in three sites – Beagle Bay, Broome and Halls Creek by two local Aboriginal community consultants.



The project was undertaken in response to calls by the community of the urgent need to find holistic, culturally and local relevant solutions to the crisis in mental health and social and emotional wellbeing health in the Kimberley that builds on Aboriginal people's strengths.



Community were asked:

'What do we need to do to make ourselves, our families, and our communities stronger?'

This is what the community told us:

- We need to "build self first", identify with ourselves. We need more self worth. We need to make ourselves strong and find our inner strengths.
- We need role models from our own backyards.
- No more shame factor.
- We want to get it right in families. We need to feel the love of families, need to feel good about sharing, don't hide things from family. Keep in touch with families. Make families aware to care and communicate with each other.
- We need to learn how to talk to one another again, to share and care for one another and to praise and credit to those who do good things for themselves and for others.
- We need to feel and be a part of our community. Have a sense of belonging, have cultural identity.
- Help us to become good parents and set good examples for our children. We really want to be good parents.
- We need to heal by getting back to country and keeping culture strong.
- We need to help our young people who don't respect their family, their culture or themselves.
- We need to learn how to deal with grief and trauma to break the cycle of pain in our families.



What does Healing, Empowerment and Leadership mean to community?

- Healing is a spiritual understanding of self, identity, love, belonging, family, security, hurt, heartache, good times, laughter and our connection to land.
- Healing is having hope and finding acceptance based on love and respect, of understanding of ourselves, our supports and being able to tell “our” stories.
- Becoming empowered is how we can start to deal with the pain and grief and then help others and our community.

What do people want in a program?

- Flexibility
- Programs that meet different individual needs and the different priorities of the local community
- Mentors and support at a local level
- Practical, visual and hands-on courses
- Employ and train local people including a mentorship program
- Programs that have the support of the community
- Goal setting, motivation and organisational skills to achieve goals
- Culturally based programs that go back to country and use the knowledge of our elders
- Different options and pathways that meet different capacity and stages of readiness for healing and change

Where to from here?

We will be telling government and relevant people that they need to listen to Aboriginal people, and to provide more resources to develop local programs that can help individuals take charge of their lives and help their families and communities.

We will further develop and deliver a program through Kimberley Aboriginal Medical Services Council that:

- responds to the different needs and issues identified by the communities
- is well resourced and relevant to local issues
- respects and supports culture and connection to country empowers people to continue their healing journey over the longer term.

We will seek funds to develop and deliver workshops that can build people’s readiness so they can be able to start an accredited empowerment and leadership program.

Project Team

Professor Pat Dudgeon, Associate Professor Roz Walker, Dr Clair Scrine, Ms Cheryl Dunkley, Divinna D’Anna and Kathleen Cox.

If you want more information or to talk to someone about this project you can call 9489 7772.



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RESEARCH AND POLICY BRIEF

Developing an Innovative, Culturally Responsive Healing, Empowerment and Leadership Program for Aboriginal people living in the Kimberley Region of Western Australia

KEY POINTS

- Aboriginal people have particular conceptions and understanding of healing, empowerment and leadership based on their historical, political and social experiences and cultural values.
- There is a high level of need in the Aboriginal communities of Broome, Beagle Bay and Halls Creek for a range of culturally appropriate and locally responsive healing, empowerment and leadership programs and strategies.
- Programs need to address empowerment in different ways, for different groups and in multiple settings, to accommodate differing levels of need and community, family and individual readiness.
- The content, design and delivery of empowerment programs need to have legitimate community support and engagement, and be culturally appropriate, locally based and relevant to people's needs.
- Empowerment programs are an effective strategy for enhancing social and emotional wellbeing and addressing suicide risk factors, especially among young people.
- Programs that empower individuals to change their lives, their communities' lives and the systems that are barriers to good social and emotional well being can have an impact on a number of key policy areas.

BACKGROUND

The damage and trauma inflicted on Aboriginal people by colonisation, including the forcible removal of lands, the break-up of societies and families, and the removal of children away from their cultural heritage and often into situations of cultural, physical and sexual abuse has had a devastating and lasting impact.

Evidence shows Aboriginal and Torres Strait Islander people are exposed to a disproportionate number of stressful life events compared to other Australians, contributing to high levels of serious psychological distress and suicide. The National Aboriginal and Torres Strait Islander Health Survey: Australia, 2004-05 shows that Indigenous people report high to very high rates of psychological distress, up to twice that of other Australians (Australian Bureau of Statistics, 2006). The Western Australia Aboriginal Child Health Survey also provides alarming evidence of poor mental health among Aboriginal children and youth, with one in four Aboriginal children found to be at high risk of developing serious emotional or behavioural difficulties (Zubrick et al, 2005).

The Kimberley region in north Western Australia has come to national attention recently with an exceptionally high number of Indigenous suicides occurring. The mental health of people

in these communities is highly concerning and the impact from such trauma is manifested at the level of individuals, the family and the community. The need for healing at all of these levels through dealing with the range of trauma and its effects is increasingly recognized.

This project identified a need to respond to the crisis in mental health in the Kimberley communities in a holistic, culturally and geographically appropriate and sustainable way. It sought to do this by considering the role personal empowerment can play in assisting Aboriginal people to deal with many of the issues that underlie their trauma, grief and dysfunction.

It examined to what extent healing, empowerment and leadership programs are effective in supporting individuals and communities to overcome feelings of chronic hopelessness, enhance and build on their unique 'protective factors' and change the systems that are barriers to good social and emotional well being. It also explored the level of need and the relevant content and delivery required for culturally appropriate and locally responsive leadership, empowerment and healing programs in three communities in the Kimberley region.

RESEARCH METHOD

This project involved an extensive community consultation process, literature and program review. The project is community driven using participatory action research processes. Qualitative data was gathered through focus groups and one-on-one interviews with a range of local community members and relevant stakeholder agencies. Over 78 people were consulted across three communities.

An in-depth review of relevant programs in Australia was undertaken. The specific focus of the program review was identifying some of the current healing, empowerment and leadership programs in Australia to examine their application and understanding of these concepts; their aims and objectives and to what extent they are effective in achieving them. A number of different programs, evaluations and studies were documented. In addition, the review sought to understand what programs or aspects of programs are working to facilitate greater individual and community wellbeing in order to identify a set of core elements critical to the effectiveness of

healing, empowerment and leadership programs and program delivery in diverse Aboriginal contexts.

A comprehensive review and analysis of some of the key literature and theory on healing, empowerment and leadership was the third element to the research project. The review examined a range of research, both Australian and International, to identify conceptions of empowerment, healing, and leadership; to understand why these concepts are considered effective in addressing the trauma and dysfunction experienced by Aboriginal communities; and in what ways they build esteem, capacity and improve people's social and emotional health and wellbeing.

KEY FINDINGS

There is an Aboriginal conception and understanding of healing, empowerment and leadership.

The concept of healing for Aboriginal people is itself specific to their experiences and cultural values and differs considerably to many Western ideas of healing as 'treatment'. Healing is conceived holistically involving physical, social, emotional, mental, environmental, and spiritual well being. Many regard healing as a spiritual journey that requires initiatives to assist in recovery from trauma and addiction, and reconnection to the family, community and culture. For many Aboriginal people, empowerment is understood as a process of healing that involves coming to terms with the past and present situations, dealing with the pain and redressing the ongoing inequality they and their communities' experience. In this conception, healing, empowerment and leadership are seen as all part of one continuum. Programs designed to foster empowerment are increasingly recognized as an effective way that Aboriginal people can begin the healing journey and, by becoming empowered, can continue that journey where they are able to lead and assist others in their own healing.

There is a high level of need for a range of culturally appropriate and locally responsive healing, empowerment and leadership programs in the Aboriginal communities of Broome, Beagle Bay and Halls Creek.

The consultation process produced a range of responses to the question “what do we need to make ourselves, our families and our communities stronger”? There was an overwhelming consensus that there was a real need to support people to change their lives. People spoke of needing to “build self first” and to “make ourselves strong”; to focus on rebuilding family and learning to be good parents and role models. Respondents said they wanted to learn how to talk to one another again, to share and care for one another and to praise those who do good things for themselves and their communities. Of particular note was the high level of concern and urgency for the need to focus on young people who, it was felt, have lost respect for their culture, their family and themselves.

One of the critical elements to an effective healing and empowerment program is the readiness for change of individuals, families and communities.

One of the critical elements to an effective healing and empowerment program is the readiness of individuals and communities to take on such a journey. This readiness includes ensuring people are physically and emotionally able to participate in a program. The various challenges in people’s lives means that programs need to address empowerment in different ways, at different levels and in multiple settings, to accommodate the differing levels of community, family and individual readiness. People need to be given options and pathways that meet both where they are in the healing journey and their own preferences and capacity. Thus programs need to be flexible and designed to be suitable for people with poor health, drug or alcohol addiction, history of suffering or perpetrating abuse and at varying levels of denial, grief and poverty.

The content, design and delivery of empowerment programs need to have legitimate community support and engagement, and be culturally appropriate and locally based.

Much of the literature examined for the project demonstrated that in order to be effective, programs needed to be culturally-based and incorporate traditional elements into their content and teaching, learning and healing processes. In this regard, the Aboriginal notion of holism is central to any program

design so that it enables participants to address the physical, emotional, mental and spiritual dimensions of their health and wellbeing.

Programs also need to be relevant to local circumstances and adopt practices that suit a particular region, cultural or language group and link with localised practices be they traditional or contemporary. This includes employing local people to work on interventions and training them in community development skills and processes.

The support and engagement of community throughout the design, implementation and evaluation of programs and any related materials is another critical factor in the effectiveness of programs. This level of engagement is deemed necessary for programs to be meaningful, for people to have ownership over the issues and the solutions and, ultimately, to be both effective and empowering.

Empowerment programs are effective health and suicide prevention strategies.

As a concept and a strategy empowerment enables Aboriginal people to address the social inequality and relative powerlessness that are considered major factors in their disadvantage and some of the key social determinants of health. By providing Aboriginal people with the tools to understand and address many of the issues associated with their sense of powerlessness and thereby improve their physical, social and emotional health and wellbeing themselves, empowerment programs can be seen as an effective health strategy.

Empowerment and healing strategies address many of the underlying issues that have removed or actively suppressed people’s self determination and resiliency and contribute to chronic feelings of helplessness and hopelessness. In working to enable people to take greater control over their life and responsibility for their situation; to become strong culturally and spiritually; and establish more equitable power relations, these programs can be effective ways of addressing many of these known suicide risk factors. In addition, the focus of these programs on mentoring, restoring family relationships, enhancing parenting roles and communication skills means they are proving particularly effective in restoring a family’s ability to

support and nurture its young people, which is a major factor in their social and emotional wellbeing and suicide.

POLICY IMPLICATIONS

The Centre of Research Excellence in Aboriginal Health and Wellbeing (CRE) is a strategic program of intervention research that is focused on achieving radical and sustainable change at a policy level in order to improve the lives of Aboriginal people. As part of that objective, this research highlights the urgent need for current policy reform agendas to better target and maximise the potential of proven existing community empowerment initiatives. Resources need to be directed towards programs and strategies that build on Aboriginal people's unique protective factors; and facilitate their own identification and understanding of the core issues impacting on their lives and the ways to address them.

Policy Makers need to ensure that these types of programs and strategies are well resourced so they are sustainable and can enable people to be supported to continue their healing journey over the longer term. These types of programs and strategies require a long-term approach involving regular group discussions, interviews, critical reflection and feedback to promote and assess.

Empowerment strategies and Aboriginal understandings of healing need to be integrated and applied within larger policies and programs to maximize funding directed to achieving vital health gains for Aboriginal people and communities and working to close the gap in a number of key areas.

Providing the tools that empower individuals to change their lives, their communities' lives, and the systems that are barriers to good social and emotional well being, can

have an impact on a number of key policy areas.

This research has identified that empowerment programs are instrumental in resourcing Aboriginal people to develop their understanding of the underlying causes of their poor social and emotional wellbeing and ways to tackle those issues. As such, healing, empowerment and leadership programs are:

- an effective way to address the alarming rates of suicide in many Aboriginal communities;
- a means of supporting people to be in a position where they are capable of taking on further training leading to employment and leadership positions; and,
- facilitating community empowerment and responsibility leading to better governance, safety and leadership within these communities and their organisations.

FURTHER INFORMATION

The full report for this project can be found aboriginal.ichr.uwa.edu.au or by contacting Professor Pat Dudgeon pat_dudgeon@optusnet.com.au

This Research and Policy Brief is based on research by Professor Pat Dudgeon, Associate Professor Roz Walker, Dr Clair Scrine and Ms Cheryl Dunkley and Community Consultants, Divinna D'Anna and Kathleen Cox.

The project is located within the National Health and Medical Research Council (NHMRC) Centre for Research Excellence Aboriginal Health and Wellbeing, at the Telethon Institute of Child Health Research in partnership with University of Western Australia, the Kimberley Aboriginal Medical Services Council, Regional Centre for Social and Emotional and Well Being.



THE UNIVERSITY OF
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Australian Government
Department of Health and Ageing



RESEARCH AND POLICY BRIEF

Appendix 5: National Advisory Committee Membership

Confirmed List of National Advisory Committee Members

Professor Pat Dudgeon, Project Lead and Research Fellow, the School of Indigenous Studies, University of Western Australia. (Chair)

Tom Brideson, Statewide Coordinator, NSW Aboriginal Mental Health Workforce Program. NSW.

Chris Bin Kali, CEO, Broome Regional Aboriginal Medical Services, Broome, WA.
Dr Robert Brooks, Research Director, The Aboriginal and Torres Strait Islander Healing Foundation.

Eric Cook, Training Manager, Aboriginal Access Centre, TAFE, Berri Campus, SA.

Adele Cox, ACOX Consultancy, WA.

Divina D'Anna, Community Consultant, Empowerment, Leadership and Healing Project, NHMRC Centre of Research Excellence in Aboriginal Health and Wellbeing, Telethon Institute for Child Health Research. Broome. WA.

Cheryl Dunkley, Project Officer, Empowerment, Leadership and Healing Project, NHMRC Centre of Research Excellence in Aboriginal Health and Wellbeing, Telethon Institute for Child Health Research. WA.

Dr Kate Hams, Manager, Kimberley Aboriginal Medical Services Council, Social and Emotional Workforce Support Unit, WA.

Georgie Harman, First Assistant Secretary, Mental Health and Drug Treatment Division, Department of Health and Ageing, ACT.

Michael Mitchell, Manager, Statewide Indigenous Mental Health Services, WA.

Kel O'Neil, Kimberley Aboriginal Medical Services Council, Social and Emotional Workforce Support Unit, WA.

Marge Quartermaine, Director, Marr Mooditj Training, Perth, WA.

Dawn Ross, Coordinator, Family & Wellbeing, Faculty of Health, Business & Science, Alice Springs, NT.

Professor Fiona Stanley AC, Director of the Telethon Institute of Child Health Research, WA.

Dr Claire Scrine, Senior Researcher, Empowerment, Leadership and Healing Project, NHMRC Centre of Research Excellence in Aboriginal Health and Wellbeing, Telethon Institute for Child Health Research. WA.

Professor Komla Tsey, Tropical Leader, Education for Social Sustainability, James Cook University, QLD.

Associate Professor Roz Walker, Senior Researcher, Empowerment, Leadership and Healing Project, NHMRC Centre of Research Excellence in Aboriginal Health and Wellbeing, Telethon Institute for Child Health Research. WA

Eddie Wright, Manager, Aboriginal Education, Kimberley Education Regional Office. WA.

EMPOWERMENT PROGRAM INDIGENOUS CONSULTATION WOKSHOP



Moving Towards Healthy Communities HAVE YOUR SAY



This workshop is aimed to identify the needs of the indigenous community and allow them to have a say on the development of accredited programs to empower the individual and community as a whole.

Presenters: Divina D’Anna, Kathleen Cox & Cheryl Dunkley
When: Tuesday, 19th July 2011
Where: Notre Dame University, Broome
Time: 9.00am – 1.00pm
Registration: Ph: 0400 099 205



MORNING TEA AND LUNCH WILL BE PROVIDED

Appendix 7: Project Fact Sheet



A Project through the Telethon Institute for Child Health Research (TICHR) NHMRC Centre for Research Excellence in Aboriginal Health and Well Being in collaboration with Kimberley Aboriginal Medical Services Council (KAMSC) Regional Centre for Social and Emotional Wellbeing.

Developing an Innovative, Culturally Responsive Empowerment, Healing and Leadership Program for Aboriginal People Living in the Kimberley Region, Western Australia.

How the idea came about

In recent times a range of discussions took place about ways to make Aboriginal individuals, families and communities strong.

There was talk about what could be done to deal with the range of risk factors that Aboriginal people live with.

Personal empowerment is seen as one of the strategies in overcoming the hopelessness that some Aboriginal people live with.

From literature about the empowerment programs, the empowerment process works from an individual perspective and from this other learning and actions can take place that bring about positive changes in self, family, others and the community.

What the project is about

The project is community driven using participatory action research processes. Information will be gathered through consultation with local community members and relevant stakeholder agencies. The team are also reviewing successful programs in Australia to inform the development of an empowerment program to meet local needs.

Project aims

The empowerment project aims to strengthen Aboriginal social and emotional wellbeing through the development of a range of programs or courses specifically designed to address priorities in this area. The courses will take a holistic life promoting view of health that enhances the protective factors of the social, emotional, spiritual and cultural wellbeing of the whole community

Project outcomes

The key outcome of this project will be the development of culturally appropriate community workshops and an accredited innovative program that promote empowerment, healing and leadership of Aboriginal people in their local communities.

For further information:

Professor Pat Dudgeon
Project Leader
Telethon Institute for Child Health Research (TICHR)
Telephone: 0422615003

If you know someone else who would like to have input or participate in the community consultations, please contact the community consultants:

Divina D'Anna
Mobile: 0400 099 205

Kathleen Cox
Mobile: 0429 505 347

The background features a repeating pattern of stylized fish and circular motifs. The fish are depicted in various orientations, some within oval frames. The circular motifs contain abstract human figures. The entire pattern is rendered in a lighter shade of red against a darker red background.

hear our voices