Urban Health: Strengthening our voice, culture and partnerships

Urban Health: Strengthening our voice, culture and partnerships

Edited by

Brian F McCoy, Paul Stewart and Nerelle Poroch

Developed from papers presented in the Representation and Cultural Expression stream at the 2009 AIATSIS National Indigenous Studies Conference 'Perspectives on Urban Life: Connections and reconnections'

First published in 2012 by AIATSIS Research Publications

This volume has been produced with funding support from the Lowitja Institute, Australia's National Institute for Aboriginal and Torres Strait Islander Health Research, which incorporates the CRC for Aboriginal and Torres Strait Islander Health. The Cooperative Research Centres program is an Australian Government initiative.

Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS)
GPO Box 553, Canberra ACT 2601
Phone: (61 2) 6246 1111
Fax: (61 2) 6261 4285
Email: research@aiatsis.gov.au
Web: www.aiatsis.gov.au

National Library of Australia Cataloguing-in-Publication entry:

Title:	Urban health [electronic resource] : strengthening our voice, culture and partnerships / Brian McCoy, Paul Stewart and Nerelle Poroch, editors.
ISBN:	9781922102034 (eBook : pdf)
Subjects:	Aboriginal Australians--Health and hygiene. Urban health--Australia. Public health--Australia.
Other Authors/ Contributors:	McCoy, Brian. Stewart, Paul. Poroch, Nerelle
Dewey Number:	362.1089915

Cover design by Inprint Pty Ltd

Contents

Contributors

Dr Karen Adams is Wiradjuri and has worked for more than 20 years in Aboriginal health as a health care provider, educator and researcher. She is currently employed by the Victorian Aboriginal Community Controlled Health Organisation and is an Adjunct Associate Professor to Moondani Balluk Indigenous Academic Unit, Victoria University. <karen.adams@vu.edu.au>

Dr Reuben Bolt is a descendant of the Wandandian and Ngarigo peoples and holds the position of lecturer at Nura Gili, The University of New South Wales. He is the first Indigenous doctoral graduate of the Faculty of Health Sciences, The University of Sydney, has ten years teaching experience across six universities in New South Wales and has worked on various research projects within Aboriginal communities. His research interest is Indigenous knowledge and identity. <r.bolt@unsw.edu.au>

Professor Yvonne Cadet-James is a Gugu Badhun Aboriginal woman from the Valley of Lagoons in north Queensland. She is currently the Chair of Indigenous Australian Studies in the School of Indigenous Australian Studies at James Cook University. She has an extensive background in health, first as a registered nurse and midwife and later as an academic, and is involved in teaching and learning, research and community development.

Professor Kathleen Clapham is an Aboriginal Australian, a descendant of the Murrawarri people of north-western New South Wales. She holds a Bachelor of Arts (first-class honours) and a doctorate, both in Anthropology, from The University of Sydney. She is currently a Professorial Fellow in the Australian Health Services Research Institute (University of Wollongong) and a Visiting Professorial Fellow in the Injury Division of The George Institute for Global Health (The University of Sydney). Prior to this she was Director of the Woolyungah Indigenous Centre and Convener of the Indigenous Studies Program at the University of Wollongong. Her research interests include injury prevention and safety promotion in Indigenous communities, Indigenous community development, Indigenous child health and resilience and Indigenous health workforce development. <kclapham@uow.edu.au>

Leonie Cox was awarded first-class honours in 1993 and in 2001 a doctorate in Social Anthropology from The University of Sydney. These studies explored barriers Aboriginal and Torres Strait Islander people experience in achieving equity and social justice. Her socio-political interpretation of the material was contextualised in terms of the impact of colonisation, subsequent oppressive state legislation and practices, social marginalisation and the struggle for autonomy. A critique of individualism, the medicalisation and criminalisation of difference and poverty, and studies of knowledge, power, class and race relations are themes that underpinned her honours and doctoral studies. These varied experiences contributed to her research interests in the social, political and cultural determinants of health and in the interface between communities and government institutions. She now writes, teaches and researches on the interaction between health and culture, with a specific focus on cultural safety and the impact of Indigenous history on health outcomes and social and emotional wellbeing. In terms of any future research with Aboriginal and Torres Strait Islander people, she is committed to community-driven research and community research priorities.

Associate Professor Jacinta Elston is an Aboriginal woman from north Queensland and is Associate Dean, Indigenous Health in the Faculty of Medicine, Health and Molecular Sciences at James Cook University. With a Masters of Public Health and Tropical Medicine, and a growing number of collaborative research grants in her academic and research achievements, her research interests include healthy ageing in Indigenous Australians, health service issues in relation to Indigenous cancer patients, Indigenous health workforce and services research, and the development of health capacity (including research capacity) within the Aboriginal and Torres Strait Islander community.

Dr Freidoon Khavarpour was born in Iran and received his postgraduate educational degree from The University of Michigan. He worked with intellectually handicapped children and African-American communities during his stay in the United States. After migrating to Australia in 1982, he joined the New South Wales Department of Health, holding a variety of positions, mainly in health education and promotion portfolios, for nine years. He joined The University of Sydney in 1992 and from 1995 to 2009 was involved in teaching and research in the discipline of Indigenous Health. He has been involved in various community-based organisations, as a community developer and volunteer, and as a workshop facilitator on need assessments, evaluation and health promotion for government and non-government organisations. <F.Khavarpour@tpg.com.au>

Meegan Kilcullen is a psychologist who is currently completing a Masters of Psychology (Clinical) and Doctor of Philosophy at James Cook University. Her area of interest is Aboriginal and Torres Strait Islander health and wellbeing.

Brian F McCoy was born on Wurundjeri country in Melbourne and is of Anglo-Celtic ancestry. He has worked in a number of Aboriginal and Torres Strait Islander communities over nearly four decades in the north of Australia, including time in Townsville and Palm Island between 1979 and 1985. In that time he worked in a range of roles as ordained priest, football coach, and with prisoners and young people in juvenile detention. He completed his doctorate at The University of Melbourne in 2004 and focused on the health of men in the Kutjungka region of Western Australia. He is also an Adjunct Principal Research Fellow at the Indigenous Health Unit, James Cook University. <b.mccoy@latrobe.edu.au>

Ngarra Murray is a Wamba Wamba/Yorta Yorta woman who works as a Research Assistant for the Onemda VicHealth Koori Health Unit and is currently working on the Aboriginal Cultural Walking Tour Project for The University of Melbourne. She worked as Onemda's Project Officer for the 'From Margins to Mainstream Conference: 5th world conference on the promotion of mental health and the prevention of mental and behavioural disorders' project. She previously worked at Museum Victoria, City of Melbourne, and on the Pastor Sir Douglas and Lady Gladys Nicholls Memorial Project.

Tom Ogwang was awarded first-class honours in Indigenous Health from The University of Queensland in 2005. He has worked with rural and urban Aboriginal communities undertaking research and practice principally in health-related work spanning injury prevention, inhalant misuse, social service provision for marginalised young people and adults, alcohol and other drug service reviews, chronic disease service delivery improvement and workforce planning. He is an experienced cultural safety workshop facilitator with an ongoing role in the co-facilitation of the Queensland Aboriginal and Islander Health Council cultural safety curriculum. He is currently an Associate Lecturer at The University of Queensland Aboriginal and Torres Strait Islander Studies Unit. He hails from black African and Anglo-Celtic Australian ancestry and has lived in Australia since boyhood. <t.ogwang@uq.edu.au>

Nerelle Poroch has a master's and a doctorate from the University of Canberra. She currently carries out research at Winnunga Nimmityjah Aboriginal Health Service in Canberra. Over the past seven years she has been involved in research on Aboriginal and Torres Strait Islander peoples' health and wellbeing. <Nerelle.Poroch@winnunga.org.au>

Randal Ross shares Bindol (Townsville), Juru (Ayr; Birragubba Language Group), Oompala (Kunjun — Lockhart River), Erub (Darnley Island) and Kanaka (Australian South Sea Islander) ancestry. He has been involved in Indigenous men's health research

at James Cook University, is the co-designer of the Red Dust Healing Program, Board member of the Jezzine Barracks Community Trust, Talk Trimmer Indigenous Men's Radio Host and National Indigenous Men's Leadership Senior Facilitator. He is currently a postgraduate student in public health research. He is a husband, father and uncle.

Jude Saldanha is highly experienced in the delivery of services to address homelessness and alcohol and other drug dependency among Aboriginal and Torres Strait Islander young people. He has a strong track record in the collaborative development and delivery of innovative responses to volatile substance misuse among Indigenous young people in Brisbane. He is currently Manager of Indigenous Youth Health Services, Aboriginal and Torres Strait Islander Community Health Service Brisbane Limited. He is currently completing a Masters of Public Health (Indigenous Health). <Jude.Saldanha@atsichsbrisbane.org.au>

Professor Mark Stevenson is Chair of the Accident Research Centre in the School of Public Health and Preventive Medicine at Monash University. Prior to this he was Senior Director, Research and Development at The George Institute for Global Health and Professor in the School of Public Health at The University of Sydney. He is a strong advocate for road and child injury prevention and has worked on numerous national and international projects related to these areas. He has extensive research experience, including investigations of mobile phone use and motor vehicle crash, childhood pedestrian injuries and alcohol-related road traffic injury, as well as studies involving pediatric fire- and burn-related injuries. He is a member of the Australasian Trauma Society, Chair of the New South Wales (Sydney) chapter of the Australasian College of Road Safety, a member of the editorial boards for a number of international journals, and a member of the Technical Advisory Group for the international not-for-profit Alliance for Safe Children. <Mark.Stevenson@monash.edu.au>

Paul Stewart is a Taungurong man from central Victoria who has more than ten years experience working in Aboriginal community organisations. He commenced with Onemda VicHealth Koori Health Unit at The University of Melbourne in April 2002 and previously worked with the Aborigines Advancement League and the Victorian Aboriginal Health Service in Melbourne. His interests include health research methodologies and ethics in Aboriginal communities. <paul.stewart@unimelb.edu.au>

Assistant Professor Steve Su is Assistant Professor in the School of Mathematics and Statistics at The University of Western Australia. His key research interests include the generalised lambda distribution and its applications, density estimation, statistics in accounting and business, statistics in medicine and statistics computing. <ssu@maths.uwa.edu.au>

Dr Anne Swinbourne is a Senior Lecturer at James Cook University. Her areas of interest are in physical and mental health promotion.

Julie Tongs is the Chief Executive Officer of Winnunga Nimmityjah Aboriginal Health Service and has 20 years experience working in Aboriginal and Torres Strait Islander affairs. She has extensive experience in advising, formulating, implementing and evaluating public health initiatives, programs and policy at a local, regional and national level. She has been a national leader and strong advocate of quality improvement initiatives within the Aboriginal community-controlled sector. <Julie.Tongs@winnunga.org.au>

Dr Michael Wright is Aboriginal, a Yuat Nyungar man, and his mother and grandmother's booja (country) is north of Perth in an area known as Victoria Plains, which includes the townships of Mogumber, Moora and New Norcia. He is currently a National Health and Medical Research Council Fellow at the Telethon Institute for Child Health Research. He is currently working with the local Aboriginal community exploring the experiences of mental health and wellbeing for Aboriginal people. <michaelw@ichr.uwa.edu.au>

Introduction

Brian F McCoy, Paul Stewart and Nerelle Poroch

In the 2006 Australian Census the median age of Aboriginal and Torres Strait Islander[1] people was 21 years, compared with 37 years for other Australians, with more than one-third less than 15 years of age (ABS and AIHW 2008:4). Although the Australian Aboriginal and Torres Strait Islander community is much younger than mainstream society, life expectancy remains much lower, with mortality rates almost three times those of other Australians (ABS and AIHW 2008:151).

Addressing the future health of Aboriginal and Torres Strait Islander people means improving our understanding about those who live in our diverse urban communities. Seventy-five percent of Australia's Aboriginal and Torres Strait Islander people live in major cities and regional areas (ABS and AIHW 2008:xxi). In the past, attention has focused on those living in remote areas, with the result that the needs of urban communities have largely been ignored. Whether attention is needed in relation to type 2 diabetes, child safety or mental health, it is important that the urban voices of Aboriginal and Torres Strait Islander people be heard.

The purpose of the 2009 AIATSIS National Indigenous Studies Conference 'Perspectives on Urban Life: Connections and reconnections' was to gather together a wide range of ideas and discussions that focused specifically on the needs of major city and regional communities. While the conference brought together papers about education, history, urban culture and much more, this particular collection of papers has a specific focus on health. All the papers in this volume involve the experiences and insights of Aboriginal and Torres Strait Islander health researchers. Some have single authorship and others are co-authored. They arose out of urban experiences in Townsville (Queensland), Sydney (New South Wales), Melbourne (Victoria), Canberra (ACT) and Perth (Western Australia).

This volume is bookended by two papers that identify and describe key and important messages that underlie all the papers in this volume. The first, by Paul Stewart and Ngarra Murray, describes how urban Aboriginal researchers were supported in telling their stories at an international mental health conference. Their recounting of this process is a clear reminder of how important knowledge within communities and among individuals has, in the past, been too easily ignored, marginalised and silenced.

Universities, health researchers and health providers have too often sought to know and voice the health needs of Aboriginal and Torres Strait Islander people without listening and *connecting* with the people first. Getting that voice heard in public was Stewart and Murray's primary goal; hearing those voices within the other papers has been a similar goal.

The final paper, by Michael Wright and Brian McCoy, concludes the collection with an important reminder: that such voices can only come through forming new partnerships, where careful listening and respectful conversations occur. This paper arose out of a conversation between the authors, who are Aboriginal and non-Aboriginal health researchers.

Chapter 4, by Kathleen Clapham et al., also speaks about the importance of developing trusting and resilient partnerships in order to work within Aboriginal and Torres Strait Islander urban and health contexts. And Karen Adams, in Chapter 2, emphasises that research is about sustaining trusting partnerships between those who deliver health services and those who live in communities. This process becomes a journey that privileges *reconnections* with each other.

The topics in this volume range widely, from the resilience of grandmothers to early onset chronic disease in men, from type 2 diabetes prevention to the care of youth involved in chroming, and from footballers to prisoners. The young and those experiencing mental illness are not ignored.

In Chapter 8 Michael Wright argues that there can be a tendency to pathologise Aboriginal people in research; Tom Ogwang et al., in Chapter 5, note a similar temptation in relation to young people involved in chroming. Hearing people's voices changes the ways we begin to converse with and relate to one another. Several authors, such as McCoy et al. in Chapter 6, express their conviction that partnerships and meaningful engagement with the local Aboriginal communities are paramount to the success of their work.

Addressing the health needs of Aboriginal and Torres Strait Islander people in urban and rural communities remains no simple achievement. In Chapter 7 Nerelle Poroch and Julie Tongs address the concerns of prisoners whose voices have often been muted by institutions and policies. The research of Meegan Kilcullen et al. in Chapter 3 reveals the importance of developing the resilience and capacity of grandmothers in order to influence and strengthen their community.

All the papers address, in different ways, the importance of recognising local ways of doing research and understanding how 'culture' is shaped and lived within a particular social and urban space. These values underlie all of the enclosed, whether the issue is the length of time it takes to consult local people before beginning research, or listening to the resilient and protective factors at work with those experiencing mental health issues, or recognising what is being 'played out' in the social context of a sporting club. Listening to, paying close attention to and respecting the people who live in an urban culture remain critically important. What connects and makes

communities strong and healthy can then become evident. Too often, however, these possibilities and strengths have not been seen, heard or respected.

The theme of the AIATSIS conference was a reminder that health services and policies need to engage with the wide range of health issues facing urban communities. They need to be reflexive about their ability to *connect* with those most in need. At the same time they need to remember to *reconnect*: re-forming and re-sustaining trusting relationships remains a lifelong task.

Recent projections by the Australian Bureau of Statistics suggest that Australia's Aboriginal and Torres Strait Islander communities are likely to reach around 700 000 people by 2021 (ABS 2009). Whatever the accuracy of this projected number, it is likely that the number of children (aged 0–14) will increase about fourfold from the 2006 Census figures, and that urban communities will experience the greatest increase in population numbers (ABS 2009:31).

As a result, *connecting* with Aboriginal and Torres Strait Islander people of urban communities will remain critically important for the future of health knowledge and better health outcomes, and *reconnecting* and forming strong partnerships will similarly remain critical. We hope that this volume of papers can make one further contribution to reducing the existing knowledge and health gap and encourage more voices to be heard, strengths to be built upon and resilient partnerships to be formed.

Finally, we would also like to acknowledge the support and advice of Jane Yule, at the Lowitja Institute, who helped and encouraged these papers to fruition.

References

ABS (Australian Bureau of Statistics) 2009 *Experimental Estimates and Projections, Indigenous Australia, 1991 to 2021*, ABS, Canberra (Cat. no. 3238.0).

—— and AIHW (Australian Institute of Health and Welfare) 2008 *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, ABS, Canberra (Cat. no. 4704.0 ABS and AIHW 21).

Note

1. The editors have preferred to use the terms 'Aboriginal' and 'Torres Strait Islander' wherever possible. However, as with the naming of this National Indigenous Studies Conference, the term 'Indigenous' has also been used, and within this volume refers to the Aboriginal and Torres Strait Islander peoples of Australia, but also, at times, to other Indigenous communities beyond Australia.

Chapter 1

Promoting Aboriginal voices within health: Developing a new model of engagement

Paul Stewart and Ngarra Murray
Onemda VicHealth Koori Health Unit, The University of Melbourne

Abstract: *This paper focuses on enabling the urban Aboriginal voice to be heard in the context of health. As evidenced in the many papers featured in this volume, Aboriginal voices do exist: in stories about football and fatherhood, justice and culture, about grandmothers and grandchildren, and healthy hearts and healthy minds. However, the process of enabling an urban Aboriginal voice to be heard requires a process that is innovative, empowering and supportive. This paper tells how a group of Aboriginal presenters from urban communities came to share their good health and wellbeing stories at a major international mental health conference. We describe the important elements associated with our model of engagement that allowed Aboriginal voices to be heard at the conference. Our model of engagement aimed to help spread the message that Aboriginal community health professionals are doing valuable and significant work out in their communities.*

The idea

In October 2007 the Victorian Health Promotion Foundation (VicHealth) approached Onemda VicHealth Koori[1] Health Unit at The University of Melbourne for assistance in ensuring the participation of Aboriginal presenters at 'From Margins to Mainstream: 5th world conference on the promotion of mental health and the prevention of mental and behavioural disorders' (hereafter referred to as M2M), which was to be held in Melbourne in September 2008. Onemda considered this request and put forward two options, the first of which was the temptation to consider the more traditional paradigm. This meant approaching and nominating Indigenous presenters who are deemed to be experts in the field (generally academics both from Australia and overseas), and who are therefore more familiar, experienced and resourced to speak in large public forums like a conference. The second approach was to challenge this more

traditional paradigm and uncover those community experts who are working on the ground in urban organisations and are engaged in activities that enhance social and emotional wellbeing. It is often the case that such experts in community organisations are 'time poor' due to the under-resourcing of their organisations. They do not have the time or resources to develop well-framed and carefully reflective papers. Not only are they totally consumed meeting the needs of their organisations and clientele, but they face the challenge of engaging the social contexts of their community health within paradigms that often do not wish to hear alternatives. Therefore, a new model of engagement was needed.

In order to overcome such barriers we wanted to be able to offer support and mentorship to potential presenters through a process that would ultimately lead to them presenting their work at the M2M conference. VicHealth was particularly taken with the idea of both building capacity and ensuring that the Aboriginal voice was being told and heard, and so funded Onemda to establish and run the project now known as 'Sharing Our Stories, Building on Our Strengths'.

The model of engagement

To facilitate the meaningful participation of Aboriginal communities in M2M, we developed a model of engagement that would strengthen the promotion and dissemination of good practice in Aboriginal health. The model aimed to increase capacity in project report writing, presentation skills and public speaking, which would then allow our presenters to promote and showcase the work they were currently undertaking. It also provided a great opportunity for the broader mental health sector — practitioners, educationalists, health experts and policy makers — to engage with the social and emotional wellbeing needs of Aboriginal people living in urban settings.

The people

Onemda is an Aboriginal-run organisation within a mainstream academic institution (The University of Melbourne). For more than a decade, Onemda has had close ties with the local Aboriginal community in Melbourne and throughout Victoria. Consequently, Onemda's staff knew about the positive health and wellbeing programs operating in our community, which certainly helped us to convince those Aboriginal health professionals working in these programs that it could be a good idea for them to participate in the conference.

We identified several Aboriginal health professionals within Aboriginal and mainstream health organisations through our networks. We talked with potential presenters about what aspects of their work they might present. We also discussed with them the cultural knowledge and experience they could bring to their presentations, as this was invaluable and crucial to the success of the project.

To make sure everything ran smoothly, Onemda appointed a Koori project officer who has a strong connection with the local Aboriginal community in Melbourne and who would be able to liaise easily with everyone involved. Having a single contact person helped to get everybody on board from the start and was really important to the success of a project like this. Flexibility and time management were crucial when working with presenters who had work, family and cultural commitments.

The other key to success was the support of Onemda's staff, eight of whom acted as mentors along with other University of Melbourne researchers. Mentors worked one on one with presenters and were able to provide them with continuous support and encouragement leading up to their presentations at the conference. The mentoring program was individually tailored, as presenters' skills in this area were at different levels.

Word had got around about what we were doing in the early stages of our project. The Cooperative Research Centre for Aboriginal Health (now operating under the Lowitja Institute) heard about our project and we were asked if we could include two Aboriginal health professionals working in the Northern Territory. We welcomed our colleagues from the Northern Territory and rolled out our model from a distance. To support our brothers in the Northern Territory, a researcher/educator based in Darwin was employed to act as a local mentor for the two health workers, which gave them access to someone who could meet more regularly with them to work together on their presentations.

In total, we worked with 11 Indigenous mental health workers to get their papers presented at M2M. They came from a diverse array of health organisations and showcased a range of innovative projects and programs, including 'I'm an Aboriginal Dad', Maya Living Free Healing Centre, Neighbourhood Justice Centre, Victorian Aboriginal Community Controlled Health Organisation, Koori Kids Adolescent Unit at the Victorian Aboriginal Health Service (VAHS), Fitzroy Stars Football Club and Top End Association for Mental Health.

The workshops

To assist our presenters in getting their messages out to a wider audience, we prepared a number of workshops, seminars and meetings to develop their abstracts, posters and papers for the conference. As an Aboriginal teaching and learning unit, Onemda was able to garner the expertise, knowledge and resources to run effective and friendly sessions: 'It was good, one of the best workshops I've attended' (Participant 5); 'I thought the whole set up [workshop] was excellent' (Participant 7).

The two-day intensive abstract writing workshop was held six months before the conference. Our two days included how to choose a conference, the process of submitting an abstract, a specific description of the components of an abstract and tips on how to put an abstract together. Presenters shared details on what they wanted

to speak about at the conference, and the whole group worked on developing titles for each other's topics.

At the end of the first day every participant was assigned a mentor with whom he or she worked intensively on the second day to develop an abstract. While the presentation from Day 1 provided a structure on which to base the abstract, the mentors were able to bring their specific experiences and skills to guide the presenters. By the end of Day 2 most presenters had a complete abstract for submission, and presenters continued to receive support from their mentors to complete their abstracts over the following days.

A follow-up workshop provided presenters with the opportunity to work further with their mentors on preparing their presentations for the conference. Mentors helped with the development of the presentations and also provided effective tips on how to prepare PowerPoint slides. Presenters trialled their presentations to a small group of Onemda staff and were all provided with feedback. The presenters found the advice helpful, subsequently reporting that they remembered these points when presenting on the day. Some also took up the option to trial their presentations at the Centre for Health and Society (Onemda's host organisation) Seminar Series over the ensuing weeks and receive feedback: 'The information provided by my mentor was sufficient and enabled me to feel that I would know what I was doing when preparing my presentation. The dos and don'ts of preparing a presentation were very useful and something I had in mind when developing my presentations' (Participant 4).

The third workshop, held just before the conference, gave presenters the opportunity to fine tune their papers, which they again presented to a small audience. These 'trial runs' really prepared them for the 'main event', and meant that they could speak with greater confidence at the conference about what they did and how they did it. A fourth workshop in Darwin was also held for our Darwin participants to hone their presentations with their mentor leading up to the conference. Working within a collaborative and friendly atmosphere, presenters were able to work closely with their mentors, which helped them gain confidence and build their skills in presentation and public speaking: '[I was] nervous but confident because I was prepared' (Participant 5); 'I was well prepared for the presentation so I was relaxed and looking forward to presenting' (Participant 6).

Some of the presentations covered culturally sensitive content, so without this support and exhaustive preparation presenters might have found it more difficult to get up and talk about emotional wellbeing, mental health and their experiences. Our personalised, one-on-one mentoring approach gave presenters the support and encouragement they needed to talk about such sensitive matters. And having our mentors attend all of the conference presentations provided them with further support, encouragement and personal feedback.

The conference

From 10 to 12 September 2008 VicHealth hosted M2M at the Melbourne Convention Centre. With more than 800 presenters, this conference provided VicHealth and its stakeholders with a significant opportunity to profile their collective work and leverage longer-term local, national and international partnerships.

M2M saw a large contingent of Aboriginal and Torres Strait Islander presenters from around Australia. More than 20 of the presenters at the conference were Aboriginal, and more than half of these were mentored and supported by the 'Sharing Our Stories, Building on Our Strengths' project. Five conference plenaries and sessions were chaired by three Aboriginal health researchers.

Our speakers presented at M2M on a variety of health topics impacting upon their communities, and had a common theme of how best to achieve mental health and emotional wellbeing. They all spoke passionately about their work and described the practical solutions that are of benefit to their communities.

Many of the presentations had an air of positive change to them — that good health outcomes were possible from both Indigenous and public health programs, as long as Indigenous people controlled, participated in and delivered them. Nearly all the presenters talked about the need to increase Aboriginal capacity and empowerment as a way of improving the emotional wellbeing of Aboriginal people. The programs, both preventative and curative, showed positive results through evaluations. Most of our presenters said that their programs could be expanded and replicated in other settings, taking account of cultural differences.

As a result, many positive on-the-ground stories about urban Aboriginal community health projects and research in Australia were showcased at M2M. What made this occasion unique was that many of our speakers were presenting their work for the first time to a wider audience, let alone to an international conference. Overall, the experience proved to be a positive one for our speakers and for the organisations they represented: 'I felt good during the presentation and enjoyed presenting with other Indigenous community members' (Participant 6).

The film

If running workshops and mentoring our speakers was not enough, a film was also to be produced (Knowledge Transfer Group 2009). A few months before the conference, the Knowledge Transfer Group at The University of Melbourne's Faculty of Medicine, Dentistry and Health Sciences heard about our project and approached us with the idea of filming the journey of the presenters before, during and after the conference. The Knowledge Transfer Group wanted to capture the work of our presenters and acknowledge the significant contribution that they make in their communities.

The Knowledge Transfer film crew went first to the Fitzroy Stars Football Club's last match for the season, held at Crispe Park in the northern Melbourne suburb of Reservoir in August 2008, and shot footage of the game, the players and the VAHS at work carrying out health checks on the day. The film crew later filmed an Aboriginal dance group, the Koori Youth Will Shake Spears, which has several members who also play football for the Fitzroy Stars Football Club.

The film crew then attended the conference and shot footage of most of the presenters, and went on to focus on two of them — Troy Austin from the Fitzroy Stars Football Club and Anthony Brown from the VAHS Koori Kids Adolescent Unit — and film them in their workplaces as well. This additional filming not only showcased the different workplaces of the presenters — for example, Anthony has a show on 3KND (local Aboriginal radio station 1503AM) and Troy works in the Victorian Government's Department of Justice — but set them in a community context.

In this way, the film showed how VAHS and 3KND are able to collaborate to promote health messages to the Koori community, and the role of sport (the Fitzroy Stars) and culture (Koori Youth Will Shake Spears) in improving social and emotional wellbeing among community members in Melbourne. It was also one of the few collaborative projects between The University of Melbourne and the local Aboriginal community in Melbourne.

The outcomes

Following the conference, all of our speakers who were mentored expressed enthusiasm for the training process and were very positive about their presentations. The majority of speakers were satisfied with the way they had presented at the conference, and had found their mentors useful and supportive throughout the process. All presenters believed that maintaining regular contact with their mentors had been really important to their success: 'The Onemda staff were constantly in contact with me to offer support and seek updates of the progress of the presentation' (Participant 6).

Presenters were glad to see staff and mentors attending the conference and felt supported by them on the day. Overall, presenters commented that the support, advice and assistance given by Onemda and their mentors had been really useful to them in how they prepared and presented their papers at the conference: 'I felt confident that I would be able to deliver my presentation with the support I had from Onemda…I know that what I have gained is something that will positively affect how I prepare and present my presentations in the future' (Participant 4); 'I was able to present on a topic that I am passionate about, and the preparation that went into the planning provided a good foundation for the presentation' (Participant 6).

All presenters claimed they would be happy to participate in a similar process all over again if presenting at any future conference, and were pleased with the skills they had developed. Some of the presenters found the experience of communicating their

valuable work to a mainstream audience exhilarating and uplifting, and were proud of the confident way in which they had presented their papers in their own styles: 'It has provided me with a better understanding of what makes a good presentation' (Participant 6).

Overall, the evaluation feedback affirmed Onemda's work with Indigenous people and organisations, as summed up by the following comment (Participant 4):

> An excellent concept that helps our mob to be the expert that presents on a subject that we know best about; as opposed to non-Aboriginal. Our points of view are personal and not just work: it's our very livelihoods and makes our messages that we want mainstream Australia to hear stronger.

Other outcomes

Although presenters felt that Onemda supported them well throughout the process of preparing for their presentations, as is usually the case with first-time projects, there were some areas that could be improved upon. A few presenters felt that it was hard to find time out of their busy schedules — with family and work commitments and cultural obligations — to travel to and from workshops and the conference.

With their confidence still high, two of the presenters at M2M, Troy Austin (2009) and Anthony Brown (2009), travelled with the authors of this paper to Canberra a year later in September 2009 to present at the AIATSIS biennial conference, 'Perspectives on Urban Life: Connections and reconnections'. This paper is based on the paper that four of us delivered at that conference (Murray et al. 2009).

Brown has been able to continue spreading the word. In September 2010 he once more presented to an international conference on the valuable social and emotional wellbeing programs he is running in Melbourne's Koori community — this time at the 'Healing Our Spirits Worldwide Conference' in Hawai'i (Brown 2010).

Another outcome from this process has been the involvement of Brown in the teaching program at Onemda. Building on the presentation he gave at the conference, he has delivered a number of guest lectures in the subject 'Aboriginal health: Past to present' in the Master of Public Health program run by The University of Melbourne. Onemda hopes to use the model documented here to encourage other Aboriginal health professionals to participate in its teaching program at the university. Such collaboration is only a matter of learning from each other — the essence of true knowledge exchange.

Recommendations

We would encourage future conferences — both those that attract a lot of Indigenous participation and more mainstream affairs — to invite and support Indigenous presenters

to showcase their work. One way to do this is by adopting and adapting our model of engaging local Aboriginal people working in their communities to talk about what they do and how they do it. Although we appreciate that our community workers do have demanding workloads, we believe that creating a well-structured, flexible and supportive environment will enable Aboriginal voices to be heard.

Employing a local Aboriginal person as a project officer allowed us to keep in regular contact with presenters and mentors, to set up the various workshops (abstract writing and preparing presentations), to register the presenters and to liaise with the conference organisers. It was essential to develop flexible support mechanisms that could be tailored to suit each individual's work commitments, and to assign each participant with a mentor to provide regular one-on-one support.

Conclusion

The new model of engagement developed by Onemda, and described here, has helped spread the message that Aboriginal community health professionals are doing valuable and significant work out in their communities. We wanted to support people in communities to talk up and share with others their positive stories, and we believe that our model of engagement enables and encourages Aboriginal people to develop their skills in this area within a safe and supportive environment. Most importantly, it allows the Aboriginal voice to be heard, and collectively celebrates our achievements across the wide array of great community work targeting our children, our youth, our men, our women and our Elders.

Acknowledgments

The authors would like to thank all of our mentors and funders (VicHealth and the Cooperative Research Centre for Aboriginal Health) who made this project possible. Our sincere thanks also go to various staff members at Onemda, the Centre for Health and Society, the Centre for Excellence in Indigenous Tobacco Control, Charles Darwin University and the many other collaborating partners. Finally, this project would not have achieved what it set out to do without the support and commitment from all our presenters and the organisations that they represent. We would like to wish you all success and encourage you to keep up the great work you all do for our people.

References

Austin, Troy 2009 '"It's more than a game": The Fitzroy Stars Football Club performing off the field', paper presented at the AIATSIS National Indigenous Studies Conference 'Perspectives on Urban Life: Connections and reconnections', Australian National University, Canberra, 29 September – 1 October.

Brown, Anthony 2009 'Koori kids and adolescent health: Integrating a culturally appropriate team approach for the Aboriginal community in Victoria', paper presented at the AIATSIS National Indigenous Studies Conference 'Perspectives on Urban Life: Connections and reconnections', Australian National University, Canberra, 29 September – 1 October.

——2010 'Koori kids and adolescent health: Integrating a culturally appropriate team approach for the Aboriginal community in Victoria', paper presented at the Healing Our Spirit Worldwide Conference, Honolulu, Hawai'i, 3–10 September.

Knowledge Transfer Group 2009 *Sharing Our Stories, Building on Our Strengths* (DVD), Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne.

Murray, Ngarra, Anthony Brown, Paul Stewart and Troy Austin 2009 'Sharing our stories and building on our strengths: Indigenous presenters talk up their community health projects', paper presented at the AIATSIS National Indigenous Studies Conference 'Perspectives on Urban Life: Connections and reconnections', Australian National University, Canberra, 29 September – 1 October.

Note

1. The term 'Koori' as used in this paper refers specially to Aboriginal people from the south-eastern region of Australia.

Chapter 2

Diabetes prevention evidence and urban Aboriginal and Torres Strait Islander peoples: Reshaping a square peg

Karen Adams
Moondani Balluk Indigenous Academic Unit, Victoria University

Abstract: *This paper considers existing evidence for urban Indigenous type 2 diabetes prevention through the lens of a local urban Aboriginal and Torres Strait Islander context. A comprehensive literature review on diabetes prevention interventions was conducted and those set in urban environments were extracted and analysed. The identified literature mostly focused on lifestyle modification programs with one school and one general practice-based study. Notably, literature addressing the intrauterine environment as a risk factor was absent from the evidence. Prevention programs had utilised a number of engagement strategies, including contacts of Aboriginal Health Workers, Elders and community workers, as well as physical settings where people naturally congregated, such as churches and cultural centres. When considering this evidence for a localised urban Aboriginal population, a number of issues were identified. These included local population characteristics, health service resources and skills, and cultural blindness. Evidence arising from health studies is derived from a particular environmental setting. This evidence can provide useful strategy options but may not translate well into other settings and be reflexive to local Indigenous settings and experiences. Consequently, evidence may be useful, need adjustment or not be suitable in particular contexts.*

Introduction

Type 2 diabetes rates are increasing worldwide and have become a growing concern due to the costly and debilitating nature of this chronic disease. Indigenous populations, an estimated 300 million people globally (Ferreira and Lang 2006), have a sevenfold higher chance of developing diabetes[1] when compared to their non-Indigenous

counterparts (Yu and Zinman 2007). A significant proportion of these Indigenous peoples live in urban areas. Type 2 diabetes can be prevented and yet few studies have addressed methods of doing this with urban Indigenous populations. Described here is a comprehensive review on available urban Indigenous diabetes prevention and the investigation of the applicability and limitations of this information when considering possible diabetes prevention approaches through the lens of a particular urbanised Aboriginal and Torres Strait Islander population.

Background

In Australia, New Zealand, Canada and the United States there are significant urban Indigenous populations, with indications that these populations are increasing. Census data in Canada show slow, but steady, growth in the number of First Nations people residing in the nation's cities. In 2001 almost half (49%) of the First Nations populations lived in urban areas, increasing from 47% in 1996 (Indian and Northern Affairs Canada 2009). In Australia slightly more than one-half of the Aboriginal and Torres Strait Islander population lives in areas classified as major cities or inner regional areas (53%) (ABS 2007). Similarly, in the United States 56% of the Native American population live in urban environs (United States Bureau of the Census 2000). In contrast, New Zealand has the highest proportion, with more than 80% of Maori living in urban areas (Statistics New Zealand 2005).

Internationally, rates of diabetes in Indigenous populations are higher in urban areas than in rural areas (Yu and Zinman 2007), and regardless of geographic location there is a disproportionate burden of diabetes complications for all Indigenous peoples (Naqshbandi et al. 2008). The International Diabetes Federation in 2006 reached consensus on risk factors and lifestyle modifications that can prevent diabetes developing in individuals and populations. This consensus includes a number of factors for increased risk, including being overweight, having a sedentary lifestyle, having a previously identified glucose intolerance, presence of metabolic syndrome, inadequate diet intake and poor intrauterine environment (Alberti et al. 2007). It has been well established that prevention or delay of diabetes can be achieved through modest weight reductions (7% of total body weight) and by changes to nutrition and physical activity practices. Medication, such as metformin, has also been shown to have an impact on diabetes risk, but at a lowered rate than for modifying diet and activity (Knowler et al. 2002). Interventions with this preventative focus have potential to address the diabetes burden of morbidity and mortality for Indigenous populations (Naqshbandi et al. 2008).

Comprehensive literature review

A literature search of English language articles from 1998 to 2009 in PubMed and Indigenous health internet sites was conducted. Articles over the past ten years were

included, as environmental, policy and social influences change over time and more recent studies were considered more likely to have relevance for current situations. Indigenous search terms were drawn from previous reviews on diabetes prevalence and related complications in Indigenous people (Yu and Zinman 2007; Naqshbandi et al. 2008). This included a combination of MeSH (Medical Subject Headings), and text words for the PubMed search and text words for Indigenous health internet sites search (Figure 1) (Alberti et al. 2007; Naqshbandi et al. 2008).

Consensus on type 2 diabetes prevention was reached by the International Diabetes Federation in 2006. The consensus included identification of modifiable risk factors, some of which were lifestyle related. These included overweight; sedentary lifestyle; previously identified glucose intolerance; metabolic syndrome; dietary factors; and intrauterine environment (Alberti et al. 2007). Search terms (Figure 1) focused on these modifiable lifestyle risk factors. Articles were included if they focused on measuring intervention change for type 2 diabetes modifiable lifestyle risk factors. Publications included system audits, process and impact evaluations, pre- and post-test evaluations, quasi-experimental study designs and experimental designs. All sample sizes and age ranges were included. Prevalence or incidence studies of type 2 diabetes were excluded. Data on improved diabetes management (i.e. post-diabetes diagnosis) were not included as they did not focus on prevention but, rather, focused on treatment and reduction of complications from the chronic condition. Medication for prevention and management of type 2 diabetes was also excluded as it does not fit the lifestyle modification criteria.

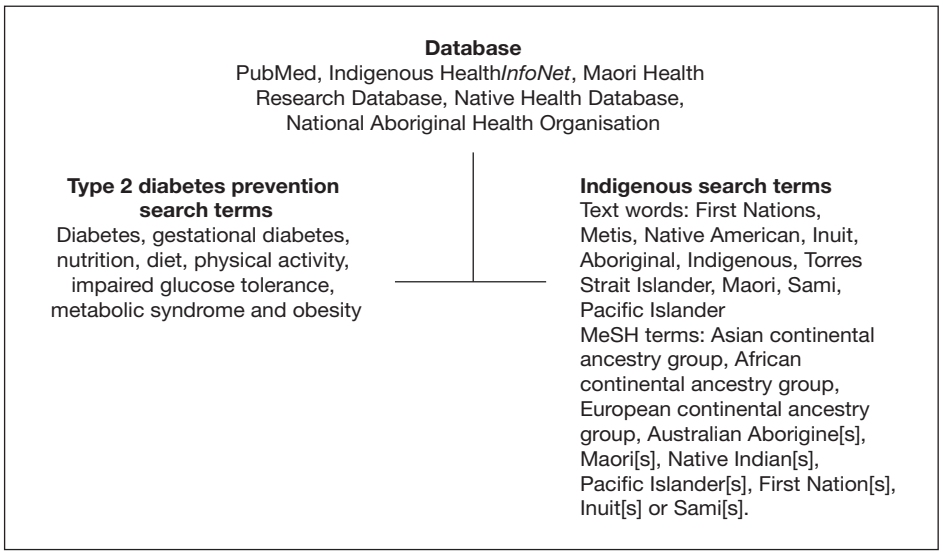

Figure 1: Literature search method

The literature search identified a total of 34 studies, with the majority of these focusing on rural and remote communities. Figure 2 shows the proportion of urban populations in each country (dashed line) and the proportion of studies identified that focused on urban and rural or remote areas. The majority of studies had taken place in rural or remote regions in all countries except New Zealand. A total of ten studies had taken place in urban areas and these are further discussed below.

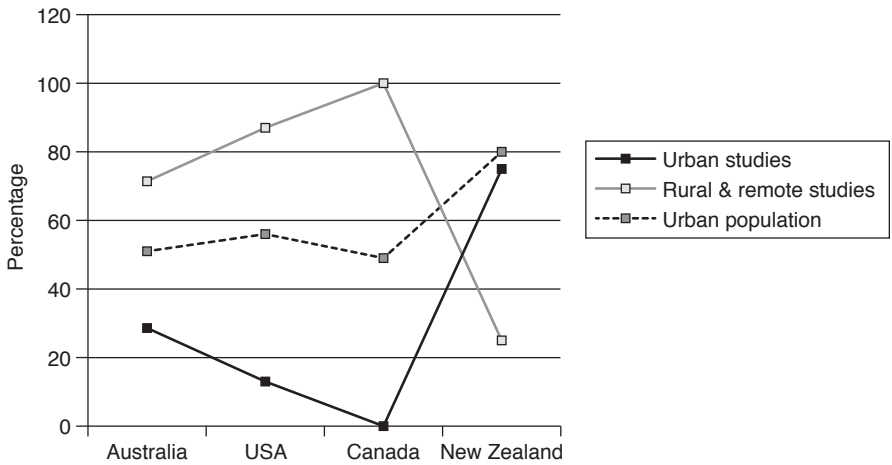

Figure 2: Percentage of urban population, urban studies and rural or remote studies by country

The ten urban studies utilised three main approaches to diabetes prevention, with the majority lifestyle modification programs (Chan et al. 2007; Murphy et al. 2003; McAuley et al. 2003; Witmer et al. 2004; Oliver et al. 2007; Simmons et al. 2004; Bell et al. 2001; Simmons et al. 2008). There was also one general practitioner script program (Croteau et al. 2006) and one school and child-focused program (Parker et al. 2006). Notably, none of these studies targeted the risk factor of intrauterine environments other than if there happened to be a female in the study who was pregnant or planning to become pregnant.

There were eight lifestyle modification studies and six of these found statistically significant changes had occurred through participation in the programs aiming to change nutrition and activity practices (Table 1); these findings are consistent with non-Indigenous studies in this area (Knowler et al. 2002).

There were two further studies that had conducted process and impact evaluations on the lifestyle modification programs. These studies found that non-clinical/social or community settings, time for relationship building, flexibility, engagement strategies and intensive follow-up were important elements for success of programs (Murphy et al. 2003; Oliver et al. 2007). One lifestyle modification program had been running over a long-term period and reported an initial ease in recruitment of participants

Table 1: Summary of urban Indigenous diabetes prevention studies

Country	Indigenous population	First author (reference)	Study design	Sample size	Study duration	Intervention	Outcome measures with change not tested or $p>0.05$*	Outcomes with change $p<0.05$
Australia	Aboriginal	Chan 2007 (Chan et al. 2007)	Baseline and six-month measures, single sample group	101 adults	Two years	Early intervention lifestyle nutrition and physical activity	Waist–hip ratio BMI† Fasting plasma glucose Systolic BP‡ Diet score LDL§ HDL‖ Triglycerides	↓Waist circumference ↓HbA1C# ↓Diastolic BP ↓Total cholesterol
Australia	Cook Islander	Oliver 2007 (Oliver et al. 2007)	Process and impact	24	12 months	Eight-week nutrition and physical activity intervention	Physical activity change Nutrition change	Not tested
Australia	Aboriginal	Parker 2006 (Parker et al. 2006)	Process and impact	200 children	16 months	School-focused physical activity	Number of times community forum met Numbers of children participating Focus group with adults Survey with children	Not tested
New Zealand	Maori	Simmons 2008 (Simmons et al. 2008)	Baseline and secondary measures, case and comparison samples	160 participants *Comparison groups* 52 weighed before intervention & 1,143 from the same geographic area		Pilot of a personal trainer lifestyle approach	Weight	↓Weight loss for those with impaired glucose tolerance and all participants

Table 1: Continued

Country	Indigenous population	First author (reference)	Study design	Sample size	Study duration	Intervention	Outcome measures with change not tested or $p>0.05^{*}$	Outcomes with change $p<0.05$
New Zealand	Maori	Croteau 2006 (Croteau et al. 2006)	Cross-sectional survey	710	N/A	Scripting scheme for physical activity through primary health care		↑Self-reported physical activity advice from primary health care ↑Self-reported physical activity script from primary health care
New Zealand	Samoan and Tongan	Simmons 2004 (Simmons et al. 2004)	Baseline and 12-month measures at two Tongan and two Samoan church communities	Samoan control: 144 Samoan intervention: 78 Tongan control: 106 Tongan intervention:188	Two years	Nutrition, diabetes awareness and physical activity interventions	Weight Height Waist and hip circumference Readiness to change weight and physical activity Dietary and diabetes knowledge	Samoan ↑Readiness to change weight ↓Weight ↓Waist ↑Dietary and diabetes knowledge Tongan ↑Dietary and diabetes knowledge
New Zealand	Maori	Murphy 2003 (Murphy et al. 2003)	Process and impact	36	Four months	Lifestyle intervention program	Acceptability by participants Program strengths Reasons for leaving program Barriers to changing lifestyle	Not tested

Table 1: Continued

New Zealand	Maori	McAuley 2003 (McAuley et al. 2003)	Baseline and four-month measures, single sample group	36	Four months	Lifestyle intervention program	Diastolic blood pressure Lipids Insulin sensitivity Exercise test	↑Insulin sensitivity ↓Weight ↓Waist circumference ↓BMI ↓Systolic blood pressure ↓Total and truncal fat ↓Fasting glucose and insulin
New Zealand	Samoan	Bell 2001 (Bell et al. 2001)	Baseline, 12-month and 24-month measures with two intervention and one control church community	Intervention: 365 Control: 106	Two years	Nutrition awareness and physical activity interventions	Fat knowledge Dietary intake	Post-intervention ↓Weight ↓BMI ↓Waist ↓Hip ↓Blood pressure ↑Vigorous physical activity 12 months post-intervention ↓Blood pressure ↑Vigorous physical activity
United States of America	Alaskan	Witmer 2004 (Witmer et al. 2004)	Case and control groups randomly assigned with baseline and 12-month secondary measures	44 case 32 control	12 months	12 weekly sessions on lifestyle and goal setting	Height Weight Resting blood pressure Lipid levels blood glucose Diet Physical activity Tobacco use Psychosocial status	↑Moderate walking ↑Physical activity self-efficacy

Note: * = power; †BMI = body mass index; ‡BP = blood pressure; §LDL = low density lipoprotein; ||HDL= high density lipoprotein; #HbA1C = glycated haemoglobin test

(assumedly, the proportion of those in the community who were highly motivated) and then a difficulty and an identified need to change recruitment and engagement strategies (Murphy et al. 2003). The programs had also used varying methods of engaging urban participants in programs. For instance, studies had used personal contacts of Aboriginal Health Workers, Elders and community workers, as well as physical settings where people naturally congregated, such as churches and cultural centres.

The school study (Parker et al. 2006) aimed to improve physical activity levels through reinvigoration of cultural activity and games. Process evaluation of this program found that participants experienced satisfaction with the program, that there was good uptake of the games training and the games had sustainable implementation of in-school curricula. The study also found barriers to physical activity included poor walking paths and limited access to recreational facilities (Parker et al. 2006). The general-practice based study measured delivery of introduced general practice physical activity scripts. The study found that the Indigenous population experienced an increase in receiving advice and scripts for physical activity through the introduction of the program. Whether the script or advice changed physical activity behaviour was not measured (Croteau et al. 2006). In non-Indigenous populations studies of general practitioner scripts with follow-up phone support or referral have been shown to have some impact in increasing activity (Cobiac et al. 2009). It is therefore likely that Indigenous participants would also improve activity levels to some unknown degree.

An urban Aboriginal and Torres Strait Islander region — looking through the local lens

The literature review evidence was considered in relation to a local urban setting in Victoria (south-east Australia) in Melbourne's western suburbs. The region is made up of five local government areas, and approximately 3000 Aboriginal people (0.6% of the broader population), or 10% of the total Victorian Aboriginal population, reside in the region. This population (as with other parts of Melbourne) is scattered among the broader population, with occasional densities and, increasingly, movement towards living in the outer suburbs (ABS 2006). Melbourne's western suburbs are characterised by suburbs with low socio-economic populations, cultural diversity and an industrial environment (Brimbank Melton PCP 2006). There is one small Aboriginal health service, which was established in 2005, located in the inner suburbs. In comparison, Aboriginal health services in Melbourne's northern and eastern suburbs have been long established and in existence since the 1970s and 1980s.

As already discussed, there is ample evidence that lifestyle modification programs can make a significant change in people's weight and activity levels. The local Aboriginal health service had implemented a weekly group program at the service aimed at lifestyle modification and found that limited numbers of the Aboriginal community attended

and most did not attend all sessions. Previously, a women's wellbeing program had been held in the outer suburbs and had better attendance and covered a broader scope of activities beyond nutrition and activity, including emotional wellbeing elements. Both programs were run on weekdays, excluding those participants who worked during this time. Child care was supplied in recognition that mothers would require this in order to fully participate. Lifestyle modification studies had also utilised physical settings where Indigenous people were already meeting. In the region there are groups of Aboriginal people who meet regularly; however, these tend to be a small number of Aboriginal people employed in varying services for Aboriginal people. There are no regular large groups of Aboriginal people who meet, as apart from the Aboriginal health service there is no particular social or cultural hub in the region. Targeting lifestyle modification programs at naturally occurring groups of Aboriginal people who regularly meet or live close to each other is a limited possibility. It would seem the strongest possibility to apply lifestyle modification programs in the region is to create programs in the outer suburbs where there are larger numbers of Aboriginal people; however, as this population is scattered across suburbs, strategies to recruit this group need to be thoughtfully considered.

The Aboriginal population generally, and also in the western suburbs of Melbourne, has a larger younger population when compared to the non-Aboriginal population (ABS 2006). This means that potentially a large proportion of the Aboriginal population will be of an age where they and their families will be engaged in early childhood centres or schools. An analysis of attendance at Maternal and Child Health Services in Melbourne's western suburbs shows that, particularly in the outer suburbs (Brimbank, Melton and Wyndham), there is an under-utilisation of the service (Figure 3). The school study identified in the literature review had targeted schools with large numbers of Aboriginal students (Parker et al. 2006); however, in Melbourne's western suburbs students are present in most schools in relatively small numbers. Cultural blindness by school employees also exists, whereby students' identity as Aboriginal may be denied or diminished. For instance, on approaching a school with more than 20 Aboriginal students to be a part of an Aboriginal health project, the principal responded, 'We do have over 20 enrolments but really only one is a real Aboriginal'. The principal's belief was that these students were not interested in Aboriginal culture and did not really look Aboriginal; so their Aboriginality, although stated and acknowledged by each child's family, was diminished or non-existent. Engaging a school principal and school such as this in an Aboriginal health program would require an organisational shift in thinking about who Aboriginal people are. On a more positive note, schools have been used as a method to engage families and communities in tackling diabetes prevention. This approach views schools as a means of engaging families rather than just focusing on children as program participants (Macaulay et al. 1997; Sanigorski et al. 2008). As a large proportion of the Aboriginal population will be associated with schools either as students or carers, these organisations do have potential as an

engagement point for health programs, particularly for parents who are likely young adults who may be becoming unwell but are as yet not in acute states of ill health and therefore not attending health services (see below).

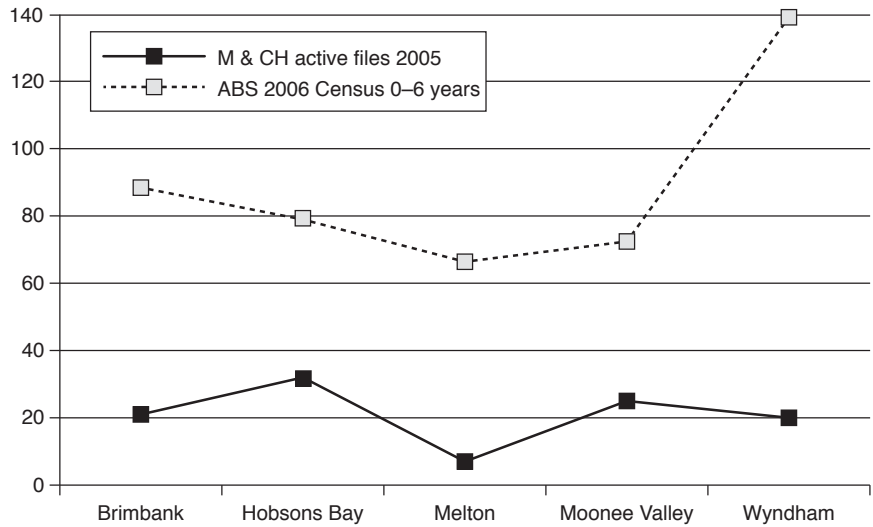

Figure 3: Numbers of Aboriginal children attending Maternal and Child Health (M & CH) Services by local government area in Melbourne's western suburbs

The small Aboriginal health service in the western suburbs of Melbourne has a general practice, which is open five to six hours a day on weekdays during business hours. The service has estimated that in 2007 approximately 15% of the Aboriginal population in the region were accessing the practice for medical care. Aboriginal people in the region may also be using mainstream general practice services, which have been identified as having limitations in being able to accurately ascertain Aboriginal status and therefore diminished capacity to implement care (Adams, K and Hill 2008). In addition, there is likely to be a group of Aboriginal people who are relatively well but with risk factors for diabetes, such as incremental weight gains. People in this group may not see themselves as requiring medical attention as they do not see themselves as unwell and so do not regularly attend general practices for health care. This group will particularly contain young adults aged 15–30 and older children who no longer need to be immunised. Despite these limitations, general practice is well positioned to deliver timely advice and referral to clients, particularly as presenting unwell clients are often motivated to become well and change behaviour. Clients also attend general practices for a variety of other reasons, such as mental health management and reproductive health, with these visits providing opportunities for other health assessments and messages, such as diet and nutrition and referral to other programs and services. The Australian Government introduced Medicare

items for health screening or 'checks' of Aboriginal and Torres Strait Islander people in general practice (Australian Government Department of Health and Ageing 2008). These have been used successfully to degrees in local settings to identify risk factors and apply preventive intervention, but have experienced poor uptake overall (Spurling et al. 2009; DiGiacomo et al. 2010). The success of health checks does rely on a well-functioning, culturally safe general practice and access to good quality referral and interventions (Mayers and Couzos 2004; DiGiacomo et al. 2010).

In the western suburbs of Melbourne there exist a number of sports and fitness clubs and associations. These organisations, almost without exception, have no strategies for engaging Aboriginal people in their programs. In the region Aboriginal-targeted activity programs include an Aboriginal netball team and a small number of activity programs run through the local Aboriginal health service (on a limited budget). Sports and fitness agencies have potential to provide activity opportunities for Aboriginal people with some thoughtful planning. Cultural safety training and partnerships with Aboriginal organisations and groups could increase numbers of Aboriginal people participating in sports and fitness programs in local areas. However, little is understood about enablers and benefits to Aboriginal people participating in activity individually or in social groups (Salmon et al. 2000). In the broader population physical activity and social inclusion is known to have several benefits to wellbeing (Fox 1999).

Food security is another issue that needs to be considered in relation to improving nutrition, and therefore health status. Aboriginal people have lower incomes, larger families and experience higher rates of food insecurity than non-Aboriginal people (AIHW 2008). Food insecurity is particularly an issue for diabetes risk, as it has been linked to higher rates of obesity (Adams, E et al. 2003). This means that while Aboriginal people may receive advice to improve diet, costs of food and issues with running out of food may limit people's ability to implement these recommendations. Currently, there is limited information available about what improves food security for Aboriginal and Torres Strait Islander people (Browne et al. 2009).

Improving intrauterine environments is also a challenge, with Aboriginal women often experiencing less and later antenatal care (Campbell and Brown 2004). While some women may attend clinical settings, these may not always be the best place to engage pregnant women early enough to improve intrauterine environments and prevent gestational diabetes from developing. Effectiveness comparison of interventions aimed at women once pregnant or young women as a group who are likely to become pregnant are relatively unknown; however, both are likely to have an impact. In the western suburbs of Melbourne there are two major maternity hospitals. One hospital has recently developed an Aboriginal program for Aboriginal clients in all areas of the hospital, including the maternity section. In comparison, other hospitals in urban Melbourne have had Aboriginal programs since the 1980s. The second hospital has no existing Aboriginal program. The local Aboriginal health service offers shared care with

a male general practitioner and has had a small number of Aboriginal women attend for antenatal care. Improving Aboriginal access to antenatal care has shown success in improving intrauterine environments in terms of babies' weight (D'Espaignet et al. 2003) and a program such as this in the west of Melbourne for Aboriginal and Torres Strait Islander women is likely to have an impact on the risk factor of intrauterine environments. Women who develop gestational diabetes are known to have better outcomes with tight control and management of blood glucose levels (Ratner 2007). Gestational diabetes is two to three times higher in Aboriginal and Torres Strait Islander mothers (O'Dea et al. 2007) and how well this is controlled during pregnancy is relatively unknown. In addition, women who experience gestational diabetes are at higher risk of developing diabetes later in life and are a particular group requiring preventative action (Ratner 2007).

Conclusion

There have been limited studies on diabetes prevention and Indigenous people living in urban areas despite evidence that Indigenous people living in these environments are more likely to develop diabetes. The majority of evidence identified was about lifestyle modification programs: these programs suit some people and not others for various reasons. Little evidence exists about other methods of improving physical activity levels and nutrition, particularly in relation to social elements, environments and food insecurity experiences. These complex interventions do not often lend themselves to case control studies, and process and impact evaluations can provide valuable information about barriers and enablers of interventions. Evidence about interventions that improve intrauterine environments was limited, particularly in regard to gestational diabetes. Health providers and researchers should reflexively consider evidence in light of local situations, experiences and environments of Aboriginal and Torres Strait Islander people — in other words, sometimes a square peg needs to be reshaped to fit into a round hole.

References

ABS (Australian Bureau of Statistics) 2006 *Census of Population and Housing*, ABS, Canberra (Cat. no. 2068.0).

——2007 *Population Distribution, Aboriginal and Torres Strait Islander Australians*, ABS, Canberra.

Adams, Elizabeth J, Laurence Grummer-Strawn and Gilberto Chavez 2003 'Food insecurity is associated with increased risk of obesity in California women', *Journal of Nutrition* 133:1070–4.

Adams, Karen and Elizabeth Hill 2008 'Positive partnerships for Aboriginal and Torres Strait Islander health in Melbourne's west', *Aboriginal Health Research Conference 2008: Strong Foundations, Strong Future,* Sax Institute, Sydney.

AIHW (Australian Institute of Health and Welfare) 2008 *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*, AIHW, Canberra.

Alberti, K George, Paul Zimmet and Johnathon Shaw 2007 'International Diabetes Federation: A consensus on type 2 diabetes prevention', *Diabetes Medicine* 24:451–63.

Australian Government Department of Health and Ageing 2008 *Medicare Health Checks for Aboriginal and Torres Strait Islander Australians,* Australian Government, Department of Health and Ageing, Canberra.

Bell, Colin, Boyd Swinburn, H Amosa and Robert K Scragg 2001 'A nutrition and exercise intervention program for controlling weight in Samoan communities in New Zealand', *International Journal of Obesity Related Metabolism Disorders* 25:920–7.

Brimbank Melton PCP (Primary Care Partnership) 2006 *Brimbank Melton PCP Community Health Plan 2006–2008*, Caroline Springs, Vic.

Browne, Jennifer, Sharon Laurence and Sharon Thorpe 2009 *Acting on Food Insecurity in Urban Aboriginal and Torres Strait Islander Communities: Policy and practice interventions to improve local access and supply of nutritious food*, Victorian Aboriginal Community Controlled Health Organisation, Melbourne.

Campbell, Sandra and Stephanie Brown 2004 'Maternity care with the Women's Business Service at the Mildura Aboriginal Health Service', *Australian and New Zealand Journal of Public Health* 28:376–82.

Chan, Lionel C, Robert Ware, Janine Kesting, Maureen Marczak, David Good and Joanne T Shaw 2007 'Short term efficacy of a lifestyle intervention programme on cardiovascular health outcome in overweight Indigenous Australians with and without type 2 diabetes mellitus. The healthy lifestyle programme (HELP)', *Diabetes Research in Clinical Practice* 75:65–71.

Cobiac, Linda J, Theo Vos and Jan J Barendregt 2009 'Cost-effectiveness of interventions to promote physical activity: A modelling study', *PLoS Medicine* 6:e1000110.

Croteau, Karen, Grant Schofield and Grant McLean 2006 'Physical activity advice in the primary care setting: Results of a population study in New Zealand', *Australian and New Zealand Journal of Public Health* 30:262–7.

D'Espaignet, Edouard T, Mary-Anne L Measey, Michelle A Carnegie and Dorothy Mackerras 2003 'Monitoring the "Strong Women, Strong Babies, Strong Culture Program": The first eight years', *Journal of Paediatric Child Health* 29:668–72.

DiGiacomo, Michelle, Penny Abbott, Joyce Davison, Louise Moore and Patricia M Davidson 2010 'Facilitating uptake of Aboriginal Adult Health Checks through community engagement and health promotion', *Quality in Primary Care* 18:57–64.

Ferreira, Manoel L and Gretchen Lang 2006 *Indigenous Peoples and Diabetes: Community empowerment and wellness*, Carolina Academic Press, Durham, NC.

Fox, Kenneth R 1999 'The influence of physical activity on mental well-being', *Public Health Nutrition* 2:411–18.

Indian and Northern Affairs Canada 2009 *Fact Sheet — Urban Aboriginal population in Canada,* Government of Canada, Ottawa.

Knowler, William C, Elizabeth Barrett-Connor, Sarah E Fowler, Richard F Hamman, John M Lachin, Elizabeth A Walker and David M Nathan 2002 'Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin', *New England Journal of Medicine* 346:393–403.

Macaulay, Anne C, Gilles Paradis, Louise Potvin, Edward J Cross, Chantel Saad-Haddad, Alex McComber et al. 1997 'The Kahnawake Schools Diabetes Prevention Project: Intervention, evaluation, and baseline results of a diabetes primary prevention program with a native community in Canada', *Preventative Medicine* 26:779–90.

McAuley, Kirsten, Eleanor Murphy, Rebecca T Mclay, Alex Chisholm, Gretchen Story, Jim I Mann et al. 2003 'Implementation of a successful lifestyle intervention programme for New Zealand Maori to reduce the risk of type 2 diabetes and cardiovascular disease', *Asia Pacific Journal of Clinical Nutrition* 12:423–6.

Mayers, Naomi R and Sophie Couzos 2004 'Towards health equity through an adult health check for Aboriginal and Torres Strait Islander people: An important Australian initiative that sets an international precedent', *Medical Journal Australia* 181:531–2.

Murphy, Eleanor, Kirsten A McAuley, Damon Bell, Rebecca T McLay, Alex Chisholm, Roanne Hurley et al. 2003 'A new approach to design and implement a lifestyle intervention programme to prevent type 2 diabetes in New Zealand Maori', *Asia Pacific Journal of Clinical Nutrition* 12:419–22.

Naqshbandi, Mariam, Stewart B Harris, James G Esler and Fred Antwi-Nsiah 2008 'Global complication rates of type 2 diabetes in Indigenous peoples: A comprehensive review', *Diabetes Research and Clinical Practice* 82:1–17.

O'Dea, Kerin, Kevin G Rowley and Alex Brown 2007 'Diabetes in Indigenous Australians: Possible ways forward', *Medical Journal of Australia* 186:494–5.

Oliver, Nick, David Perkins, Lesley Hare and Karen Larsen 2007 '"Stories from the past, the reality of the present, taking control of the future" — lifestyle changes among Pukapuka people in the Illawarra', *Health Promotion Journal of Australia* 18:105–8.

Parker, Elizabeth, Beryl Meiklejohn, Carla Patterson, Kenneth Edwards, Cilia Preece, Patricia Shuter and Trish Gould 2006 'Our games our health: A cultural asset for promoting health in Indigenous communities', *Health Promotion Journal of Australia* 17:103–8.

Ratner, Robert E 2007 'Prevention of type 2 diabetes in women with previous gestational diabetes', *Diabetes Care* 30:S242–S245.

Salmon, Jo, Rachel Breman, Michael Fotheringham, Kylie Ball and Caroline Finch 2000 *Potential Approaches for the Promotion of Physical Activity, A Review of the Literature*, Deakin University, Bundoora, Vic.

Sanigorski, Andrea M, Colin Bell, Peter J Kremer, Rosemary Cuttler and Boyd A Swinburn 2008 'Reducing unhealthy weight gain in children through community capacity-building: Results of a quasi-experimental intervention program, Be Active Eat Well', *International Journal of Obesity* 32:1060–7.

Simmons, David, Judith A Voyle, F Fou, S Feo and L Leakehe 2004 'Tale of two churches: Differential impact of a church-based diabetes control programme among Pacific Islands people in New Zealand', *Diabetic Medicine* 21:122–8.

——, Elaine Rush and Nic Crook 2008 'Development and piloting of a community health worker-based intervention for the prevention of diabetes among New Zealand Maori in Te Wai o Rona: Diabetes Prevention Strategy', *Public Health Nutrition* 11:1–8.

Spurling, Geoffrey, Noel Hayman and Anna Cooney 2009 'Adult health checks for Indigenous Australians: The first year's experience from the Inala Indigenous Health Service', *Medical journal of Australia* 190:562–4.

Statistics New Zealand 2005 'New Zealand, an urban/rural profile: Historical context', <www.stats.govt.nz/browse_for_stats/people_and_communities/geographic-areas/urban-rural-profile/historical-context.aspx> accessed 13 June 2012.

United States Bureau of the Census 2000 *2000 Census of the Population: General population characteristics — United States*, United States Bureau of the Census, Washington DC.

Witmer, Julie, Michelle R Hensel, Peter S Holck, Alice S Ammerman and Julie C Will 2004 'Heart disease prevention for Alaska Native women: A review of pilot study findings', *Journal of Women's Health* 13:569–78.

Yu, Catherine H and Bernar Zinman 2007 'Type 2 diabetes and impaired glucose tolerance in Aboriginal populations: A global perspective', *Diabetes Research and Clinical Practice* 78:159–70.

Note

1. The word 'diabetes' in this paper refers to type 2 diabetes.

Chapter 3

Factors affecting resilience of Aboriginal and Torres Strait Islander grandmothers raising their grandchildren

Meegan Kilcullen, Anne Swinbourne and Yvonne Cadet-James
James Cook University

Abstract: *Grandmothers have reported negative social pressures that have affected their psychological and social functioning in their roles as primary carers. As grandmothers who are raising their grandchildren are in effect addressing and interrupting the intergenerational transfer of trauma and distress, it is critical to support the grannies who take up this important role. This study utilised a positive psychology framework in order to investigate resilience in a sample of urban Aboriginal[1] grandmothers who are raising, or have raised, their grandchildren. Data was collected during seven semi-structured individual face-to-face interviews. Qualitative analysis was conducted using a grounded theory method in order to reduce data to theoretical categories reflecting areas of strength of the grandmothers. Grandmothers described gaining support and strength from the interaction between psychological and socio-cultural factors. These factors included developing and maintaining social networks, maintaining traditional kinship structure, participating in traditional adoption, participating in employment, spiritual belief, acceptance of life situations, self-reliance, implementing problem-solving skills, and flexibility of responses. This study provides an Aboriginal perspective on positive mental health in the context of raising grandchildren. As grandparents are becoming increasingly involved in the rearing of grandchildren, these results have implications for delivery of culturally sensitive support programs to this community.*

Background

There are currently (in 2009) 14 000 grandparent-headed families in Australia and, to date, the exact number of Aboriginal children in grandparental care is not available

(ABS 2008). However, Aboriginal children are more than seven times more likely to be in kinship, foster or out-of-home residential care than non-Aboriginal children (AIHW 2008). It is recognised that Aboriginal and Torres Strait Islander children are over-represented in out-of-home care and that there are not enough carers for these children (Queensland Department of Child Safety 2009; Bromfield and Osborn 2007). The shortfall of carers is compounded by historical policies that have had a negative impact upon the willingness of individuals to engage with government departments in order to become carers. While a significant number of Aboriginal carers are taking on the responsibility of caring for children, there continues to be a shortfall between carer numbers and children in need of care. It is the case that 'once a carer, always a carer' is the norm for Aboriginal carers.

Under the Aboriginal and Torres Strait Islander Child Placement Principle the first priority for placing a child or young person in out-of-home placement is in kinship care (COTA 2003; SNAICC 2005; Queensland Department of Child Safety 1999). Kinship care maintains family and community connections and links to cultural heritage (Bromfield and Osborn 2007). The number of children being placed in accordance with the Aboriginal and Torres Strait Islander Child Placement Principle varies across states (SNAICC 2005). However, the number of appropriate placements increases when placements that comply with any of the priorities are considered. Despite kinship care being the preference for placement of Aboriginal and Torres Strait Islander children, there is limited research into the experiences of children and carers (Bromfield and Osborn 2007). Given that the guidelines for the placement of Aboriginal and Torres Strait Islander children mandate kinship care, it is essential to understand the environment into which children are being placed.

It is well recognised that government policies since colonisation — such as removal from land, assimilation, mission isolation and the more recent Stolen Generations — have resulted in numerous mental and social health issues that span several generations (Mellor and Haebich 2002; Wilson 1997). Aboriginal culture has traditionally transmitted knowledge orally. The cultural disconnection resulting from the removal of children, and the resulting Stolen Generations, has resulted in the degradation of Aboriginal values and traditional knowledge and has left many Aboriginal people dispossessed of social and cultural continuity. Breaking these links has created an interruption in transmission of knowledge, particularly basic parenting skills, and thus affected parenting in the Aboriginal community. Due to the loss of culture and identity, many have turned to alcohol and drug use and those with children are often rendered unable to care for their children. This may result in the care of the children falling to the grandmothers (as a result of family violence, and parental incarceration and mental health problems), as in non-Aboriginal families (Hammill 2001; Fitzpatrick 2004).

The responsibility that rests with these grandmothers takes a great emotional and physical toll and has been termed 'granny burnout' (Hammill 2001). The Aboriginal

Elders, particularly the grandmother carers, or grannies, are at greatest risk of being overwhelmed by the enormity of the problems that deliver their children's children to their care. However, in among the health statistics, there is an almost invisible yet resilient group that is being fatigued by the burdens left to them by the historical imbalance of justice — transgenerational transfer of that trauma — manifesting in their children's inability to cope.

While the difficulties of grandparents raising grandchildren are becoming well documented (see COTA 2003; Hammill 2001; Orb and Davey 2005; Fitzpatrick 2004; Backhouse 2006), it is important to identify those grandparents who are functioning well in their role as carers. As the grannies provide a link to their traditional culture, supporting these women is crucial to improving the health of the Aboriginal community by addressing and interrupting the intergenerational transfer of trauma and distress. The appropriateness of support is augmented when those in the kinship carer role identify factors affecting the delivery of optimum parenting. This may in turn facilitate the development of appropriate and self-determined interventions. Beneficial flow-on from supporting these women will be manifested in enabling all grandparents to foster the growth of 'healthier' grandchildren.

Our study was conducted in Townsville in 2006. Its aim was to describe the experiences of urban Aboriginal grandmother carers raising their grandchildren. A positive psychology framework was applied, which advocates identifying and amplifying strengths in order to develop and maintain positive psychological wellbeing (Seligman and Csikszentmihalyi 2000). Using this framework, this study aimed to identify and explore the interplay between factors that promote resilience in this group.

Study methodology

Townsville has an Aboriginal population of approximately 5.6% (ABS 2006), some 3.3% above the Aboriginal national population distribution. A qualitative research method was used in the study, with analysis conducted via a grounded theory framework (Glaser 1978; Glaser and Strauss 1967). Interviews were transcribed and analysis was conducted by hand. Approval from the James Cook University Human Ethics Committee was obtained.

A purposive sample of urban Aboriginal grandmothers who reported coping well in their role was sought. A deliberate sampling method was used to identify those women who were coping well in their roles as grandmothers in order to identify factors that facilitated their functioning. The sample comprised seven Aboriginal grandmother carers who had, or had had, informal or formal custody of their grandchildren or great-grandchildren. Three grandmothers identified as being of Aboriginal descent, two identified as being of Aboriginal/South Sea Islander descent, and two grandmothers identified as being of Aboriginal/Torres Strait Islander descent. The

participants' ages ranged from 46 to 61 years (M = 56.14 years, SD = 5.34). The total number of grandchildren for each grandmother ranged from one to 46 grandchildren, with the number of grandchildren or great-grandchildren currently in their care ranging from one to four. Three grandmothers were married, three were not married and one was widowed.

Interviews were conducted by the principal author using a yarning, informal style of interview in keeping with recommended methods of engaging with Aboriginal participants (Tuhiwai Smith 1999). Each interview was approximately 60 minutes in length. Interviews were conducted at each participant's home or workplace, or in outdoor locations. In order to validate findings, each grandmother was given the opportunity to comment on, verify or amend the interpretation of interview data. All participants expressed agreement with the analysis and no amendments were suggested. Names have been changed to protect the anonymity of participants.

Results

The grandmothers discussed their strength and resilience in the support provided via socio-cultural factors and personal agency. The following socio-cultural themes emerged from the interviews, which described the factors that allowed them to cope in everyday life. The themes emerging from the interviews included social networks, kinship structure, traditional adoption, employment, spiritual belief, acceptance, self-reliance, facilitators, problem-solving and flexibility.

Social networks

All grandmothers described the importance of establishing and maintaining effective community support networks. Support was gained by forming reciprocal bonds within the local community. Nina noted, 'it's not what you know but who you know and how to access what we have within our own community'. She also acknowledged reciprocity by adding, 'it's a give and take relationship'. Indeed, survival was equated with having a thriving social support network. Grandmothers proved to be resourceful and persistent in maintaining and strengthening community support networks. Nina commented, 'when it comes to social outings, my daughter, my granddaughter's mum, doesn't have a vehicle, so, if it means I have to do two or three runs to make sure our outing's a success, so be it, and I do it'. This was 'not as a payback' for raising the granddaughter, but was done to strengthen the social and family network. Creating social support networks allowed the grandmothers to effectively support their grandchildren by providing sources of respite and was acknowledged by the comment, 'I know the few friends that I've got, we meet. That's how we coped, we kept one another, we kept propping one another up.'

Nina noted, 'as an Aboriginal grandmother…social outings…it's all about family'. Family gatherings constituted the main social outlet for most of the grandmothers.

However, others also described community gatherings and social events as providing a cornerstone for their social support. Rose described being heavily involved with organising and attending community events such as NAIDOC Week. Taking her grandchild to these events provided a way of reinforcing cultural links. Rose added, 'when they're around [child's family from a different cultural group], we always make sure she identifies'. Continuity and maintenance of cultural connections allowed the grandmother to fulfil her cultural obligations, expectations and requirements.

Five grandmothers demonstrated the ability to contact support services, such as psychological, medical and legal advice, when required. Psychological services were sought for themselves but also for others in the family. The grandmothers described the importance of having access to multiple sources of medical support, such as the hospital, local medical centre and Aboriginal medical centres, when medical services were required. A grandmother described access to psychological help in helping to cope with her grandchildren's anger: 'after my therapist…the doctor, psychiatrist/psychologist, she said, they're angry, they can't express their feelings'. One grandmother described her experiences of accessing medical care:

> I take the both of them to [the Aboriginal medical centre] when they get sick, yeah. If I can't get to [the Aboriginal medical centre], I'll take them to the Healthlink [local medical centre], because it's closer. So, if I can't ring up [the Aboriginal medical centre] to come and pick us up, well that's what I'll do, I'll just go straight to Healthlink. Or otherwise, if it's on the weekend, [my granddaughter]'s the main one that gets sick, I'll take her to the hospital.

For some, the experience of a harsh childhood created a disconnection in the family structure. Wariness of the family was developed due to a problematic childhood and helping behaviours were viewed as dependent upon a positive or negative outcome for the potential support giver. Possible isolation resulting from the disconnection from familial support was reduced by the development of social networks outside the family and, in particular, with other women also raising their grandchildren. However, it was acknowledged that successfully managing difficult situations was rarely achieved alone.

Alice said she never takes her problems to the family but, instead, gathers support from friends in the same situation: '[you won't cope] if you don't talk to somebody, a friend…it's never the family'. Thus, strength was gained from the mutual exchange of coping strategies and diversion and distraction from the problems at hand in the company of other grandmothers raising their grandchildren.

Kinship structure

All but one woman in this study described their greatest source of strength as the support of the family structure. They described the extended family as the greatest source of social support and central to the provision of quality child care. Edith

commented, 'we do it the traditional way…the Aboriginal way, child rearing and that sort of thing'. The traditional way of raising children was described as a 'communal system', where support is given by all members of the extended family. She added, 'It's…nothing new, because…when you're reared up in a semi-tribal way like I was reared up, I had…my grandmother, my father's mother was full-blood and she had a lot to do with our child rearing'.

These women were viewed as the custodians of cultural traditions and 'overall supervisors' of the following generations. They ensured that child rearing was 'being done in that proper traditional way'. Edith described her grandmother being removed to Palm Island and still maintaining the position as matriarch of the family. The matriarch is important to the family group as 'she's the one that the young ones take instruction from'. She also noted, 'you're not born with [childcare] skills, they're a learned skill…they're learned from…the grandmother in particular. She's the one that…instructs you, even with how to raise boys.'

In this sample, women in single parent situations had the support of the family, enabling them to raise the children the 'Aboriginal way' and in a stable environment. The oldest son was given the role as the head of the family, while uncles/brothers support the women financially and also with the discipline of the children. When discipline was needed for grandchildren, Lesley commented, 'I called on an uncle/brother to discipline them…he took her in for a year to discipline'. This sharing of responsibility across members of the family was described as in keeping with the traditional way of child rearing within the Aboriginal community.

As noted, support for these women was derived, as Edith commented, from a 'communal' way of life with 'women stepping in and supporting another woman'. This was also reflected by another grandmother's comment that, 'Yeah, they're [sisters] a big support…yeah, I've got other sisters there and they just step into the role of taking care of grandchildren'.

This support was available to all women, in all circumstances. It was the role of any woman who had the capacity to assist another woman during times of need to offer such support. For Ivy, this included the support from her granddaughter who 'helps me a lot in the house'. This support is provided by the grandchildren as a sign of respect and genuine concern for their grandmother. In addition, when a mother was struggling to raise a child, women of the grandmother's generation (i.e. grandmother, aunties) were called upon to take the child in order to support the mother. Support of the family, particularly by female relatives, reinforced the strength of those caring for the next generations.

Traditional adoption

Traditional adoption was made explicit as a source of strength by Nina, a grandmother of Torres Strait Islander descent. She described traditional adoption as the giving of a child to the grandmother to raise, not as an 'assumption…but more of a cultural

thing'. For Nina, this meant raising a grandchild as a matter of cultural tradition within functioning families rather than assuming fault within the parent of the child and the removal of that child from dysfunction. This was done in order to keep the grandmother 'young at heart and mind…the emotional side, the physical side…I can't mention enough about the mind, because it keeps them [grandmothers] active', she said.

It was understood that the child goes to the grandmother on a long-term basis, in order to 'keep [the grandmother] active'. After the child has stayed with the grandmother for a few years, the child is returned to the parental home and another grandchild is sent to be with the grandmother. The grandmother was viewed as a mentor and custodian of knowledge to the family. The child was there not only to keep the grandmother active, but also to be taught 'emotions, sensitivity and respect [for Elders in the family]…at a young age'. It was expected that this knowledge, and humanitarian skills developed, would be passed along to other children by the child upon return to the parental home. While women of Aboriginal descent did not operate in the same cultural paradigm of traditional adoption, these grandmothers enjoyed the support of their families when required or if procured.

Employment

Four grandmother respondents were employed. They described gaining a great deal of strength and support from their employment roles. They were actively involved in helping others in the Aboriginal community. Employment was viewed as supportive, not only because they were out in the workforce and interacting with colleagues, but also because working in the community strengthened the grandmothers as it provided an opportunity to support others in need.

Lesley commented, 'this job makes me go into houses and homes and look at the community'. The positions of employment held by some grandmothers offered a source of knowledge for addressing their own issues in raising their grandchildren. Nina noted differences across time in legal obligations pertaining to disciplining children. For example, laws regarding corporal punishment (smacking) children had changed since the grandmothers raised their own children and were raised themselves. Disciplinary measures taken by the grandmothers were influenced, and softened, by this information. Awareness of these changes was heightened through access to information through their employment as community support staff. Rose also noted, 'where I work, a different way of thinking…change and things like that, and it all does influence you'. She also described her employment as providing respite for her:

> I'm pretty much an independent sort of person. I think, the time that I get to myself is when I go [out of town on business]. I'm there for work…it's just a bit of time away, it's like respite, you know, you just need that little bit of time away, as grandparents. And I think it's a role that with any parents, you can't get away from…personal space [is crucial for coping].

Spiritual belief

Spiritual belief was described as a source of strength and was linked with cultural connection to traditions and ceremonies. Edith said she had been reconnected with her culture through participation in traditions and ceremonies. These cultural practices had ceased around the late 1950s and early 1960s and recommenced in 1995. Prior to her reconnection with her cultural heritage in 1995, she commented, 'I coped'. She stated:

> I've just come back from the women's ceremonies in [state] and they just made me a senior Elder of the women's group over there. You know, that's a privilege… you're senior Elder women who carry out law and different things like that, for women's business, you know. So, I was really privileged I thought. So…I think that's where my strength comes from. I mean, before 1995 [reconnection with ritual and ceremony], I coped. I coped. And I think it was my belief, and, my belief in myself that carried me through…plus other people around me.

Faith and Christianity were also described as a mainstay of support for four of the seven grandmothers. Faith was described as underpinning coping, especially for those less connected to family, and was equated with survival during times of adversity and beyond. Alice described herself as:

> always [having] that faith and I think that if I didn't have…I wouldn't have survived…I don't go to church a lot, but you don't have to go to church to have faith…I used to talk to myself, talk to God and say 'oh God, please help me, I need to get through this. How do I do it?'

Many grandmothers described praying to God, offering prayers for grandchildren and adult children and themselves in order to gain knowledge of how to deal with hardships. Nina described encouraging her grandchild to pray for her mother and sisters as a way to keep a connection between them even though they were absent from the family home.

Lesley described Christianity as providing support for her throughout her life. Her belief in God underpinned her compassion for others and 'going that extra mile'. She described gaining strength from her religious beliefs and values, and particularly while providing the grandchildren with a stable environment in which to grow up. She noted that religious teachings state that the children should be raised by their parents; however, she said she provides her support regardless, as that is also the Christian way. The study found that when considering the issue of agency of grandmother, the internal factors were acceptance, self-reliance, facilitators, problem-solving and flexibility (described below).

Acceptance

An overarching factor that emerged from the interviews regarding strengthening the grandmothers was acceptance of life and all situations presented to them. When asked about her experience raising her grandchildren, Marjorie responded, 'there's really no great big deal with it', and Nina commented, 'I love it'. This sentiment was echoed by all of the grandmothers. They described being able to accept and understand the limitations of being able to help the children in all situations. This allowed them to concentrate on those aspects of the children's lives where the grandmother's assistance was possible. Marjorie noted, 'I can't help them with that [not being able to feel love for the mother]' but explained that this may change for the child as time passed.

The grandmothers accepted fault within themselves and the grandchildren without being paralysed by the need to perfect. One said, 'that's how it is. You've gotta teach kids right from wrong, you know. And you also gotta have discipline on yourself, so you can do it for your grandchildren.' Many women described their grandchildren as 'not perfect' but as 'normal kids' who do normal things. As Lesley noted, 'you've gotta look beyond' and accept that the child is operating in the social environment beyond their influence. 'At the end of the day, I mean, I know where I've come from. I know where I'm going to be, and I know where I'm at now, but what I'm trying to do is make my children's life and their path a little bit smoother.' They trusted that their previous teachings of principles and values to the grandchildren would guide their decisions.

Self-reliance

Developing self-reliance allowed these women to provide effective parenting to their grandchildren. Strategies used to increase their self-reliance included positive self-talk and gaining access to support from a variety of sources. Particularly for those who did not access family or social support, positive self-talk was described as being a mechanism that provided motivation and strength. Utilising this mechanism allowed the women to access knowledge from previous experiences in order to find ways of dealing with current situations. Alice described talking with herself to gain knowledge and provide the basis for action in the present and during times of crisis or adversity. She described herself saying, 'you've gotta keep going, you've got your kids, God's with you, just keep going girl'.

Facilitators of family healing

Facilitating healing within the family and transmission of knowledge across the generations was demonstrated by all grandmothers. Grandmothers saw themselves as the teachers of skills on a practical level and also as teaching values and principles, and described gaining strength from teaching the next generation. The women felt the responsibility of their role as grandmother encompassed transmission of values and principles to the grandchildren in order for them to understand their place in a larger

societal structure. Respect for Elders and truth in word and deed were taught as the most valuable assets for the grandchildren.

Problem-solving skills

Women in this study demonstrated a range of problem-solving skills and proved to be resourceful and persistent in their efforts. Both direct and indirect problem-solving strategies were used. Direct or proactive strategies such as drawing upon previous experiences and using alternative strategies were employed by the grandmothers. Problem-solving skills were demonstrated in day-to-day practicalities, such as controlling finances and confronting difficult situations head-on.

Situations were described where the grandmothers tackled the problem in a forthright manner in order to solve it efficiently. These situations were especially apparent when dealing with the parents of the grandchild, but also with the grandchild. Rose described 'taking a more proactive approach' when dealing with previously unspoken topics. She also described keeping an open mind and being open to new ideas and the points of view of others. Alice described being in a difficult situation with a parent of her grandchild and going directly to the parent to solve the problem. Edith also described her problem-solving as direct, and stated, 'I go straight to them, we sit down and we sort it out'.

Many of the grandmothers reported drawing upon their previous experiences raising their own children and their parents' methods as a means of dealing with raising their grandchildren. In particular, the women recalled the way they were parented and made conscious efforts to either emulate or improve upon past parenting practices. For those women who felt their own childhood was not optimal, efforts were made to improve upon the past. For example, Alice described authority figures in her life, such as parent, grandparent and teachers, as 'cruel' and she made a conscious decision early in her life — 'I wasn't going to be like [them]'.

Sometimes the effect of childhood was implicitly manifested. Marjorie noted, when asked if she had been influenced by her childhood, 'no, no', but then added, 'I've been thinking about it…like, when we were growing up we didn't have much'. She went on to add, 'I don't want my grandkids to be brought up that way'.

Others described being less strict upon their grandchildren, less so than they were on their own children. Rose commented, 'I probably draw upon improving how I was parented…[my] parents were very strict…I tend to take an approach where I talk about anything and everything'. As a proactive strategy providing strength, grandmothers described being able to find alternative routes to solving problems. When difficulties arose, if the way of dealing with the problem was unsuccessful, then another way was found.

Avoidance strategies such as distraction and diversion were also utilised by the women to help cope with raising their grandchildren. Though not widely used, diversionary tactics were engaged by gathering around them women in similar

situations. Before going on an outing away from the grandchildren, a conscious decision was made not to discuss family problems. Grandmothers described this strategy as providing strength; after such outings, the grandmothers described being more able to deal with the problems of raising their grandchildren.

Flexibility

The grandmothers described being flexible in their approach to raising grandchildren. The most fundamental changes were evident when dealing with the traditional way of raising children and grandchildren. When the traditions were no longer viewed as relevant to this generation, the grandmothers were able to selectively make changes. Changes in thinking were seen in relation to marriage practices, such as arranged marriage. This practice was viewed as no longer appropriate for this generation and therefore able to be changed or discarded. The grandmothers acknowledged the changing social context and gained strength from being able to adapt to the changes and provide adaptive responses.

The grandmothers also demonstrated flexibility in their responses regarding providing guidance to their grandchildren. This allowed them to deal with the changes in their grandchildren. Responses ranged from Ivy's simple comments, such as 'you allow for things like that', to more complex rationalities, such as Edith describing allowing self-development of her granddaughter even in times where she did not agree:

> they have to develop their own personalities, their own principles and their own style of how they want to cope with it…we can only just advise her…and it's up to her to whether she wants to honour those principles.…[I] might not agree.… it may be alien to us but we have to just watch it and support it if it need to be supported.

Discussion

The study results provide important insights into the experiences of urban Aboriginal and Torres Strait Islander grandmothers raising their grandchildren. While areas of difficulty are acknowledged for grandmothers raising their grandchildren, this study focused on the areas of strength identified by these grandmothers. A positive psychology framework was applied, which advocates identifying and amplifying strengths in order to develop and maintain positive psychological wellbeing (Seligman and Csikszentmihalyi 2000; Snyder and Lopez 2005). Successful life functioning may be best understood when considering the interplay between individual, environment, society and culture. Strengths encompassed socio-cultural factors of social networks, kinship structure, traditional adoption, employment, spiritual belief, acceptance, self-reliance, facilitators, problem-solving and flexibility. These strengths reflect positive psychology factors as contributing to resilience.

Areas of difficulties for custodial grandparents are well documented and acknowledged in the literature (COTA 2003; Dunne and Kettler 2007; Hammill 2001; Orb and Davey 2005; Pruchno 1999; Standing et al. 2007; Higgins et al. 2005; Hayslip et al. 2006; Musil et al. 2006; Fitzpatrick 2004; Backhouse 2006). Similar to the findings of previous research, the respondent grandmothers described difficulties regarding legal, financial, parenting and social issues. Effects of the legal aspect of custody flowed on to the financial situation of the grandmothers. Those who made custodial arrangements based upon mutual trust tended to benefit from some financial support from the parents. However, consideration of the parental financial situation was made before grandmothers made application for government benefits. Some described not making application due to the effect it would have upon the parent's financial situation, even when the parent did not have the child. Grandmothers who were raising the grandchildren due to a parent's inability to cope tended to make application for financial assistance.

It was noted by all grandmothers that raising the grandchildren presented financial strain at some point. However, those grandmothers on government pensions or allowances reported experiencing difficulties on a week-to-week basis, particularly having problems providing basic necessities for the grandchildren. Grandmothers who were employed reported less financial difficulties, although they were not eligible for governmental financial support. These experiences are clearly reflected by others in the carer role across different communities (COTA 2003; Higgins et al. 2005; Fitzpatrick 2004).

Grandmothers in this study acknowledged difficulties in raising the children. However, they did not describe these issues as overwhelming or insurmountable. Difficulties raising their grandchildren appeared to be mediated by psychosocial factors that facilitated support to, and resilience of, the grandmothers. In fact, these grandmothers appeared to be protected from being overwhelmed by daily problems by their connection to culture and their acceptance of life. Moreover, grandmothers were keen to advance the view that raising their grandchildren was not out of the ordinary or exceptional but, rather, just a normal part of life. These findings support other reports that describe protection of psychological wellbeing through adherence to cultural norms and expectations (Pruchno 1999; Goodman and Silverstein 2002).

When asked how she was coping with raising her grandchildren, one grandmother stated, 'I love it'. The grandmothers reported acceptance of life situations as providing the mechanism for being able to positively reframe these events and find the meaning within. Even though they had experienced negative life events, such as the loss of spouses, a harsh childhood or a lack of financial support, they remained optimistic and accepting of life's events. As one grandmother described her situation raising her grandchildren, 'there's no great big deal with it'.

These comments may reflect the experience of positive psychological functioning due to adherence to cultural norms. For these Aboriginal grandmothers, 'doing

it the Aboriginal way' was stated to be a source of strength. Similarly, the practice of traditional adoption was culturally appropriate for grandmothers of Torres Strait Islander descent. They stated that they gained strength from operating within these cultural frameworks.

Both traditional adoption and the 'Aboriginal way' meant grandmothers were supported by their family groups, and thus socially connected. The kinship structure provided stability for family members during times of adversity, such as when marriages broke down. The kinship structure allowed for roles, such as grandmother, to be fulfilled by other members of the family who identified as grandmother. Grandmothers stated that this provided family members with clear role definition pertaining to their responsibilities during these times. Grandmothers also described the extended family network and kinship structure as providing support. Social issues regarding the grandchildren were also dealt with by the extended family. Discipline issues in single-mother families were passed on to uncles/brothers to contend with. This was described as a culturally normative and appropriate way of dealing with family issues. Grandmothers reported that meeting cultural expectations and being grounded in culture and tradition allowed them to be more socially integrated.

Historically, many Aboriginal people have experienced disconnection from their culture as a result of government policies (Wilson 1997). However, within this cultural context grandmothers continued to demonstrate resilience and psychological wellbeing. Maintaining cultural connection provides a context in which to understand and make meaning of one's life course and circumstances.

One grandmother stated that she only 'coped' with her life situation prior to her reconnection to culture through participation in traditional ceremonies. She stated that since her reconnection to culture the source of her strength has come from a sense of meaning and a balanced view of life. Overall, the strengths and experiences described in this study go some way to understanding the factors that facilitate resilience and positive psychological functioning of Aboriginal and Torres Strait Islander grandmothers raising their grandchildren (Bromfield and Osborn 2007; Mason et al. 2002). As the Aboriginal and Torres Strait Islander Child Placement Principle (AIHW 2008; Queensland Department of Child Safety 1999) places priority on kinship placement of children in care, it is essential to understand the psychosocial mechanisms that allow grandparent carers to develop and maintain well-functioning placements.

Conclusion

The results of this study provide an insight into the experience of Aboriginal and Torres Strait Islander grandmothers who are raising, or have raised, their grandchildren. In particular, this study highlights the view that positive psychological functioning for these grandmothers was gained through the strengths provided by interplay

between cultural connection and personal agency. The grandmothers' agency was demonstrated by self-reliance, developing and strengthening problem-solving skills, being facilitators of healing within the extended family, flexibility when responding to difficult situations and acceptance of life situations. Socio-cultural factors included participating in traditional adoption, developing and maintaining kinship structures and social networks, participation in employment and maintaining spiritual beliefs. Grandmothers stated that together these psychosocial factors positively affected their psychological wellbeing through increasing optimism and providing meaning to their lives. A positive psychology perspective maintains that optimal life functioning is best achieved when individuals identify their own strengths and are then supported in amplifying these psychosocial factors (Seligman and Csikszentmihalyi 2000; Snyder and Lopez 2005).

Overall, this study has contributed to knowledge regarding the strengths of Aboriginal and Torres Strait Islander grandparent carers by providing a snapshot of their experiences raising their grandchildren. As older Aboriginal women who are caring for their grandchildren provide a link between generations through their connectedness to traditional knowledge and support mechanisms, supporting these women may be crucial to the improvement of the health and wellbeing of the Aboriginal community. Beneficial flow-on from this support may be manifested in enabling grandparents to foster the growth of 'healthier' children. As noted by one grandmother, 'it's a balancing act between culture, tradition, custom, as opposed to Western ways'.

References

ABS (Australian Bureau of Statistics) 2006 *Population Distribution, Aboriginal and Torres Strait Islander Australians,* ABS, Canberra, <www.abs.gov.au/AUSSTATS/abs@.nsf/ProductsbyCatalogue/14E7A4A075D53A6CCA2569450007E46C?OpenDocument> accessed 2 May 2006.

——2008 *Family Characteristics and Transitions Survey,* Australian Government, Canberra, <www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/5E0A33B317158C79CA25745F001694CB/$File/44420%20Reissue%20July%202008.pdf> accessed 2 May 2008.

AIHW (Australian Institute of Health and Welfare) 2008 *Child Protection Australia 2006–07*, AIHW, Canberra (AIHW Cat. no. CWS 31), <www.aihw.gov.au/publications/cws/cpa06-07/cpa06-07-20080229.pdf> accessed 20 March 2009.

Backhouse, Jan 2006 'Grandparents-as-parents: Social change and its impact on grandparents who are raising their grandchildren', paper presented at the Social Change in the 21st Century Conference, Queensland University of Technology, Brisbane, 27 October.

Bromfield, Leah and Alexandra Osborn 2007 *Kinship Care,* National Child Protection Clearinghouse, Melbourne, <www.aifs.gov.au/nch/pubs/brief/rb10/rb10.pdf> accessed 28 October 2008.

COTA (Council of the Ageing) 2003 *Grandparents Raising Grandchildren: A report of the project commissioned by the Hon. Larry Anthony, Minister for Children and Youth Affairs, July 2003*, <www.facs.gov.au/internet/facsinternet.nsf/VIA/grandparents/$File/GrandparentsRaisingGrandchildrenReport.pdf> accessed 6 May 2006.

Dunne, Emer G and Lisa J Kettler 2007 'Grandparents raising grandchildren in Australia: Exploring psychological health and grandparents' experience of providing kinship care', *International Journal of Social Welfare* 17:333–45.

Fitzpatrick, Margaret 2004 *Grandparents Raising Grandchildren: A report of the project commissioned by the Hon. Larry Anthony, Minister for Children & Youth Affairs*, COTA National Seniors Partnership, Melbourne.

Glaser, Barney G 1978 *Theoretical Sensitivity: Advances in the methodology of grounded theory,* The Sociology Press, San Francisco, CA.

Glaser, Barney G and Anselm L Strauss 1967 *The Discovery of Grounded Theory: Strategies for qualitative research*, Aldine Publishing Co., Chicago, IL.

Goodman, Catherine C and Merril Silverstein 2002 'Grandmothers raising their grandchildren: Family structure and well-being in culturally diverse families', *Gerontologist* 42:676–89.

Hammill, Jan 2001 'Granny rights: Combating the granny burnout syndrome among Australian Indigenous communities', *Development* 44:69–74.

Hayslip, Bert Jr, Jeff R Temple, Jerald Shore and Craig E Henderson 2006 'Determinants of role satisfaction among traditional and custodial grandparents' in B Hayslip and P Kaminski (eds), *Custodial Grandparenting: Individual, cultural, and ethnic diversity*, Springer Publishing Co., New York, pp.21–36.

Higgins, Daryl, Leah Bromfield and Nick Richardson 2005 *Enhancing Out-of-home Care for Aboriginal and Torres Strait Islander Young People,* Australian Institute of Family Studies, National Child Protection Clearninghouse, Melbourne, <www.aifs.gov.au/nch/pubs/reports/empirical/empirical.pdf> accessed 18 November 2005.

Mason, Jan, Jan Falloon, Leonie Gibbons, Nigel Spence and Eric Scott 2002 *Understanding Kinship Care,* NSW Association of Children's Welfare Agencies Inc and University of Western Sydney, Haymarket, NSW.

Mellor, Doreen and A Haebich (eds) 2002 *Many Voices: Reflections on experiences of Indigenous child separation,* National Library of Australia, Canberra.

Musil, Carol M, Camille B Warner, Jaclene A Zauszniewski, Alexandra B Jeanblanc and Kyle Kercher 2006 'Grandmothers, caregiving, and family functioning', *Journals of Gerontology, Series B, Psychological and Social Sciences* 61B:S89–S98.

Orb, Angelica and Margaret Davey 2005 'Grandparents parenting their grandchildren', *Australasian Journal of Ageing* 24:162–8.

Pruchno, Rachel 1999 'Raising grandchildren: The experience of black and white grandmothers', *Gerontologist* 3:209–21.

Queensland Department of Child Safety 1999 *Child Protection Act 1999,* Office of the Queensland Parliamentary Counsel, Brisbane, <www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf> accessed 29 October 2009.

——2009 *Final Report: July 2009 – March 2009,* Queensland Department of Communities, Brisbane, <www.childsafety.qld.gov.au/department/annual-report/2008-09/index.html> accessed 12 August 2009.

Seligman, Martin EP and Mihaly Csikszentmihalyi 2000 'Positive psychology: An introduction', *American Psychologist* 55:5–14.

SNAICC (Secretariat of Aboriginal and Islander Child Care) 2005 *Achieving Stable and Culturally Strong Out of Home Care for Aboriginal and Torres Strait Islander Children,* SNAICC, Melbourne.

Snyder, C Rick and Shane J Lopez (eds) 2005 *Handbook of Positive Psychology,* Oxford University Press, Oxford.

Standing, Theresa S, Carol M Musil and Camille Beckette Warner 2007 'Grandmothers' transitions in caregiving to grandchildren', *Western Journal of Nursing Research* 29: 613–31.

Tuhiwai Smith, Linda 1999 *Decolonizing Methodologies: Research and Indigenous peoples,* Zed Books, London.

Wilson, Ronald 1997 *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families,* Human Rights and Equal Opportunity Commission, Sydney.

Note

1. The term 'Aboriginal' in this paper represents Aboriginal and Torres Strait Islander peoples.

Chapter 4

Researching the safety of Indigenous children and youth: An urban perspective

Kathleen Clapham
University of Wollongong

Freidoon Khavarpour
The University of Western Sydney

Reuben Bolt
The University of New South Wales

Mark Stevenson
The George Institute for Global Health, The University of Sydney

Steve Su
The University of Western Australia

Abstract: *Injury is one of the leading causes of Indigenous mortality in Australia and safety in Indigenous communities has become increasingly prominent in commentary on Indigenous communities. However, our knowledge of urban Indigenous people and their experiences has been largely ignored in these debates; most of the discussions to date have focused on remote areas, despite the fact that around one-third of Indigenous Australians live in urban settings. This paper reports on the Safe Koori Kids study, which addressed the safety of Indigenous children, carried out in Sydney's outer metropolitan area of Campbelltown between 2006 and 2009 (Clapham et al. 2006a, 2006b). The study aimed to increase our understanding of the broad range of factors involved in injury in Indigenous communities and to create a culturally acceptable and effective intervention program by addressing child and youth resilience. The program, delivered to Indigenous and non-Indigenous primary-aged children across 11 primary schools and evaluated in five of these schools, drew on local knowledge and resources to address safety issues. The program was underpinned by recognising that a multitude of factors affect the safety of children and families. Additionally, the program embedded*

positive messages to reinforce the cultural identity of Indigenous people living in urban areas. The theme of connections and reconnections embedded in our study emerged as children responded positively to the way urban Indigenous identity was represented in the program. Researchers recorded an increase in self-efficacy in questionnaire responses among the primary-aged children after the program was delivered over one school term in five schools. Qualitative data collected from teachers also revealed that Indigenous children responded to the program with an increased sense of achievement and pride in Aboriginal heritage. Improving the safety of Indigenous children in urban areas is complex and currently not well understood. Intervention programs need to incorporate a much better comprehension of the factors that increase the vulnerability of urban Indigenous children. Safety programs must recognise the social and cultural context in which children live, draw on local resources and reinforce a sense of pride in Indigenous identity to build resilience among vulnerable children.

Introduction

This paper reports on the Safe Koori Kids (SKK) study, which was carried out in Sydney's outer metropolitan area of Campbelltown between 2006 and 2009 (Clapham et al. 2006a, 2006b). The study addressed the safety of Indigenous children living in urban areas. It did this, first, by increasing our understanding of the broad and complex factors involved in injury in Indigenous communities. It drew on local knowledge and resources to address safety issues that had been identified in the first phase of the research. Over a three-year period (2006–08) a school-based program was designed and delivered to Indigenous and non-Indigenous primary-aged children across 11 primary schools, with a formal evaluation undertaken in five of these schools. The program was underpinned by recognition that a multitude of factors affect the safety of children and families. Additionally, the educational material reinforced the positive cultural identity of Indigenous children living in urban areas.

The theme of the 2009 AIATSIS conference was connections and reconnections. It posed questions such as 'What does it means to be Aboriginal and "urban"?' and 'What are the issues of relevance for Indigenous people living in urban and semi-urban and regional areas?' Researchers in the SKK study asked similar types of questions. We were particularly interested in questions such as 'How does safety feature among the concerns of urban Aboriginal families with children?', 'Is safety a priority and why?' and 'Will a preventive health program which connects with Indigenous cultural themes resonate with urban Indigenous children and families?' While we did not expect that a single educational program would have an immediate impact on rates of injury, we hoped that the program would contribute to improving the safety knowledge and attitudes of children, teachers and families.

Injury, youth and urban Indigenous communities

Injury is one of the leading causes of Indigenous mortality in Australia, and safety in Indigenous communities has become increasingly prominent in commentary on Indigenous communities. Indigenous people suffer nearly three times the rate of fatal injuries (Helps and Harrison 2004) and are hospitalised at around twice the rate of all Australians (Helps and Harrison 2006). With a population of 517 200 in 2006, Indigenous people make up around 2.5% of the Australian population (ABS 2007). Most Indigenous Australians live in major cities (32% or 165 800 people) or regional areas (43%; 223 900 people) (ABS 2008a). However, our knowledge of urban Indigenous people and their experiences has not been reported widely; almost all of the research focus in this area has been on remote areas. Lack of effective, sustainable and culturally appropriate interventions are barriers to improved health for Indigenous Australians. Indigenous Australians have not benefited to the same extent from advances that have led to improvements in injury mortality and hospitalisations for most Australians.

Children aged 0–14 are the most vulnerable group for injury (SIPP 2001) and are the most rapidly growing sector of the Indigenous population (ABS 2007). The injury issues confronting children in Indigenous communities are more complex than those experienced by the general population. Injuries to Indigenous children and youth go beyond immediate physical injury from transport, recreation, and accidents in the home and school. They are linked to Indigenous social disadvantage, poverty, alienation, and family and community dysfunction. Indigenous children may be put at risk due to an overcrowded home environment, economic deprivation, high stress levels and recurring domestic violence (Moller et al. 2004). Interventions that target young people have a strong likelihood of success; first, because intervention can reduce or prevent injuries and, second, because interventions can address factors to which children are exposed, which influences injury experienced at older ages (Pointer et al. 2003). This raises the possibility of early intervention to address injury in later adolescence and early adulthood.

The study site — south-west Sydney

South-west Sydney was chosen for the SKK study site because of its large, diverse and young Aboriginal population. At the 2006 Census 34 515 Indigenous people, or a quarter of the total number of Indigenous people in New South Wales, were recorded as living in Sydney (ABS 2008b). The Aboriginal and Torres Strait Islander population is known to be a 'young' population. Nationally, the median age of the Indigenous population at 30 June 2006 was 21.0 years, compared to 37.0 years for the non-Indigenous population. South-west Sydney contains one of the largest concentrations of Indigenous people in the Sydney area.

The city of Campbelltown is a growth area located on the south-west periphery of Sydney's sprawling outer metropolis. Campbelltown City includes 3785 people of Aboriginal and Torres Strait Islander descent, comprising 2.7% of the city's population. Primary-school-aged children aged 5–11 years, the SKK target population, comprise 11.1% of Campbelltown's total population. Campbelltown is also known as an area of high socio-economic disadvantage. Based on 2006 Census figures, compared to the Sydney statistical division, Campbelltown has a higher proportion of low-income households and a lower proportion of high-income households, although this concentration of household wealth varies across the city (Campbelltown City Council 2012). Campbelltown has more unemployed people, more people aged over 15 with no formal qualifications, significantly more people who left school at Year 10 or below, significantly less people with tertiary qualifications, more one-parent families with children under 15 years of age, larger households, a lower proportion of households with no car, a lower proportion of homeowners who fully owned their home and a significantly higher proportion of public renters (Campbelltown City Council 2012). Aboriginal and Torres Strait Islanders living in Campbelltown are concentrated in a number of the city's public housing estates located in the most socially and economically disadvantaged areas. As in most Australian cities, 'urban' Aboriginal people, who are often 'hidden' from the urban majority, frequently have roots in regional and rural towns, and many families regularly maintain contact and move between town and city.

Background to the study

The SKK project was funded by AIATSIS and the National Health and Medical Research Council. It was implemented during 2006–08 following a period of extensive consultation with the local Indigenous community in the previous two years. During the first phase of the project, quantitative and qualitative data were collected on injury incidence and impact in the New South Wales Aboriginal population. The second phase involved the design and development of the intervention and an evaluation and dissemination plan. During the third phase the intervention was implemented in schools and communities. This involved Aboriginal and non-Aboriginal primary school children, their teachers and parents, as well as community members and service providers. The program was evaluated and work on translation to policy was undertaken during 2009–10.

The study applied insights from the emerging literature on family and community resilience to the prevention of intentional and unintentional injury in Indigenous communities (Clapham et al. 2007). Resiliency has been defined in the literature as 'positive adaptation in response to adversity' (Masten and Coatsworth 1998). This capacity to successfully adapt, in the face of challenging or adverse circumstances, is often considered an individual trait or characteristic. However, studies based on a strengths perspective, which have emerged within the field of family and community

resilience (e.g. Walsh 1996), seek to identify the characteristics of individuals, groups and environments that seem to protect against the negative consequences of adverse circumstances. Such studies provide promising frameworks for the development (or enhancement) of interventions targeting injury prevention among Indigenous children and families (Kalil 2003). Building on the resiliency of families, organisations and communities can assist them to cope with or withstand difficulties. To date, however, there is a lack of empirical evidence to support the widespread adoption of these approaches and few examples of research in Indigenous contexts.

Methodology

To understand the context in which injury and safety concerns occur, the first phase of the SKK project involved interviews and focus groups with Aboriginal and non-Aboriginal service providers across a range of health and community sectors, teachers and school staff, and Aboriginal community members. Participants were asked about the injury and safety issues affecting Aboriginal children and youth, including the safety of their environment. They were also asked about their views on appropriate intervention strategies to address these issues, as well as strategies for further engaging the local Indigenous community. Based on the analysis of qualitative data and in collaboration with community partners, researchers developed a module-based program for implementation in local schools. The findings from the qualitative data collection further informed the development of the intervention and the ongoing direction of the research.

Broad risk factors were identified in the first phase of the project. At the community level these included risky urban environments, unsafe playing areas, poor transport and communication, lack of activities for kids, drug dealers in local areas, racially related bullying in schools and the normalisation of Koori kids to freedom, which was directly attributed to parenting styles. At the individual and family levels risk factors included risky home environments, the impact of domestic violence on kids, lack of parental supervision, the absence of responsible adults, high levels of risk taking by children and young people, high levels of local drug and alcohol use, and kids taking on adult responsibilities. Analysis of qualitative data also revealed a number of important protective factors. These included Aboriginal people's capacity to 'survive', their strong sense of connection to family and the local Aboriginal community, the support of Aboriginal staff in schools (particularly Aboriginal Education Workers), the provision of cultural rooms in some schools (which were regarded as 'safe places' for Koori kids within the sometimes hostile school environment), development of 'toughness' in kids, the protection and support of older siblings (which Koori kids frequently experienced) and access to prevention programs.

Throughout the project we attempted to provide opportunities for Aboriginal people to have input into the direction of the research, as well as to raise concerns.

Ethical approval for the study was obtained through the Human Research Ethics Committees of the University of Wollongong, the Aboriginal Health and Medical Research Council of New South Wales, and the Board of the Tharawal Aboriginal Corporation.

From the outset the development of a comprehensive dissemination plan was considered a key component of the research. The plan took into account the varied audiences for the project and used various media to reach these audiences. These promotion strategies followed guidelines developed by Flinders University Primary Health Care Research and Information Service (PHCRIS 2003). Using this model, information was disseminated throughout all phases of the project using various strategies: participation in local Indigenous forums; regular reports to the local Aboriginal Corporation, Aboriginal Education Consultative Group and various Indigenous consultative committees; websites; flyers and pamphlets for the local community; fact sheets for policy makers, service providers and organisations; and presentations and workshops for teachers and community groups in the local area. Results of the research were disseminated through various academic publications and conferences.

Intervention development phase

The intervention, which was developed as a result of the consultation, data collection and analysis, consisted of a school-based safety program, a teacher training program, and a family and community program. The research team developed and sustained partnerships with Indigenous and non-Indigenous service providers across a range of government and non-government organisations in the Campbelltown area throughout the project.

Schools were selected to participate in the study on the basis of the number of Indigenous students in the school, formal support from the school and a formal expression of interest from local Indigenous communities. After designing, developing and writing the educational modules on which the SKK study was based, the research team developed a teacher training workshop, which was also used as a forum for evaluation activities. An interactive educational online game was also developed and funding was provided to schools for an excursion to local resources that promoted environmental safety.

Figure 1 illustrates the key aspects of the intervention model developed for the SKK project.

The school-based intervention comprised five modules, which incorporated local traditional Aboriginal culture into the existing safety curriculum. These were integrated into the school curriculum for children aged 8 to 12 years (stages two and three). The five modules — namely, 'Survival' (safety in the outside environment), 'Getting Around' (transport safety), 'Playing It Safe' (sports safety), 'Living Together'

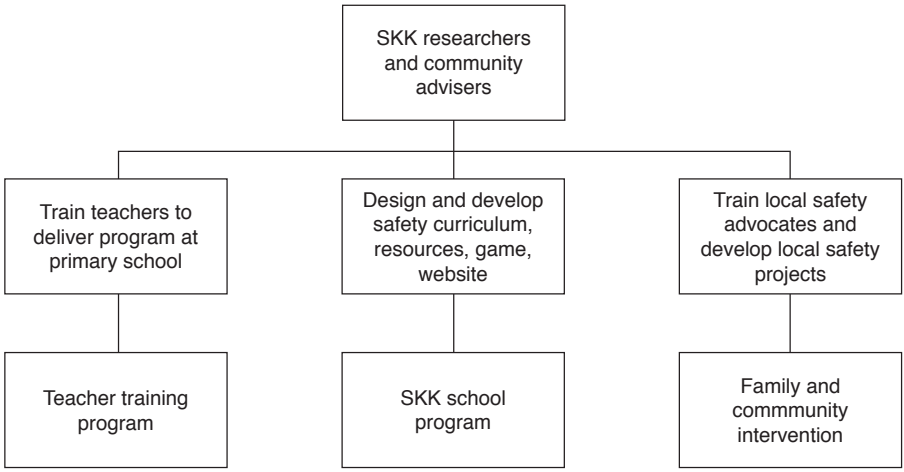

Figure 1: The Safe Koori Kids Model

(home and school safety) and 'Values and Respect' (interpersonal relations, bullying and racism) — were implemented in the schools over a ten-week period during term two. The interactive online game was able to be viewed by the children online (Safe Koori Kids Project: Community Based Approaches to Indigenous Injury Prevention n.d.) or through a DVD version provided to the teachers. The content of the game was directly linked to the safety lessons presented in the modules and provided positive visual reinforcement for 'traditional' Aboriginal cultural themes, safety, and contemporary urban Indigenous lifestyles and values. At the end of the game children were asked questions relating to the safety aspects they encountered in the game: these were linked to the learning objectives of the SKK program. The intervention also reached out to the parents and carers of the children participating in the intervention: the SKK program identified activities for Aboriginal parents and carers who were specifically encouraged to participate in the SKK activities in the classroom and at the school level.

Intervention evaluation phase

The research team used a pre-test / post-test design to evaluate the effectiveness of the intervention in five of the primary schools. These schools were chosen on the basis of high Indigenous enrolments. Twenty-four teachers, 790 children (Indigenous and non-Indigenous) and a number of children's parents and/or carers participated in the final stage of the study. A questionnaire designed by the researchers and comprising 30 questions was administered to the 790 school children on two occasions. Questions were based on the knowledge, skills and attitudes taught across the five safety modules

by the classroom teachers. The pre-test was administered by classroom teachers in weeks one to two of the second school term. The post-test was administered towards the end of the same term, nine to ten weeks later. The purpose of the questionnaire was to assess the change (or otherwise) in the child's self-efficacy and knowledge and attitudes towards safety. A teacher questionnaire was also administered pre- and post-intervention to a total of 24 classroom teachers from the five schools. The purpose of the teacher questionnaire was to measure change in the teachers' safety knowledge and attitudes to Indigenous children and teaching practices in these areas, as well as the level of Indigenous parental involvement in the program.

Community engagement

The research team engaged with the Indigenous communities throughout the development and implementation of the SKK project. Local Indigenous organisations and Indigenous workers within government and non-government organisations were identified early in the project and invited to contribute to the design and development of the research. An Aboriginal Research Advisory Committee was established specifically for the SKK project to provide input into the direction of the research and strategies to implement the initiatives. It was important to recognise existing local power and authority structures and relationships; for example, the Tharawal Aboriginal Medical Service was the only Aboriginal community-controlled health service provider in the area and acted as an important community 'gate keeper', as well as a source of advice and approval. The Aboriginal Education Consultative Group provided an important forum for discussion and communication about the project with Aboriginal parents and teachers in local schools.

The project was led by an Indigenous researcher and employed Aboriginal research staff. Local resources were used whenever practicable; for example, an Aboriginal teacher was contracted to design and oversee the development of the school program. The research team, working through the local Aboriginal health service, held regular meetings with the members of the Indigenous community and participated in the annual NAIDOC Week activities in the local area. Local TAFE colleges and first aid organisations were utilised to provide first aid courses. Indigenous community members participated in the First Aid Safety Program classes at various stages of the program. Parents and carers provided positive feedback to the research team on their experience of the first aid courses.

Findings

The full program evaluation was completed during 2009–2010 and the main findings are summarised below; detailed study results will be reported elsewhere. A total of 104 Indigenous children and 679 non-Indigenous children and 24 teachers

participated in the evaluation of the school program. Statistical analysis on the pre- to post-intervention across key outcomes was undertaken using paired T-tests at a 5% level of significance (with confirmatory checks via Wilcoxon Ranked sum tests when sample size falls below 30). We also carried out mixed model analysis to account for the age, gender and clustering effect of class in schools of our study design. Findings indicate that teachers across the five intervention schools successfully prioritised safety education in the classroom in an enhanced safety curriculum over a ten-week period. Positive findings from the teachers' questionnaires showed increased teacher knowledge of safety and Indigenous culture.

The SKK intervention afforded an opportunity for positive school experiences and building of self-efficacy in relation to safety in an innovative way; that is, by positively supporting an Aboriginal cultural identity. Teachers reported an increased sense of pride and achievement among Indigenous children. Indigenous children participated in activities that reinforced their sense of mastery, with a view to building resilience through positive reinforcement of their cultural identity. Children responded positively to representations of urban Indigenous identity in the program.

It is important to note that Indigenous children scored lower than non-Indigenous children at baseline (or pre-intervention) on all outcomes; namely, self-efficacy, attitude and knowledge. At post-intervention Indigenous children also scored lower than non-Indigenous children on self-efficacy. However, the improved scores for each of the outcomes were greater for Indigenous children than for non-Indigenous children, with varying levels of statistical significance.

Results of the tests show a significant increase in self-efficacy scores among both Indigenous and non-Indigenous children from pre- to post-intervention. For Indigenous children this increase in self-efficacy was substantially higher compared to non-Indigenous children. This finding shows that Indigenous children were more likely to achieve a sense of mastery in regard to safety as a result of the SKK program than non-Indigenous children. Safety knowledge among Indigenous children and non-Indigenous children also increased significantly. Again, the increase in safety knowledge of the Indigenous children post-test was greater than that of the non-Indigenous children. The significant increase in safety knowledge among both Indigenous children and non-Indigenous children as reported in this study is very encouraging. Knowledge of safety at baseline (or pre-intervention) revealed a substantial gap in safety knowledge between Indigenous and non-Indigenous children. However, following the intervention there was a higher change in the Indigenous children's knowledge of safety compared to non-Indigenous children — albeit, still lower overall for Indigenous children compared to non-Indigenous children.

There were no significant improvements in attitudes towards safety. The lack of change in attitudes towards safety, while disappointing, indicates the difficulty of achieving fundamental attitudinal changes, and indicates that more work needs to be done in this challenging area.

The participation of Indigenous families in their children's education was a key objective in this study. The intervention created opportunities and incentives for Indigenous children, parents, carers and teachers to come together around the physical safety, as well as the 'cultural safety', of Indigenous children (Bin-Sallik 2003). The 8% increase in participation of Indigenous families reported by teachers is an encouraging result, even though not statistically significant.

Conclusion

The SKK study has increased our limited knowledge about effective child injury prevention for disadvantaged Indigenous children in urban areas. The school and community safety program recognised that the social and cultural context in which urban Indigenous children live has differences and similarities to rural and regional communities from which many of its Indigenous residents originate. The program that was developed was a result of broad community consultation and drew on local resources to reinforce a sense of pride and positive Indigenous identity in order to build on the resilience of vulnerable children. Findings suggest that a school-based, culturally affirming safety intervention can have a positive impact on improved self-efficacy and knowledge about safety. Innovative use of Indigenous knowledge in the curriculum resonated with all children and the Indigenous parents/carers. Based on the findings from this study, the intervention shows considerable promise as a resource for increasing resilience in Indigenous children through an increase in self-efficacy, albeit in relation to this single construct, namely safety.

Improving the safety of Indigenous children in urban areas is complex and currently not well understood. Intervention programs need to incorporate a much better comprehension of the broad range of factors that increase the vulnerability of urban Indigenous children. Inter-sectoral collaboration and partnerships between researchers and local service providers and Indigenous community organisations are essential components of program development in urban Indigenous communities. Sustainability depends on ongoing commitment by government, non-government and community sectors working together. Programs such as Safe Koori Kids need to be trialled in a broader range of settings.

References

ABS (Australian Bureau of Statistics) 2007 *Population Distribution, Aboriginal and Torres Strait Islander Australians 2006,* ABS, Canberra (Cat. no. 4705.0).

——2008a *Experimental Estimates of Aboriginal and Torres Strait Islander Australians, June 2006*, ABS, Canberra (Cat. No. 3238.0.55.001).

——2008b *Sydney A Social Atlas: 2006 census of population and housing*, ABS, Canberra (Cat. no. 2030).

Bin-Sallik, Maryann 2003 'Cultural safety: Let's name it!', *Australian Journal of Indigenous Education* 32:21–8.

Campbelltown City Council 2012 *Campbelltown City Community Atlas*, <www.id.com.au/campbelltown/commatlas/default.asp?id=208&pg=2> accessed 11 May 2012.

Clapham, Kathleen, Freidoon Khavarpour and Mark Stevenson 2006a *Injury Prevention and Safety Promotion for Urban Aboriginal Children and Youth in South Western Sydney*, AIATSIS Grant (G05/7047), AIATSIS, Canberra.

——, Freidoon Khavarpour and Mark Stevenson 2006b *Safe Koori Kids: Community based approaches to Indigenous injury prevention*, NHMRC Project Grant ID 402521, National Health and Medical Research Council, Canberra.

——, Kerin O'Dea and Richard D Chenhall 2007 'Interventions and sustainable programs' in B Carson, T Dunbar, RD Chenhall and Ross Bailie (eds), *Social Determinants of Indigenous Health*, Allen & Unwin, Sydney, pp.271–95.

Helps, Yvonne and James E Harrison 2004 *Reported Injury Mortality of Aboriginal and Torres Strait Islander People in Australia, 1997–2000*, Australian Institute of Health and Welfare, Adelaide.

—— and James E Harrison 2006 *Hospitalised Injury of Australia's Aboriginal and Torres Strait Islander People 2000–02*, Australian Institute of Health and Welfare, Adelaide.

Kalil, Ariel 2003 *Family Resilience and Good Child Outcomes: A review of the literature*, Centre for Social Research and Evaluation, Ministry for Social Development, Te Manutu Whakahiato Ora, Wellington, New Zealand.

Masten, Ann S and J Douglas Coatsworth 1998 'The development of competence in favorable and unfavorable environments: Lessons from research on successful children', *American Psychologist* 53:205–20.

Moller, Jerry, Neil Thompson and Janette Brooks 2004 *Injury Prevention Activity among Aboriginal and Torres Strait Islander Peoples, Volume 1: Current status and future directions*, Australian Government Department of Health and Ageing, Canberra.

PHCRIS (Primary Health Care Research and Information Service) 2003 *Dissemination Matters…Thinking beyond the project*, PHCRIS, Adelaide.

Pointer, Sophie, James Harrison and Claire Bradley 2003 *National Injury Prevention Plan Priorities for 2004 and Beyond: Discussion paper*, Australian Institute for Health and Welfare, Canberra.

Safe Koori Kids Project: Community Based Approaches to Indigenous Injury Prevention n.d. <www.georgeinstitute.org/safekoorikids> accessed 8 March 2012.

SIPP (Strategic Injury Prevention Partnership) 2001 *National Injury Prevention Plan: Priorities for 2001–2003*, Australian Government Department of Health and Aged Care, Canberra.

Walsh, Froma 1996 'The concept of family resilience: Crisis and challenge', *Family Process* 35:261–81.

Chapter 5

‘My people right here…’ Indigenous young people, alienation and paint sniffing in inner Brisbane

Tom Ogwang
Aboriginal and Torres Strait Islander Studies Unit, The University of Queensland

Leonie Cox
Queensland University of Technology

Jude Saldanha
Indigenous Youth Health Service, Aboriginal and Torres Strait Islander Community Health Service Brisbane Limited

Abstract: *This paper describes and explains the social worlds of a group of young Murris who are engaged in chroming (paint sniffing) and who sleep rough in inner Brisbane. In particular, the paper considers the ways young Indigenous drug users describe their marginalisation from wider society and its structures of opportunity, but it also includes some reflections from their youth worker and a young man who frequents the young people’s squat. The paper demonstrates the centrality of racism and material disadvantage to the experience of a group of young Aboriginal and Torres Strait Islander sniffers, a perspective largely unreflected in the literature on Indigenous volatile substance misuse. Further, the young people’s ways of interacting with the broader society are described to explain the ways their rejection of mainstream norms form a significant political response to their marginality and reflect, at least in part, the wider Indigenous historical experience. The work draws on theories of alienation and subculture to analyse the young people’s descriptions of their social estrangement and the formation of the ‘paint sniffer group’. It is concluded that paint sniffing among urban Indigenous youth is, at least in part, an obnoxious and encoded distillation of a wider Indigenous rebuttal of broader societal norms, and that the dominant — normalising — modes of treatment risk further alienating an already oppositional group of young people.*

Introduction

This paper is about a number of homeless young Indigenous people who, among other things, chrome and sleep rough under a bridge in inner Brisbane.[1] It is based on the findings of Honours degree ethnographic fieldwork undertaken in 2004 examining the impact of legislative responses to urban volatile substance misuse.[2] Here, we focus on the young people's interaction with broader society and examine how their self-estrangement forms a response to their ascribed subordinate, outcast status. We regard this self-estrangement as situated in the well-documented exclusion and dehumanisation of Aborigines and Torres Strait Islanders in Queensland (both before, and then under, 'the Act'[3]) and their marginalisation from structures of opportunity such as employment, higher education and other elite social networks (Kidd 1997; Cox 2000).

The fieldwork was undertaken at a sensitive time for relations between the young people, law enforcement personnel and the broader community. General alarm at the practice of chroming in Brisbane came to a fever pitch in 2003 when a group consisting mostly of Indigenous young people engaged in a range of behaviours (including open sniffing) in King George Square and the Queen Street Mall. These are major inner-city civic areas and the young people's actions were branded by the print media, police and the broader public as criminal, deviant and dangerous (Gregory 2004a:5; Heffernan 2004:6; Gregory 2004b:1, 9).

The media sensationalised the issue for the public and politicians alike to see. As D'Abbs and Brady (2004) argue, media portrayals of Indigenous sniffing as social disintegration drive a range of 'crisis' responses, and the treatment of paint sniffing in Brisbane was no exception. Press reports of particular sniffers' involvement in the criminal justice system, detailing inner-city rampages of assault, vandalism, theft and recidivism, were suggestive of crime sprees driven by urchin criminality among the entire group (Gregory 2004a:5; Heffernan 2004:6; Gregory 2004b:1, 9). The media described the young people's behaviour in moralistic terms, and exposed apparent parental inability to 'instruct them on the virtues of education' and 'a respect for justice and law', and argued that they were taught 'shamelessness, dishonesty and antisocial and abusive attitudes' (Gregory 2004a:5).

The young people's 'unruly' and intoxicated public behaviour before affronted inner-city workers confirmed media and wider reports of the sniffers' disregard for the law, and led directly to laws empowering police to remove young people found with paint in certain designated localities to a '*safe place*' (Queensland Government 2003).

This occurrence of urban Indigenous volatile substance misuse evoked the standard law and order and morality tropes that have long surrounded Indigenous volatile substance misuse. Equally, much attention is given to the psychodynamic issues surrounding Indigenous volatile substance misuse among the small body of literature on the topic (Maruff et al. 2004; Cairney et al. 2004; Drugs and

Crime Prevention Committee 2002; Carroll et al. 1998; Butt 2004). Given these circumstances, and the timing of the fieldwork in a storm of media-driven outrage at the young people's morality and disregard for law and order, this research sought to redirect the discussion from the young people's well-described pathos and criminality towards an examination of how societal responses recreate the social conditions conducive to sniffing. This approach questions the helpfulness of the medicalised deviance discourse that concerned civic leaders and therapeutic and welfare personnel create about the young people. Further, through providing an emic account the paper corrects the imbalance in the portrayal of sniffing (disintegration of morality, law and order, parenting) and sniffers (antisocial, harmful urchins) that saturated the public consciousness through popular news media. Thus this paper seeks to orient onlookers towards the voices of the young people and away from the pathologising, disciplinary gaze of the state (Foucault 1995) and the outraged concern of citizens widely seen in the popular media and academic literature.

Methodology: yarning the sniffers

This research utilised brief ethnographic methods with a group of 16 Indigenous young people aged between 14 and 18 years. Significant experience of public volatile substance misuse and 'sleeping rough' was a prerequisite for an invitation to participate. All the study participants had such experience and frequented an area under a bridge in an inner-Brisbane park at night. Access to the study group was enabled by an Indigenous community-controlled health service that provided nightly outreach to the young people in the park. The researcher accompanied the health service staff, enabling the young people to become familiar with the researcher and his aims. After a few nights of participant observation 'under the bridge', participants who were observed to sniff or consort with those sniffing were invited to participate in a focus group and in semi-structured one-on-one interviews. Question structures were a loose guide allowing interviews to follow conversation-like modes of interaction also described by many Indigenous people as 'yarning'. Wiradjuri mens' wellbeing worker Larry Maxwell Towney convincingly argues yarning can be used as a culturally appropriate 'approach to conversation' by therapeutic workers because it is an Indigenous narrative practice that 'is a very special and powerful way Aboriginal people connect' and is a 'unique part of our culture we have been practicing for many years' (Towney 2005:39–40).

The study adhered to National Health and Medical Research Council Standards for Ethical Conduct in Research Involving Humans, and to Standards for Research Involving Aboriginal and Torres Strait Islander Peoples, including informed consent. Indigenous community-controlled health services were closely consulted during the research design and implementation, and Indigenous youth workers known to the young people were nearby at all interviews to ensure participant safety.

Ethical approval was provided by a University of Queensland Ethics Committee, whose members agreed seeking parental consent for the participation of minors was inappropriate given the estrangement of the young people from their parents and families. Consent was provided by the young people themselves, who were given a written information sheet that was also verbally summarised for them to avoid the possibility of discrimination against participants with literacy challenges. Young people nominated themselves for participation in consultation with their youth worker, who assisted in ensuring intoxicated young people were excluded from participation while they were affected by volatile substance misuse.

'My people right here…' Under William Jolly Bridge

Much of the fieldwork for this research took place where the participants congregated at night, in Kurilpa Park — a narrow strip of land situated in inner-southern Brisbane between the river and the Paul's milk factory. First impressions of the park are of an orderly, clipped space with a curving concrete pathway leading past leafy subtropical gardens, mown grass areas and a barbecue-equipped gazebo offering million-dollar city views across the river. Kurilpa Park extends for some distance towards the city from William Jolly Bridge, and not-so-distant buildings remind the viewer that the park is a cosmopolitan thoroughfare emerging near the CBD at the arts precinct, Southbank and Victoria Bridge. Part of the Brisbane City riverside bikeway, the pathway is a thoroughfare for fluorescent walkers, joggers and cyclists, as well as urbane strollers perhaps coming from the arts precinct nearby or the city. These (mostly non-Indigenous) people are not to be seen here at night though, and for most Brisbane residents the evening view of the bridge and park from an outbound commuter train is the closest they get to the young people's world.

A closer look in the park reveals pavers missing, perhaps ripped out. Jagged names sit scratched in the gazebo; here and there wood is missing from the furniture; the concrete is covered in tell-tale splatterings of gold and silver paint. The bridge juts out from a bend in the river, and walking under it brings a modern but memorably unhygienic toilet facility into view around the corner. The area around the bridge foundations is strewn with clothes lying trodden into the dirt alongside flattened beer and wine cartons, broken fence palings and other flammables awaiting the next fire. Chrome-stained soft drink bottles sit squashed among the other detritus. The debris, vandalised facilities and trampled garden beds clearly signal to passers-by that this park, even when empty, is regularly inhabited by people who espouse values contrary to those of the wider society, including sobriety and disciplined daily work leading to the accumulation of a small amount of property (Young 1971; Lattas 1993).

At the time of data collection, the young Aboriginal and Torres Strait Islander people (who, along with many of their Queensland counterparts, describe

themselves as Murris) whose words are presented here regularly congregated under William Jolly Bridge to get 'smashed' and sleep out in the company of friends. They described an attachment to the space and to the other people who spent time there:

> You get addicted to this place man [pause] you always come here. You just wanna stay here, all your friends are here. When you come here you can do whatever you wanna do y'know, like, when you stay home, people there tell you what to do, do this or that, or go there. (Simon, 16)[4]

'Whatever they wanna do' is exactly what they get up to as they wander between constantly shifting micro groups. Often a few young people stood shoulder to shoulder in a semicircular arrangement facing the river, sucking paint fumes from coke bottles under their jackets and conversing among themselves before one went to investigate the action at the picnic table or, in the way of teen boys and girls, chase one another about. Not everyone was sniffing, but the majority down at riverside were on one intoxicant or another, each for their own reason:

> Everytime I come down here, I have fun, that's why I wanna come here for. (Michelle, 16)
>
> I come down here a fair bit. Mainly for friends and sniffing. It's the only place that's alright for sniffin. It's better here than the city — in the mall and King George Square you get pulled up by coppers and taken from there. (Rhianna, 14)
>
> Family and that, they come here to say hallo and that. Sometimes they hang around overnight, they don't sniff paint but, they just like to hang around and that. (Anita, 14)
>
> Down riverside, you get to do your own thing y'know and all that, all the uncles and aunties, all the blacks and all that, they just down the road in the hostels and s…t …so we alright down there. (Peter, 16)

'Three meals a day…' Class, culture and Indigenous youth alienation

The well-documented economic disadvantage of Aborigines and Torres Strait Islanders has a profound impact on the culture, life and everyday experiences of many, including these young people (SCRGSP 2005:S3 38–46). The young Murris in Kurilpa Park were aware of status and, when asked to describe the main differences

between themselves, as Murris, and white kids, drew clear links between Aboriginality and poverty:

> Like with white kids, they probably got more stuff than what I've got, or what every other blackfella's got, y'know. Yeah, they probly went to a flash school and, cruise around in the car with they mum, in a flash car or somethin y'know. Some blackfellas y'know, they walk. Walk everywhere. They get by with what they've got, y'know. But these whitefellas, they used to havin three meals a day man. C'mon [pause] like, f…k that. (Sarah, 18)

> They got it easy and we got it hard. They can do anything they like. They can go anywhere they like. They mother and father, they give em money anytime they want while we gotta like [pause] we gotta wait for payday. (Deanne, 16)

The young people's poverty is central to their experiences and observations, but their words also support Hall and Jefferson's (1976:11) understanding of culture as the way social groups develop distinct patterns of life and social relations, and express the raw material of their social and material life experience:

> We're very different. Like [in] the things we do, the way you react.
> Something different from them Australian [pause] Anglo Saxon people. They gotta be very clean y'know, very posh ay.
> Yeah, we're very different.
> *Different how?* [researcher]
> In the things we do, the way we react around other people.
> Like, just different. How they act [pause] how Murris act y'know. Their talk and y'know, how white people talk.
> We got our own little thing goin, y'know. We just do our own little thing, we don't worry bout their little thing.
> Nah, we don't even talk to em, all those rich poshy fellas. They all stuck up!
> (Focus Group: Patrick, 14; Rhianna, 14; Michelle, 16; Simon, 16; and Anita, 14)

Kleinman (1995:58) notes that culture can be thought of as 'lived meanings that are contested…really practices of ways of being-in-the-world'. He elucidates further that culture is 'moral context, process and performance' (Kleinman 1995:59). In this take on culture, as being about meanings that are fluid with and emerge from specific contexts, the young people's rejection and defiance of mainstream norms reflect their families' historical experience, since handed-down memories and stories are crucially part of this particular cultural context. As Marx notably argued, 'Men make their own history, but they do not make it as they please; they do not make it under circumstances

chosen by themselves, but under circumstances directly found, given and transmitted from the past' (Marx 1852[1978]:595).

It is well documented that the processes of the European colonisation of Australia included active and long-running attempts to incorporate Aboriginal people into the norms of European society (Lattas 1993:240). In Queensland, as Kidd (1997:175) tells us, 'Bylaws stated that every resident "shall observe habits of orderliness and cleanliness" and shall attend, and cause their children to attend, all medical examinations and treatments. [Aborigines must] keep a dwelling and surrounds neat and tidy "to the satisfaction" of the superintendent.' Through historically accumulated structures of social relationships and meaning, Indigenous people collectively experienced and interpreted the perpetration of immense indignity at the hands of the state and wider society.

As argued by Cowlishaw (1988), Morris (1989), Lattas (1993), Cox (2000) and others, Indigenous Australians continue to situate themselves within distinctive social and material domains in the face of the historical backdrop of humiliatingly imposed European cultural values and surveillance. Celebrating the Aboriginal reclamation of 'our history and place in Australian society on our terms', Huggins (1993:459) asserts:

> I detest the imposition that anyone who is non-Aboriginal can define my Aboriginality for me and my race. Neither do I accept any definition of Aboriginality by non-Aboriginals as it insults my intelligence, spirit and soul, and negates my heritage…There are no books written by non-Aboriginals that can tell me what it is to be Black as it is a fiction and an ethnocentric presumption to do so. I would never presume to know what it is to be white (except when I dine at the Hilton).

According to Cowlishaw (1988), aspects of contemporary Aboriginality include defiance of white cultural authority as powerless groups reclaim dignity by defining values in their own terms (see, for example, Fredericks 2004). In this way, prerequisites for dignified bearing may no longer include 'neat attire', for example — honour and esteem arise instead from shared experience and group integrity (Cowlishaw 1988:232).

Although there is considerable contact and shared experience with non-Aboriginal young people, the young people's vernacular and behaviour incorporate resistance to white norms and baffle the majority of their white peers (also see Cowlishaw 1988:236). When asked what keeps them from having many friendships with white kids, the young people at Kurilpa Park describe not being able to 'talk' to them:

> I understand where blackfellas are comin from. I rather choose my colour over anybody y'know like with them whitefellas. Because they don't understand, they never been there [pause] they can't say oh I understand how you're feeling because they don't. They're just [pause] they all ignorant. (Sarah, 18)

This feeling of isolation from the mores of the wider populace and its modes of communication is described by Indigenous young people across the country (see Palmer and Collard 1993:117). The young Murris in this study recognise that their materially disadvantaged and at times brutal experience of life leaves them estranged from their materially advantaged peers from early on. While talking about the characteristics of his peer group, some of whom were sniffing nearby, Peter was asked by one of the authors (TO) to explain what sets him apart from private school kids, and what imaginings he has of their perceptions of him. He explained:

> Those f…kin private school c…ts? They too f…kin uptight for me y'know…when I was small man [pause] ever since, y'know like, as far as I can remember man, since the day I was born [pause] we was always in and out of, f…kin like hostels, women's shelters. Because y'know different fathers, y'know five of us kids and all different fathers [pause] just all woman bashers y'know, so it was pretty hard for me to go to school and that. And I just look at them and they just look at me, when I'm walkin around y'know, they look at me [pause] they won't say anything but you can't really associate with other people y'know. Who knows what goes through their thick f…kin minds… (Peter, 16)

School forms an important part of early socialisation and provides the context for growth through important formative phases of life, forming the earliest interactions with institutions and wider society for many of us (Brake 1985:61). It is a cornerstone of preparation for life and work and, to that extent, acts to mould children into compliant subjects of the dominant order through its ideological goals of imposed discipline, etiquette and acceptance (Moysey 1993). It is common, as Moysey (1993:15) points out, for children to be 'taught to obey petty rules and regulations, to wear a uniform, to adopt a particular attitude, to behave in a particular way'. In schools, instructors predominantly drawn from (and reflecting the values of) the wider populace use domination to instil values such as individual achievement, autonomy and personal growth, all useful in capitalistic society but arguably dysfunctional for much of Aboriginal Australia (Saggers and Gray 1991:81).

In contrast, Indigenous culture places such strong emphasis on the autonomy of the individual in modes of parenting and conduct in interpersonal relations that 'individuals are, at times, allowed to harm themselves, and to disrupt the flow of daily life for others' (Brady 1991:74). Responding to questions about why they had not been to school lately (no participant had), the young Murris at Kurilpa Park variously described a range of factors, in particular enforced conformity, that they found unacceptable:

> Teachers just kept telling us what to do [pause] they think they can tell us what to do man. I hate that s…t. When they do I just don't listen, I just sit there. I just don't like wearin a uniform and s…t too, some schools you gotta wear black shoes and s…t, I don't like that sorta s…t man. (Mitchell, 17)

> I was doing a TAFE course but it was just too much for me, people lookin over my shoulder, sayin 'good work, blaah blaah'. It was just [pause] y'know too much for me. I like to do my own thing y'know like, no one telling me what to do [pause] like use a ruler, use a rubber, blah blah. People looking over my f…kin shoulder n s…t. Too much [pause] too much pressure. (Peter, 16)

At odds with institutional environments characterised by petty rules and conformity, the young people also found themselves alienated by dominant modes of communication used by teachers and peers, which, to characterise, this young person used emphatically scornful intonation and body language:

> I don't like the way people go at school, man. Like how they f…kin chit chat and all that sort of s…t [pause] how they carry on and s…t. (Mitchell, 17)

Hence, for many young Indigenous people school is the first significant encounter with institutionalised white cultural authority and presents the first significant opportunities to violate customary dictates of the dominant culture. In the following quote, the young man shows his alienation from, and pours scorn on, a classroom culture to him characterised by teacher rewards and in-jokes. His aggressive intolerance towards his giggling classmates reflects a rejection of what they value and find humorous, but also reveals frustration at the relative privilege expressed in their childish sensibilities. His anger was expressed at lunchtime through crunching tackles:

> And in primary school you know how whitefellas got like a little (reward) sticker [pause] at everything? Everything's really 'teeheeheeheeeheee'. Us blackfellas must be real serious people cos we just go 'what's so funny about that? Stop f…kin giggling you c…k heads! This next c…t giggles I'm gonna kick him in the f…kin back y'know.' Someone would do something, and everyone be giggling. I heard it. It wasn't funny. Wait for lunchtime, we'll play football [pause] I used to have a field day, take out all the c…ts I hated. I used to just spend the lunchtime just takin out every c…t to get rid of my frustration. (Young man, 24)

Marx's theory of alienation has particular relevance to the experience of these Indigenous young people. His original ideas relating to the deadening effect of labour have generated discussion of alienation as a subjectively identifiable psychological state involving feelings of powerlessness, isolation, meaninglessness, normlessness, self-estrangement and discontent (Marshall 1998:14). Beset with shame, relative poverty, cultural isolation, oppression, anger, hopelessness and helplessness, the young people employ violence to vent frustration and redress imbalances of power institutionalised by teachers. While discussing relations with their peers at school, the young people overtly situated a range of violent actions within the search for respect and dignity:

> At school, y'know how it's like [pause] you feel like you gotta prove somethin to other people y'know. That kinda s…t, that just got me into trouble y'know [pause] like the first day I went to school, when we was in women's shelters…and the first day I turned up there and enrolled [pause] f…kin, I was doin high jump but I missed it and this cheeky little s…t just givin me s…t so I just turned around and f…kin boom! Busted him man [pause] got expelled then, just like that…(Peter, 16)

> What can you do when you the only blackfella at school? White c…ts, you just f…kin bash em, you just f…kin bash the respect out of em [pause] that fear will do for respect. Not gonna listen to me, I'll smack the c…t outta ya. They listen then. (Young man, 24)

> Yeah I wanna get back into school but I can't. I got caught smokin yarndi in the toilets [pause] I got suspended coupla times [pause] I backed this fella up when we was avin a fight with these Chinese c…ts [pause] and white c…ts too, at school, me and him fightin em [pause] we was drillin em man [pause] I dropped a few of em too… (Joseph, 15)

The search for respect through violence demonstrates how the young men's acts mirror the violence of enduring mainstream exclusion in what they perceive as wholly hostile environments. Expulsion from school is a predictable result of these antisocial coping strategies, and a picture of exclusion from mainstream structures of opportunity emerges when the young people are asked why they did not go to school today:

> If I had a job, I wouldn't be doin this s…t [sniffing] [pause] I rather do that job and s…t, I rather be employed and s…t, but see I can't get into school [pause] no one will sign me up for school. (Joseph, 15)

> I do wanna go to school, but right now I haven't got time for it, cos they haven't got time for me. (Deanne, 16)

'I'm old enough to sniff man, you don't tell me what to do…' Sniffing style, alienation and the general public

When paint sniffing in central Brisbane came under the mainstream media gaze in 2003, there was no doubt of the horror evoked by these young people's public rebuttal of mainstream codes of decency (Gregory 2004a, 2004b; Heffernan 2004). Prior to amendments to public space laws aimed at ending their occupation of King George Square, the young people congregated before office workers and other ostensibly 'good' citizens to act out all manner of 'uncouth' behaviour:

> When ya high [pause] like y'know, ya hallucinatin there [pause] hallucinatin bigtime, its mad man [pause] but f…kin, yarndi's better [pause] but sniff's alright man, it gets ya high [pause] yeah, at least it gets ya high [pause] and grog man, that f…kin gets ya f…kin spinnin, that's mad s…t [pause] get charged up, stagger round the place. (Joseph, 15)
>
> When I was sniffin it was so mad, y'know. You could walk around and just be like whackin on and everything. (Sarah, 18)
>
> When we sniffed out we all fight each other. (Michelle, 16)
>
> Sometimes when we charged up and sniffed up we have fights amongst each other [pause] we have lots of fights round here [pause] when they drink too much, they mouth gets out of control [pause] sometime other person like brothers or sister or elders stop us. (Simon, 16)

Sniffing paint in public was one of a range of the young people's illicit behaviours, which, through strong public reactions, confirmed for them a kind of embodied outlaw identity. When asked about passer-by reactions to her open paint sniffing, this former sniffer indicated keen awareness of the effect of her behaviour (seen by her as *who* she is), and showed how it reaffirmed her commitment to a disregard for mainstream values:

> Yeah lotta people used to look, it was weird though to have people lookin at ya while you're doin it. Like I used to go *hey don't go f…kin lookin at me, what you never seen a blackfella before?* But they never seen a blackfella *sniffin* before. And that's why they lookin. They probly thinking *oh I feel sorry for her, look at her she's just totally lost her life*. But I didn't care about what people thought, y'know. I just cruise around. If they don't like ya for who y'are then just don't worry bout them. (Sarah, 18)

Aborigines who fail to express and uphold orderliness and socially respectable norms of the dominant culture through dress, manner, speech and other public behaviour are subject to wider societal expressions of disapproval (Cowlishaw 1988). Whenever they left the squat at Kurilpa Park, the young people experienced strong responses from the general public to their behaviour and presence:

> Everytime we're like [pause] oh well mostly, they give us dirty look when we walk around in public with sniff, and like when we sit on the train it's [pause] when we jump on, you can tell everybody's gettin angry cos their face, all them white people, their face goes red.
> The facials, and the way they look at us ay.
> How they turn around and swear at ya [pause] turn around and swear at ya when ya don't even really expect it.
> (Focus Group: Simon, 16; Michelle, 16; and Anita, 14)

> Like…if they [white people] see ya smoking, and they don't smoke…they don't like it cos ya smoke, or sniff, or cos ya smoke yarndi, or drink or something. (Joseph, 15)

Such outraged public responses build the young people's sense of alienation in a spiral of deviance amplification[5] that can be seen in this young person's description of general public reactions to his sniffing:

> It depends what person it is you're talking to [pause] like, just cos we're sniffers, f…kin they don't like it that we sniff. I don't even carry on at them, like they carry on and when they carry on, when they wanna bring it, I'll bring it [pause] if they wanna, thing [pause] slug it out, I'll slug it out. If they leave me alone, I leave them alone. (Joseph, 15)

Through such behaviour, this young man confirms wider perceptions of him — he is part of a dangerous, lawless group of people best avoided or incarcerated. Their sense of injustice suitably inflamed, the young people enact more overt forms of resistance, and the more they behave with disdain for establishment values, the more 'good' citizens baulk with filthy looks and unexpected rants. When the focus group participants were asked what they think when people give them dirty looks, they responded:

> F…k em.
> Feels like we wanna smash em.
> Don't worry about em. Pooh on their grave haha.
> First we'll just say like, *whatta you lookin at*, like, *look at this slut ere look*.
> (Focus group: Anita, 14; Simon, 16; and Michelle, 16)

The social reaction to non-sanctioned methods of demonstrating allegiance to contrary values is one of outraged rejection, as with this establishment voice (Street 2005):

> Confrontational behaviour — whether by gesture, speech or T-shirt slogan — is almost always offensive. There is room for tolerance in contexts such as the Gay and Lesbian Mardi Gras, but current community standards are affronted by intentionally intimidating or shocking conduct. The T-shirt can be a vehicle for gentle levity, but deliberate affronts are simply not acceptable. Those who perpetrate them are best avoided. — Sir Laurence Street, former NSW Chief Justice.

Establishment disapproval of alternative meaning systems and modes of expression, merely asinine as expressed above, is a regular and perilous part of the young people's lives. A number of the young people shared experiences of police brutality, stories made plausible by the well-documented systematic entrenchment of racism, corruption and misconduct and a culture of silence in the Queensland Police Service[6] (Cunneen 2001).

Indigenous people are prosecuted under 'public order' legislation much more than non-Indigenous people, and studies have consistently found Indigenous people are many times more likely to appear in court for petty offences and to become incarcerated than their non-Indigenous counterparts (AIHW 2008; White 1999). Lattas (1993) argues the outraged responses that culminate in savage over-policing, bordering on moral panic, reveal the threat these subversive acts pose against the established order, situating it among the few forms of power Aborigines have over whites.

While the broader society reacts to the sniffers with expressions ranging from disapproval to outrage and outburst, the young people closely watch how they are perceived as they turn a number of everyday items into the accoutrements of ostensibly scandalous drug use. The investment of meaning in everyday items, so they symbolise a threatening assertion of individuality, is encapsulated by Hebdige's (1979) 'bricolage' — the subcultural reinvestment of everyday items with new, threatening meaning through their use as part of style. Described among punk subcultures of 1970s Britain, household objects with ordinary meaning, such as safety pins, garbage bags and more, were taken out of their familiar context for use as provocative bodily adornment or dress (Hebdige 1979:107). As Hebdige (1979:105) notes, 'the motor scooter, originally an ultra respectable means of transport, was turned into a menacing symbol of group solidarity…metal combs, honed to a razor-like sharpness, turned narcissism into an offensive weapon'. One method of sniffing paint is to spray the aerosol paint into a plastic soft drink bottle until there is enough to swill around at the bottom. The swilling motion gives rise to fumes that are inhaled through the mouth, and the young people often, but not always, conceal the bottles under their clothing while they sniff. Even when it is concealed, the bulging jacket makes apparent there is a hidden, suggestive of illicit, object held inside the jacket by the arm missing from a tracksuit sleeve. The mouth enters the jacket top occasionally to inhale fumes, in what onlookers could mistake for a close examination of the ground. To middle class sensibilities, it is perhaps not widely considered a good look. Incorporating such overt drug use and intoxicated demeanour into their style provokes the kind of interchange and rugged assertion of individuality seen earlier and in this young person's response to public criticism:

> People try tell me off for sniffin, but they can't. If they try tell me, put that bottle down there, blaah blaah [pause] I just tell em, I'm old enough to sniff man, you don't tell me what to do [pause] you'll never f…kin stop me from sniffin, you and me have a fight, c…t. (Joseph, 15)

Hence, in the paint-stained hands of young Indigenous sniffers, plastic soft drink bottles became menacing symbols of defiance — grounds for a fist fight, if you dare — that passers-by could observe any night of the week in King George Square. It is, of course, legal to be in possession of a pipe used for smoking tobacco. Once used for illicit drug taking, such a pipe is an 'implement' unlawful to possess. Through public

sniffing, the young people transform mundane drink bottles and aerosol paint cans into 'implements', obnoxious objects that sinfully reject social norms without breaking the law. Such bricolage adds offensive layers to the young people's reportedly raucous (Gregory 2004a, 2004b) behaviour and subscription to the broader Indigenous defiance of white cultural authority. Dutifully chronicled by a tabloid press practised in imbuing 'folk devil' status (Cohen 2002), the entire protestural act was then quickly crushed by police applying new 'public nuisance' move on powers introduced to eradicate sniffers in the inner city.[7]

'…someone who they can connect with' — the way back from here

Reflecting on the implications of these dynamics for program responses to sniffing, the dominance of the medicalising gaze (Foucault 1975) in assessment of, and responses to, paint sniffers has disabled consideration of the young people's contemplated revolt against the norms of a society they perceive does not serve them. In all of the energy expended situating the sniffers squarely in a deviance discourse and responding to them accordingly, a message of care fails to emerge from the services aimed at them. Care — as the young people perceive it — we suggest is a better genesis for service frameworks than the standard moral outrage and desire to restore order. As Sarah (a former sniffer) pointed out, in among the bravado and assertions of individuality that reject mainstream norms, sniffing can be a vulnerable request for care:

> I think it is a cry for help. I really wanted help [pause] like I'd push people away but I still wanted their help. I didn't want them to give up on me. I think with these kids they just need to talk to someone about it. They just need someone who they can connect with. (Sarah, 18)

The way back from here for the young people is one of connectedness with a community (particularly welfare and law enforcement) that engages them on their terms. The young people revealed how 'good citizens', among them health and welfare workers, teachers, police and the legislature, often succumb to the temptation to react to the far-out behaviours with value judgments and affronted sensibilities. We have seen how such hostility alienates the young people from early life, and it is argued that it provides sniffers further basis for a cycle of response congruent with wider strategies undermining European attempts to eradicate Indigenous culture. Such Indigenous response is unsurprising given the disastrous outcomes of longstanding attempts to eradicate Indigenous culture and collective memory.[8]

Attachment to traditional culture, on the other hand, gives significantly better outcomes in many indicators of wellbeing, including health and the likelihood of

risky alcohol use (Dockery 2009:22). Hence, we argue lasting solutions to issues the young Indigenous people describe here are, at least in part, to be found in the protective mechanisms of contemporary and traditional Indigenous culture, and are best developed and implemented on their terms.

Engaging the young people in such a way is not impossible for members of the wider community, as the young people also made evident a strong social conscience. Asked what they would do to make people in Brisbane stop sniffing if they were the Lord Mayor, the young people responded:

> That's a hard question. I dunno what I'd do. *Should the lord mayor stop sniffing*? Yep. I reckon he should stop sniffing. He's got people to think of, and he's got the community to think of. And umm. Yeah. (Deanne, 16)

> Make it, if you get caught with sniff you get sent to jail. (Joseph, 15)

Also emerging was a capacity to put others before themselves, despite considerable discomfort, revealing a softness and humanity among the young people that goes unremarked in the medicalised deviance discourse:

> I'm the eldest out of my brothers and sisters and that. And like, that's why I don't go home for ages, cos I don't want them to sniff [pause] cos they all go to school and I don't, I want them to get an education and all that. (Scott, 15)

For the therapeutic and alcohol and other drug workforce, connecting and engaging with the young people requires reflection on the treatment frameworks' subconscious emphasis on conformity to the dominant culture's expected standards of behaviour. Awed by a spectacle of self-destruction, practitioners often drawn from (and reflective of) the mainstream do not consider its rational, empowering rejection of a disdainful mainstream cultural hierarchy. Programs 'treating' paint sniffers, often established in moral indignation and panic seeded by the popular media, overtly or otherwise offer salvation through pathways into the very orthodoxy that motivates such embodied resistance.

More broadly, public health policy and program personnel must increase their knowledge of, and operation within, models authentically inclusive of Indigenous societies and their values. Such wider perspectives, as Lattas (1993:18) argues, may require some reflection on a history of violence directed at all forms of 'difference':

> Believing himself to have transcended his history and his own culture of violence, the white man cannot stand to listen to people asserting their essential otherness. He accuses them of inviting their own murder and of threatening to call a holocaust on themselves. He projects his own fear of himself onto the Other and denounces

> them for threatening to call up a monstrous part of himself…[this] difference is what the white man finds horrifying because it invokes the history of his own intolerance to it.

Ethnographic research is an essential aspect of sound policy and program design. Better understanding of the lived experiences of drug users and other marginalised people (including understanding of social benefits of drug use) is indispensable to the development of effective care frameworks and, further, has value in a neoliberal climate where individual pathology is the measure of a range of social ills. Without discounting here the young people's profound personal traumas, studies reflecting on the young people's perspectives are few among many examining what is wrong with them.

Conclusion

This paper presents the voices and experiences of a group of Indigenous young people who sniff paint and sleep rough in inner-urban Brisbane. The temptation to pathologise them, or loyally reproduce the 'folk devil' incantations of the popular press, is avoided here in favour of an analysis that situates far-out behaviours within the sphere of the rational. The young people's voices, not well represented elsewhere in the literature, give account of shared interpersonal and structural factors that humiliate and anger them, and leave them alienated from non-Indigenous peers and the mainstream society.

Excluded from school and other mainstream structures of opportunity, the young people form social groups and, united by a particular class culture, enact behaviours — among them paint sniffing — that affront the populace. Such affronts are an obnoxious distillation of the well-established wider Indigenous rebuttal of white cultural authority and its attempts to control the Indigenous subject. Conventional approaches to volatile substance misuse, particularly legislative and normalising therapeutic approaches, are failing young Indigenous people by furthering their outlaw status and subcultural identity.

The young people's drug use and resultant intoxicated behaviour, and their violent social identity, is a bravado-filled reflection of a violent mainstream rejection. The non-Indigenous community makes commendable progress to bring such rejection to a close by ending the pernicious denial of its existence through a national apology to the Stolen Generations (Hansard 2008). While not so bold as to make specific recommendations here, evidence clearly shows connectedness to culture is a protective factor for Indigenous people. With that in mind, non-Indigenous modes of engagement need reinvigoration to enable authentic inclusiveness of Aboriginal and Torres Strait Islander peoples, cultures and values.

Acknowledgments

R.I.P. 'Mitchell, 17'.
Heartfelt gratitude is expressed to the young people who generously shared their stories. This research was supported by the Cooperative Research Centre for Aboriginal Health. Thanks also to the deadly Youth Health team at Aboriginal and Islander Community Health Service Brisbane for fieldwork support, and to the Queensland Aboriginal and Islander Health Council based National Health and Medical Research Council Centre of Clinical Research Excellence for support during writing. Many thanks also to Honours research supervisors Dr Mark Brough and Dr Leonie Cox.

References

AIHW (Australian Institute of Health and Welfare) 2008 *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2008 Report*, AIHW and Australian Bureau of Statistics, Canberra.

Brady, Maggie 1991 'Drug and alcohol use among Aboriginal people' in Janice Reid and Peggy Trompf (eds), *The Health of Aboriginal Australia*, Harcourt Brace Jovanovich, Marrickville, NSW, pp.173–217.

Brake, Michael 1985 *Comparative Youth Culture*, Routledge and Kegan Paul, London.

Butt, Julia 2004 *Summary of Findings from the Get Real Challenge Evaluation*, UniQuest and Brisbane City Council, Brisbane.

Cairney, Sheree, Paul Maruff, Chris Burns, Jon Currie and Bart Currie 2004 'Neurological and cognitive impairment associated with leaded gasoline encephalopathy', *Drug and Alcohol Dependence* 73(2):183–8.

Carroll, Annemaree, Stephen Houghton and Peta Odgers 1998 'Volatile solvent use amongst Western Australian adolescents', *Adolescence* 33(132):877.

Cohen, Stanley 2002 *Folk Devils and Moral Panics: The creation of the mods and rockers*, Routledge, London.

Cowlishaw, Gillian 1988 *Black, White or Brindle: Race in rural Australia*, Cambridge University Press, Melbourne.

Cox, Leonie 2000 Freeloadin' for Tea, Freeloadin' for Children, Freeloadin' for Tribe: Bureaucratic apartheid and the post-colonial condition, unpublished PhD thesis, Department of Anthropology, The University of Sydney.

—— 2007 'Fear, trust and Aborigines: The historical experience of state institutions and current encounters in the health system', *Health and History: Journal of the Australian and New Zealand Society for the History of Medicine* 9(2):70–92.

Cunneen, Chris 2001 *Conflict, Politics and Crime: Aboriginal communities and the police*, Allen & Unwin, Crows Nest, NSW.

D'Abbs, Peter and Maggie Brady 2004 'Other people, other drugs: The policy response to petrol sniffing among Indigenous Australians', *Drug and Alcohol Review* 23(3):253–60.

Dockery, Alfred M 2009 *Culture and Wellbeing: The case of Indigenous Australians*, Centre for Labour Market Research, Curtin University, Perth, <www.business.curtin.edu.au/clmr>, accessed 20 February 2009.

Drugs and Crime Prevention Committee 2002 *Inquiry into the Inhalation of Volatile Substances — Final Report*, Victorian Government Printers, Melbourne.

Foucault Michel 1975 *The Birth of the Clinic: An archaeology of medical perception*, Vintage Books, New York.

——1995 *Discipline and Punish: The birth of the prison* (2nd edn), Vintage Books, New York.

Fredericks, Bronwyn 2004 'Urban identity', *Eureka Street: A Magazine of Public Affairs, the Arts and Theology* 14(10):30–1.

Gregory, Jason 2004a 'Don't blame it on the children', *Courier Mail*, 7 February, p.5.

——2004b 'Homeless find space among city decay', *Courier Mail*, 6 November, pp.1, 9.

Hall, Stuart and Tony Jefferson 1976 *Resistance through Rituals: Youth subcultures in post-war Britain*, Hutchinson, London.

Hansard (Commonwealth) 2008 (13 February) 'Apology to Australia's Indigenous peoples' in *Parliamentary Debates* of the 1st session of the 42nd Parliament, Canberra.

Hebdige, Dick 1979 *Subculture: The Meaning of style*, Methuen and Co. Ltd, London.

Heffernan, Ryan 2004 'Two worlds collide in the city: Runaways living hard on the streets', *Courier Mail*, 6 November, p.6.

HREOC (Human Rights and Equal Opportunity Commission) 1997 *Bringing them Home: Report of the National Enquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, HREOC, Sydney, <www.humanrights.gov.au/pdf/social_justice/bringing_them_home_report.pdf> accessed 24 February 2009.

Huggins, Jackie 1993 'Always was always will be', *Australian Historical Studies* 25:100, 459–64.

Kidd, Rosalind 1997 *The Way We Civilise: Aboriginal affairs: The untold story*, University of Queensland Press, Brisbane.

Kleinman, Arthur 1995 *Writing at the Margin: Discourse between anthropology and medicine*, University of California Press, Berkeley, Los Angeles, London.

Lattas, Andrew 1993 'Essentialism, memory and resistance: Aboriginality and the politics of authenticity', *Oceania* 63(3):240–68.

Marshall, Gordon 1998 *Oxford Dictionary of Sociology*, Oxford University Press, Oxford.

Maruff Paul, Chris Burns, Paul Tyler, Bart Currie and Jon Currie 2004 'Neurological and cognitive abnormalities associated with chronic petrol sniffing', *Brain* 121(10): 1903–17.

Marx, Karl 1852[1978] 'The Eighteenth Brumaire of Louis Bonaparte' in Robert C Tucker (ed.), *The Marx-Engels Reader* (2nd edn), WW Norton and Company Inc., New York, London, pp.594–617.

Morris, Barry 1989 *Domesticating Resistance: The Dhan-gadi Aborigines and the Australian state*, Berg Publishers, Oxford (Explorations in Anthropology Series).

Moysey, Sean 1993 'Marxism and subculture' in R White (ed.), *Youth Subcultures: Theory, history and the Australian experience*, National Clearinghouse for Youth Studies, Hobart, pp.11–18.

Ogwang, Tom, Leonie Cox and Jude Saldanha 2006 'Paint on their lips: Paint sniffers, good citizens and public space in Brisbane', *Journal of Sociology* 42(4):412–28.

Palmer, Dave and Len Collard 1993 'Aboriginal young people and youth subcultures' in R White (ed.), *Youth Subcultures: Theory, history and the Australian experience*, National Clearinghouse for Youth Studies, Hobart, pp.114–21.

Queensland Government 2003 *Police Powers and Responsibilities and Other Legislation Amendment Bill* 2003, Queensland Government Printers, Brisbane.

Saggers, Sherry and Dennis Gray 1991 *Aboriginal Health and Society: The traditional and contemporary Aboriginal struggle for better health*, Allen & Unwin, St Leonards, NSW.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2005 *Overcoming Indigenous Disadvantage: Key indicators 2005*, Productivity Commission, Canberra.

Street, Sir Laurence 2005 'Modern dilemma', *Weekend Australian Magazine*, 5–6 February, p.10.

Towney, Larry Maxwell 2005 'The power of healing in the yarns: Working with Aboriginal men', *International Journal of Narrative Therapy & Community Work* 2005(1):39–43.

White, Rob 1999 'Indigenous youth and offensive spaces', *Social Alternatives* 18(2):39–43.

Young, Jock 1971 'The role of the police as amplifiers of deviancy, negotiators of reality and translators of fantasy: Some consequences of our present system of drug control as seen in Notting Hill' in S Cohen (ed.), *Images of Deviance*, Penguin, Middlesex, pp.27–61.

Notes

1. Chroming (to chrome) is a colloquialism describing the deliberate inhalation of the intoxicating volatile fumes from metallic aerosol paint.
2. See also Ogwang et al. 2006.
3. Queensland's *Aborigines Protection and Restriction of the Sale of Opium Act 1897* and an evolving complex legislative framework (see Cox 2007).
4. Pseudonyms used for all young people quoted here.
5. Deviance amplification occurs when a group of alienated people (particularly young people), inspired by a sense of injustice at societal responses to their deviance, increase their provocative profile. This increases the original alienating societal response, which in turn increases the group's isolation, and so on (Young 1971).
6. Widespread police maltreatment of Indigenous people in Queensland is perpetuated by 'unbridled racism' and a culture of silence that allows individual officers to exhibit 'obsessional hatred' for Aborigines and 'become notorious' for bashing and arresting them without reason (Fitzgerald, 1989, Royal Commission into Aboriginal Deaths in Custody, Ministerial Summit on Indigenous Deaths in Custody 1997 in Cunneen 2001, pp.131–47).

7. See Cunneen (2001) for contextualisation of the acrimonious relations between police and Indigenous people.
8. *The Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* reports the legacy of child removal policies — a deliberate attempt to discontinue Indigenous cultural practice — revealing significantly higher likelihood of recent arrest, lower employment, poor health and alcohol and other drug abuse among Stolen Generation members and their descendants (HREOC 1997:12–14).

Chapter 6

After the final siren: The power of sport to reduce chronic disease for Aboriginal and Torres Strait Islander men

Brian F McCoy
La Trobe University
Randal Ross
James Cook University
Jacinta Elston
James Cook University

Abstract: *Popular descriptions of contemporary Aboriginal and Torres Strait Islander communities often depict those who live in remote, rural and urban communities as being essentially different from one another.*[1] *Remote communities can be seen to be more 'traditional', enjoying greater social and cultural wellbeing. At the same time they can be seen to be removed from key urban services and isolated from valuable health resources. Apart from these differences, men across these diverse communities share two things in common: a great interest in sport and alarming signs of early onset chronic disease. The health of all Aboriginal and Torres Strait Islander men across the nation remains generally poor and their future health remains a critical challenge. There is substantial evidence that suggests that many Aboriginal and Torres Strait Islander men invest themselves quite deeply within the social arena of sport. Sport has become much more than a game. Understanding how these young men engage with sport can offer valuable insights into the development of more effective and healthy social pathways. It suggests a range of strategies to prevent the early onset of chronic disease.*

Introduction

In 2008 two Aboriginal and Torres Strait Islander researchers, Randal Ross and Jacinta Elston, and I returned to examine the health of men who had shared in a

significant sporting and community experience 25 years before (McCoy et al. 2008, 2009). In 1983, with significant support from the local Aboriginal and Torres Strait Islander community, the Under 17 Garbutt Magpies Australian Rules football team went on tour to Melbourne. Most of the members of that Touring Side were Aboriginal and/or Torres Strait Islander men. The results of this research were later published in the community report *Boys to Men: Garbutt Magpies twenty-five years on* (McCoy et al. 2008). In 1983 I happened to be the coach of that Touring Side. Randal was a member and Jacinta's two brothers were also members. In our research we wanted to explore the remembered experiences of the men from that time and whether the experience had made any long-term or significant differences to their health.

Sport (and, for the purposes of this paper, Australian Rules football) engages many Aboriginal and Torres Strait Islander people in this country (Gorman 2005; Hallinan and Judd 2009; Judd 2005, 2007). Their extensive involvement and relative over-representation in the Australian Football League (AFL) is one example. In the 2011 Toyota AFL Premiership Season, Aboriginal and Torres Strait Islander players comprised 11% of all players. There are currently 90 000 participants involved in Australian Football programs (AFL 2011). This involvement did not come easily or quickly. While sport has often been perceived as a game, a leisure activity, and a time for relaxation and enjoyment, it has also been infected with racism and discrimination. While much has been achieved in overcoming those barriers, some remain. So, overcoming those discourses that separate sport from its implications for community health and wellbeing also remains.[2] While health can often be understood in relation to 'physical bodies', it can also share important connections with social, gendered and educational bodies as well. Its health outcomes move beyond the realm of the physical.

The Clontarf Foundation, which began as a sporting academy to introduce Aboriginal and Torres Strait Islander young men to education, and which began with 25 boys in Perth in 2000, now involves more than 2200 in 36 sporting academies spread throughout Western Australia, Victoria and the Northern Territory (Clontarf Foundation 2010). Its urban centres include Alice Springs, Katherine, Geraldton, Broome and Perth. The growth of this academy, and its ability to link sport with education and later employment, has shown some remarkable results. In one school the proportion of Aboriginal students rose from 14% to 40% in three years. Discipline problems dropped and attendances greatly increased (McFarlan and Vitale 2009:10).[3]

Sport can also, for young Aboriginal and Torres Strait Islander men, draw them away from personal and social influences that cause them great harm (McCoy 2008).[4] It can protect them and also provide them with physical, as well as social, wellbeing. As discovered in the Garbutt Magpies project, young men can experience 'safety' within the social space of a sporting club, more than they experience within the contexts of alcohol, violence and abuse in some home situations (McCoy 2008). In the words of the Melbourne-based Fitzroy Stars Football Club coach Alan Brown, a number of young men who play football also experience serious health and social

problems. However, when involved in the football club, 'they stop doing all sort of stuff' (Knowledge Transfer Group 2009).

The place of sport in a young Kimberley man's life is reflected in a painting by Lawrence Lulu Tjangala (Figure 1).[5] Here, he has described his range of interests. They include alcohol and tobacco (lower centre). These potentially harmful influences sit quite comfortably with his other interests, including church (upper left), education (upper centre), hunting (lower right) and men's ceremonies (lower left). Football (upper right) holds another key space in his life.

Figure 1: Painting by Lawrence Lulu Tjangala, 2003

As with the comments by Alan Brown previously quoted, this painting is a reminder that not only is sport a key ingredient in the lives of many young Aboriginal and Torres Strait Islander men, but it can also provide a choice. Many young men are known to have given up or put aside competing interests in order to play sport (McCoy 2008).[6] Football can provide one of the most inviting and engaging social experiences for many young Aboriginal and Torres Strait Islander men, across very different urban, remote and rural communities and across all states and jurisdictions. What urban communities and research can offer is a better understanding of that engagement between sport and the community that gathers around it, and also how to support more healthy pathways for young men through their involvement in sport.

Before exploring how this engagement between sport and health might be better understood and further developed, some further comments need to be made in terms of the context of young Aboriginal and Torres Strait Islander men's health.

The health of young Aboriginal and Torres Strait Islander men

First, across Australia young Aboriginal and Torres Strait Islander men begin to disengage from clinic and health care as they enter adolescence (Figure 2).

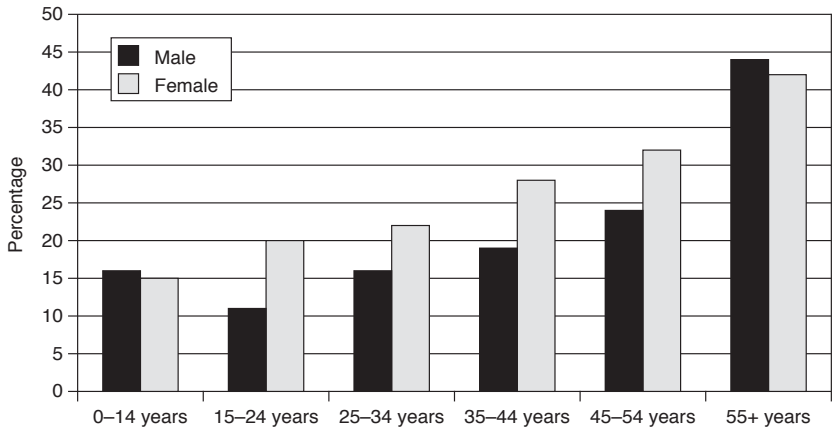

Figure 2: Indigenous use of general practitioner and specialist services (Lingwoodock 2007)[7]

The patterns of disengagement of men differ quite markedly from the patterns of engagement by women, who gradually increase involvement as they get older. It is only after the age of 55 that men show an increase in engagement over women and a long-neglected attention to their health suggests why this may occur.

Second, the current status of Aboriginal and Torres Strait Islander men's health remains critical. One-third of young Aboriginal and Torres Strait Islander men currently aged 15 will be dead before age 60, compared to 8% in the overall Australian population (Vos et al. 2007:vii), a rate four times higher. As we discuss a little later in this paper, key aspects that affect men's health and early onset chronic disease begin to appear at the same time that many are also being engaged in sport and the culture of sporting clubs.

Third, when the three major high-risk health factors for health are combined—that is, when tobacco, obesity and alcohol co-exist and interact—their combined effect contributes to 37% of the total burden of disease and injury in the Aboriginal and Torres Strait Islander community (ABS and AIHW 2008:148). As shown in the following graphs, these are three risk factors that particularly affect the health, and subsequent life expectancy, of Aboriginal and Torres Strait Islander men.

Tobacco

The leading cause of burden and injury for Aboriginal and Torres Strait Islander men's health is the smoking of tobacco (ABS and AIHW 2008:138). As Figure 3 shows, a very clear gap between Indigenous and non-Indigenous male rates of smoking begins with the high rate of smoking by young Indigenous men.

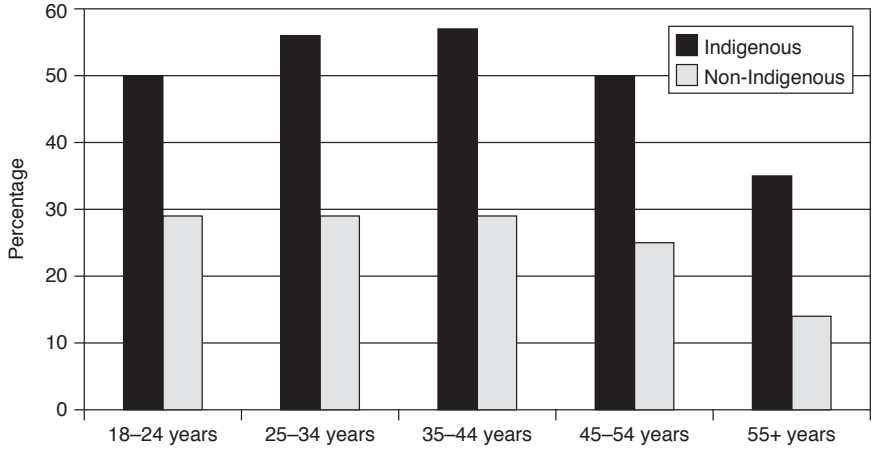

Figure 3: Males, 18 years and over and current daily smoker (ABS 2006)

Obesity

When gathered into overweight and obese categories both Indigenous and non-Indigenous men show a similar pattern of increasing Body Mass Index after the age of 24, peaking in the 45–54 age group (Figure 4).

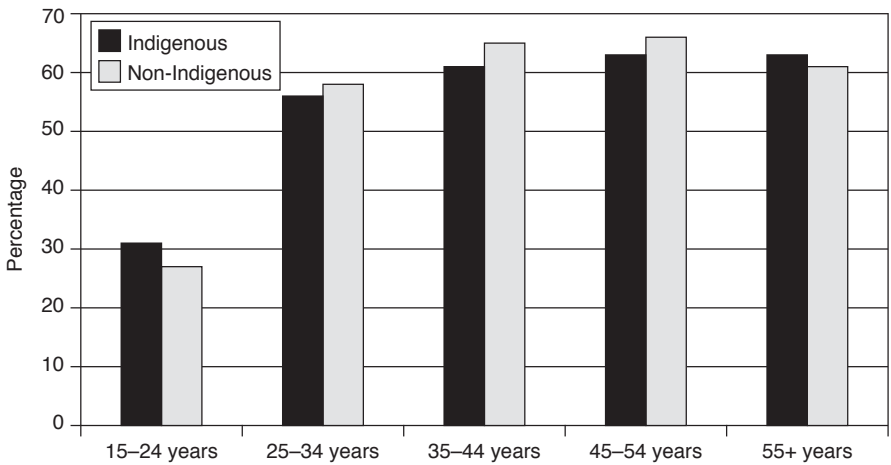

Figure 4: Males, overweight and obese, Indigenous and non-Indigenous (ABS 2006)

However, if one pays attention only to the obese group the difference becomes much more marked, particularly in the 15–24 year age group of Indigenous men. Hence, signs of obesity within young Indigenous men begin to appear at a much earlier age when compared with men of similar age in the wider Australian community (Figure 5).

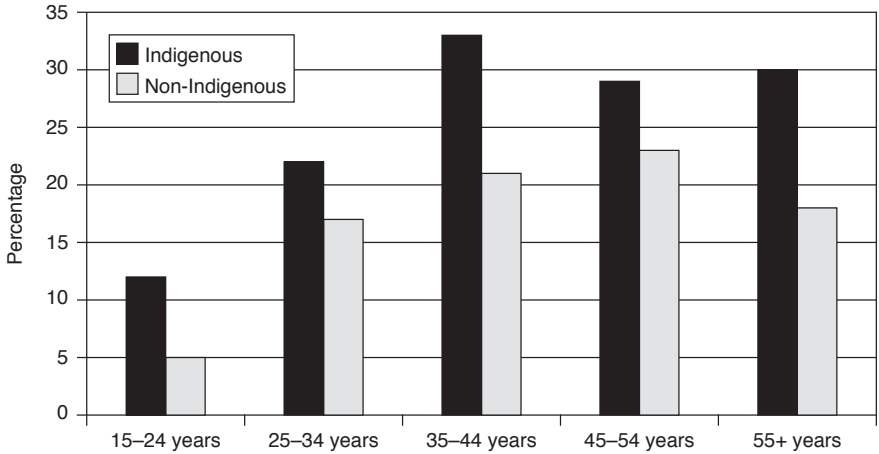

Figure 5: Males, obese, Indigenous and non-Indigenous (ABS 2006)

Alcohol

In terms of low-risk use of alcohol, Indigenous men consume much less than non-Indigenous men across all age groups (Figure 6). However, when the risk moves to the next and higher category of risk, young Indigenous men are much more clearly identified when compared with other young men their own age. Signs of risky alcohol use are clearly revealed in later teenage years (Figure 7).

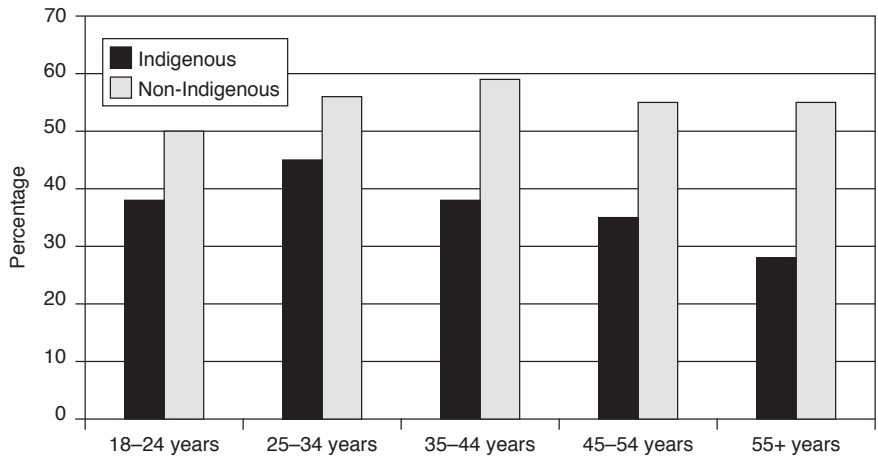

Figure 6: Males, low-risk alcohol use, Indigenous and non-Indigenous (ABS 2006)

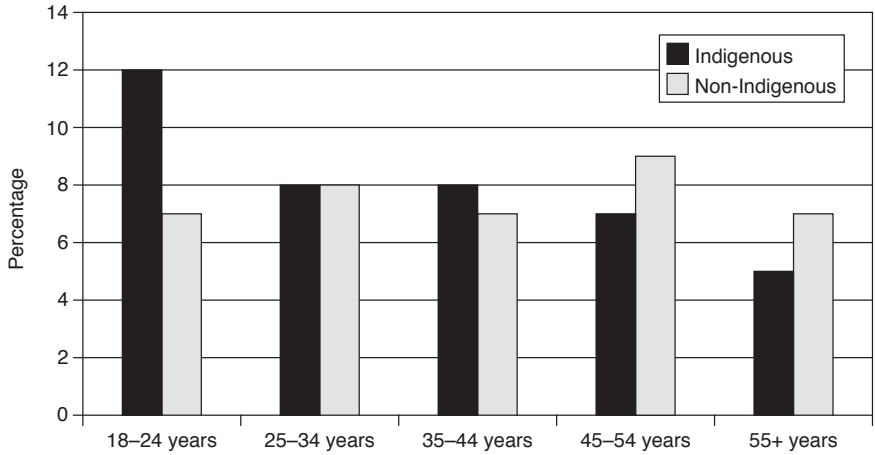

Figure 7: Males, risky alcohol use, Indigenous and non-Indigenous (ABS 2006)

When the risk moves to the highest category of risk, older Indigenous men are more significantly represented (Figure 8). Patterns of risky alcohol use by Indigenous men when they are young translates, much more than for other Australian men, into higher risk as they get older.

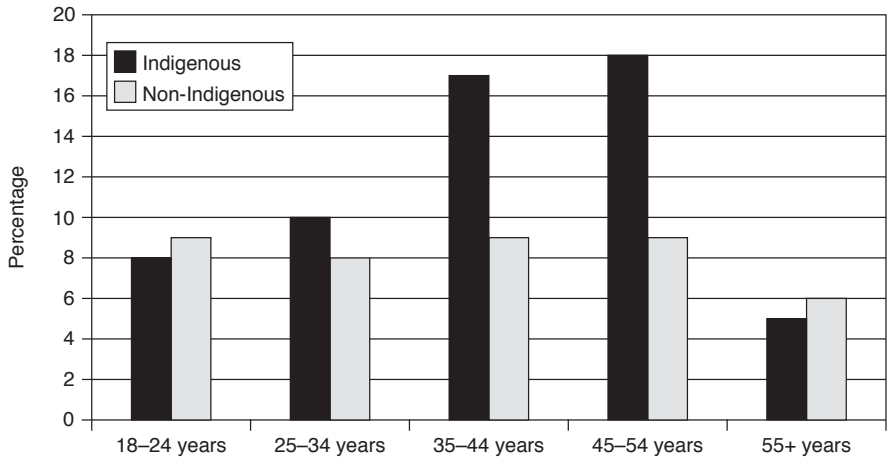

Figure 8: Males, high-risk alcohol use, Indigenous and non-Indigenous (ABS 2006)

Hence, in relation to smoking, obesity and alcohol there are very clear and concerning signs for the long-term health of Aboriginal and Torres Strait Islander men. In addition, they take up these high-risk and inter-related health activities at a relatively younger age than other Australian men. What effect can sport, particularly within its social context, have on these men in their younger years?

The Garbutt Magpies research project, *Boys to Men: Garbutt Magpies twenty-five years on,* sought to explore the health of a group of men who had shared in a significant sporting experience when they were young. In 2008 all of the men were still alive and many had families and children. What did they remember about their involvement in this event and what effect did it have on them at that time and in later years? The research revealed a number of things (McCoy et al. 2008).

- A significant physical and emotional energy can be found among young men when they are engaged in sport. In the Townsville group those who went on tour had to give up many of their weekends over several months in order to work and raise enough money to pay for the trip. They remembered that, at that time, it was football that motivated them, as it was sport that motivated them to attend school. 'School was an extended playground', remembered one. Sport provided this particular group of young men an important and valued gendered and generational cultural space.
- Linked with this physical and emotional energy can also be found a significant attention and focus by young men. Within the framework of coaching, young men can be particularly attentive to what they are told in this sporting space by older men. For the Townsville group, their hope was to play on a 'field' they had never ever seen or engaged before. Young men at this time can be particularly vulnerable as they seek to compete, display skill and perform well in front of their families and others. At the same time, they are open to those leading them to guide, protect, advise and even inspire them. Older men are expected to take this leadership, speak strongly, motivate and set clear boundaries of group and individual behaviour. Peers, particularly ones that are slightly older, can also, within this sporting space, exert great influence as younger men look to them for guidance and support. Young men are known to modify their behaviour in response to all of these challenges.
- The tour, the games, the highlights and lowlights, the funny and ridiculous moments are deeply remembered and easily retold in later years. These events can be important moments in the shaping of a young man's identity, particularly on his pathway to male adulthood and as he prepares to join older men on the adult field of play. Not only will many stories be told and retold in later years, but they also remain stories describing human learning, growth and change. New social skills, attitudes and relationships were learned and they are remembered as having been received at that particular time and within that social context.

Hence, energy, physical and relational, can become a significant element in young men's lives as it is directed through their engagement in sport and as it shapes them for an adult future. Their attention to those who guide, coach and mentor them can form lasting friendships with deeper understandings about themselves and others. During this time, they can allow older men to set boundaries and place expectations on them, far more than they will accept within their own immediate parent and extended family structures. Sport, and the social context if offers, can provide opportunities for young

men's lives to be significantly re-shaped and re-directed. Behaviours around personal health and wellbeing can be set in these highly formative teenage years.

When those who were involved in the 1983 tour were interviewed, both as players or supporting parents or relations, the research discovered that some of the key relationships within the Garbutt Magpies Sporting Association at times mirrored those values and relationships found in the Western Desert concept of *kanyirninpa* (holding), although not described in such terms (McCoy 2008). Young men seek to come under the guiding influences of older men as they enter into adolescence; within this context they follow the example of those slightly older than themselves (McCoy 2008). In the Garbutt Magpies Club (hereafter referred to as the 'Club') at that time there existed a strong bond between older and younger people where close kinship ties and responsibilities were extended beyond one's immediate family to a wider group of Aboriginal and Torres Strait Islander people. The Club became a 'family of families'. Adults trusted other adults to look after their children when they were not present and, in turn, the young expected this wider group of adults to care for them but also to have the right to correct, advise and admonish as well. Not all young men 25 years ago felt safe within their own homes and families. Some experienced more safety and protection within the Club, this 'family of families', and among their peers than they did at home. However, all experienced being nurtured and valued, and belonging within the wider and social relationships of this particular football club.

The research also identified how a sporting club has the ability to provide a social space where young men can learn to develop their own dreams and trust others. It can provide a social and relational space that shapes, corrects and modifies. In this aspect, as commented by the coach Alan Brown of the Fitzroy Stars, 'sometimes the sport is irrelevant' (Knowledge Transfer Group 2009). A sporting club thereby holds the potential to seriously affect and modify young people's attitudes and behaviour and hence their health. It can affect young men in ways beyond the arena of the sport and the game itself.

Addressing three key health issues

When addressing the key health issues caused by tobacco, obesity and alcohol, and how each can play a part in the lives of many young Aboriginal and Torres Strait Islander men, it might be tempting to conclude that men playing more sport, or having more exercise in later years, is what's needed. While physical exercise remains an important ingredient for adult health, the lesson from the Garbutt Magpies research is the importance of understanding and increasing the capacity of the social space that a particular sport or sporting club occupies. There are three key elements.

The first key element is the attention that needs to be given to those who lead, manage and coach. They are the ones who 'protect' the space that teaches and nurtures. In the Garbutt Magpies experience, however, it was not just the men. Parents and

older women contributed to the importance of this space as well. Not only do these older people 'lead' and 'manage' the club, but they also hold great influence over the behaviour and attitudes of the young, of club members and of those who come and watch the game. Developing their capacity to set goals, frame acceptable behaviour and work within local cultural norms is critically important.

A second key element is developing a culture (including the use of language, symbols and key messages) that links the sport and the club with the immediate and long-term health of the local community. While many Aboriginal and Torres Strait Islander communities meet regularly for funerals, sport provides one of the few relaxed and enjoyable social spaces for families and relations. It is a 'healthy' space in itself, coming along with a range of social, humorous and relaxing elements. In addition, as with the Fitzroy Stars, it can provide an acceptable geographical space where the local Aboriginal Medical Service can attend and provide service. The trust that is generated in such a space can spread far beyond the sporting arena.

The third key element of this social space is its potential to influence the attitudes, values and behaviour of young men. If a football club develops an adult and/or Elder-led culture that includes a non-smoking environment, endorses safe alcohol consumption and supports men to reduce weight through a combination of diet, social support and exercise, young and older men associated with the club will seek to adopt those values. While the adoption of such values, and others, is no simple or easy process of social translation, the potential to change and improve the short- and long-term health of all involved in a club remains. The cultural reciprocity that is experienced, where older and younger people are engaged in a sustaining and enjoyable 'sporting exercise' together, can have important and long-term implications for both groups and across both generations.

Conclusion

For many young Aboriginal and Torres Strait Islander men, as for other young men in Australian society, their transition into adulthood, sometimes quite fragile, often occurs when many are also involved in sport. Those who lead, manage and coach them at those times are assisting them into the cultural and gendered space of male adulthood. When done well those who are older protect, teach and nurture those who are younger. A young man can experience being safely cared for in the company of peers and friends and, in return, he is invited to repay that relationship through attention, dedication and respect. He comes also under the influence of peers, particularly slightly older ones. Their influence, while important, is constrained within the culture set by older members: club directors, managers and coaches.[8] In order to participate within this space he is often willing to listen, pay attention, modify his behaviour and discipline his life. His desire to enter the company of adult males is engaged within a boundary of authority and the experience of care. Individual behaviour can become quite willingly negotiated, modified and even deeply changed.

In seeking to address and improve the future and long-term health and wellbeing of young Aboriginal and Torres Strait Islander men we need greater awareness of the cultural contexts of their various sports and their sporting clubs. In particular, we need to develop and increase the capacity of those who hold great influence over younger men at this time. It is not enough to focus solely on the needs of the young, nor on the price of success and that of competition. We need to invest in older men and their abilities to lead, motivate and challenge those younger than themselves. More so, we need to invest in developing social spaces where new patterns of health, including tobacco, alcohol and obesity, can begin to be addressed.

As a result, we need to better understand the nature of these recreational spaces, but also associated ones, such as sporting knock-out competitions, tours and carnivals. Their capacity, through the supporting and complementary roles of men and women, are important in providing a safe and generational experience for the young. Clubs have the ability to set guidelines for the use of tobacco and alcohol among older and younger players. They also have the ability to address obesity as men get older. Sporting clubs, their trips and annual sporting events also provide windows of opportunity by offering older men the responsibilities and privileges of caring for those who are younger. It is this cultural relationship that can help address the challenge of obesity, a particular challenge for some men after the final siren of their playing has sounded.

We also need to address that critical disconnection that was mentioned at the beginning of this paper. Discourses that separate the playing of sport from issues of health, culture, education and gender fail to address the ways in which young men engage sport and its potential to improve their health, as well as their lives. We need to explore ways that men can aspire to achieve continued health and wellbeing from their early teenage years, including systems of safe access to appropriate health care services. Men live in physical, but also social and gendered, 'bodies' and the arena of sport and sporting clubs can offer spaces where the health needs of young Aboriginal and Torres Strait Islander men can be more positively affirmed and addressed.

The current and critical status of Aboriginal and Torres Strait Islander men's health demands concerted, creative and sustainable effort. There is evidence that sport can provide far more readily and easily available responses to these challenges. Sporting clubs within urban communities are valuable resources. They have the capacity to engage the health of men within their own communities and influence men in rural and remote communities. As urban communities continue to hold and develop those who play and are involved in sport at the highest levels of competition, these men remain key role models and influences on male youth. Urban sporting clubs have the capacity to work with these role models, players, coaches and managers, and to take sport and shape it into contemporary and cultural settings. This will have important health implications for these men, but it also holds the potential to influence the health of many other Aboriginal and Torres Strait Islander men.

Acknowledgments

The authors would like to acknowledge and thank those members of the Garbutt Magpies Touring Side of 1983 who participated in the research project *Boys to Men: Garbutt Magpies twenty-five years on.*

References

ABS (Australian Bureau of Statistics) 2006 *National Aboriginal and Torres Strait Islander Health Survey 2004–05*, Australian Government Publishing Service, Canberra (Cat. no. 4715).

——and AIHW (Australian Institute of Health and Welfare) 2008 *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, Australian Government Publishing Service, Canberra (ABS 4704.0 and AIHW 21).

AFL (Australian Football League) 2011 'AFL and the Indigenous community', <www.afl.com.au/indigenous%20community/tabid/14282/default.aspx> accessed 6 June 2011.

Clontarf Foundation 2010 'Clontarf Foundation', <www.clontarffootball.com/> accessed 2 December 2010.

DEEWR (Department of Education, Employment and Workplace Relations) n.d. 'Learn earn legend!', Australian Government, <www.deewr.gov.au/Indigenous/Pages/LearnEarnLegend.aspx> accessed 7 June 2011.

Gorman, Sean 2005 *Brotherboys: The story of Jim and Phillip Krakouer,* Allen & Unwin, Crows Nest, NSW.

Hallinan, Chris and Barry Judd 2009 'Race relations, Indigenous Australia and the social impact of professional Australian Football', *Sport and Society* 12(9):1220–35.

Judd, Barry 2005 'Australian Rules football as Aboriginal cultural artifact', *Canadian Journal of Native Studies* XXV(1):203–25.

——2007 Australian Game, Australian Identity: (Post)colonial identity in football, unpublished PhD thesis, Centre for Australian Indigenous Studies, Monash University, Caulfield East, Vic.

Knowledge Transfer Group 2009 *Sharing Our Stories, Building on Our Strengths* (DVD), Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne.

Lingwoodock, Geoffrey 2007 A Literature Review: Aboriginal and Torres Strait Islander males and type 2 diabetes, unpublished Masters of Public Health minor thesis, Institute of Koorie Education, Deakin University, Waurn Ponds, Vic.

McCoy, Brian 2008 *Holding Men: Kanyirninpa and the health of Aboriginal men,* Aboriginal Studies Press, Canberra.

——, Randal Ross and Jacinta Elston 2008 *Boys to Men: Garbutt Magpies twenty-five years on*, Townsville, Qld (community report).

——, Randal Ross and Jacinta Elston 2009 'Boys becoming men: What makes a difference?', *Australasian Psychiatry* 17:S37–40.

McFarlan, F Warren and Michael Vitale 2009 *From Little Things Big Things Grow: The Clontarf Foundation Program for Aboriginal Boys*, Harvard Business School, Harvard University, Massachusetts.

Vos, Theo, Bridget Barker, Lucy Stanley and Alan D Lopez 2007 *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples 2003*, School of Population Health, The University of Queensland, Brisbane.

Notes

1. While the term 'Aboriginal and Torres Strait Islander' is used as a preference in this paper to refer to the First Nations Peoples of Australia, occasionally the term 'Indigenous' is used.
2. Links between sport and traditional hunting activities have also been made (McCoy 2008).
3. The link between education and sport has been recognised by the Australian Government in its 'Learn Earn Legend!' messages (DEEWR n.d.).
4. See, particularly, Chapter 6, 'Football: More than a game', in McCoy 2008.
5. This painting was offered by Lawrence Lulu Tjangala as part of McCoy's PhD research in the Kutjungka region of the Kimberley, 2001–04 (see McCoy 2008).
6. See, particularly, Chapter 6, 'Football: More than a game', in McCoy 2008.
7. Figures are of percentage of age cohort who consulted a general practitioner/specialist in the two weeks prior to the survey. National Aboriginal and Torres Strait Islander Health Survey 2004/05 data stratified by gender as reported in Lingwoodock 2007.
8. In those cases where the attitudes and behaviours of one's older peers within a social club are not constrained by the leadership of older men, there remains the possibility that younger men will enter into more risky forms of behaviour.

Chapter 7

Beyond the Winnunga Holistic Health Care Prison Model

Nerelle Poroch and Julie Tongs
Winnunga Nimmityjah Aboriginal Health Service

Abstract: *In 2006, in anticipation of the Alexander Maconochie Centre (AMC) opening in the Australian Capital Territory in March 2009, Winnunga Nimmityjah Aboriginal Health Service initiated a study to consider the whole-of-life view of Aboriginal people incarcerated in Australian prisons. This qualitative study drew in part on the knowledge Winnunga had gained in providing prison health care to Aboriginal people in New South Wales prisons and in juvenile justice centres and remand centres in the Australian Capital Territory. The resultant publication* You Do the Crime, You Do the Time *was released in 2007 and included the Winnunga Holistic Health Care Prison Model. This paper connects the Phase 1 Winnunga Prison Health Study with the resultant deliberations associated with the opening of the AMC, including the Phase 2 Winnunga AMC Study entitled* We're Struggling in Here. *This study identified the needs of Aboriginal people in the AMC and the needs of their families, and considered the relevance of the model. It also contributed to a national prison health research focus on reducing recidivism.*

Introduction

Aboriginal and Torres Strait Islander people comprise 2.5% of the total Australian population and 1.2% of the Australian Capital Territory (ACT) population (ABS 2008). They suffer the poorest health and greatest socio-economic disadvantage of all Australians, with life expectancy at birth up to 17 years less than that of other Australians (ABS and AIHW 2008:154; AIHW 2008:68; Couzos and Murray 2008; Anderson et al. 2007; Carson et al. 2007; Thompson 2003). The disadvantage suffered by Aboriginal and Torres Strait Islander Australians is associated with both historical and contemporary racism, colonisation, the Stolen Generations and oppression (Larson et al. 2007; Paradies et al. 2008; HREOC 1997). Aboriginal Australians

are over-represented in prisons, where major health priorities include mental health, substance misuse, disruption of family relationships, hepatitis C and housing issues on release (Krieg et al. 2008).

Background

The rate of imprisonment of Aboriginal and Torres Strait Islander people is 14 times higher than for non-Indigenous people in Australia. They represent 25% of the total prisoner population in Australia (ABS 2008). Current ACT-specific data for Indigenous justice issues are minimal due to the small ACT sample size. However, data from the 2008 *Report on Government Services* indicates that the ACT rate of Aboriginal and Torres Strait Islander imprisonment was 799 per 100 000 adults, well above the rate of ACT imprisonment for non-Indigenous offenders at 58 per 100 000 adults (Productivity Commission 2008). Data from the ACT *Criminal Justice Statistical Profile* (ACT Government 2009), September 2009 quarter, in the year that the AMC opened, shows that sentenced Aboriginal and Torres Strait Islander people comprised 22 of the 104 prisoners and 11 of the 62 remandees in the AMC.

Winnunga Holistic Health Care Prison Model

Winnunga Nimmityjah Aboriginal Health Service (Winnunga) in Narrabundah, ACT, is an Aboriginal Community Controlled Health Service. For the past 13 years Winnunga doctors and Aboriginal Health Workers have been visiting Aboriginal prisoners and remandees in ACT remand centres and juvenile justice centres, and Goulburn and Cooma prisons.

The Winnunga Holistic Health Care Prison Model (the Winnunga Model) was developed in 2007, prior to the opening in March 2009 of the new regional prison in the ACT, the Alexander Maconochie Centre (AMC). The model resulted from a year's study into Aboriginal and Torres Strait Islander prison health care. The study investigated Aboriginal and Torres Strait Islander ex-prisoners' experiences of health service provision during incarceration and on release. It also took into consideration the needs of their families (Poroch et al. 2007).

Swan and Raphael (1995:13) define Aboriginal health thus:

> [The] Aboriginal concept of health is holistic, encompassing mental health and physical, cultural, and spiritual health. Land is central to well-being. This holistic concept does not merely refer to the 'whole body' but in fact is steeped in the harmonized inter-relations which constitute cultural well-being. These inter-relating factors can be categorized largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood

that when the harmony of these inter-relations is disrupted, Aboriginal ill health will persist.

The Winnunga Model (Figure 1) is based on practical experience and on data gained from interviews with 22 male and female ex-prisoners; 17 family members of prisoners and ex-prisoners; and 39 representatives of health and justice support organisations. In addition, the Phase 1 Winnunga Prison Health Study (the Phase 1 Study) examined the literature on Australian Aboriginal and Torres Strait Islander prisoners (for example, AMA 2006; Beresford and Omaji 1996; Butler and Milner 2003; Cunneen 2002; Hazlehurst and Dunn 1988; HREOC 2002; Krieg 2006; Lawrie 2002; RCIADIC 1991; SCATSIH 2005) and overseas literature (see Brinded et al. 2001; Bailey 2003; CSC 2006; Canadian HIV/AIDS Legal Network 2004; Prinsonjustice.ca 2005; Simpson et al. 2003; Tomasevski 1992; USADJ 1999).

The Winnunga Model addresses incarceration, release from prison and breaking the cycle of incarceration.

A strong sense of identity is at the centre of the model's thesis. This is crucial in coping with prison and community life and is also linked to good health. Stuurman

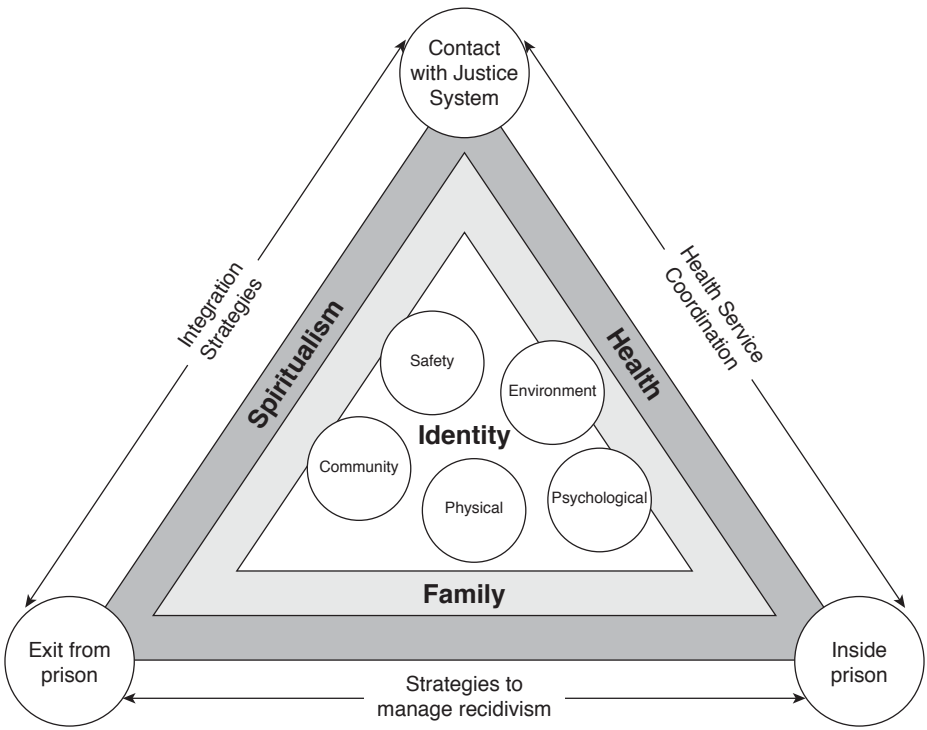

Figure 1: The Winnunga Model (Arabena 2007)

(2004) considers that Aboriginal and Torres Strait Islander people's identity is 'shaped, reaffirmed and nurtured by relational interaction of family and land. It is the affirmation of identity within identities; what's your name, where do you come from?'

Carson et al. (2007:194) also consider that country 'is an important determinant of identity, social cohesion and ultimately health'. When a strong sense of identity is undeveloped through attaching ritual knowledge to place, it can result in frustration of not being recognised as having value within a community and may be expressed through substance abuse and violence.

Positioning identity at the centre of the Winnunga Model means that factors contributing to identity in this sense are a person's environment (whether inside prison or in the community), his or her safety, community support, and his or her physical and psychological wellbeing. Health, family and spirituality support these components, while a network of Aboriginal and Torres Strait Islander and non-Indigenous health and justice organisations work with Winnunga to integrate and co-ordinate these strategies in prison and on release.

The model has three parts which address the needs of Aboriginal and Torres Strait Islander people while in prison, when they are released and to prevent recidivism. Briefly, they are:

- inside prison — provides holistic care for prisoners and their families and planning for release; this care builds a strong sense of identity, a safe environment with community support, and physical and psychological wellbeing inside prison and when released
- release from prison — provides holistic care in returning to the community and includes collection from prison, help with assisted living accommodation or the family home, ongoing assistance with reintegrating into the family and community, employment, parole commitments, and ongoing support with health and social and emotional wellbeing for the whole family
- preventing recidivism — provides holistic care in supporting families in delivering programs such as Healthy for Life, Youths at Risk, Parents' Programs, Men's and Women's Groups, Life Skills and midwifery care.

A fundamental premise of the model is that post-release needs should be addressed as a priority on entry into prison. The focus of imprisonment should be release into an environment that is better than being in prison and the drug culture associated with the cycle of incarceration.

The measures to prevent the cycle of incarceration identified in the Phase 1 Study were found to commence with health care during pregnancy and early childhood, followed up by good parenting and mentoring programs, and access to employment, housing and education. The model also takes into consideration the need for early intervention with Aboriginal women in addressing their lack of education and employment opportunities, and treatment of sexual and physical abuse.

Research beyond the Winnunga Holistic Health Care Prison Model

Following the launch of the Winnunga Model in August 2007 by John Stanhope, Chief Minister of the ACT, the Cooperative Centre for Aboriginal Health and AIATSIS (partners in the Winnunga Prison Health Study) conducted an Aboriginal Prisoner Health Roundtable in November 2007. The roundtable recognised the need to establish an evidence base on:

- diversionary programs and alternatives to prison
- programs run within prison, ranging from health services to programs around self-esteem, empowerment, grief and trauma, and healing
- post-prison programs, including continuity of services and rebuilding connections with community and culture.

Prior to and since the AMC opened, ACT community groups such as the ACT Community Coalition on Corrections Group and Families and Friends for Drug Law Reform have been lobbying the ACT House of Assembly about issues such as mental health, smoking, strip searching and body scanning, a needle and syringe program, safer tattooing initiatives, and throughcare and aftercare for transition from the AMC.

The Winnunga Model specifically addresses throughcare and aftercare, as well as safe tattooing and a needle and syringe program. On 18 June 2009, only three months after opening the highly technical facility, the *Canberra Times* (Kretowicz 2009) reported that detainees in Canberra's new prison had been found with drug paraphernalia and had failed drug tests. The ACT Government had previously indicated it would review the need for a needle and syringe program after the AMC had been open for 12 months. This proposed initiative remains under ACT Government review. Examples of ex-prisoners' stories about drugs in prison in the Phase 1 Study (Poroch et al. 2007:82) are:

> 'The first time I went to gaol was in 1997–98 for stupid reasons. I was only young and I ended up catching Hep C in gaol. And I disagree about not letting the needle and syringe program come through. There is heaps more stuff that could be done for people but they are not doing it' (Male ex-prisoner).

> 'In jail you don't rehabilitate. If you want, you can get drugs any day, all that, if you want. And when you're in there you meet older peole who've been in there for 10 or 15 years and you learn new tricks off them. So you come out and you've got new things to do. And so you try them and it works, it pays off. And then you go out and you know more things, how to do crime a lot easier without being detected. And so you're going in there really to do crime school and take drugs. That's all gaol is. And you're in there and you take the drugs, what can they do to you — put you in gaol? You're already in gaol, so, you know, who cares? Yeah. It's up to you, whether you take drugs in gaol but when you're in there you think, stuff it. I'm in gaol, my family's not here, who cares?' (Female ex-prisoner).

Reinstating prisoners' federal election voting rights and allowing access to the Pharmaceutical Benefits Scheme and Medicare were other areas of particular concern highlighted in the Phase 1 Study. The Public Health Association has taken up the Pharmaceutical Benefits Scheme/Medicare matter with the Australian Government. In August 2007 a partial victory was won by Vickie Roach, an Aboriginal woman incarcerated in the Dame Phyllis Frost Centre in Victoria. Prisoners sentenced to less than three years can now vote in federal elections (Holroyd 2007).

Winnunga's interaction with the AMC since opening in March 2009

In December 2009, out of a total of 147 people in the AMC, there were 21 Aboriginal and Torres Strait Islanders comprising 13 sentenced males, two sentenced females and six males on remand (P Sharp, Winnunga Medical Director, pers. comm., 10 December 2009). The Winnunga Medical Director, the late Dr Peter Sharp, visited the Aboriginal and Torres Strait Islander people in the AMC, including those who had been relocated from New South Wales prisons, and the ACT remand centres once a week for three weeks each month after it opened in March 2009. He visited patients with an Aboriginal Drug and Alcohol Worker from the ACT Alcohol and Other Drugs Sector. An Aboriginal Mental Health Worker from Winnunga also accompanied him on these visits.

The Phase 2 Winnunga AMC Study (Phase 2 Study) commenced in April 2011. This study addressed social and emotional needs in coping with the stress of incarceration in the AMC and reintegration into families and the community on release based on the data gained in the Phase 1 Study. Respondent accounts in the Phase 1 Study had indicated a high level of stress experienced by Aboriginal people in prison and within families who have a member in prison. Some examples are (Poroch et al. 2007:69–111):

> ***How I got to be in Prison***: 'Small things got me into prison. Temptation mainly. If it was there I took it and that was it — petty theft, in and out, in and out — supporting me habit' (Male ex-prisoner).
>
> ***How I did and didn't cope in Prison***: 'Just coped. I would always get back in a corner and just sit there and hope for the day the sun come up that I would be released…I was only young and it was like being taken out of the closet and thrown into humanity, like into society. And when you get out into society the whole world is harsh — it is like dropping a little kitten into a pan full of pit bulls. I have done broken and enters and fight back at society because I want my mum to hear' (Male ex-prisoner).
>
> ***How I did and didn't cope in Prison*** 'Missed me family and being back out in the community — couldn't cope all that well. Family crises happened a couple of times. And it got me down but I learned to bring myself back up again. A couple of friends in prison helped' (Female ex-prisoner).

How we coped when Mum went to Prison 'It was a bit hard — pretty hard you know when mum went to gaol. I did not want to live with me father. It was no good for all four of us children, so we stayed with an auntie. We didn't like it there and then we went and stayed with our nan and the two girls liked it there, but me and me brother went our own ways — living on the streets and getting into crime and bad things like that back in the day. It was a bit hard. We didn't have any income. You know we had to…well, I went and stayed with an auntie and uncle and they put me on an income, Centrelink income. I stayed with them for about two years then I come back up to Canberra. Got into bad crime and violence. I was picked up then, and that is all part of the way. I got a family now to look after, responsibilities and that. And I wasn't going to school after me mother sort of left me. Well she never left me, she got put away, that was it. Even if I went to school the other kids would talk about me mum, you know what I mean, and that would probably set me off to be violent towards them. That's why I did not worry about school. When mum came out of prison we all got together in a house in Canberra — the four kids and mum was there' (Male family member).

The Phase 1 Study also identified that post-release needs should be addressed as a priority on entering prison, and the focus of imprisonment should be release into an environment that provides accommodation, employment, health services, and reintegration into the family and community. Two respondents commented (Poroch et al. 2007:126, 129):

'Need a Job Network member working on the inside for inmates advising they have jobs for ex-prisoners — looking for the right person for the right job. Could stop a person from reoffending again. I am on the path where I am trying to fix myself up now. I am 29 and I still find life hard. I think about going back to gaol just to have time out sometime because I can't have a life on the outside. It is hard. Basically you just need some sort of support system there for younger people so they don't end up where I am today. I know I could go to work but I have got a pretty bad criminal record — not that that will stop me. I haven't been in trouble now for nearly two and a half years, besides a couple of misdemeanors. The more support from the Aboriginal community, the better' (Male ex-prisoner).

'I come out to nothing, really. I come out to my family's place but I felt like, I don't know, a lot different. Like, I've been in gaol so I'm not worth nothing. I won't really get a job. I've got gaol on my thing, I can't work with kids, I can't work with the elderly. What's left? Nothing, really. A Macca's job behind the counter? Because I've been done for fraud I won't get a cash register job or nothing. And I thought, stuff it. Why not take drugs and sell drugs, I'll get paid more. You know?' (Female ex-prisoner).

Winnunga has now taken steps towards meeting former AMC prisoners' needs in arranging with ACT Housing, Centrelink and ACT Corrective Services, Probation and Parole to conduct meetings with Aboriginal and Torres Strait Islander people at Winnunga each week. This assists in keeping probation and parole commitments and reducing instances of re-incarceration. It also provides opportunistic occasions for Winnunga to provide primary health and social and emotional support for people who have been incarcerated, as well as their families. The respondents in the Phase 1 Study also explained their state of mind when release was imminent (Poroch et al. 2007:124):

> ***The fear of release:*** 'Every day the sooner you get out the longer the days get. That's the worst; that's when stress and everything really hits ya — the fear of getting out once you get settled. You get used to one place and it's just like being kicked out of a home. You sorta just got used to know the run of the things and how to get by and live in there. And when it is done, bang you are on your own and you've gotta do things from scratch. I've got no place to live at the moment. I'm on the streets. Got a wife and two kids, and I've nothing I can do to help them because I've got no place or a roof over my head to settle down in. I might be moving into prison again for 18 months, then I can finally settle down. I am still a loose cannon, I don't know when I am going to go off' (Male ex-prisoner).

In December 2008 the National Health and Medical Research Council awarded a capacity building grant to carry out research across Australia to provide better prison health services for Aboriginal and Torres Strait Islander people. Winnunga is one of the grantee organisations associated with this grant. The projected outcomes are improved health and wellbeing of people in prison, and an Australia-wide network of prison health research. This grant has enabled the Phase 2 Study to be carried out into the needs of Aboriginal people and the needs of their families. It has also provided the opportunity to test the worth of the Winnunga Holistic Health Care Prison Model. The study commenced in April 2011. A total of 24 respondents were interviewed in the study, including 12 AMC Aboriginal remand and sentenced respondents (ten male and two female), family members and support organisations.

The resultant report, entitled *We're Struggling in Here* (Poroch et al. 2011), found that the Winnunga Holistic Health Care Prison Model was relevant to the needs of the Aboriginal people in the AMC and their families for the following reasons:

- it is based on planning for release into a positive and highly supportive environment with the prospect of accommodation and employment, and includes training for employment at the time of entry into prison
- it advocates throughcare for remandees, as well as sentenced people
- it concentrates on developing a sense of identity in prison through connection with the spirituality of the Aboriginal culture.

At the time of the Phase 2 Study the ACT Government was considering findings and recommendations of two AMC reviews it had commissioned. It responded positively to their recommendations relating to throughcare, health care service, individually centred case management, introduction of a new framework for drug-related policy, service and counselling matters, and extension of throughcare services in the community to assist the high numbers of remandees' transition to the community.

The Phase 2 Study also found that the needs of Aboriginal people in the AMC and the needs of their families stemmed from the lack of individually centred case management and adequate throughcare measures while incarcerated and on release. As a result increased Winnunga outreach has been put in place at the AMC. For example, an Aboriginal Health Worker from Winnunga visits the AMC two days each week accompanying the Winnunga doctor the first day and working on throughcare requirements, carrying out individual case management, and attending to social and emotional wellbeing matters the following day. They also support family members and attend pre-release meetings and art classes. This approach promotes efficient throughcare and co-operation between all support services accessed by Aboriginal people in the AMC and on release.

Conclusion

Aboriginal and Torres Strait Islander people of Australia suffer the poorest health of all Australians and they are significantly over-represented in prisons. There are limited qualitative studies of the experience of incarceration for Aboriginal and Torres Strait Islander prisoners and their families in Australia. The Phase 2 Study found that the Winnunga Holistic Health Care Prison Model was relevant to the needs of the Aboriginal people in the AMC and their families. It has utilised the findings of the Phase 1 Study and identified the needs of Aboriginal people in the AMC and the needs of their families in the early stages of AMC development. The Phase 2 Study has allowed Winnunga to respond to these needs into the future, and has contributed to a national research focus on reducing recidivism. Strong health identified in the words 'Winnunga Nimmityjah' (Aboriginal Health Service) is the right of all Aboriginal and Torres Strait Islander people.

References

ABS (Australian Bureau of Statistics) 2008 *Experimental Estimates of Aboriginal and Torres Strait Islander Australians, June 2006*, ABS, Canberra, <www.abs.gov.au/AUSSTATS/abs@.nsf/mf/3238.0.55.001> accessed 17 February 2010.

——and AIHW (Australian Institute of Health and Welfare) 2008 *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*, ABS/AIHW, Canberra, <www.aihw.gov.au/publications/index.cfm/title/10583> accessed 17 February 2010.

ACT Government 2009 *Criminal Justice Statistical Profile — September 2009 Quarter*, ACT Government, Canberra, <www.jcs.act.gov.au/eLibrary/crimstats.html> accessed 17 February 2010.

AIHW (Australian Institute of Health and Welfare) 2008 *Australia's Health 2008*, AIHW, Canberra, <www.aihw.gov.au/publications/index.cfm/title/10585> accessed 17 February 2010.

AMA (Australian Medical Association) 2006 *Undue Punishment? Aboriginal people and Torres Strait Islanders in prison: An unacceptable reality*, AMA, Barton, ACT (AMA Report Card Series 2006).

Anderson, Ian, Fran Baum and Michael Bentley (eds) 2007 *Beyond Bandaids: Exploring the underlying social determinants of Aboriginal health: Papers from the Social Determinants of Aboriginal Health Workshop, Adelaide, July 2004*, Cooperative Research Centre for Aboriginal Health, Darwin.

Arabena, Kerry 2007 *Winnunga Holistic Health Care Prison Model*, Winnunga Prison Health Workshop, Canberra, 23 February.

Bailey, Sue 2003 'Native women suffer most in "discriminatory" prison system: Advocates', DAWN Ontario, <http://dawn.thot.net/fsw2.html> accessed 23 March 2006.

Beresford, Quentin and Paul Omaji 1996 *Rites of Passage: Aboriginal youth, crime and justice*, Fremantle Arts Centre Press, Fremantle, WA.

Brinded, Philip MJ, Alexander IF Simpson, Tannis M Laidlaw, Nigel Fairley and Fiona Malcolm 2001 'Prevalence of psychiatric disorders in New Zealand prisons: A national study', *Australian and New Zealand Journal of Psychiatry* 35:166–73.

Butler, Tony and Lucas Milner 2003 *The 2001 New South Wales Inmate Health Survey*, NSW Corrections Health Service, Sydney, <www.justicehealth.nsw.gov.au/pubs/Inmate_Health_Survey_2001.pdf> accessed 20 April 2007.

Canadian HIV/AIDS Legal Network 2004 *HIV/AIDS in Prisons 2004/2005, Aboriginal Prisoners and HIV/AIDS*, Canadian HIV/AIDS Information Centre, Toronto, ON.

Carson, Bronwyn, Terry Dunbar, Richard D Chenhall and Ross Bailie (eds) 2007 *Social Determinants of Indigenous Health*, Allen & Unwin, Sydney.

Couzos, Sophie and Richard B Murray (eds) 2008 *Aboriginal Primary Health Care: An evidence-based approach* (3rd edn), Oxford University Press, South Melbourne.

CSC (Correctional Service Canada) 2006 *Aboriginal Federal Offender Surveys: A synopsis*, <www.csc-scc.gc.ca/text/pblct/forum/e121/e121h_e.shtml> accessed 10 July 2006.

Cunneen, Chris 2002 *NSW Aboriginal Justice Plan Discussion Paper*, Aboriginal Justice Advisory Council, Sydney, NSW.

Hazlehurst, Kayleen and Albert T Dunn 1988 *Aboriginal Criminal Justice*, Australian Institute of Criminology, Canberra (Trends & Issues in Crime and Criminal Justice No. 13).

Holroyd, Jane 2007 'Prisoners win right to vote', *Age*, 30 August, <www.theage.com.au/news/national/prisoners-win-right-to-vote/2007/08/30/118> accessed 14 September 2009.

HREOC (Human Rights and Equal Opportunity Commission) 1997 *Bringing Them Home: Report of the National Inquiry into Separation of Aboriginal and Torres Strait Islander Children from Their Families*, HREOC, Sydney.

—— 2002 *Aboriginal & Torres Strait Islander Social Justice Commissioner Social Justice Report 2002*, HREOC, Sydney.

Kretowicz, Ewa 2009 'Needles, bongs — in new jail already', *Canberra Times*, 18 June, pp.1, 8.

Krieg, Anthea 2006 'Aboriginal incarceration: Health and social impacts', *Medical Journal of Australia* 184(10):534–6.

——, Mark Wenitong and J Daniels 2008 'Custodial health' in S Couzos and R Murray (eds), *Aboriginal Primary Health Care: An evidence-based approach* (3rd edn), Oxford University Press, South Melbourne, pp.806–29.

Larson, Ann, Marisa Gillies, Peter J Howard and Juli Coffin 2007 'It's enough to make you sick: The impact of racism on the health of Aboriginal Australians', *Australian and New Zealand Journal of Public Health* 31(4):322–9.

Lawrie, Rowena 2002 *Speak Out Speak Strong: Researching the needs of Aboriginal women in custody*, Aboriginal Justice Advisory Council, Sydney.

Paradies, Yin, Ricci Harris and Ian Anderson 2008 *The Impact of Racism on Indigenous Health in Australia and Aotearoa: Towards a research agenda*, Cooperative Research Centre for Aboriginal Health, Darwin (Discussion Paper 4).

Poroch, Nerelle, Julie Tongs, Peter Sharp, Michael Dodson, Steve Larkin, Katya Mikhailovich et al. 2007 *You Do the Crime, You Do the Time: A best practice model of holistic health service delivery for Aboriginal and Torres Strait Islander inmates of the ACT prison*, Winnunga Nimmityjah Aboriginal Health Service, Canberra.

Poroch, Nerelle, Kacey Boyd, Julie Tongs, Peter Sharp, Eddie Longford and Steven Keed 2011 *We're Struggling in Here! The Phase 2 Study into the needs of Aboriginal and Torres Strait Islander people in the ACT Alexander Maconochie Centre and the needs of their families*, Winnunga Nimmityjah Aboriginal Health Service, Canberra.

Prisonjustice.ca 2005 'Native leaders call for alternatives to jail for women', <www.prisonjustice.ca/starkravenarticles/alternatives_mb_0605.html> accessed 13 June 2006.

Productivity Commission 2008 *Report on Government Services*, Productivity Commission, Canberra, <www.pc.gov.au/gsp/reports/rogs/2008> accessed 17 February 2010.

RCIADIC (Royal Commission into Aboriginal Deaths in Custody) 1991 *National Report, vols. 1–5 and Overview and Recommendations*, Australian Government Publishing Service, Canberra.

SCATSIH (Standing Committee on Aboriginal and Torres Strait Islander Health) 2005 *Guidance on Operational Standards for the Provision of Health Services to Aboriginal and Torres Strait Islander People in Custody*, Australian Health Ministers Advisory Council, Canberra.

Simpson, Alexander IF, Philip M Brinded, Nigel Fairley, Tannis M Laidlaw and Fiona Malcolm 2003 'Does ethnicity affect need for mental health service among New Zealand prisoners?', *Australian and New Zealand Journal of Psychiatry* 37:728–37.

Stuurman, Robert J 2004 'Aboriginal identity in contemporary society', paper delivered at the Access to Indigenous Records National Forum, State Library Queensland, Brisbane, 19–20 June 2003, <http.//eprints.qut.edu.au/2081/1/2081.pdf> accessed 25 June 2010.

Swan, Pat and Beverley Raphael 1995 *'Ways Forward' National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health, Part 1 and Part 2,* Australian Government Publishing Service, Canberra, <www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-w-wayfo> accessed 23 September 2009.

Thompson, Neil (ed.) 2003 *The Health of Indigenous Australians*, Oxford University Press, South Melbourne.

Tomasevski, Katarina 1992 *Prison Health: International standards and national practices in Europe*, Helsinki Institute for Crime Prevention and Control, Helsinki (Publication Series No. 21).

USADJ (United States of America Department of Justice) 1999 *American Indians and Crime*, <www.ojp.usdoj.gov/bjs/pub/press/aic/pr> accessed 9 March 2007.

Chapter 8

Giving and receiving care: Reframing the work of Aboriginal care-giving

Michael Wright
Telethon Institute for Child Health Research

Abstract: *This paper discusses how care-giving provides stability in Indigenous families affected by serious mental illness. It is based on the results from the author's doctoral thesis (Wright 2009). Findings included a serious disconnect between mental health providers and Indigenous families living with serious mental health issues. Mental health providers are at risk of becoming irrelevant due to their lack of understanding of the complexity and concepts of Indigenous care-giving. The experience of racism was a decisive factor in the disengagement by Aboriginal families with mental health providers. This paper discusses how the critical role of care-giving in an Aboriginal context provides a framework for holding and sustaining culture. The key element of care-giving in an Aboriginal context is the presence of a cultural framework that includes reciprocity and relationships, which are essential for holding and sustaining families and communities.*[1]

Introduction

It is widely acknowledged that the health and wellbeing of Indigenous Australians is poor, and that they are the most disenfranchised and disadvantaged group in the country (COAG 2003). Mainstream health approaches often fail to provide adequate services to Indigenous people, because services are provided with little understanding of the realities of their social and cultural situation (Stanley 2007). Designing health services for Indigenous people that demonstrate a better understanding of the pathways to health from social disadvantage would ensure health services are more effective (Germov 2005). Indeed, improved living standards can only be achieved through community participation and by interventions that reduce the impact of social disadvantage (Germov 2005).

In 2009 I completed a PhD entitled Out of the Blue: Giving and Receiving Care: Aboriginal experiences of care-giving in the context of mental illness (Wright 2009). The findings from the study underpinned the concept of care-giving in the context of healing people and healing communities. It was also based on my experiential learning as a researcher and practitioner, from readings and interactions with participants, as well as my attendances at conferences, lectures and workshops. As researchers we are located at the nexus of power in a dominant society, and as academics we are accorded high status and have membership to a very privileged group in society. Colonising practices are still present within most mainstream research practices. In particular, the appropriation and re-interpretation of cultural knowledge by non-Indigenous researchers has been a justifiable means of contributing to academic learning (Hooks 1990). So as an Aboriginal researcher I was conscious throughout my research process of not repeating past poor research practices, particularly research practices that have legitimated the colonisation of Indigenous people (Foley 2003; Tuhiwai Smith 2005; Bishop 2005; Dudgeon 2008; Tuck 2009). Participants informed me that they expected transparency in the research process; they also told me that they expected to be kept updated of the findings from the research process. Participants also wanted some control in how they were to be represented in the thesis. Therefore, all participants were provided with a copy of their interview transcripts and were able, if they wished, to edit their interviews. Participants were also given a copy of the findings chapter, and were invited to edit the chapter if required. I was told by one participant who had been involved in other research projects that I was the first to invite this level of participation in the research process.

In designing the study I was very keen to ensure that participants and community members were given the opportunity to be co-creators in a study. For the participants to be co-creators I was keen for the participants to have some control over the research process (Fine, Michelle and Weis 2005; Fine, Michelle and Torre 2006; Land 2011; Fredericks et al. 2011; Wright 2011). Therefore, the research needed to be reflexive and responsive to the participants and community involved in the research. It was apparent from the interviews that participants were frustrated and angry by the lack of meaningful engagement by mental health services and this ongoing tension was a cause of stress and was underpinned by a sense of powerlessness. I was keen for this research to change this reality, so for the study I selected participatory action research as the research methodology. Participatory action research is about sharing responsibility and it is based on the principles of action–reflection–action sequences, so that the participants have greater control over the research process (Wallerstein 1999; Pyett 2002; Fine, Michelle and Weis 2005; Minkler and Wallerstein 2008; Tuck 2009; Fredericks et al. 2011). Participatory action research is a philosophy underpinned by a social theory that seeks social justice, human rights, and personal and community liberation (Wallerstein and Sanchez-Merki 1994; Weis and Fine, Michelle 2004; Fine, Michelle and Weis 2005; Battiste 2008; Minkler and Wallerstein 2008; Tuck 2009;

Wright 2011). The research methodology for the study had a twin focus: to work at the interface between the lived experiences of participants in a society that rewards and privileges some members and discriminates against others; and to raise the consciousness and understanding of social inequality in the community (Lather 1991).

An opportunity presented itself for me to apply participatory action research principles of reciprocity and reflexivity. While conducting the interviews, several of the participants asked if I could assist them in being more proactive in setting mental health policy for Indigenous people in Western Australia. As a researcher I felt quite humbled by their request as they were placing their trust in me to assist them in their aspirations. As a researcher I was limited, as I did not have the resources to fully comply with their request, so with their permission I contacted a community-based mental health organisation, which agreed to partner with the participants in facilitating a process that could help them with their request. The organisation provided a space for meetings and staff to assist with logistics and administration. For example, some of the participants needed transport, so staff members were provided to transport them to and from the meetings. The meetings were held on Saturday afternoons for three hours. The group met over a period of nine months and helped shape the design for the postdoctoral project that I submitted for a research fellowship and was successful in receiving.

This paper is based on the findings from this study. They included the impact of mainstream delivery of health services for Aboriginal families living with serious mental illness and of families whose situation was exacerbated by their experiences of institutionalised racism, stigma and discrimination. It also discusses an Aboriginal worldview of care-giving from the participants' perspectives, and, finally, how care-giving in an Aboriginal context is fundamental to healing people and healing community.

Indigenous worldview of care-giving

The study explored the experiences of care-giving for Aboriginal families living with mental health issues in the Perth metropolitan area. The findings from the study showed that the experience of care-giving within an Aboriginal context can be a seamless activity involving individuals, families and communities (Wright 2009). This can be different from the Western concept of care-giving as an activity that often has a binary focus of a single caregiver and care-receiver as reported in mainstream literature (Lefley 1997; Biegel and Schulz 1999; Williams, C and Mfoafo-M'Carthy 2006). The politics of care-giving in Western society privilege 'individualisation' by limiting care-giving to the person receiving care and the carer and, if one can afford it, accessing paid care (Tronto 1995; Held 1995; Fine, Michael 2005; Allen and Ciambrone 2003).

The Western concept of 'individualisation' that mainly privileges the person requiring care does not reflect the collectivist values inherent in Indigenous care-giving practices. Alex Brown, an Aboriginal physician and health researcher living and working

in Alice Springs (pers. comm., July 2009) emphasises that core collectivist values in Indigenous society are law, family, country and reciprocity. The reciprocal approach within the activity of care-giving recognises the unique and important contribution of these values with particular Indigenous ways of knowing. These need to be incorporated into the care-giving process. The notion of 'individualisation' is unfortunately reflected in the Australian Bureau of Statistics (2003:3) definition of 'primary carer':

> Disability was defined as any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities. Examples range from hearing loss, which requires the use of a hearing aid, to difficulty dressing due to arthritis, to advanced dementia requiring constant help and supervision.

Most of the participants in the study were Aboriginal women who were the primary caregivers and who described their experiences of care-giving as being complex. Care-giving requires flexibility, both in respecting and privileging the rights of the individual receiving care, without compromising the needs and responsibility of family, community and culture (Crosato et al. 2007). Participants in this study considered family, community and culture to be interconnected and important to the social health and wellbeing of the family member with poor mental health. Studies on the ecological effects of social support on families have identified that the positive recognition of kin, community and work is necessary for any healthy family system (Bronfenbrenner 1986; Elder et al. 1985; Scarr and McCartney 1983). The ecological context of Indigenous families and communities is an important factor in care-giving experiences for Indigenous people. Therefore, when systems and institutions in society adopt an approach that is too rigid towards individuals and families without considering the wider ecological context, they can become oppressive (Bronfenbrenner 1979, 1986, 1994).

The sharply demarcated boundary between the role and identity of the caregiver and care-receiver, as explicated in Western literature, did not emerge in this study. Findings from the study revealed that Indigenous caregivers and their families work within a cultural framework that provides cultural knowledge, a sense of belonging, and an affirmation of an Indigenous worldview. The core values that underpin an Indigenous worldview are shared obligations and commitments to family and community obligations. Within this cultural framework there is an understanding of the importance of relationships and reciprocity (Cook-Lynn 2008; Battiste 2008).

Impact of a mainstream delivery of health services

There are now greater pressures from contemporary society on Indigenous families to be more self-sufficient, even when they lack the necessary resources and skills

(Giroux and Giroux 2008). My study showed that there are still health providers who have little understanding of the complexity of care-giving for Aboriginal families and, disappointingly, they still view care-giving from a very narrow perspective. They emphasise the single caregiver approach of a single person providing care to another person needing care. In my study, Indigenous families were emphatic. For them, care-giving was not an individual experience but, rather, an activity involving the family and community.

This study highlighted a major disconnection between the mainstream health system and Indigenous families living with serious mental health issues. Of critical concern was the extent of the lack of knowledge and acknowledgment by the mental health system that Indigenous people may have a different concept of care-giving. There are occasions where there is ongoing tension between health providers and Indigenous families because the service delivery model is market driven and privileges individual rights rather than providing a service based on the diversity of needs (for example, those determined by issues of ethnicity, class or gender) (Fine, Michael 2004). My study was intended as a pathway to begin the dialogue between health providers and the Indigenous community by highlighting and amplifying the often ignored voices of Indigenous people. One of the participants spoke of a disturbing experience with a nurse (Wright 2009:164):

> I had advice given to me once…by a psychiatric nurse who was working with my youngest son. [The nurse] was running a behaviour program, he told me 'Here's a trailer', he gave me the address of a place out in the middle of the bush somewhere. He said, 'You tell your kids (boys) nothing, get in the car and go. Run away from it. Take your daughter and run'.

As Paradies (2006:144) states, 'The intertwined concept of privilege/oppression can be defined as: A societal system in which actors are divided along socially constructed dimensions with power unevenly'. The participant tried to access support for her son from the mainstream mental health system and was told by a male mental health nurse that the service could not, or would not, provide her with any support for her son, even though he was eligible, because the system viewed his situation as being too difficult. The worker offered the participant a trailer in a remote location and recommended that she abandon her son. Power and privilege are major contributing factors in relationships where one person is in need and accesses another person, who has institutional power, for help. In this instance the mental health worker who was employed in a powerful position in a legitimated institution misused his position of authority.

The participant had requested a mental health worker to come to her house to do a mental health assessment of her son. Her son was both paranoid and psychotic and he would not leave the house. Her request for a home visit was refused and she was

told that she would need to take her son to the clinic. The reason given for not coming to the participant's home was that the service had discontinued home visits because of lack of funding. The options were limited for the participant. If she contacted the mental health emergency team they would be accompanied by the police. She had serious concerns and doubts about the integrity of the mental health emergency team process so she was not prepared to pursue that option. Mental health issues are not predictable, for when a person is mentally unwell the situations and circumstances can quickly change. When this happens it is often very stressful for the families living with serious mental illness. For mental health providers to be effective for families living with serious mental health issues they need to acknowledge the diversity of needs, for both the person living with a mental illness and for the family. If they fail to do so, they risk becoming irrelevant for Aboriginal families living with serious mental health issues.

The actions and attitudes of the worker were clearly discriminatory; in his privileged position of systemic power as an employed person he felt justified in telling the participant to leave her sons, because the system would not provide for her. He felt justified to direct her personal choices rather than staying within his professional role of providing support for her son's mental health issue. Was there an assumption by the worker that, because the caregiver was a sole parent, Indigenous and on a limited income, he judged his advice as being appropriate? Would someone who was a White employed male be offered similar advice if he had asked for assistance for a family member with mental illness?

Analysis of the multiplicative effects of stigma, discrimination and racism

Western societies are organised into those that are granted privilege and those that are not. In Australia this ordering is often based around race and is underpinned by the impact of colonisation of Indigenous peoples by Europeans (Watson 2005; Huggins 2003). To maintain control and to assert authority over those who were colonised, racist mythology was presented and enforced as truth. For example, a popular racist mythology suggested that people with white skin were inherently superior and right, and those with black skin were inherently inferior and wrong (Lake and Reynolds 2008; Memmi 1965; West 1999). The term 'race' as a biological concept has not always been scientifically supported, but that has not stopped it being propagated as science, which affects people's belief that they must align themselves psychologically with the groups with whom they have a racial connection. Race then becomes socially defined on the basis of physical criteria. It becomes, therefore, a vehicle to separate individuals into groups as defined by their physical and cultural similarities. As a cognitive construct it is additionally linked to assumed predetermined superiority and inferiority of those groups (Lake and Reynolds 2008; West 1999).

Even though in contemporary society scientists and academics agree that there is no biological basis to racism, the general population still uses pseudoscientific explanations for cultural differences. James Jones (1997:364) suggests that the use of the idea of race persists because it 'has meaning for us in everyday life because it provides a good way to value our own group over others; to encapsulate social conflicts, and rationalise our way of handling it; and to talk about group differences, values, and social hierarchy'. He further proposes that racism is complex and in contemporary society it should be viewed from individual, institutional and cultural frameworks. He states that 'culture is to society as personality is to the individual' (Jones, J 1997: 471) and therefore culture is integral to discussions of racism. Cultural racism is insidious, and therefore more difficult to define. The definition for cultural racism proposed by James Jones (1997:472) is:

> Cultural racism comprises the cumulative effects of a racialized world-view, based on belief in essential racial differences that favour the dominant racial group over others. These effects are suffused throughout the culture via institutional structures, ideological beliefs, and personal everyday actions of people in the culture, and these effects are passed on from generation to generation.

Cultural racism is a phenomenon that is a by-product of colonisation (Memmi 1965; Lake and Reynolds 2008) and is still a reality for Indigenous people (Memmi 1965; Watson 2005; Tuhiwai Smith 2003). The ongoing experience of cultural racism continues to have a corrosive effect on Indigenous culture and the mental health wellbeing of Indigenous people (Watson 2005; Huggins 2003).

Racism in Australia remains a contentious topic, rarely acknowledged or discussed (Lake and Reynolds 2008). Policy can address institutional racism but may be less effective in addressing individual and cultural racism. Even though the participants discussed their experiences of both individual and institutional racism, most of their stories were embedded in stories of a deeper context of cultural racism which has been historically devastating for Indigenous Australians. There is now evidence that racism is linked with poor health outcomes (Larson et al. 2007; Paradies et al. 2008; Krieger 2003; Williams, D 1999; Williams, D et al. 2003; Jones, C 2000). The stigma and discrimination of being Indigenous and living with a serious mental illness can be experienced as stressful and can be a precursor to other serious health problems (Paradies et al. 2008). An analysis (Larson et al. 2007; Paradies et al. 2008; Jones, C 2000) of the multiplicative effects of stigma, discrimination and racism revealed that an Indigenous family living with a serious mental illness experienced the same stigma and discrimination common in the wider community, but these families also experienced further stress because of the stigma and discrimination they experienced in relation to racism.

Linking instances of racism and health issues is difficult, but the sheer scale of Indigenous people reporting instances of racism, where they were treated badly because they were Indigenous, is of concern. The effects of cultural racism are also damaging to the psyche of any racial group. In Australia the continual undermining of Indigenous culture has had that effect. Racism, it seems, is enough to make you sick. There is a relationship between poor mental health and racism, as Larson et al. (2007:322) state: '[i]nternalising negative racial stereotypes is a consequence of institutional and interpersonal racism and can result in low self-esteem, depression and hostility'. Links between racism and poor health are becoming accepted: the ongoing impact of racism does have health consequences.

Participants believed that racism was a major obstacle to providing care to an Aboriginal family member living with a serious mental illness. It is highly likely that an Indigenous person living with a serious mental illness will often experience dual discrimination on the basis of both identities: race and mental illness. As one of the participants living with a serious mental illness quite graphically described when asked what it was like to be Aboriginal and have a mental illness (Wright 2009:172):

> I mean it's bad enough living with a mental illness but they look at you because you're Aboriginal anyway; you're getting the look and it's ten times worse if you've got a mental illness. I mean, people look at you like you're lower than low and you're not. It's not right! It's badder than being low but then you're lower than low. You can't win! I think it's really, really bad and I think really serious.

This participant's experience was amplified by the public discrimination against people with mental illness. The experiences of the participant were compounded; she felt she was not only being judged harshly for having a mental illness but also because of her Aboriginality. She was both confused and angry, and, as she says, 'you can't win'. Indeed, as a young Aboriginal woman she was experiencing a form of cultural racism, for as she says, 'people look at you like you're lower than low'. Living with this form of racism becomes the central point of reference for Indigenous people, and then it can be internalised as the psychological reality of their being (Jones, J 1997).

The issues of stigma and discrimination confronting Indigenous families living with a serious mental illness are similar to, but also distinct from, those experienced by non-Indigenous people. Indigenous Australians experience racism and discrimination that has been shown to have an impact on their health and wellbeing (Larson et al. 2007; Paradies et al. 2008; Cunningham et al. 2003; Hall et al. 2004). If you are Indigenous and have a mental illness the stress of the stigma and discrimination of living with a serious mental illness further exacerbates the situation (Thornicroft et al 2009; Sartorius 2002; Schulze 2009; Thompson et al. 2005). Combined effects of dual discrimination, of racism and stigma, have a multiplicative effect in terms of the stress placed on both the family and the Indigenous person living with a mental illness.

Conclusion

The study sought to define the full scope of care-giving by including multiple perspectives on the care-giving experiences of participants in an Indigenous context. The contribution and importance of the activity of care-giving in providing stability in Indigenous families and communities is often underestimated. Care-giving in an Indigenous context is an integral part of the web of Indigenous life and is a major contributor to the health and wellbeing of people and community.

I argued in my thesis that the current Australian Bureau of Statistics definition has significant limitations when applied in an Indigenous context. The binary focus of care-giving as stated in the mainstream literature does not adequately describe an Indigenous experience of care-giving. I therefore proposed the following definition of care-giving be applied as I believe it provides a more realistic explanation (Wright 2009:204):

> Indigenous care-giving should be viewed as a whole of life experience and seen in the context of an individual nested within their family, and their community. Care-giving includes all of the social, emotional and cultural support that enhances the well-being of the individual, family and the community where a member has a disability.

A family member receiving care was held within a kinship system based on Indigenous cultural norms and values that are present in family and community. This kinship system provides support and healing around the multiple stresses and traumatic events that often accompany serious mental illness. An Indigenous experience of care-giving as shown in my study needs to be nested within the ecological context of the family, kin system and community and needs to reflect the reciprocal care needs of the caregiver and the family. An Indigenous caregiver's experience cannot be accurately reflected by simply focusing on the non-Indigenous concept of an 'individual caregiver and care receiver' (Wright 2009:202).

Indigenous people have experienced the worst aspects and indignity of what colonialism offers and its legacy continues today in poor health and wellbeing outcomes (Larson et al. 2007; Paradies 2006; Paradies et al. 2008). Mental health is included in these outcomes. The ongoing effects of racism in Australia remain a defining issue for Indigenous Australians, and the experiences of the Aboriginal respondents in my study affirmed that their experiences of racism impacted on their ability to provide care for family members living with serious mental illness (Wright 2009).

Acknowledgments

I would like to acknowledge the participants, who gave generously of their time, intellect and wisdom. Their very generous and supportive contributions allowed me

to complete my studies and provided the impetus for submitting an application for a National Health and Medical Research Council Training Fellowship. I am very grateful for their support. I would like to also acknowledge Ruah Community Services for assistance in supporting both the project and participants and with the generous contribution of resources, time and goodwill.

References

Allen, Susan and Desiré Ciambrone 2003 'Community care for people with disability: Blurring boundaries between formal and informal caregivers', *Qualitative Health Research* 13(2):207–26.

Australian Bureau of Statistics 2003 *Disability, Ageing and Carers: Summary of findings*, <www.abs.gov.au/ausstats/abs@.nsf/mediareleasesbytitle/49BEE5774F0FB1B1CA256E8B00830DF6?OpenDocument> accessed 27 April 2012.

Battiste, Marie 2008 'Research ethics for protecting Indigenous knowledge and heritage: Institutional and researcher responsibilities' in N Denzin,Y Lincoln and L Smith (eds), *Handbook of Critical and Indigenous Methodologies*, Sage Publications Inc., Thousand Oaks, CA, pp.497–509.

Biegel, David and Richard Schulz 1999 'Caregiving and caregiver interventions in aging and mental illness', *Family Relations* 48(4):345–54.

Bishop, Russell 2005 'Freeing ourselves from neocolonial domination in research: A Kaupapa Maori approach to creating knowledge' in N Denzin and Y Lincoln (eds), *Handbook of Qualitative Research*, Sage Publications Inc., Thousand Oaks, CA, pp.109–38.

Bronfenbrenner, Urie 1979 *Basics Concepts: The ecology of human development experiments by nature and design*, Harvard University Press, Cambridge, MA.

——1986 'Ecology of the family as a context for human development: Research perspectives', *Developmental Psychology* 22(6):723–42.

—— 1994 'Nature–nurture reconceptualized in developmental perspective: A bioecological model', *Psychological Review* 101(4):568–86.

COAG (Council of Australian Governments) 2003 *Steering Committee for the Review of Government Service Provision Overcoming Indigenous Disadvantage: Key indicators 2003*, Council of Australian Governments, Canberra.

Cook-Lynn, Elizabeth 2008 'History, myth, and identity in the new Indian story' in N Denzin, Y Lincoln and L Smith (eds), *Handbook of Critical and Indigenous Methodologies*, Sage Publications Inc., Thousand Oaks, CA, pp.329–46.

Crosato, Kay, Catherine Ward-Griffin and Beverly Leipert 2007 'Aboriginal women caregivers of the elderly in geographically isolated communities', *Journal of Rural and Remote Health Research, Education, Practice and Policy* 7(3):1–12, <www.rrh.org.au/publishedarticles/article_print_796.pdf> accessed 23 June 2012.

Cunningham, Chris, Jeff Reading and Sandra Eades 2003 'Health research and indigenous health', *British Medical Journal* 327:445–7.

Dudgeon, Patricia 2008 'Empowering research with Indigenous communities', *Ngoonjook: A Journal of Australian Indigenous Issues* 32:8–26.

Elder, Glen Jr, Tri Van Nguyen and Avshalom Caspi 1985 'Linking family hardship to children's lives', *Child Development* 56(2):361–75.

Fine, Michael 2004 'Renewing the social vision of care', *Australian Journal of Social Issues* 39(3):217–32.

——2005 'Individualization, risk and the body: Sociology and care', *Journal of Sociology* 41(3):247–66.

Fine, Michelle and Marie Torre 2006 'Intimate details: Participatory action research in prison', *Action Research* 4(3):253–69.

——and Lois Weis 2005 'Compositional studies, in two parts: Critical theorizing and analysis on social (in) justice' in N Denzin and Y Lincoln (eds), *Handbook of Qualitative Research*, Sage Publications Inc., Thousand Oaks, CA, pp.65–84.

Foley Dennis, 2003 'Indigenous epistemology and Indigenous standpoint theory', *Social Alternatives* 22(1):44–52.

Fredericks, Bronwyn, Karen Adams, Summer Finlay, Gillian Fletcher, Simone Andy, Lyn Briggs et al. 2011 'Engaging the practice of Indigenous yarning in action research', *Action Learning Action Research Journal* 17(2):8–20.

Germov, John 2005 'Class, health inequality, and social justice' in J Germov (ed.), *Second Opinion: An introduction to health sociology*, Oxford University Press, South Melbourne, pp.3–27.

Giroux, Henry and Susan Giroux 2008 'Challenging neoliberalism's new world order: The promise of critical pedagogy' in N Denzin, Y Lincoln and L Smith (eds), *Handbook of Critical and Indigenous Methodologies*, Sage Publications Inc., Thousand Oaks, CA, pp.181–9.

Hall, Sonja, Caroline Bulsara, Max Bulsara, Tim Leahy, Margaret Culbong, Delia Hendrie and D'Arcy Holman 2004 'Treatment patterns for cancer in Western Australia: Does being Indigenous make a difference?', *Medical Journal of Australia* 181(4):191–4.

Held, Virginia 1995 *Justice and Care: Essential readings in feminist ethics*, Westview Press, Boulder, CO.

Hooks, Bell 1990 'Marginality as a site of resistance' in R Ferguson, M Gever, T Minh-ha and C West (eds), *Out There: Marginalization and contemporary cultures*, Massachusetts Institute of Technology, Cambridge, MA, pp.337–56.

Huggins, Jackie 2003 'Always was and always will be' in M Grossman (ed.), *Blacklines: Contemporary critical writings by Indigenous Australians*, Melbourne University Press, Melbourne.

Jones, Camara 2000 'Levels of racism: A theoretic framework and a gardener's tale', *American Journal of Public Health* 90(8):1212–15.

Jones, James 1997 *Prejudice and Racism*, McGraw-Hill, New York.

Krieger, Nancy 2003 'Does racism harm health? Did child abuse exist before 1962? On explicit questions, critical science, and current controversies: An ecosocial perspective', *American Journal of Public Health* 93(2):194–9.

Lake, Marilyn and Henry Reynolds 2008 *Drawing the Global Colour Line: White men's countries and the question of racial equality*, Melbourne University Press, Melbourne.

Land, Clare 2011 'Decolonising activism/deactivating colonialism', *Action Learning, Action Research Journal* 17(2):42–62.

Larson, Ann, Marisa Gillies, Peter Howard and Juli Coffin 2007 'It's enough to make you sick: The impact of racism on the health of Aboriginal Australians', *Australian and New Zealand Journal of Public Health* 31(4):322–9.

Lather, Patti 1991 *Getting Smart: Feminist research and pedagogy with/in the postmodern*, Routledge, New York.

Lefley, Harriet 1997 'The consumer vision: Will it alleviate family burden?', *American Journal of Orthopsychiatry* 67(2):210–19.

Memmi, Albert 1965 *The Colonizer and the Colonized*, The Orion Press, New York.

Minkler, Meredith and Nina Wallerstein 2008 'Introduction to community-based participatory research' in M Minkler and N Wallerstein (eds), *Community-based Participatory Research in Health*, Jossey-Bass, San Francisco, CA, pp.5–23.

Paradies, Yin 2006 'Defining, conceptualizing and characterizing racism in health research', *Critical Public Health* 16(2):143–57.

——, Ricci Harris and Ian Anderson 2008 *The Impact of Racism on Indigenous Health in Australia and Aotearoa: Towards a research agenda*, Cooperative Research Centre for Aboriginal Health, Darwin (Discussion Paper No. 4).

Pyett, Priscilla 2002 'Working together to reduce health inequalities: Reflections on a collaborative participatory approach to health research', *Australian and New Zealand Journal of Public Health* 26(4):332–6.

Sartorius, Norman 2002 'Iatrogenic stigma of mental illness', *British Medical Journal* 324:1470–1.

Scarr, Sandra and Kathleen McCartney 1983 'How people make their own environments: A theory of genotype – environment effects', *Child Development* 54(2):424–35.

Schulze, Beate 2009 'Mental-health stigma: Expanding the focus, joining forces', *Lancet* 373:362–3.

Stanley, Fiona 2007 'Keynote address: The health and wellbeing of Australians', address to Treasury Staff, 21 November, Canberra (Treasury Seminar Series).

Thompson, Vetta, Noel Jeffrey and Jean Campbell 2005 'Stigmatization, discrimination, and mental health: The impact of multiple identity status', *American Journal of Orthopsychiatry* 74(4):529–44.

Thornicroft Graham, Elaine Brohan, Diana Rose, Norman Sartorius and Marven Leese 2009 'Global pattern of experienced and anticipated discrimination against people with schizophrenia: A cross-sectional survey', *Lancet* 373:408–15.

Tronto, Joan 1995 'Women and caring: What can feminists learn about morality from caring?' in V Held (ed.), *Justice and Care: Essential readings in feminist ethics*, Westview Press, Boulder, CO, pp.101–15.

Tuck, Eve 2009 'Suspending damage: A letter to communities,' *Harvard Educational Review* 79(3):409–27.

Tuhiwai Smith, Linda 2003 *Decolonizing Methodologies: Research and indigenous peoples*, University of Otago Press, Dunedin.

——2005 'On tricky ground: Researching the native in the age of uncertainty' in N Denzin and Y Lincoln (eds), *Qualitative Research*, Sage Publications, Thousand Oaks, CA, pp.85–107.

Wallerstein, Nina 1999 'Power between evaluator and community: Research relationships within New Mexico's healthier communities', *Social Science and Medicine* 49:39–53.

——and Victoria Sanchez-Merki 1994 'Freirian praxis in health education: Research results from an adolescent prevention program', *Health Education Research: Theory and Practice* 9(1):105–18.

Watson, Irene 2005 'Illusionists and hunters: Being Aboriginal in this occupied space', *Australian Feminist Law Journal* 22(15):15–28.

Weis, Lois and Michelle Fine 2004 'Compositional studies in four parts—Critical theorizing and analysis on social (in) justice' in L Weis and M Fine (eds), *Working Method: Research and social justice*, Routledge, New York, pp.xv–xxiv.

West, Cornel 1999 *The Cornel West Reader*, Basic Civitas Books, New York.

Williams, Charmaine and Magnus Mfoafo-M'Carthy 2006 'Care: Giving, receiving and meaning in the context of mental illness', *Psychiatry* 69(1):26–44.

Williams, David 1999 'Race, socioeconomic status, and health: The added effects of racism and discrimination', *Annals of New York Academy of Sciences* 896:173–88.

——, Harold Neighbours and James Jackson 2003 'Racial/ethnic discrimination and health: Findings from community studies', *American Journal of Public Health* 93(2):200–08.

Wright, Michael 2009 Out of the Blue: Giving and receiving care: Aboriginal experiences of care-giving in the context of mental illness, unpublished PhD thesis, School of Public Health, Curtin University, Perth.

——2011 'Research as intervention: Engaging silenced voices', *Action Learning, Action Research Journal* 17(2):25–46.

Note

1. I use the term 'Aboriginal' rather than 'Aboriginal and Torres Strait Islander' in the title because there were no Torres Strait Islander people involved in my study and also because the participants were more familiar and comfortable with the use of the word 'Aboriginal'. I also use the term 'Indigenous' in this paper to refer both to the Aboriginal and Torres Strait Islander people of Australia and other indigenous groups residing in other parts of the world.

Chapter 9

Empowering public health research: An Indigenous and non-Indigenous reflection on public health research

Michael Wright
Telethon Institute of Child Health Research

Brian F McCoy
La Trobe University

Abstract: *The emergence of Indigenous[1] researchers in health research provides a challenge to the dominance of particular Western-based research understandings, approaches and practices. Tensions can exist between very different worldviews and the resulting research approaches taken by Indigenous and non-Indigenous researchers, expressed in key elements of underlying, and sometimes quite different, ontologies (how we understand ourselves and our world; i.e. what it means to exist) and epistemologies (how we describe what we understand; i.e. what it means to know). Hence, in the contemporary context of health research among Indigenous peoples, how is health perceived from Indigenous and non-Indigenous perspectives? What remain the challenges?*

Introduction

This paper arose out of discussions between two men, one of Indigenous descent and one not, both presently engaged in health research within the Australian Aboriginal and Torres Strait Islander community. We wish to illustrate different experiences and approaches to research through the particular lens and background of colonisation. This starting point serves to challenge existing research methods and their often unreflective and underlying ontologies and epistemologies. It raises questions around the nature of research partnerships and relationships with Aboriginal and Torres Strait Islander communities and between Indigenous and non-Indigenous researchers. We

wish to present two very different voices, but also try to seek a common voice that will enable a new pathway to be explored within health and health research.

Within Australia there currently exists an obvious and serious challenge for Indigenous and non-Indigenous researchers when conducting research with Indigenous peoples. There are guidelines that outline the requirements for such research and they have been reviewed, developed and improved in recent years (NHMRC 2003, 2006). On the one hand, there would appear to be a growing consensus to introduce these research guidelines, however long it takes to implement them within projects or communities. On the other hand, there can be pressures from universities, funding bodies and researchers' families (apart from the researcher) for research projects to be completed as quickly and efficiently as possible. Tensions can arise when time is taken for consultation and negotiation, or in establishing advisory groups or in gaining community understanding and approval. Indigenous people and their values can be put aside in the interest of expediency and efficiency. The exclusive dominance of Western medical health care results.

An Indigenous health researcher's perspective

As an Indigenous health researcher I would like to begin with a focus on understanding the impact of 'social pathology' (Bishop 2005) in the representation of Indigenous people and its influences on the conduct of health research. Bishop (2005:110) has argued:

> There has developed a social pathology research approach in Aotearoa/New Zealand that has implied, in all phases of the research process, the 'inability' of Maori culture to cope with human problems and proposed that Maori culture was and is inferior to that of the colonizers in human terms.

Hence, researchers can come to address Indigenous health along with a number of assumptions around the superiority of Western medicine and health care. I would like to argue that there needs to be a greater acknowledgment of and respect for ontological and epistemological perspectives held by Indigenous people and, finally, argue for the role of the public health researcher as activist.

Social pathology

Researchers play a major role in the lives of the participants they engage. The Indigenous educator and activist Lilla Watson offered the following challenge to those intending to be, or who were already, involved in the struggle for Indigenous rights (Lilla: International Women's Network n.d.): 'If you have come to help me, you are wasting your time. If you have come because your liberation is bound up with mine, let us work together.'

As an Indigenous researcher I was determined to adopt research methods that would not further disadvantage and oppress Indigenous people. Therefore, I am conscious of engaging with the community in a way that incorporates partnership and collaboration, striving for more transparency in my research practices. There always remains the need and challenge to disseminate information with the purpose of highlighting social injustices and health inequities without inadvertently causing harm and the continuation of the perception of 'social pathology'.

Research practices have long been intricately linked to colonising activities, not just in Australia but in other parts of the world as well (Tuck 2009; Bishop 2005; Cook-Lynn 2008; Grande 2008). For example, in the area of knowledge development and advocacy, the enduring structures of colonisation continue to restrict the ability of Indigenous people to gain legitimacy for their own worldview (Battiste 2008; Nakata 2007; Tuhiwai Smith 2003). To truly engage with Indigenous people a research process requires openness and trust. Unfortunately, Indigenous people often do not experience complete openness or trust, much less dialogue, either from non-Indigenous researchers or from the wider society.

Consequently, researchers are now faced with the challenge when working with Indigenous people that their research processes do not disempower or oppress (Tuhiwai Smith 2003). Indigenous researchers Eve Tuck (2009) and Russell Bishop (2005) are challenging health researchers to reflect on their research practices, in particular the practice of presenting research findings that continually give the impression that Indigenous cultures are universally dysfunctional and broken. Bishop (2005) describes this type of research practice as 'pathologising'; they are research practices that inadvertently undermine Indigenous culture because their research findings usually portray Indigenous people as being uniformly dysfunctional and incapable of coping with contemporary society. Even though researchers have 'good intentions' in their practice of presenting findings that can be very graphic, their intention to highlight the disparity between Indigenous and non-Indigenous people is causing long-term damage. Tuck (2009) refers to it as 'damaged-centered research', and I believe it is no longer acceptable and researchers need to re-think their research approaches and practices, as well as the ways in which they communicate their research findings.

The question relating to the unique ontological and epistemological frameworks of Indigenous peoples is important. However, as there is not sufficient time in this paper to explore those frameworks in great detail, I wish to acknowledge Indigenous and non-Indigenous scholars who have been working on the development of an Indigenous standpoint theory (e.g. Rigney 1997, 2001; Nakata 2007; Moreton-Robinson 2000; Henry et al. 2002; Foley, Dennis 2003; Foley, Douglas and Valenzuela 2005; Bishop 2005; Battiste 2008; Cook-Lynn 2008). Their work has provided, and continues to provide, inspiration and encouragement and I am very grateful for their efforts and insights in helping me in my own development as an academic. I believe Indigenous frameworks and standpoints are critical as they shape the way people see

the world and give it meaning. Links to land, the ancestral 'dreaming' or creation time are such examples. People come with a deep spirituality that affects their relationships with others, including living creatures. People also have frameworks around the ways in which knowledge is learned and passed on to younger generations. Indigenous people have a long oral tradition in which songs, dances and ceremonies maintain cultural knowledge and provide social reproduction. People are deeply educated in many ways.

Once we accept that there exists a range of Indigenous knowledge and understanding frameworks, we also need to accept that there are different Indigenous approaches to exploring and discovering key elements of health and wellbeing within people's lives (Wright 2011). Hence, these elements affect research and people's experience of research. An Indigenous research framework acknowledges family, community obligations and commitments as being core values, in contrast to a Western approach to research that privileges individualism and objectivity (Wright 2011).

To seek 'objectivity' (i.e. framing issues clearly and without hidden bias) for Indigenous researchers is important, but it should not compromise the network of relationships that bind communities. There are researchers who are critiquing the work of research methodologies, and argue that researchers need to be more than narrowly objective in their practice. Weseen and Wong (2000:34) state that there 'has long been a tendency to view the self of the social science observer as a potential contaminant, something to be separated out, neutralised, minimised, standardised, and controlled'. My approach to research has been to work with research methodologies that fit with the rhythm and pace of the participants and, importantly, are committed to redressing social inequalities (Wright 2011). For example, participatory action research is a research methodology that works with an action–reflection–action practice and insists that participants have the opportunity to control the research process (Wallerstein and Sanchez-Merki 1994; Bishop 2005; Fine and Weis 2005; Battiste 2008). I believe that Indigenous people involved in research activities, either as participants or researchers, are all engaged in the construction and validation of knowledge within a community context and on terms that validate ancient knowledge.

Often, there is only token acceptance by the Academy of an Indigenous worldview that speaks of time, space and consciousness in a holistic context. This context includes life in both human and non-human forms, space and time, and includes people, animals and the landscape. It is all of these elements that influence the Indigenous worldview/cosmos. Importantly, Indigenous research processes tend to value the relational; more time is regularly spent on preparation and on establishing and holding of relationships. All of this requires a high regard and responsiveness to a community. It requires a different method and approach to research. As Marker (2004:105) states, research needs to be approached with 'humility, sensitivity and openness'. The relational approach adopted by Indigenous researchers would seem to be a core part of an Indigenous methodology. Indigenous research seeks to protect

culture with the continued awareness of a cultural belonging. Within the framework of Indigenous knowledge, there is an understanding of the importance of relationships for they are held within oral traditions of history and culture.

The health researcher as activist

There is a challenge for researchers to be more than just one-dimensional. They need to be focused on two outcomes: first, dismantling the structures of oppression, and, second, facilitating a process that provides for consciousness-raising (Rigney 2001). Researchers working with Indigenous people need to be involved in activism at a grassroots level and to engage with communities in consciousness-raising activities to challenge the structures of colonisation (Madison 2005; Bishop 2005; Wright 2011). I believe that when the researcher is involved in Indigenous research it follows that his or her position would also be that of an activist.

Researchers who adopt the activist position understand that Eurocentric research practices are linked to the continuation of social inequality. There is the false notion of research neutrality, for the social contexts in which we all live are political. There is the need for public health researchers to be political and proactive and challenge social inequality. There is the need and role for public health researchers to be involved in uncovering social injustice and inequalities in health.

As an Indigenous researcher I am left with a final question: given the cultural sensitivity of certain issues within an Indigenous community, and bearing in mind how research has historically aided the perception of pathology within Indigenous communities, should all information be included in a study or research project? If not, why not, and who decides?

A non-Indigenous perspective

As a non-Indigenous researcher I, also, am interested in how not to engage a 'social pathology' that I have witnessed in the representation of Indigenous people over recent years, witnessed particularly, and more recently, in relation to the Northern Territory intervention. On this, Pat Dodson (2007:21) has commented:

> Our nation is confronted with a searing moral challenge. A cultural genocide agenda has been foisted on the Australian public in the context of extensive media coverage about the social collapse of Indigenous communities, centred on sexual abuse of children and rampant violence fuelled by alcohol and drugs. Rather than explaining the human tragedy caused by decades of under-investment by governments in capital and social infrastructure, the Howard Government has promoted a neo-conservative public discourse in which Aboriginal people's failure to take responsibility has become the central tenet of the debate.

I am also wishing to engage that representation within the concrete context of Indigenous life and health. In coming to understand something of the ontological and epistemological bases of human knowledge within Indigenous peoples, I want to explore how that affects my own understanding of research. And, finally, ask the question: what are the challenges this engagement now makes of me?

Working with Indigenous people necessarily causes me to consider the attitudes and assumptions that I bring to the social and cultural context of their health. It also, and sometimes with great difficulty, causes me to grapple with a knowledge and value system sometimes quite different from my own. An ontology that connects the meaning and experience of health with an ancestral past that is linked to particular land or 'country' is not one I was brought up in as a member of a Western culture with a Judaeo-Christian spiritual worldview. Nor was I brought up with an epistemology that seeks to understand what is knowledge, valid and 'true' through relationships with Elders, spirits and ceremonies that are performed upon the land. Similarly, as I seek to explore how I might better understand these meanings, I have come to realise that health research does not always or comfortably attend to those understandings that Indigenous people are making of their world or to the questions they sometimes prefer to ask. What I seek to find meaning about, and hence what I seek to understand, resolve and improve, is not necessarily what Indigenous friends and colleagues are asking or seeking to know, relate with or, much less, change. Many times I experience a common ground; at other times, I experience difference.

When living in a remote Aboriginal community I was often reminded of this common but different ground of health that I shared with the local people (McCoy 2008:226):

> It was a Saturday morning when news had gone around the community that an older woman was dying. People came and filled the house where she lay, unconscious in her bed. Some cried as they watched and waited. Attending her were nurses, church leaders and local healers or *maparn.*[2] Each provided moments of care and attention, attempting to save her from death. The nurses maintained a drip, the church leaders prayed and anointed her with oil and the *maparn* worked to remove the sickness from her body.[3] After a long period of time the old lady suddenly stirred and a little later sat up in bed. She seemed oblivious to the large and concerned gathering around her and shortly spoke and asked for something to eat. The change in her physical state was remarkable. Later, the nurses said that she had recovered from a diabetic coma, but the church leaders and *maparn* also maintained that their interventions had made a significant difference to her recovery. Her family was happy and all those involved were pleased. She was alive and well, all due to the efforts of nurses, church leaders and *maparn.*

This event became one of the clearest examples in my experience of the interplay of different health models. Each model had its own particular way of understanding how

sickness and healing can affect the human person. This range of models applies across all of Australia. In urban Indigenous communities the biomedical, the cultural and the spiritual offer different ways of understanding illness and approaches to healing.

However, the event just described is an example where a partnership around providing health care is possible. Here, different groups came together with their particular skills and concerns. No group sought to dominate the other but worked together. The patient, and her family, had trust in the various means for healing that were being offered. At the same time, I was aware that some of the healers saw their efforts as a contribution to that offered by others. Some, however, saw their form of healing as the most appropriate one at that time.

In this context, it is worth noting the emphasis in recent years that has been placed on understanding Aboriginal perspectives on health and wellbeing, particularly through the lens of spirituality. In the Family Wellbeing project that was developed in the community of Yarrabah (north Queensland), an approach was made to research the role that spirituality played in the social and emotional life of the people who lived there (McEwan et al. 2008). Spirituality 'was obviously important to participants' (McEwan et al. 2008:1), and 'feelings, attitudes and values — such as empathy and hope — are important aspects of individual and community spiritual life' (McEwan et al. 2008:20).

Similarly, Vicki Grieves, in her discussion paper *Aboriginal Spirituality: Aboriginal philosophy, the basis of Aboriginal social and emotional wellbeing* (2009:1), notes that there are 'differences in belief, practice and history' across the Indigenous groups of Australia. However, 'there are also many commonalities' (Grieves 2009:1). One commonality that is shared is around 'spirituality as the philosophical basis of wellbeing' (Grieves 2009:1).

It is the experience of the authors of this paper that Aboriginal and Torres Strait Islander people who live in urban communities both believe and practise forms of healing that derive from their cultural and community identity. These forms of healing can remain hidden from Western health providers, but they continue.

In the context of this discussion, it is worth noting that a category of 'traditional healers' (or something similar) was not offered in the 2008 edition of *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008* (ABS and AIHW 2008). The report aimed to present 'a comprehensive picture of Indigenous Australians' access to, and use of, health services' (ABS and AIHW 2008:187). It alerted the readers to 'factors that impact on access to and use of health services', such as cultural factors (ABS and AIHW 2008:187). It noted that 16% of Aboriginal and Torres Strait Islander people 'felt they were treated badly when they sought health care because they were Indigenous' (ABS and AIHW 2008:191). While the report clearly offered a perspective of health access and service delivery through the lens of Western medical care, it also quoted this comment from Bailey (2005): 'A lack of understanding of Aboriginal and Torres Strait Islander culture, concepts of health and history, and Western-dominated models of care can result in Indigenous Australians feeling disempowered and less likely to use health services' (ABS and AIHW 2008:191).

It is within this experience of being 'disempowered' that Indigenous experiences across Australia share much similarity. While the example of traditional healers, as mentioned, might suggest a more significant issue for some Western health providers in remote communities and towns, the concept of health and history with Western-dominated models of care applies across all Indigenous communities. In fact, it may apply more to urban Indigenous people whose culture may seem less obvious to outsiders. As a result, Indigenous people can feel disempowered as they engage health service provision. They can believe that their culture and history, however it is understood and expressed within local communities, is ignored, and perhaps even negatively judged. They can lead some to believe that their experience of ill-health is, somehow, a result of simply being Indigenous. The price of a short life-expectancy is associated with being Aboriginal or Torres Strait Islander.

The various ways in which a dominant Western model of health care can be assumed, and Indigenous peoples' beliefs about sickness and health can be ignored or marginalised, suggest a number of things. We are not dealing here simply with a lack of recognition of traditional healers and their efforts to improve their peoples' health, but with Western cultural assumptions about the nature of health (hence questions about how we understand this world and the nature of sickness in it; i.e. ontological questions) and resistance to other forms of human healing (questions about how we come to know and describe the different ways in which health and healing can be communicated and understood; i.e. epistemological questions).

As non-Indigenous people we can admit to a need to understand Aboriginal and Torres Strait Islander culture, concepts of health and history, and Western-dominated models of care, without any self-scrutiny as to the deeper implications of our attitudes and behaviour. Do we do so because we do not see any link between Indigenous culture, health and history? Do we wish to interrogate the limitations of our Western models of health care? Do we continue to pathologise Indigenous communities because we believe that it is their culture that prevents them from being well?

I have come to understand that the provision of Western health care can continue the colonising process. As it seeks to heal and improve people's health, it can also work within narrow parameters of service and closed paradigms of belief. Why is it that alternative models of healing, in remote, rural and urban communities, are not recognised and acknowledged? What is the history and culture that Indigenous people bring with them? How does this history and culture shape their experience of health but, also, how can it better shape and influence those who are providing health care?

Conclusion

In this paper we have argued that it is not possible to consider the nature of Indigenous health research outside the history of colonisation within this country. In this context, it is not surprising that developing research protocols will continue to take time, but will

also be in constant need of change and adaptation. Such an active reflective process will necessarily engage a number of particular challenges: the need to prioritise and privilege Indigenous peoples' experiences and values and a more active engagement by them with researchers, research methods and research results. At the same time, we will need to develop a more lively awareness and discussion about the health implications of greater attention to Indigenous ontologies and epistemologies. The particular and distinctive ways in which Indigenous people understand and express meanings of their social, spiritual and communal worlds will continue to shape how health research is to be understood, done and done well.

As we have suggested in this paper, this change of relationship acknowledges a moving away from a 'pathologising' of Indigenous people. It puts priority on an Indigenous perspective and approach to research; it acknowledges a shifting in how non-Indigenous people perceive their attitudes, power and privilege. This is not to suggest that research methods become compromised, that poor research is done, or that Indigenous people will only hear the results they want to hear. It suggests a more robust and honest relationship between researchers and Indigenous people.

The importance of developing and promoting such a process cannot be over-stressed. Nor can the potential benefits. As the Academy and also policy makers and providers shift in their understandings of the ways in which they continue to endorse the provisions of health, this will encourage both Indigenous and non-Indigenous researchers to engage a process that will provide greater and longer-term benefit to Indigenous communities. It also offers Indigenous people within these communities the right to expect greater respect of their own values and beliefs in improving their life, health and wellbeing outcomes.

References

ABS and AIHW (Australian Bureau of Statistics and Australian Institute of Health and Welfare) 2008 *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*, ABS, Canberra (ABS 4704.0 and AIHW 21).

Bailey, Jenine 2005 *You're Not Listening to Me!! Aboriginal mental health is different — don't you understand??*, <http://archive.healthinfonet.ecu.edu.au/html/html_culture/published_resources/pub_conferences.htm> accessed 14 June 2011.

Battiste, Marie 2008 'Research ethics for protecting Indigenous knowledge and heritage: Institutional and researcher responsibilities' in N Denzin,Y Lincoln and L Smith (eds), *Handbook of Critical and Indigenous Methodologies*, Sage Publications Inc., Thousand Oaks, CA, pp.497–509.

Bishop, Russell 2005 'Freeing ourselves from neocolonial domination in research: A Kaupapa Maori approach to creating knowledge' in N Denzin and Y Lincoln (eds), *Handbook of Qualitative Research*, Sage Publications Inc., Thousand Oaks, CA, pp.109–38.

Cook-Lynn, Elizabeth 2008 'History, myth, and identity in the new Indian story' in N Denzin, Y Lincoln and L Smith (eds), *Handbook of Critical and Indigenous Methodologies*, Sage Publications Inc., Thousand Oaks, CA, pp.329–46.

Dodson, Patrick 2007 'Whatever happened to reconciliation?' in Jon Altman and Melinda Hinkson (eds), *Coercive Reconciliation*, Arena Publications Association, North Carlton, Vic., pp.21–9.

Fine, Michelle and Lois Weis 2005 'Compositional studies, in two parts: Critical theorizing and analysis on social (in) justice' in N Denzin and Y Lincoln (eds), *Handbook of Qualitative Research*, Sage Publications Inc., Thousand Oaks, CA, pp.65–84.

Foley, Dennis 2003 'Indigenous epistemology and Indigenous standpoint theory', *Social Alternatives* 22(1):44–52.

Foley, Douglas and Angela Valenzuela 2005 'Critical ethnography: The politics of collaboration' in N Denzin and Y Lincoln (eds), *Handbook of Qualitative Research*, Sage Publications Inc., Thousand Oaks, CA, pp.217–34.

Grande, Sandy 2008 'Red pedagogy: The un-methodology' in N Denzin, Y Lincoln and L Smith (eds), *Handbook of Critical and Indigenous Methodologies*, Sage Publications Inc., Thousand Oaks, CA, pp.233–54.

Grieves, Vicki 2009 *Aboriginal Spirituality: Aboriginal philosophy, the basis of Aboriginal social and emotional wellbeing*, Cooperative Research Centre for Aboriginal Health, Darwin (Discussion Paper No. 9).

Henry, John, Terry Dunbar, Allan Arnott, Margaret Scrimgeour, Sally Mathews, Lorna Murakami-Gold and Allison Chamberlain 2002 *Indigenous Research Reform Agenda: Rethinking researching methodologies*, Cooperative Research Centre for Aboriginal and Tropical Health, Darwin.

Lilla: International Women's Network n.d. 'About', <http://lillanetwork.wordpress.com/about> accessed 7 July 2012.

McCoy, Brian 2008 'Outside the ward and clinic: Healing the Aboriginal body', *Journal of Contemporary Ethnography* 37(2):226–45.

McEwan, Alexandra, Komla Tsey and the Empowerment Team 2008 *The Role of Spirituality In Social and Emotional Wellbeing Initiatives: The Family Wellbeing Program at Yarrabah*, Cooperative Research Centre for Aboriginal Health, Darwin (Discussion Paper No. 7).

Madison, Soyini 2005 'Critical ethnography as street performance: Reflections of home, race, murder, and justice' in N Denzin and Y Lincoln (eds), *Handbook of Qualitative Research*, Sage Publications Inc., Thousand Oaks, CA, pp.537–46.

Marker, Michael 2004 'Theories and disciplines as sites of struggle: The reproduction of colonial dominance through the controlling knowledge in the Academy', *Canadian Journal of Native Education* 28(1/2):102–10.

Moreton-Robinson, Aileen 2000 *Talkin' Up to the White Woman: Indigenous women and feminism*, University of Queensland Press, St Lucia, Qld.

Nakata, Martin 2007 *Disciplining the Savages, Savaging the Disciplines*, Aboriginal Studies Press, Canberra.

NHMRC (National Health and Medical Research Council) 2003 *Values and Ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research*, Australian Government, Canberra.

——2006 *Keeping Research on Track: A guide for Aboriginal and Torres Strait Islander peoples about health research ethics*, Australian Government, Canberra.

Rigney, Lester-Irabinna 1997 'Internationalisation of an Indigenous anti-colonial critique of research methodologies: A guide to indigenist research methodology and its principles', *Wicazo Sa Review* 14(2):109–21.

——2001 'A first perspective of Indigenous Australian participation in science: Framing Indigenous research towards Indigenous Australian Intellectual sovereignty', *Kaurna Higher Education Journal* 7:1–13.

Tuck, Eve 2009 'Suspending damage: A letter to communities', *Harvard Educational Review* 79(3):409–27.

Tuhiwai Smith, Linda 2003 *Decolonizing Methodologies: Research and indigenous peoples, University of Otago Press, Dunedin.*

Wallerstein, Nina and Victoria Sanchez-Merki 1994 'Freirian praxis in health education: Research results from an adolescent prevention program', *Health Education Research* 9(1):105–18.

Weseen, Susan and Mun Wong 2000 'Qualitative research, representations, and social responsibilities' in L Weis and M Fine (eds), *Speed Bumps: A student-friendly guide to qualitative research*, Teachers College Press, New York, pp.32–66.

Wright, Michael 2011 'Research as intervention: Engaging silenced voices', *Action Learning Research Journal* 17(2):25–46.

Notes

1. The term 'Indigenous' in this paper refers to the Aboriginal and Torres Strait Islander people of Australia and also includes other indigenous peoples in other countries.
2. *Maparn* is the Kukatja word for healer; this word is shared among the other desert languages of this area of the Kimberley, such as Walmajarri. In other desert languages *maparn* is also used to describe a healer's power or spirit or their healing tools or equipment. In Warlpiri, healers are called *ngangkayi* and in Pitjantjatjara *ngangkari*. The term *mabarn* is used by the Martu people further south.
3. While members of Christian churches pray for the sick, Catholics also pray with the use of holy oil. In this region, most Catholic desert people believe in, and support, the work of the *maparn.*