UNIVERSITY OF SOUTHERN QUEENSLAND

'IN THE EVENT OF A CRISIS'

"What services are accessed and available?
to the Aboriginal community of Dalby who have been affected by suicide and/or self-harm"

A Dissertation submitted by

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"Several basic requirements need to be met to achieve a level of satisfactory health, growth and development. They include peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity".

It goes on to state:

"Health requires a secure foundation in these basic prerequisites."

World Health Organization's Ottawa Charter for Health Promotion 1986

ABSTRACT

Aboriginal and Torres Strait Islander people face a number of difficulties when accessing any type of service and these difficulties are more prominent when living in communities that are located in rural, remote and isolated areas. The difficulties that Aboriginal and Torres Strait Islander people are confronted with are not new to any person who has an understanding of the history and struggles nevertheless the difficulties still remain to be the same. However government policies both past and present don't appear to have made any significant impact upon how Aboriginal and Torres Strait Islander people access services or improving the overall health of this population. It is apparent after reviewing the literature that there is limited research done at a local level with an emphasis on Aboriginal populations and access to services. Therefore, the purpose of this research is to explore and identify the different types of health and counselling services available in the community of Dalby and to identify if the local Aboriginal people use these services when in crisis or need.

The methodology used for this research is both quantitative and qualitative focus which incorporated researching what types of services existed including the establishment of four (4) focus groups within the community for the purposes of interviewing local Aboriginal people. There were a total of twenty three (23) Aboriginal people who participated in the focus groups. From the data collected and analysed the recurring themes identified were: 1. racism and discrimination, 2. beliefs, attitudes and misconceptions, 3. leadership, 4. culture and four (4) subthemes 1. Institutional racism, 2. Social justice, 3. Cultural safety, 4. Cultural awareness. Findings from the research

indicate that Aboriginal & Torres Strait Islander people are more likely to access mainstream services in the event of a crisis as well as Aboriginal & Torres Strait Islander services accessing mainstream services. Hence it is very important that services create an opportunity for Aboriginal culture and practices to be acknowledged and imbedded into the planning and delivery of effective and efficient services to enable a more client-friendly and culturally appropriate service that Aboriginal people can access. Access to health services, the ability to act on health advice, and the capacity to modify health risk factors are all influenced by the circumstances in which people live and work.

Certification of Dissertation

The work contained in this dissertation is my bonafide work, has not been previously submitted for an award and, to the best of my knowledge and belief, contains no material previously published or written by another person except where due acknowledgement and reference is made in the discussion to that work.

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Signature of Candidate:	Date:
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Signature of Supervisor:	Date:

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'Life is Family and Family is Life'

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The Aboriginal community of Dalby particularly the Aboriginal people who resided in the community at the time of this research, who participated in this research and who allowed me into their community with open arms and shared their stories honestly. I would like to also acknowledge the Aboriginal and Torres Strait Islander and mainstream organisations within the Dalby community who also participated in this research

CONTENTS

OVERVIEW

In my thesis 'What services are available and accessed by the Aboriginal community of Dalby who have been affected by suicide or self-harm' I will provide an introduction outlining background information about myself and the concept behind the research question and how this developed into the framework of this Masters in Health postgraduate studies. I will then provide information related to the aim and scope of the research question. Background information will be provided specific to this study briefly capturing gaps and what is current within the literature relevant to this topic. A structure will follow outlining the foundations of the thesis including what each chapter will discuss and provide.

INTRODUCTION

My name is Raelene Ward I am an Aboriginal woman from Cunnamulla. I am a descendent of the Kunja and Kooma people, on both my grandparents' side which are my mother's parents (South-West Queensland) and Kamileroi, on my father's side (New South Wales). I have been residing in Toowoomba since 1994 to present day. I am thirty eight years of age and married with three children. I have spent all of my childhood growing up in small communities such as Cunnamulla, Windorah, Jundah and Bedourie; the last three being situated in far South-West Queensland. In my teenage years I always had a vision of becoming a nurse in the Australian Navy but decided to continue through with my schooling and finish grade twelve. I completed my senior year in 1989 then moved from Cunnamulla to Goondiwindi where I commenced my Enrolled Nursing studies in 1990 to 1991 at the local hospital. I continued to work in the hospital

up until I was accepted into University in Brisbane for Bachelor of Registered Nursing. I transferred to University of Southern Queensland and graduated in 1997. I worked from 1994 to 1999 in a number of hospitals throughout the region including Baillie Henderson Hospital, a mental health psychiatric institution in Toowoomba. I later gained employment in an Aboriginal Community Controlled Health Organisation where I worked as a Registered Nurse from the year 2000 leading into Management in 2005. I took up another position within the same organisation as Executive Officer from 2006 to 2007. In 2006 I was involved in the planning stages of a project called the National Suicide Prevention Strategy Project which I later took up the position as project coordinator through to June 2009. This project will be discussed in more detail in the background section. Throughout my life and working career a strong emphasis has been on Aboriginal health, which further demonstrates my passion and commitment and the desire to contribute to the betterment of the health and lives of Aboriginal and Torres Strait Islander people and their communities.

The idea for the above research question came from my previous employment with 'Goondir Health Service', an Aboriginal & Torres Strait Islander Medical Service. I was employed in the capacity as the Executive Officer to assist the Chief Executive Officer by working closely in developing and maintaining the organisations operational and strategic planning processes as well as day to day management of the whole service. Goondir has an identified boundary for service delivery reaching up to a 240,000 kilometre radius which incorporates other smaller communities and towns such as St George, Oakey, Miles, Tara, Chinchilla and Dirranbandi. Refer to appendix 1 for map of boundaries for Goondir Health Service. One of my main roles was to monitor, maintain

and update the Service Delivery Reporting Framework (SDRF) document, and report this to the funding body six monthly. During this process, I began to wonder and question the capacity of this particular service in relation to its service delivery and identify what partnerships this service had in relation to other local health service providers regarding health issues and concerns for the Aboriginal population of Dalby. Through my questioning I identified partnerships in place however there was no record of any partnership with Queensland Health (such as mental and community health services) in the year 2006 or with any other service providers locally for the delivery of mental health services which were being accessed and available to the Aboriginal community. My employment background over the last six years has largely been focused on Aboriginal Health particularly in areas such as managing a health service, providing supportive environments for training and professional development, project management, building the capacity of a community through empowerment, implementing programs and initiatives within a community and within the research arena as well as being an advocate for Aboriginal people.

FOCUS OF RESEARCH

The topic that I researched over the last few years has never been researched in Aboriginal communities in South West Queensland. In the literature review it is clear that there is limited research done in this area with an emphasis on the Aboriginal population and service delivery. The research articles that have been published have focused on Aboriginal communities in Northern Queensland, for example Yarrabah and Cape York communities and other States and Territories. It is important to note that results from those studies should not be generalised to other Aboriginal communities due to differences between communities. These research articles have looked at similar factors to this study, for instance encouraging and supporting Aboriginal people and their communities to become empowered and self-resilient through the transfer of knowledge and through gaining an understanding of their local community resources. I believe this study will offer new and innovative information for Aboriginal communities and their people that could lead to strategies being developed to aid in the prevention of suicide and self-harming behaviours for those at 'risk groups'.

AIM AND SCOPE

Identify what services are available, and determine if these services are being accessed by the Aboriginal community.

OBJECTIVES OF THIS STUDY ARE TO:

1. Identify existing professional health and counselling services available in Dalby
2. Map how services are delivered and accessed

3. Identify the types of community programs and/or support groups available in the community of Dalby

STRUCTURE OF THE THESIS

To achieve these aims, **Chapter 1** will provide information relating to the chosen site (Dalby community) where the research was undertaken and completed. Included in this section will be a profile of the Dalby community, an outline of community issues ,as well as highlighting statistics on suicides, self-harm and mental health for both Aboriginal and non-Aboriginal people within Australia. It is very difficult to generate more specific statistics for the Dalby community, because of its size, the problem with obtaining correct and up-to-date information on this health problem, problems with identifying status of death (cause of death) and whether they identify as Indigenous and the lack of significant information being collected locally and regionally. **Chapter 2** will provide a historical overview of Government policies within Australia, how these policies have impacted upon Aboriginal people and their communities and how that is being translated into today's society. An outline of selected major government reports will also be provided, their recommendations and how these are being implemented in relation to Aboriginal and Torres Strait Islander people, communities and health giving a context for this research. **Chapter 3** will entail information relating to Social and Emotional Wellbeing, what the significance is to Aboriginal people and how it relates. **Chapter 4** will provide information on some of the barriers that Aboriginal people face when accessing services, largely drawing upon previous and current literature in supporting this study. **Chapter 5** will entail information relating to cultural perspectives from an Aboriginal point of view and how important this is when providing services to

Aboriginal people and their communities. **Chapter 6** titled ‘Research Design’ will contain information relating to the design of the research, focus groups, and questionnaires and how the information was collected, interpreted and analysed. Chapter 6 will also detail how these were implemented within the whole study and what processes were undertaken. **Chapter 7** ‘Discussion’ will contain information specific to data collected, how and what the results and findings are from the process of analysis. Towards the end of the thesis a list of ‘References’ will be provided along with appendices containing: information sheets given to participants; consent form; presentation provided to the Dalby community attending the information session/s; partial copy of transcripts provided demonstrating conversations within a focus group.

The terms ‘Aboriginal and Torres Strait Islander’ will be referred to throughout this document as referenced. In my own work I will use the term ‘Aboriginal’ for this is the group my research has focused on as this group being more prominent than Torres Strait Islander people in the community of Dalby.

BACKGROUND TO THE STUDY (PROBLEM STATEMENT)

NATIONAL SUICIDE PREVENTION STRATEGY PROJECT

In the year 2006 the Centre for Rural and Remote Mental Health Queensland in Cairns was successful in gaining funding from the Commonwealth Department of Health and Ageing to roll out a project titled National Suicide Prevention Strategy Project: Building successful life promotion strategies within Aboriginal communities across Queensland. The project was one of many other projects occurring around the Nation at the time in addressing Suicide intervention and prevention strategies. The National Suicide Prevention Strategy Project was successfully in gaining a considerable amount of funding for three (3) years to roll-out new ground breaking successful Indigenous suicide prevention strategies. The project aimed to build on and extend effective local responses to self-harming behaviours that had been developed and implemented by an Aboriginal community known as Yarrabah in North Queensland.

The projects' implementation phase would be achieved through a collaborative process which was largely managed by the Centre for Rural & Remote Mental Health Queensland (CRRMHQ) who was responsible for providing quarterly reports to the funding body in collaboration with the identified participants. The overall project was supported in partnership by four (4) Aboriginal Community Controlled Health Organisations known as Wuchopperen Health Service located in Cairns; Gurriny Yealamucka Health Services located in Yarrabah; Apunipima Cape York Health Council in Cape York and Goondir Health Services located in Dalby which were encompassed

within four (4) Aboriginal communities known as Yarrabah; Kowanyama; Hopevale and Dalby.

Other participants include, Royal flying doctors service (Queensland Section), University of Queensland, James Cook University, Australian Institute for Suicide Research and Prevention (Griffith University), and Centre for Rural Remote Area Health (CRRAH-University of Southern Queensland) and allocated Queensland Health Districts. My role within this project was primarily as project coordinator for the Dalby community. Hence, my position and responsibility covered two (2) positions rolled into one fulltime position. Whereas the other three (3) communities retained two (2) employees I believe that my research question and the National Suicide Prevention Strategy Project would complement each other through a collaborative process through the transfer and sharing of knowledge across these projects sites. The project plan had limited information and no data to refer to in relation to the incidences and rates of completed suicides, attempted suicides and self-harming behaviours within the Aboriginal community of Dalby.

Another aim of the project was to ensure the community became empowered; self-resilient, embraced community ownership of any activities implemented and buildt the capacity of the community so that they could make safe and sound decisions regarding their health and wellbeing. So my question addressed some of the above statements by identifying what services already existed in the community and determine if Aboriginal people accessed these locally and were aware of those services available. Outcomes of the project for the Dalby community identified that “Aboriginal people

living in and adjacent to Dalby had no previous experience with men's groups or other empowerment oriented initiatives, the work of the Dalby project had a different starting point from the other communities in the project. Further, the community differs from the Far North Queensland communities in quite profound ways, with no substantive connectedness across the diverse Aboriginal population. As a consequence, there was a need for the project to establish a foundation from the beginning rather than being able to build on the precedence which existed in other communities. To establish this foundation, the Project needed to focus the initial stages on building relationships within the local Aboriginal community and identifying opportunities to link with established local services and organisations as well as local events and meetings. Despite these efforts and the distribution of information about the project, engagement of local Indigenous men in participating in the project was extremely challenging. "The differences that we started to know about and as the project progressed that the Dalby community were different and we could not understand why then we realised that in the Dalby community the Aboriginal people are classed and seen as the minority group whereas in the communities in the North such as Yarrabah, Kowanyama and Hopevale the Aboriginal community up there are seen and classed as the majority of people and the same applies down this way with Oakey and St George hence, St George have been closely knitted along time now unlike Dalby" (Centre for Rural and Remote Mental Health Queensland 2009 p.16).

COMMUNITY ISSUES

Issues impacting on the Dalby community generally were related to local politics which were largely family based, other issues included limited number of traditional owners living within the region Dalby is a culturally diverse community in which Aboriginal people are a minority and a disconnection amongst Aboriginal people between those employed and those who are not. The cumulative impact of these factors has been the need for considerably more time and effort to develop the relationships which were pre-existing in the other communities. Importantly, although the Dalby project did not see a progression to a men's group in the shape which approximated that found in the Far North Queensland communities, it would be wrong to conclude that engagement was not achieved; rather it was achieved through alternative routes. This has been an important learning in terms of recognising that it is the principles which underpin processes for engagement and empowerment that must be well understood rather than a specific sequence or format. It is through this fundamental understanding that each community or group can be supported to pursue approaches that meet the needs and character of the local environment (Centre for Rural and Remote Mental Health Queensland 2009).

Aboriginal & Torres Strait Islander people are more likely to access mainstream services in the event of a crisis instead of other community based services, which are unevenly and poorly distributed in rural and remote settings (Brown & Grant 2005). Access to health services, the ability to act on health advice, and the capacity to modify health risk factors are all influenced by the circumstances in which people live and work.

Studies have shown that those most needing care are least likely to receive it. The quality of care received by people with greater socioeconomic disadvantage is different from those with lower levels of disadvantage (Harper et al 2004). It was also identified that Indigenous people who live in rural and remote communities, from lower socio-economic backgrounds, suffer with mental illnesses and have limited or no access to a range of clinical and preventative health service (Hunter 2007).

Despite the numerous studies, projects, research, programs and policies being imposed on Aboriginal people and their communities, there has been no improvement in the overall health status of Aboriginal people nor has the gap between Aboriginal and non-Aboriginal people been reduced. Aboriginal people believe that when they have control over their health and other aspects of their lives their communities will become healthy. In defining what a 'healthy community' means to some Aboriginal people it is having 'access to services that are culturally sensitive, close to where people live, more Aboriginal people trained as health professionals, racism will be overcome, people will have been acknowledged as true owners of their land and cultures, beliefs and traditions will be respected and accepted by all members of society' (Gold's et al 1997 pp. 387). Without ignoring the past and present state of Aboriginal health we need to start involving and asking Aboriginal people what kinds of communities and services they need and want (Gold's et al 1997).

CHAPTER 1

In this chapter I will provide information relating to the chosen site (Dalby community) where the research was undertaken. Included in this section will be a profile of the Dalby community, an outline of community issues as well as statistics on suicides, self-harm and mental health for both Aboriginal and non-Aboriginal people within Australia. It is very difficult to generate more specific statistics for the Dalby community because of the small population, difficulties with obtaining accurate data on this health problem, problems with identifying status of death (cause of death), and Indigenous identity.

Indigenous populations have been recognised to have elevated rates of suicide in many countries around the world, including Australia. In Queensland, previous studies have suggested approximately 70% higher rates of mortality due to self-inflicted causes when compared to non-Indigenous Australians, with this difference more pronounced in females than males (De Leo, Klieve and Milner, 2006). However, the accuracy of investigating incidence of suicide among indigenous Australians is hindered by absence of recording systems, exclusion of equivocal deaths, and misclassification of suicides on compassionate grounds to avoid community/familial distress and stigma. Even though the rates are much higher than in non-Indigenous populations, the actual numbers (incidence) of these deaths is often too small to allow for reliable calculation of rates and monitoring of trends. This is even more difficult when investigating rates within specific strata, such as age groups or selected Indigenous communities. For example, at AISRAP, when preparing publications of suicide mortality rates, they are only calculated where the incidence in a given group is least 10, because small absolute numbers make

rates more volatile and may lead to unsubstantiated conclusions (De Leo D, Klieve H, Milner A 2006).

DALBY COMMUNITY

With a population of approximately 10,500 residents, Dalby is known as “The Hub of the Downs”. (Refer to appendix 2 for map of Dalby). The Dalby area has an Aboriginal population of approximately 1000 in the town and immediate environs. The Aboriginal population includes the Western Wakka Wakka, Barunggam, Mandandanji and Bigambul peoples. Within Dalby there are only a small number of traditional owners who reside in the community and Aboriginal people are seen as a minority group compared to other populations and as compared to some other Queensland communities in which the Aboriginal people are the majority. Aboriginal people settling in Dalby come from other communities within the region and there is no overarching connectedness across family linkages.

While enjoying the relaxed atmosphere of country living, Dalby is approximately 210 kilometres west of Brisbane and approximately 85 kilometres west of Toowoomba. As a well known farming region, Dalby is one of the few places in the world where it is possible to grow both winter and summer crops in the same soil, in the one year. The region is a major cereal and cotton growing area. Dalby has a diverse range of clubs, organisations, health services and churches. Dalby offers first class sporting facilities and excellent educational facilities. Dalby have many tourist destinations including the Bunya Mountains, Historic Jimbour House, Pioneer Park Museum, Thomas Jack Park and Lake Broadwater. The heart of Dalby supports an ever expanding retail and commerce sector. All major banks, building societies, accountancy firms, legal offices,

stock brokers and major retail stores are based in the town. Other Aboriginal and Torres Strait Islander Community Services in Dalby include - Goolburri Regional Housing Company, Gamba Lodge Hostel, Bungeeba Recreational Centre and Murrumba Aboriginal Housing Company. Nearby communities such as Toowoomba have had a declining number of Aboriginal organisations in the last ten years, whereas Dalby has largely maintained its Aboriginal and Torres Strait Islander services.

STATISTICS ON SUICIDE:

GENERAL POPULATION

In 2004, 1661 males (16.8 per 100,000) and 437 females (4.3 per 100,000) died by suicide in Australia, a total of 2098 deaths (10.4 per 100,000). The highest suicide rates for males in 2004 were in the 30-34 years age group and for women in the 45-49 years age group. Suicide rates are approximately four times as high for men as they are for women. The rates of suicide for males peaked in 1998 at 27 per 100,000, but have declined to 16.8 in 2004. Female rates peaked at 11.1 per 100,000 in 1967, but declined to 4.3 per 100,000 in 2004. Many more people attempt than die by suicide. Up to 12% of people affected by mental illness take their own lives (compared with an average of 1.7% for the whole population (Auseinet 2007 & Mindframe 2007).

ABORIGINAL AND TORRES STRAIT ISLANDER POPULATION

Suicide and self-harm used to be rare in traditional Aboriginal and Torres Strait Islander communities but has become more common in recent years. Combined 2004 data for five states and territories indicated that suicide accounted for 4.2% of deaths for Aboriginal and Torres Strait Islander people compared to1.5% of deaths for other Australians in those states (Auseinet 2007). Rates are significantly higher for Aboriginal

and Torres Strait Islander men (2.8 times) and women (1.9 times) than for their counterparts in the general population. In the Aboriginal and Torres Strait Islander population suicide is concentrated in the younger adult years for men and women. In 1990 to 1995 the death rate from suicide for Indigenous males was highest in the 15-34 year age group. For females, the rates have generally been highest in the 15-24 year age group. People in any form of custody have a suicide rate three times higher than the general population. From 1990 to1995 Aboriginal and Torres Strait Islander people were 16.5 times more likely to die in custody than other Australians (Mindframe 2007). The above statistics are based on a report produced by The Australian Bureau of Statistics on the 14th March 2007. This report is also based on data released from the 2005 records.

The Australian Bureau of Statistics releases data based on the following States (Queensland, New South Wales, and South Australia & Western Australia) and Territories (Northern Territory) reporting and recording the number of deaths by suicide among Aboriginal people. The Australian Bureau of Statistics (ABS) only publishes data on the above States and Territories due to both the comparative minimal numbers and low coverage in some parts of Australia. Accurately determining the number of suicides across the Aboriginal population is difficult. These figures are more likely to be small therefore caution must be taken when interpreting this type of sensitive data. The reliability of suicide statistics is affected by a number of factors including under-reporting, differences in reporting methods across States and Territories, and the length of time it takes for Coroners to process deaths that are reported as potential suicides.

According to Tatz (1999) and Harrison (2001) in the Aboriginal population the rates of suicide are two-three times higher than what's actually reported in recent figures due to the under-reporting of suicides as a cause of death, and the lack of data identifying Indigenous people and self-harming behaviours and suicides. The information provided by government departments demonstrates commonly held views that 'everyone sees a crisis in not identifying'. The Australian Bureau of Statistics & the Australian Institute of Health & Welfare (1999) also state that the identification process for classifying Indigenous status on a number of data systems especially death records are often problematic. In 1988 Indigenous people who were living in rural areas had a higher rate of suicide than their counter parts living in urban areas or capital cities. Factors contributing to these high rates were: isolation, rural poverty and availability of firearms.

It has been suggested that communities who have a large population of Aboriginal & Torres Strait Islander people found an increase in the rate of suicides among males, this being predominately high between the ages of 15-34 years. It was also suggested that youth, who usually have a culture of self-reliance, do not encourage or utilise their help-seeking behaviours which may be seen as one of the important contributing factors for suicides within this group of people (Mindframe 2007). There are notable differences between non-Indigenous and Indigenous populations in relation to suicides and attempted suicides. Self-harm behaviours and the characteristics of suicides appear to be different as well; for instance many Aboriginal communities have been seeing clusters of suicides throughout Australia. The differences noted indicate the urgency for such behaviours to be addressed under a separate framework than what's currently being delivered to the general population. Otherwise there is little incentive for

mainstream services to ensure that their services are delivered in a culturally sensitive and appropriate way for Aboriginal people to access; further adding reason to 'palm-off' Aboriginal people to other services. Research and development must respect and accommodate the nature of Aboriginal populations and their communities and note that they are different from community to community and the emphasis here is the need for suicide prevention strategies to be developed and designed to specifically suit individual Aboriginal people and their respective communities (Elliot-Farrelly 2004). Hunter et al (2001) identified in their analysis of suicides in the Aboriginal community of Yarrabah that there were clusters of suicides occurring in particular communities at certain points of time and more frequently than the general population.

Social risk factors within the Aboriginal population would be better understood in terms of viewing their lifestyle rather than classifying them amongst mainstream risk factors, which do not apply to Aboriginal communities anyway. A focus on the community level rather than the individual level would be better suited. Proctor (2005) identified that approaching people from a community-level with community resources and facilities would allow people to identify those in crisis which is central to implementing preventative measures. This was evident in the Yarrabah community where they engaged life promotion officers who worked to identify at "risk groups". "Education and training was provided to workers to assist young people in crisis and the closing of an alcohol outlet to reduce the risk behaviours whilst increasing pride and cultural connectivity" (Proctor 2005 p.).

CHAPTER 2

Chapter 2 will entail a historical overview of Government policies within Australia, how these policies have impacted upon Aboriginal people and their communities and how this is being translated into today's society. An outline of selected major government reports will also be provided, including their recommendations and how these are being implemented in relation to Aboriginal and Torres Strait Islander people, communities and health giving a context for this research.

HISTORICAL OVERVIEW OF GOVERNMENT POLICIES ON ABORIGINAL PEOPLE

From as far back as 1788 Aboriginal & Torres Strait Islander people, both historically and in modern times, have been affected by the numerous Government policies being imposed upon them and their communities. These policies continue to impose great difficulties on Aboriginal & Torres Strait Islander people accessing services; cultural mismatch of services; language barriers and ways of communicating; powerlessness to communicate due to self-esteem and feeling inferior; being illiterate; being controlled by authorities (chief protector) and disempowering people through the control of their power and money (Westerman 1997).

From 1788 through till 1930 the introduction of the Protectionist Act came into play giving all governments' total control and power over all aspects of the lives of Aboriginal people. Aboriginal people were shifted from town to town; placed into prisons for indefinite periods of time and institutionalized onto reserves. As a direct result people were removed from their lands; not being able to identify with those on reserves which led to a disturbance within the family network both socially and culturally. As well as

being denied access to education (Mullard 2004) the most disturbing effect upon Aboriginal people was the removal of Aboriginal children from their families who would become children of the State. Therefore, in 1915 the NSW Protectionist Act was amended and blueprinted across most States, resulting in power of governments to determine when children were deemed to be in care and protection and racially motivated judgments were made upon a child's personal and moral endangerment (Westerman 1997). The policy of Assimilation and Integration (1934 – 1972), saw the introduction of the Royal Commission of 1934 and involvement from the Federal Government in Aboriginal social policy leading to the development of the first national policy. Aboriginal people were being integrated back into wider society to enable them to acquire the same standards of living as other Australians (Brock et al 1999). Rowley (1972) as cited in Westerman (1997) argues that this policy aimed to eliminate "full-blood Aboriginals" could be viewed as a form of genocide.

From the execution of this policy Aboriginal people began to establish themselves on the fringes of towns. The assimilation process was difficult for Aboriginal people to embrace due to the overbearing control of Department bodies resulting in a high level of dependency unable to exist independently. The 1950s saw the introduction of the Education reforms making education compulsory. This created difficulties for many children; traditionally Aboriginal children were never socially prepared for any schooling due to different circumstances. Across Queensland on missions and reserves education for Aboriginal students past a year four level did not exist. This era also highlighted problems with the justice system, relationships between Aboriginal people

and police were repeatedly fuelled with conflict about the law and their own traditional lore.

The turning point for the treatment of Aboriginal people began in 1972 under the Whitlam Government with the introduction of across-the-board social reforms with an emphasis on access and funding of Aboriginal affairs which had limited direction in how to spend the funds and infrastructure for reporting purposes. From 1788 through to 1972 social policy had not advanced Aboriginal people any further even after the recommendations from the Royal Commissions and the establishment of Aboriginal Medical Services. Within this period it was obvious through statistics that Aboriginal communities were the most disadvantaged group on every scale socially, both then and now. Eighty five percent (85%) of Aboriginal children attended school on a regular basis in comparison to non-Indigenous children at one hundred percent (100%) nationally; unemployment at four (4) times the national average; mortality for adults is three (3) times the national average and infants two (2) times and for imprisonment for Aboriginal people it was twenty seven (27) times higher (Australian Human Rights' Commission 2009 and Westerman 1997).

Aboriginal people have been disadvantaged socially, educationally and economically (Kahn et al 1978) since 1788 and continually face these problems within today's society. Within the research area the illustration of negative impacts from colonialisation upon Aboriginal people and the effects on their mental health status is continually being reiterated in many research articles and studies (Radford 1999; Blum & Harmon 1992 & Australian Institute of Health and Welfare 2002). In spite of this Garvey (2000) & Vicary

(2002) dispute that services by Aboriginal people, particularly mental health, are not being accessed at a level which equates to this need (Westerman 2004). One view that is consistently publicised is that Aboriginal people have the most severe and widespread mental health problems of any population or group within Australia. The rising rates of violent deaths by means of homicide, suicide, parasuicide, increase in the accounts of depression (Kahn 1978), self-mutilation (Hunter 1990), parasuicide (McKillop 1992), anxiety (McKendrick et al 1992), psychosis (Swan & Raphael 1995), interpersonal violence, alcoholism and low self-esteem (Hunter et al 1999) are becoming even more concerning. Aboriginal and Torres Strait Islander people comprise 2.4% of the Australian population with a total population of around 500,000 people. Aboriginal and Torres Strait Islanders have a number of mental health needs and many have high levels of illness physically, higher death rates, and high levels of psychological distress.

“A large number of people are at high risk for developing a range of mental health problems and illnesses” (Kanowski & Jorm 2009 p.2). In contrast to non-Indigenous people, Aboriginal and Torres Strait Islander people have higher rates of suicides, are hospitalised at higher rates for intentional self-harm and have little access to limited education on how to deal with mental health crises as well as managing mental health problems. Swan and Raphael (1995) recommend that Aboriginal and Torres Strait Islander mental health strategies need to provide community people with programs of how to recognise respond and prevent mental health problems and suicidal behaviours. As well the National Mental Health Plan 2003-2008, and the Social and Emotional

Wellbeing Framework 2004-2008 emphasise the need to increase levels of literacy and awareness regarding mental health within the wider community (Kanowski et al 2009).

MAJOR GOVERNMENT REPORTS

Three major Government reports have been selected because of their national focus on Aboriginal and Torres Strait Islander people. These reports are referred to because of their contribution and recommendations to Aboriginal and Torres Strait Islander health in the development of policies; however the impact of these policies versus the current status of Aboriginal and Torres Strait Islander health will be the main focus throughout this research.

THE 'WAYS FORWARD' REPORT (SWAN AND RAPHAEL, 1995)

This report highlighted the high levels of unmet need in relation to mental health within Aboriginal and Torres Strait Islander communities. Although epidemiological data was generally considered inadequate, the available information suggested that Aboriginal people suffer from mental health problems such as depression at a very high rate, compared to non-Aboriginal people. Further to this the rates of self-harm and suicides are higher and substance abuse, domestic violence, child abuse and disadvantage are contributing additional risk factors (Swan & Raphael 1995). Trauma and grief were also viewed as overwhelming problems. It was also found that Aboriginal and Torres Strait Islander people perceived mainstream health services as failing them and saw a need for services that take into account the holistic value of health and spiritual and cultural beliefs. The report stressed the importance of the Aboriginal and Torres Strait Islander

views about the relationship between mental health and wellbeing, and physical health. It suggested that many of the current mental health problems stem from the poor overall physical health status of Aboriginal and Torres Strait Islander people, in addition to a range of loss, grief and other issues. It also recommended that Aboriginal and Torres Strait Islander people be given charge of their own mental health program development, because of the close relationship of mental health to wellbeing.

Swan & Raphael (1995) in their national report on Aboriginal mental health identified that the implication of mental health has only been recognized lately. Within Aboriginal populations and communities there is a lack of information available on the exact nature and extent of mental health disorders and information that does exist has inadequacies regarding the validity of reported incidences and rates (Morice 1979). Whilst this information is good, the problem is that it is not being shared across and within professions providing further validation across various contexts (Westerman 2004). Initially the impacts of the above are enormous for Aboriginal people as mental health services were essentially developed by mainstream people for mainstream users and as a result Aboriginal people's access to those services is being compromised. Consideration of methodologically and culturally valid methods of intervention at primary, secondary and tertiary levels has not been recognised within the clinical area and literature reporting the statistics on mental health for Aboriginal and Torres Strait Islander people fails to associate with the level of intervention required (Hunter 1993).

ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY

The report resulting from the Royal Commission into Aboriginal Deaths in Custody made a number of recommendations specifically linked to Aboriginal mental health.

These included: that there be a substantial expansion in Aboriginal mental health services within the framework of the development, on the basis of community consultation, of a new mental health policy; that there be close scrutiny by those developing the national policy of the number of models that exist for such expansion; that Aboriginal people be fully involved in the policy development and implementation process; and that the linking or integrating of mental health services for Aboriginal people with local health and other support services be a feature of current and expanded Aboriginal Mental Health services.

THE BURDEKIN REPORT (HUMAN RIGHTS AND MENTAL ILLNESS: REPORT OF THE NATIONAL INQUIRY INTO THE HUMAN RIGHTS OF PEOPLE WITH MENTAL ILLNESS, 1993)

This purpose of this report was to focus on fundamental issues affecting the mental health of Aboriginal and Torres Strait Islander people, as well as historical experiences and the significance of colonisation, current approaches for diagnosing and treating mental illness, and the consideration of Aboriginal perspectives on mental health problems. Some of the findings from this report highlighted that there is little information known about the incidence or occurrence of mental illness among Aboriginal and Torres Strait Islander people. The separation of families and children, dispossession of land, and continuing social and economic disadvantage have all contributed to widespread mental health problems among the Aboriginal and Torres Strait Islander people; while mental health professionals have little understanding of Aboriginal culture and society, resulting in frequent misdiagnosis and inappropriate treatment. Various mental health services rarely deal with the grief issues and emotional distress experienced by Aboriginal people. Aboriginal witnesses emphasised to the Inquiry that mental illness

among Aboriginal and Torres Strait Islander Australians cannot be understood in the same terms as mental illness among non-Aboriginal and Torres Strait Islander Australians, because of their unique culture and their experience as a dispossessed people. Witnesses specifically referred to the lack of knowledge and appreciation of Aboriginal and Torres Strait Islander society and culture by mental health professionals.

The National Aboriginal Health Strategy (1989)

Highlighted that it is essential for any health programs to be developed, owned and evaluated by local communities. Unless this occurs, community participation is unlikely and benefits will be minimal.

The role of the Health Care System

Within this section we will be exploring broadly mental health by taking a closer at Queensland's vision for the delivery and implementation of the mental health plan over the next ten (10) years.

Queensland Plan for Mental Health 2007-2017

It is Queensland's vision for the implementation of this plan to facilitate access to a "comprehensive, recovery-oriented mental health system" (Queensland Government 2008 p. 2) that improves mental health for the whole population across the state. The aim is to develop a coordinated approach that provides a full range of services: promoting mental health and wellbeing, preventing mental health problems and illnesses, reduce the impact of mental illness on individuals, families and the community, promote recovery and build resilience of people living with a mental illness to participate productively in society. "This plan will focus on fostering partnerships and improving linkages between services provided within and across the primary health

public and private specialist mental health sectors" (Queensland Government 2008 p. 22). The Queensland Plan for Mental Health 2007-2017proposes that over the next ten (10) years across Queensland they will largely focus on the development of effective partnerships in providing care that is essential for the wellbeing of the whole population. Service providers from a variety of government and non-government bodies have partnerships in place however there are still gaps in mental health services, partnerships do need to emerge. Improving partnerships across all sectors locally, regionally and within the State will be the driving force behind the implementation of the Queensland Plan for Mental Health 2007-2017. Meeting the mental health needs of Queensland's rapidly growing population poses challenges for governments, policy makers, researchers, service providers and communities. Queensland remains one of the fastest growing states in Australia (Queensland Government 2008).
Governments have long recognized the multifaceted relationship of biological, psychological, social, economic and environmental factors that influence mental health. With particular relevance to Aboriginal and Torres Strait Islander people who embrace a holistic view of health and mental health. Mental health status also influences access to various community resources and capacity to participate in society.

Over the last ten years there have been significant developments emerging within public mental health services across Queensland. These changes have been realised in knowing that responsibility not only lies with the mental health sector but also the non-mental health sectors within communities who all have a key role in maximising the mental health of Queenslanders. Presently within twenty Health Service Districts across Queensland, public mental health services primary focus is to provide care to

those people suffering from severe types of mental illnesses and disorders, particularly those subjected to the Mental Health Act 2000. These services are to work in collaboration with a range of primary health care providers such as health professionals, allied health professionals, counsellors and support groups within communities. Their primary role is to provide assistance to individuals with mental health problems and accessing services. Non-government organisations deployed within communities are to complement mainstream mental health services by providing an array of treatment, disability support and care services primarily providing psychiatric disability support for mentally ill people. Queensland Government departments are working in collaboration to ensure that the programs delivered strengthen and promote mental health and recovery across various interventions. To be able to deliver effective and responsive mental health services in response to the needs of consumers, families, carers and the whole of Queenslanders requires coordination and collaboration between all sectors (Queensland Government 2008).

Queensland Health, in particular the Toowoomba District Mental Health Service, who are responsible for providing services to communities in South West Queensland, undertook the 'Indigenous Mental Health Needs Analysis Project' which aimed to review the effectiveness of mental health service delivery to Aboriginal and Torres Strait Islander consumers, carers and communities accessing the Toowoomba District Mental Health Service. The National Mental Health Strategy (1992) and the National Mental Health Plan (1992) provided the framework for the reform of Mental Health Services throughout Australia including the development of the above project (Eley & Hunter 2006). A symposium was organised to identify and discuss issues about how people

can work together in developing strategies to assist mental health service in better meet the needs of Indigenous consumers. From these workshops seven themes or issues were identified: communication; cultural respect; culturally appropriate clinical tools; supportive management; patient compliance; career structure and empowerment for Indigenous people when accessing mental health services. Across these themes Indigenous participants believe there must be more involvement and inclusion of family and community members in the care and treatment of their own people; employing Indigenous and non-Indigenous staff who are dedicated and culturally aware; being able to communicate culturally and respectively towards Indigenous people by non-Indigenous people will achieve a greater understanding of culture and respect but more importantly awareness.

CHAPTER 3

Chapter 3 contains information relating to Social and Emotional Wellbeing, its significance to Aboriginal people and their communities and how it relates to their view of holistic health and mental health.

SOCIAL & EMOTIONAL WELLBEING

At all levels of the healthcare system within Australia social and emotional well-being and mental health problems are not fully recognised or understood. Social and Emotional Well-being and mental health problems can affect any person in society and are becoming more common among Aboriginal people (Hunter 2007). Historically regardless of what has been done to Aboriginal people they continue to possess qualities of strength and integrity to rise above the impacts from colonisation and the continual racism still being experienced across urban, rural and remote communities and in the health care system (Hunter 2007).

The terms Social & Emotional Well-being are often defined differently between various cultural groups, individuals, over time and across the development continuum. The Macquarie Dictionary defines Well-being as the: “good or satisfactory condition of existence”. The World Health Organisation’s Ottawa Charter for Health Promotion (1986), states that in order to achieve a level of satisfactory health, growth and development, an individual’s basic needs such as peace, shelter, income, food, education, stable ecosystem, sustainable resources, social justice, and equity must be met. It further states: “health requires a secure foundation in these basic prerequisites”. In conjunction with this and of importance is the requirement that individuals, family and

community are allowed to develop free from harm or threat. The Ottawa Charter (1986) defines health as:

> *… to reach a state of complete physical, mental, social well-being, an individual or group must be able to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources as well as physical capacities*

According to the National Aboriginal Health Strategy (1989), Aboriginal & Torres Strait Islander people define health as:

> *…recognising that achieving optimal conditions for health and well being requires a holistic and whole-of-life view of health, referring to the social, emotional and cultural well being of the whole community.*

Refer to the attached diagram in (appendix 3) for Social and Emotional Wellbeing.
The Social & Emotional Well Being Framework 2004-2009 (2009) recognises the strengths, resilience, and diversity of Aboriginal and Torres Strait Islander communities. It acknowledges that Aboriginal and Torres Strait Islander peoples have different cultures and histories, and in many instances different needs. The Framework recognises that supporting Aboriginal and Torres Strait Islander families to effectively deal with, and triumph over, the effects of past policies and practices is a priority.

> *…'Enjoying a high level of social and emotional wellbeing can be described as living in a community where everyone feels good about the way they live and the way they feel. Key factors in achieving this include connectedness to family*

and community, control over one's environment and exercising power of choice' (South Australian Health Partnership 2005 p.2).

The Australian Bureau of Statistics (ABS) developed a framework for measuring the wellbeing of Indigenous Australians. From a holistic approach this framework endeavours to map statistics about the wellbeing of Aboriginal and Torres Strait Islander people. The framework is used as a guide for improving statistical areas and for identifying missing data. It is also seen as a way of approaching Aboriginal and Torres Strait Islander people and their wellbeing. This framework and the previous one mentioned are similar in that they developed from a holistic concept hence this framework is much broader in that it incorporates nine domains that are based on statistical data collected (refer to appendix 4) (Australian Bureau of Statistics 2010)

The South Australian Health Partnership (2005) asserts acknowledging that social and emotional wellbeing is everybody's business from all sectors of society, the community the individual and the family. They also believe this new strategy will achieve effective and sustainable outcomes for social and emotional wellbeing whilst providing direction and guidance for all stakeholders. Enjoying a high level of social and emotional wellbeing can be described as living in a community where everyone feels good about the way they live and the way they feel. Key factors in achieving this include connectedness to family and community, control over one's environment and exercising power of choice. There are however, protective factors that contribute to achieving a high level of social and emotional wellbeing. It is important that these factors be identified and exercised throughout life.

The diagram (attached appendix 5) outlines some of the many factors that will contribute to increasing social and emotional wellbeing and also describes some of the many benefits that will accumulate throughout life. The Northern Territory Aboriginal Health Forum (2003) as cited in Cooperative Research Centre for Aboriginal Health (2006) describes those things that contribute to social and emotional wellbeing as the freedom to communicate needs and feelings, ability to love and be loved, the ability to cope with stress; being able to relate, create and assert oneself and having options for change that help the development of a problem solving approach. Aboriginal social life has provided a framework for social, psychological and economic security, in which wellbeing was socially determined through the organization of relationships with the land and with people within frameworks of law and ceremony, family origination and systems of belief known as 'the dreaming'.

Colonisation brought about radical social, economic and cultural change with, on the one hand, forced disruption of social and cultural systems of family life and welfare through policies of assimilation and child removal and, on the other, the development of distinctive but limited forms of economic participation. From a psychological viewpoint having an effective support network, certain amount of creative behaviour and situations that promote a sense of personal involvement contributes to human health and wellbeing. While the persistence of traditional practices and extended family systems have formed the basis for resiliency of Aboriginal communities there have been important and pervasive cultural changes affecting families, children and youth, and, with them, exposure to domestic violence, substance misuse, suicide and self harm, and other sources of risk (Cooperative Research Centre for Aboriginal Health 2006).

From an Aboriginal perspective, social and emotional well-being problems can result from: grief; loss; trauma; abuse; violence; substance misuse; physical health problems; child development problems; gender identity issues; child removals; incarceration; family breakdown; cultural dislocation; racism; and social disadvantage. The Aboriginal & Torres Strait Islander Health Performance Framework Report (2006) found that 83% of Indigenous people identified that they had experienced at least one stressor in the last 12 months whereas 57% of non-Indigenous people experienced a stressor in the last twelve months. The report also identified key stressors for Aboriginal & Torres Strait Islander people being: physical violence, alcohol and substance abuse, mental illness, suicide, premature death and financial stress. As a consequence of colonisation, Aboriginal and Torres Strait Islander people and communities experienced social and cultural break down. In their efforts to change this, government welfare policies made many Aboriginal and Torres Strait Islander people and communities welfare dependant and caught in a cycle of poverty.

During the consultation process, community members strongly expressed their views that, even today, there are strong links between the impact of colonisation and low social and emotional wellbeing of Aboriginal and Torres Strait Islander people. The very high death rates of Aboriginal and Torres Strait Islander peoples in their middle adult years deprive Aboriginal and Torres Strait Islander people of husbands, wives, parents and grandparents. Improving the social and emotional well-being of Aboriginal and Torres Strait Islander peoples is one of the priorities and key result areas of the National Strategic Framework. The high levels of binge drinking cause serious damage to not only the drinkers, but their families and wider communities. The high levels of mental

illness, of substance abuse, and suicide all testify to the challenges faced by Aboriginal and Torres Strait Islander peoples. The financial stress in which the majority of Aboriginal and Torres Strait Islander households survive indicates not only that they are severely limited in their ability to cope with a crisis, but also unable to accumulate resources (Mouse 2004). In addition

> *…the levels of family disruption, the stressors faced by many Aboriginal and Torres Strait Islander children, and the high degree of risk of serious long-term emotional or behavioural difficulties in which many of these children live do not bode well for their future as young adults. Unfortunately there is no reliable national trend data on the most direct measures of social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples (Australian Health Ministers' Advisory Council, 2006 p.19)*

Hence there needs to be research done in this area looking at this aspect in terms of Aboriginal & Torres Strait Islander people and culture. As identified previously, Aboriginal and Torres Strait Islander people experience reduced access to community based mental health care, particularly care that is sensitive to their specific needs. Care is effective when multi-dimensional solutions are provided, which build on existing community strengths and capacity and include counselling and social support, and where necessary, support family during reunification. Services must be culturally appropriate and safe, and provide continuity of care across the life span (Australian Health Ministers' Advisory Council 2006).

CHAPTER 4

Will provide information on some of the barriers that Aboriginal people face when accessing services, largely drawing upon previous and current literature in supporting this study

BARRIERS TO ACCESS TO HEALTH CARE

ACCESS TO SERVICES

Not much has changed in relation to the overall improvement of Aboriginal health and mental health; (however) there is an increased understanding that social policy has further disadvantaged the Aboriginal people of Australia. Consumers of Aboriginal mental health must have access to services of equal value as non-Aboriginal people in cities, including significantly improved community-based mental health services with emphasis on non-clinical needs (Hunter 2007). The problem when accessing mental health services is that Aboriginal people are more likely to be given services that are reactive in nature for instance basic counselling, advocacy, support or diversion therapy or activities and this is further evidenced by the lack of research into preventative or therapeutic approaches (Westerman 1997). Cultural competence is about the ability of practitioners to identify, intervene and treat mental health issues in ways that recognise the central role that culture plays in mental illness (Cross et al 1989 & Dana 2000). Research suggests that verification of created guidelines that increase clinicians' competency will promote benefits, results and enhance services used by Aboriginal people (Dana 2000; Vicary & Andrews 2001; Westerman 2001 & Vicary 2002). Aboriginal people in comparison to non-Aboriginal people connect less with mental health services hence, when they do engage it's for shorter periods and the illness is

usually at the chronic stage of presentation (McKendrick et al 1992; Vicary & Andrews 2001). Reasons for this occurring has been around services not being culturally appropriate whilst considering cultural aspects of health and well-being in the delivery of mental health services (Dudgeon 2004). It is widely accepted throughout Australia that Aboriginal culture is based on a holistic nature and view (Clark & Fewquandie 1996) taking into account the whole person physically, mentally, emotionally, spiritually and culturally. For example, "Aboriginal people to speak of being unwell within themselves or feeling that things are not quite right" whereas non - Aboriginal people are more likely to state they are feeling unwell by expressing they are feeling depressed or anxious (Westerman 2004). Aboriginal & Torres Strait Islander people are more likely to access mainstream services in the event of a crisis instead of other community based services, which are unevenly and poorly distributed in rural and remote settings. Access to health services, the ability to act on health advice, and the capacity to modify health risk factors are all influenced by the circumstances in which people live and work. Studies have shown that those most needing care are least likely to receive it.

Queensland Health published a report called 'Health Determinants Queensland 2004' (Harper et al 2004), based on the Indigenous population throughout Queensland which identified factors contributing to the low socioeconomic status for Indigenous people. At the time of this report they identified the following: "43% of Indigenous peoples are living in areas designated as the most disadvantaged 20% of Queensland. Unemployment (excluding Community Development Employment Projects (CDEP)) rates are 2½ times those of non-Indigenous Queenslanders. Indigenous Queenslanders are twice as likely

to live in a household with a combined gross income of less than $300 per week. Indigenous Queenslanders also have low access to computers and the Internet, meaning that many are denied the benefits of the “information revolution” (Harper et al 2004). While socioeconomic position connects people to the physical and social resources that can make life better, it is also the feelings of empowerment and status that go with the connection to these resources that are important. This second dimension is important as people who feel in control of their lives are more likely to take control of their health (Harper et al 2004). There is compelling evidence that having a mental disorder places a person, whatever their age, at considerably higher risk of suicide. A significant proportion of people (28-98%) who die by suicide are suffering from mental illness at the time. Depression is the largest single risk factor for suicide and suicidal behaviour. The relationship between depression and suicide becomes increasingly strong with age, although depression becomes less common among older people.

In this report, only statistics for suicide are presented. There are two reasons for this. Firstly, the number of deaths that occur that are coded as being principally due to mental health were low, and thus considerable caution must be used in the interpretation of comparisons of deaths due to mental health (other than suicide) between areas where the population were small. Indigenous status and level of socioeconomic disadvantage and to a lesser extent living in a rural or remote location have all impacted on the overall health of these people (Harper et al 2004). However, with current data, the effect of each of these factors is unable to be separated out. This is because Indigenous peoples throughout the state often live in areas of

socioeconomic disadvantage and 55% live in rural and remote areas of Queensland. The result is that each of these factors combines and interacts to influence the health of a particular population (Harper et al 2004). Other social risk factors include school disengagement, unemployment, incarceration and isolation. Thus, it is important to be aware that the key health issues for the socio-economically disadvantaged groups and rural and remote population groups are not independent (Auseinet 2007).

Swan & Raphael (1995) in their national report on Aboriginal mental health titled 'Ways Forward' identified that the significance of mental health has only been recognised lately. Within Aboriginal populations and communities there is a lack of information available outlining the nature and extent of mental health disorders and the information that does exist has inadequacies regarding the validity of reported incidences and rates (Morice 1979). Whilst this information is good and exists the problem is that this information is not being shared across and within professions further providing validation across various contexts (Westerman 2004).

Initially the impacts of the above are enormous for Aboriginal people as mental health services were essentially developed by mainstream people for mainstream users and as a result Aboriginal people's access to those services is being compromised. Consideration of methodologically and culturally valid methods of intervention at primary, secondary and tertiary levels has failed to be recognised within the clinical area and literature resulting in the rates of mental health for Aboriginal people fails to associate with the level of intervention required (Hunter 1993). Clearly there is a need to provide an approach to Aboriginal mental health that incorporates a unique range of

risk factors which has some relevance of importance to people. Fundamentally social and environmental stressors affect Aboriginal people distinctly and contribute to the development of mental health problems, primarily the issue of culture.

Westerman (1997) in her PhD aimed to explore the basis of misdiagnosis or the failure of mainstream mental health services to recognise early signs of mental ill health amongst Aboriginal clientele. The theory that she wanted to test was that culture is the most important factor which triggers and maintains problems with mental health. It is the responsibility of general practitioners to be able to explore and assess cultural issues on the basis of diagnosis. The failure to recognise and incorporate Aboriginal meanings and interpretations of mental health will result in the production of invalid diagnoses (Westerman 2002).

CHAPTER 5

Chapter 5 will entail information relating to cultural perspectives from an Aboriginal view and how important this in when providing services to Aboriginal people and their communities.

CULTURAL PERSPECTIVES

Aboriginal and Torres Strait Islander people are two separate groups who each have their own identity and culture. The Aboriginal culture is very large and diverse containing many different language groups and kinship. Aboriginal people have been able to adapt to diverse living conditions throughout Australia for more than 40,000 years. They have been identified as the original, first people of Australia within many types of literature hence, slowly but surely this being accepted within the wider society, their culture is one of the oldest surviving cultures in the world which is still dynamic and evolving (Australian Health Ministers' Advisory Council 2004 p.4). "There is a growing recognition that health and health care is, in fact, a cultural construct arising from beliefs about the nature of disease and the human body. Aboriginal and Torres Strait Islander peoples view their health in a broad sense, which includes consideration of the physical, cultural and spiritual components of their wellbeing.

Culture and identity are central to Aboriginal perceptions of health and ill health" (Australian Health Ministers' Advisory Council 2004 p.7). Therefore the Cultural Respect Framework 2004-2009 (2004) recognises that special attention within mainstream health settings is essential and important for the health and cultural wellbeing of Aboriginal and Torres Strait Islander people to improve. Therefore incorporating cultural respect into service planning and delivery will lead to: improved

outcomes and quality; more efficient and effective services; expenditure reduction; and improved customer satisfaction. The issue of accountability of mainstream programs and service providers is fundamental to achieving a culturally respectful system. There is also a continuing challenge for mainstream policy-makers and planners to be inclusive of the needs and expectations of Aboriginal and Torres Strait Islander peoples during the planning, development, implementation, and evaluation of health services (Australian Health Ministers' Advisory Council 2004). Hunter (2007) stated that through 1970s a shift in pattern occurring from a colonial state of mind where Aboriginal people were the objects of regulation moved towards leadership throughout the 1980s. Hunter (2007) further reported that issues relevant to the mental health of rural and remote Indigenous Australians indicate that Aboriginal people do have higher rates of severe mental illness linking to social disadvantage and the level of disadvantage appeared to be greater for those people living outside of major cities.

It was also pointed out there was a need for Aboriginal communities to demonstrate their authority in decision making and ownership of the goal of programs and services being delivered. Despite the numerous studies, projects and research done on Aboriginal people and their communities and the imposition of Government programs and policies there has been no improvement in the overall health status of these people nor has the gap between Aboriginal people and non-Aboriginal people closed. Aboriginal people believe that when they have control over their health and other aspects of their lives their communities will become healthy. This is further supported in the National Aboriginal Health Strategy identifying that only when 'the physical wellbeing of the individual and the social, emotional and cultural well-being of the whole

community' are addressed does the community become healthy. A healthy community would exist when there is access to services that are culturally sensitive and close to where people live; there are more Aboriginal people trained as health professionals; racism is overcome; people have been acknowledged as true owners of their land; and our cultures, beliefs and traditions are respected and accepted by all members of society. In contrast with the more usual analyses of the state of Aboriginal health which has centred more on problems than solutions, without ignoring these views, we need to start involving and asking Aboriginal people what kinds of communities and services they need and want (Gold's et al 1997)

"Mental health is undertaken within a mainstream context. Aboriginal people seek culturally relevant services which facilitate access to treatment from both Indigenous and western domains. Culturally sensitive service provision increases uptake and provides a platform for health promotion, outreach and support while reducing stigma attached to mental health issues" (Westerman 1997 p.3). One of the major issues that Aboriginal people with mental health problems are confronted with is they are usually seen as part of mainstream psychiatry services due to the lack of available and culturally appropriate and conventionally therapeutic treatment. Therefore it is essentially important for all Aboriginal and Torres Strait Islander people to be consulted in the design, development and promotion of mental health services within their community as a result cultural heritage is respected facilitating improvement in outcomes for mental health (Eley et al 2006; Hunter 2004 & Harrison et al 2008).

CHAPTER 6

Chapter 6 titled ‘Research Design’ contains information relating to the design of the research, focus groups, and questionnaires and how these were implemented within the study. There will also be a small section on ethical considerations and how these were incorporated into the research process.

ETHICAL CONSIDERATIONS

The National Health and Medical Research Council developed guidelines relating to consultation and engagement of Indigenous communities when conducting any type of research with Aboriginal and Torres Strait Islander people. There was three (3) imperative messages pending the development of this document: “the needs for improving the way researchers work with Aboriginal and Torres Strait Islander peoples; the need for developing the research capabilities of Aboriginal and Torres Strait Islander peoples and the need to improve awareness of rights as participants in the research journey” (The National Health and Medical Research Council 2005 p.).

Throughout the process of this research I referred to this document regularly and used it as a guide to engage and consult with the local Aboriginal people through following the ‘Eight Steps of the Research Journey’ as outlined within the document. The eight step journey contained the following areas: building relationships, conceptualisation—thinking, development and approval, data collection and management, analysis—looking at the meaning, report writing, dissemination—sharing the results and learning from our experience.

RESEARCH DESIGN (METHODOLOGY AND METHODS)

Prior to undertaking this research a proposal was developed and submitted to the University of Southern Queensland Ethics Committee at the end of 2008 with final approval given early in 2009 to commence the research. The approval number given by the Ethics Committee was HR No. H07REA660. In the early stages of research I undertook an analysis of the Dalby community firstly to identify parameters for this research in line with my objectives.

HOW WAS THIS RESEARCH CARRIED OUT?

There were two groups of participants to consider in undertaking this research, the first group were health and counselling services and the second group were the Aboriginal population. The process for identifying and gathering information about services occurred through researching: Commonwealth Care-link Centre via their database; yellow pages via the phone book; Dalby Community Directory via internet; Toowoomba City Council Community Directory via internet and other databases and information gathered from other existing studies. After researching the local community of Dalby regarding what services currently exist I identified that there were numerous services being provided locally as well as visiting specialists. A total of thirty six (36) individual services identified providing health and counselling services for the Dalby community hence, the major services that Aboriginal people utilised regularly were: the local hospital, Goondir Health Service and Stolen Generation counselling services that were also provided under Goondir Health services.

The Aboriginal community had little knowledge of other services being present within the community and their location. There was also little knowledge of what their role was in relation to providing services. The majority of the services were located within the main business area of the town so access was not seen to be a problem if you were in the same vicinity. A large proportion of the Aboriginal people in Dalby resided on the outskirts of the town so access to these services was difficult because of where they lived, lack of transport and limited finances for using public transport. According to the literature the Aboriginal population have been subordinate to other populations within Australia and society has ensured that they have little ownership of the subject of research, with no input into methodology, and thus, processes of inquiry and control of outcomes have been controlled. In effect, the process arising out of such approaches has encouraged researchers to examine and implement Indigenous protocols and practices with no sight or thought of the negative impacts on people's lives and society as a whole. This means that outsiders still maintained the balance of power when defining the problem and creating solutions with little challenge to methodologies, or ethical issues.

Despite these issues we need to move forward and make certain that we don't control and, in other instances, be active and equal participants in the field of research (Brock et al 1999). Therefore the process I undertook for identifying and recruiting Aboriginal participants occurred through networking and liaising with local Aboriginal services in the community of Dalby; networking and liaising with Aboriginal staff in identified positions who were employed in mainstream services such as Queensland Health; attending and participating in local community meetings, programs, events and

gatherings for identifying the Aboriginal population and where community people congregated. Undertaking protocols of engagement and consultation (keeping research on track: a guide for Aboriginal and Torres Strait Islander people's about health research ethics) (The National Health and Medical Research Council 2005) early were imperative in building a rapport with the Aboriginal people and maintaining future relationships before, during and after the research being done. These protocols were developed by the National Health and Medical Research Council (NHMRC) to foster consideration of ethical issues relating to health specifically addressing activities and concerns articulated by Aboriginal & Torres Strait Islander peoples in relation to the ethics of health research. Much of the research being undertaken within Australian Aboriginal communities has occurred for purposes outside Aboriginal control, needs or the interests of the people concerned.

Taking a closer look at what has occurred and is occurring in the area of research, it is evident that research is being done on Aboriginal groups and the result is that those with power have defined the 'problem' designed the methodology and blundered on to write the solution (Brock 1999) without considering Aboriginal people and their communities (Hunter 2007). The process for gathering further information for the purposes of this study occurred during: face to face interviews; focus groups; and community meetings including any health promotion and education programs being delivered within the community. In the early stages I had done some local research on the Dalby community involving me meeting with local Aboriginal and non-Aboriginal people, local Aboriginal and mainstream service providers. The Aboriginal service providers were consulted initially to identify groups and where they would mostly

congregate and a similar process was done with other groups of people for engagement and recruitment purposes. Another strategy for engagement and recruitment was to develop an advertisement for local papers with a catchy phrase 'Information about research being conducted within the community of Dalby'. This provided an opportunity for identified participants and the wider community to attend, an example of this advertisement is placed within the presentation in appendix 5. There was two (2) information sessions held within the community and at a location that was central for community access. Both information sessions were held on consecutive days and held around the same time for convenience, both sessions being held in the morning of each day. Catering, transport and child-care arrangements were prearranged for participants. The content of the information sessions covered all aspects of the research being implemented such as background information; reason behind the research; how the research would be rolled out; risk and benefits for the community and how community could become involved.

At the completion of each session participants were invited to stay and discuss with the researcher any questions about the presentation and it was an opportunity for recruitment to take place for the initial focus groups. Both quantitative and qualitative methods were used in this study. A quantitative approach aims to gather and investigate numerical and statistical data to produce findings that test or authenticate existing theories such as counting the number of services in a community; a qualitative approach aims to gather interpretive information and develop theories based on themes within the gathered data such as peoples' stories. There has been increasing interest in creating mixed methods research or research that uses both qualitative and quantitative

methods (Creswell 2003; Greene and Caracelli 1997; Long and Curry 1998). Triangulating a study or using several methods to investigate the same phenomenon has the advantage of building on strengths and compensating for the weaknesses of various methods. Mixed method approaches have the advantage of fulfilling many of the requirements of policy research "in context," because they are usually accompanied by important stories about Aboriginal peoples' lives (Kenny 2004)

HOW WERE PEOPLE AND/OR DOCUMENTS ACCESSED OR SELECTED?

In addressing the research question there were two (2) groups within the community of Dalby who were identified as participants for this research. The first groups were the Aboriginal population who resided within the township of Dalby, representing approximately 500 people. The Aboriginal people for this research were not selected individually. As a group the whole community were invited to participate and it was solely their decision to attend and participate in a focus group of their choice. Some community members did express that they would not attend if particular people were present at the same focus groups so, in dealing with this issue I asked each individual participant if there were concerns they had with other people locally that they raise this with me separately prior to attending groups in order to address any issues or concerns they had in the beginning. The second groups of participants were service providers from a variety of health and counselling services and organizations with a mental health focus. Across the community of Dalby there are approximately 20 service providers servicing the community locally within the disciplines mentioned previously There are services that are not based within the community but are based in Toowoomba that are vital to this research.

Contact initially was made via telephone with identified service providers both Aboriginal and mainstream to identify relevant people to talk with amongst services and to identify local Aboriginal people who I could approach. Once contact was made with all of the participants individually or as a group I addressed the following:

- The background to the research;
- Their agreement to proceed;
- A suitable time and place to meet and arrange the focus group
- Advice on how long the focus groups would take
- Advice that during the focus group notes and conversations would be recorded to ensure that the right information was collected and for transcribing and analysis of the data
- Information on their right to leave the study at any stage and who they could contact if they chose to leave
- Information about me; such as who I am, what I will be doing, how things will be rolled out, what was expected from participants
- Risk and benefits of the research
- How confidentiality would be maintained

Participants were informed that all of the above was outlined in the consent form which would be given to each individual in the beginning prior to the focus group commencing. Consent was sought from all participants through the signing of forms, copies of which were given to participants as well. (Refer to appendix 6) for a copy of the participant information sheet and consent. All relevant information pertaining to the study was

maintained in a locked filing cabinet on the grounds of the University of Southern Queensland at the Centre for Rural and Remote Area Health. Electronic data was stored on a password protected computer.

WHAT DATA WAS COLLECTED?

A focus group is made up of people who are already involved in an issue and know what is happening on the ground. A focus group should therefore not be the only method of consultation used but can be useful if used in conjunction with other methods, because it can help to uncover areas which require more research, more consultation, or more preparation. A focus group can be used early in a plan making process to formulate an agenda, or to discover what is not in accord with community values in a region or area. 'Snowballing' would be another possible recruitment strategy, if it was important to recruit people with a high level of knowledge of the topic.

The main characteristics of a focus group are that: it does not provide a sample of the community as a whole, but rather of a particular set of interests within an issue area and random selection is not usually used to select participants; it is a relatively small group (up to 25 people); it can meet once, several times, or at regular intervals depending on the needs of the consultation; the group can provide particular information that may not be readily available in the broader consultative methods; informal verbal or written feedback derived from the group is fed back to the commissioning body. Focus groups have a number of advantages and disadvantages that we need to be aware of. As the group meets and possesses a prior working knowledge of the issue under discussion, views can be explored in depth in a relatively faster period of time than that required in

some other consultation methods. Also, the group's knowledge tends to mean they often develop innovative ideas and solutions. Disadvantages include interest groups contain motivated people, but they are not necessarily representative of the group as a whole. Also, considerable time may be involved in finding participants and maintaining their involvement. Because this method involves tapping into already-existing knowledge and skills, it does not invoke deliberation and enhance deliberative capacity in the same way as other methods. This method can be useful for gauging the attitudes of a specific, targeted group of people and when broader community consultation will not provide the desired information. It tends to be useful in areas where the relevant interest groups are relatively easily identified. Focus groups primary method is for collecting data from participants, they were also chosen as a method for recruitment purposes and to encourage other Aboriginal participants to come together in a supportive environment. Focus groups primary aim was to explore a specific set of issues.

Focus groups are increasingly becoming popular within the research field; they are useful as a time-saving technique as well. Focus groups take the shape and form as semi-structured and person-to-person interviews. Focus groups also assist in drawing out knowledge, experiences and feedback from participants and communities. Presently focus groups are used for: "collecting background information or identifying issues that will form the basis of hypotheses, more structured questions, evaluations or needs assessments; investigating responses to policy changes; pre-testing advertising and marketing strategies; and investigating sensitive issues that are difficult to broach on a one-to-one basis" (Grbich, C. 1999 p. 108-114). One way of generating discussion and

collecting information for this study was through the establishment of focus groups; these groups were operational within the community of Dalby specifically for the Aboriginal participants. There were four (4) focus groups established each comprising of eight to ten (8-10) people within a group. Refer to the attached diagram in appendix 7 outlining demographics of focus groups. Focus groups are used on their own to gather information; they can be used in conjunction with other methods. For this study several different types of methods were used to collect information, as mentioned previously by Creswell (2003); Greene and Caracelli (1997); Long and Curry (1998). This type of mixed research is becoming increasingly acceptable across the research arena. Both quantitative and qualitative methods were used in this study. Focus groups allow people to collectively discuss particular topics and the information generated through these groups is qualitative.

The type of quantitative data that I wanted to capture in relation to services was the total number of services identified in Dalby; The total number of clients accessing services versus Aboriginal & Torres Strait Islander people. I considered it important to demonstrate findings and results in graphic illustrations to the Aboriginal community in a way that they can relate to and understand. For instance qualitative information gathered about the Aboriginal population of Dalby was a collection of stories which demonstrated Aboriginal community reasons, views, perceptions, beliefs, practices and interpretations of services. This data was analysed for descriptive themes and to find commonalities. The information that was collected from the Aboriginal people was recorded conversations that had taken place within each focus group. These conversations were recorded on a Dictaphone and later transcribed for analysis. All

participants from the four (4) focus groups were informed of this process which was also reinforced in the participants' information sheet along with their consent to proceed. Participants were also informed that if they chose to leave and to not be a part of the research that they could do so at anytime and who to contact. All participants prior to each focus group completed a consent form and were advised that this information would be held in reserve in a locked filing cabinet at the University of Southern Queensland in accordance with their policy for research carried out. If participants chose to review transcripts or other information relating to this research they would have full access to this.

FOCUS GROUPS

SETTING UP FOCUS GROUPS

Focus groups are about bringing people together as key informants on a topic of interest. Consideration was given to aspects of the interview process: the location; the physical environment and the composition of the group.

LOCATION

The location of the focus groups varied depending on the need and/or requirement of each participant, for instance if participants had young children at home, if they worked, if they had appointments and so on, these factors were taken in to consideration and groups arranged accordingly. Prior to each focus group being arranged participants were engaged at least a couple of weeks in advance to ensure commitment and attendance. Participants were engaged through collaboration with local Aboriginal service providers regarding recruitment and location of each focus group. This in turn ensured that participants were comfortable with the researcher and that relationships

were being developed. Through this process the researcher arranged to meet all participants informally to discuss the research, their involvement and how to progress from there in arranging focus groups.

CHAPTER 7

Chapter 7 the ‘Analysis of Results’ and ‘Discussion’ contain information specific to data collected, how it was interpreted, analysed and what the results are and findings were from this analysis.

FINDINGS OF THE RESEARCH

ANALYSIS OF INFORMATION & IDENTIFICATION OF THEMES

There is clearly an overlap of many themes and they appear to be linked in one way or another as well as finding that many aspects affect people differently but at the same time the need for balance across these levels is vital.

WHAT FORMS OF ANALYSIS AND INTERPRETATION OCCURRED?

The information that was collected across four (4) focus groups was immediately given to an independent person within the University of Southern Queensland for the recordings to be transcribed. On completion of each transcript they were given back to the researcher in a Word format for further interpretation and analysis. The researcher decided after numerous conversations with supervisors that the next best approach would be to conduct a thematic analysis of the information transcribed. Initially conducting a thematic analysis would take the form of using a computerised program such as NVIVO as this type of analysis appealed to both the researcher and supervisor. I commenced using the program for analysis, throughout the process a combination of technical issues and timeframes were imposing on the information being effectively and efficiently analysed. It was then decided to analyse the information manually.

Morse and Field (1995), describe thematic analysis ‘as the building of a set of themes to describe the phenomenon of interest by putting ‘like with like’, whereas Aronson (1994) describes thematic analysis as the focus on identifiable themes and patterns of living and/or behaviour. For instance, from the conversations that take place in a therapy session or those that are encouraged for the sake of researching a process, ideas emerge that can be better understood under the control of a thematic analysis. The data included transcribed conversations, patterns of experiences were listed and these came from direct quotes or paraphrasing of common ideas. The next step was to identify all data that related to the already classified patterns. For instance, all of the talk that fitted under the specific pattern were identified and placed with the corresponding pattern Aronson (1994).

The analysis carried out is described in a series of steps:

- All data collected from the four (4) focus groups were transcribed by an independent transcriber from the University into a Word format
- I then proceeded to read and reread all of the transcripts individually and highlighted chunks of the data as potential thematic statements which were broad to commence with and then became specific themes
- I then assigned a descriptive theme to each statement that reflected the meaning of that theme

THEMES/CATEGORIES

Within this section an overview of the themes emerging from the data after the process of analysis will be provided. Each theme will be discussed in detail firstly providing a definition of each of the themes then leading into quotes taken from the transcripts, followed by literature in support of these themes. The following are themes generated after the analysis of the data:

1. Racism and Discrimination
    1.1 Institutional racism
    1.2 Social Justice
2. Beliefs, Attitudes & Misconceptions
3. Leadership
4. Cultural
    4.1 Cultural safety
    4.2 Cultural awareness

Refer to appendix 8 for excerpts of transcripts.

1. RACISM AND DISCRIMINATION

From an Aboriginal perspective racism and discrimination is something that people feel, hear and see because of their identity; their culture; the colour of their skin; the way they do things; their reaction, their actions. Racism and discrimination is not only experienced when accessing the local hospital but when accessing any type of service locally. Often after hours or early hours of the morning Aboriginal people are injured

from either fighting or under the influence of drugs and alcohol whilst accessing the hospital, some Aboriginal people ended up being locked-up or transported to the nearest major hospital for psychiatric assessment the police would directly be involved if people became difficult to handle. Aboriginal people describe their experiences by saying:

"…They (non-Aboriginal people) treat you differently"

"…Look down at you, you know really degrading"

"…Putting you down all the time"

Some Aboriginal people believe that when they stand up for themselves and act in response to what is being done or said:

"…we are treated as outcasts"

The local police station does not employ any Aboriginal or Torres Strait Islander liaison officers regardless of the rate of crime as well as Aboriginal people being locked up overnight without their rights being respected and without any reference to the 'Black deaths' in custody' inquiry and recommendations coming out this investigation. Aboriginal people describe how they are treated by the police and shop attendants:

"...Police pull up our black kids, empty your pockets empty your pockets, take your pants down"

"...We're terrorists in our own country; the way we are being treated"

"…Because of the dark skin they (shop attendants) *followed her* (my mother) *around the store like she was going to steal something"*

According to Paradies, Y; Harris, R & Anderson I (2008 p. 4), "Racism is generally defined as avoidable and unfair actions that further disadvantage the disadvantaged or

further advantage the advantaged. Racism can be expressed through stereotypes (racist beliefs), prejudice (racist emotions) or discrimination (racist behaviours and practices)". As outlined in quotes selected from transcripts, there is strong evidence that systemic racism exists in a number of life domains, resulting in reduced opportunities to access the societal resources required for health. Systemic racism can be either explicit or implicit. Most explicit systemic racism is historical and includes a raft of legislation that has existed in Australia (Paradies, Y; Harris, R & Anderson I 2008). About 16 per cent of the 5757 Indigenous adults in the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) who were asked about their experiences of racism reported that, in the past twelve months, they felt they had been treated badly because they were Aboriginal/Torres Strait Islander (Paradies 2007b). Of the 9400 Indigenous respondents in the 2002–03 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), 18 per cent reported experiencing discrimination as a personal stressor in the past twelve months (ABS 2004).

Studies highlight the widespread nature of such racism in domains such as national politics (Augoustinos,Tuffin & Rapley 1999), media (Cunneen 2001), education (Sonn, Bishop & Humphries 2000) and the welfare system (Sanders 1999), as well as in the provision of public housing (Equal Opportunity Commission of Western Australia 2004) and in the legal/criminal justice systems (Blagg et al. 2005). For example, evidence from Victoria indicates that when apprehended by police, Indigenous youth are two to three times more likely to be arrested and charged with an offence than non-Indigenous youth (Department of Justice 2005; Indigenous Issues Unit 2006).

1.1 INSTITUTIONAL RACISM

From an Aboriginal perspective institutional racism is very real and present within the community of Dalby. Prominent mainstream services within the community that Aboriginal people access regularly such as the hospital, the police and centrelink do not employ any Aboriginal or Torres Strait Islander liaison officers; however this has been the case in the past. Aboriginal people face a number of barriers when accessing any type of service and more so in relation to employment particularly with major corporate bodies and agencies based in the community. Aboriginal people believe that they do not have the same opportunities as non-Aboriginal people when seeking employment or welfare assistance:

> *"…there's a gap between the opportunities that are being offered and the vast majority of people who are in categories who would want that kind of job, they (young people) have disengaged from school and racial issues impact on people having the same opportunity"*
>
> *"…they (Centrelink staff) ask the black fellow for the Aboriginality"*
>
> *"…Because we're Murris we feel it and we know it. Those people (non-Aboriginal) might have the white skin but we've got the black skin and we feel it more"*

Within the community there are a number of services available that cater for the whole population including Aboriginal people. In regards to employment agencies currently

services can be accessed by anyone within the community who seek assistance in preparing (how to do resumes, answering selection criteria, getting ready for interviews etc) for employment and information about employment opportunities. Some Aboriginal people access these services but there are many who do not or even know what is offered to them and the process involved. Therefore, Aboriginal people don't access these agencies because they don't know how to and agencies have not been forthcoming with assisting people through the process. Some Aboriginal people have relied upon one Aboriginal service in the community because they have provided a range of services more than what they are required to provide.

1.2 SOCIAL JUSTICE

From an Aboriginal perspective social justice is about being treated equally, having the same rights, access and opportunities as non-Aboriginal people, showing respect and embracing all cultures within their community. It's about being able to access whatever the mainstream has to offer. In regards to the Dalby community Aboriginal people still continually face racism and discrimination resulting in people not being able to access services effectively. There are a number of private general practitioners available within the community and there have been several ones closed down over the years. At the same time non-Aboriginal people are now accessing services specifically designed for Aboriginal and Torres Strait islander people:

> *"…Aboriginal people can't get into to see their normal doctor…the white community are told to access the Aboriginal medical services because they bulk-bill and the white community has taken advantage of it "*

In regards to services available for the elderly, sick and disabled people within the community Aboriginal people believe that there are limited services that cater for their needs:

"…We need homecare out here for the Aboriginal elders and the sick people"

"…There's no such thing out here, they don't believe in homecare"

"…We've got no homecare services here to provide for our elderly"

"…Respite is full up"

The community of Dalby provides a number of mental health services locally such as the hospital; Goondir health stolen generation counselling services; community health; lifeline; Salvation Army and the division of general practice. The Aboriginal community simply access the first two services more than the others.

"…We have suicidal problems here and we've still got them"

"…Mental health services have been promised so much"

Aboriginal people affirmed that there are dental services available even though they are really hard to access due to services being provided to other smaller communities as well. Consequently, leaving only a number of days left, catering for the whole population as well as the time required waiting for an appointment. Participants describe their experience in saying:

"…There's no dentist here for children. They've got to wait til the school dentist"

"…You've got to wait for months and months to get into see a dentist"

"…Then it's that bad they've got to get sent away to have an operation"

Aboriginal people state they have a high level of crime occurring and perpetrators' predominately being Aboriginal youth. Aboriginal Legal services are available within the community but at times are very difficult to access given the level of crime, racism and discrimination exhibited by the police. Legal representation is even more difficult because of the attitude and conduct of the Aboriginal legal aid officer:

> *"…They (aboriginal legal service) never ring if they do ring Cheryl (Aboriginal legal aid officer), she's probably hard of hearing or away somewhere or not in the township"*
>
> *"…We only know it (about legal services) when our children go to court. That's the only time we see her (Aboriginal legal aid officer)"*
>
> *"…You go to court to take your children to the court, sit with them, whether there guilty or not, it doesn't make any difference, they're guilty"*
>
> *"…There's no justice for Aboriginal people in this town, no justice whatsoever. You've got no chance here"*

2. BELIEFS, ATTITUDES & MISCONCEPTIONS

From Aboriginal perspective beliefs and attitudes signify views and opinions of Aboriginal people. They believe that their beliefs and attitudes are instilled in them from their upbringing and through their cultural heritage. Aboriginal people share similar perception of services in the community of Dalby. Aboriginal people felt that living in the community or being well known resulted in the level of racism and discrimination increasing at the same time as accessing mainstream services. Aboriginal people share some of their experiences:

"...You're an Aboriginal person (if) *you go there if you're sick, you've either been drinking or you've taken drugs"*

"...There's not enough training in the Dalby hospital on Aboriginal culture and how to talk to Aboriginal people"

"…They (Aboriginal medical service) *don't do home visits where there should be home visits"*

"…They (Aboriginal medical service) *never have a meeting to explain* (sexual health) *anything to the men or the younger men, we* (some Aboriginal community) *tend to sit down and talk about it, get a hold of the people that's got it and start chastising them, talking to them, telling them there are places* (Goondir health and the hospital)*, but they won't access those places* (Goondir and hospital)*. They go to other townships* (Toowoomba located an hour away) *where people don't know them because they don't trust the people here that work in those medical centres'* (Goondir health service) *or the hospital"*

"…They (Aboriginal medical service) *haven't even had health checks yet and they don't advertise it"*

"…We've got the same problems as they have in the cities, but ours are more noticeable"

In regards to

"…Services (Aboriginal medical services) *are too spread out. They need to be in one building"*

"…Services (Aboriginal medical service) *that are here, they have to be on the ball too. If someone is in crisis, they need to go to them"*

"…Health problems here, it's an ongoing thing. There's not enough (Aboriginal) *services… the staff* (Goondir staff) *aren't trained. They're not medically trained in a sense where they don't go to University or go to the hospitals to be trained. They're physically at the medical centre which is wrong"*

"…People (non-Aboriginal) *up there* (local hospital) *don't worry about us grass root people……They put it that way* (mental health services)*"*

There is the perception that Aboriginal staff employed at the local Aboriginal medical service are not trained or qualified for the positions they hold. Another view in relation to gaining employment within major industries, Aboriginal people believe they are discriminated against because even though they possess the necessary skills, experience and qualifications when applying for jobs locally they generally don't get to the interview stage. The problem is they are not getting the required support or assistance from employment agencies in gaining access to the interview stage:

"…A lot of our young people have been out of a job for so long it's hard to be on time".

"…They don't understand how Aboriginal people operate and work; it's a cultural thing to us"

"…No-one will help them to get their work

"…they look at their criminal record and they hold that against them.

"…no-one will give them a chance in life"

Court and justice system

"They don't realise that's its family going to support"

Socioeconomic disadvantage experienced by Aboriginal & Torres Strait Islander peoples in Australia is linked with both historical and contemporary racism, colonisation and oppression. Racism continues to be obvious through the misconceptions that non-Aboriginal people portray against Aboriginal & Torres Strait Islander peoples, for instance the belief that Aboriginal people are welfare dependent, more likely to drink alcohol and receiving special 'government handouts' (Pedersen *et al*. 2006).

3. LEADERSHIP

From an Aboriginal perspective leadership is seen as community owned and driven by the local Aboriginal community members. Aboriginal people believe that you must come from the community; usually elders within the community are seen as leaders; you must earn the respect of the Aboriginal community; seen as someone helping the local people; advocate and lobby on behalf of the people and be able to communicate between the Aboriginal and the non-Aboriginal people.

"…It's all because they're depressed, they're stressed to the max, there's no-one there to help them, they don't know where to look for help"

"…No-one will listen to help them"

"…They don't know who to talk too"

"…They've lost trust because they've lost families through suicide"

"…Some of them get sent to jail when they really need the help"

"…we need a figure here in the town, a murri person who can bring the various groups together we are in this together lets pull together rather than separate groups"

4. CULTURE

Aboriginal people feel they should not have to be assimilated into society but through reconciliation be able to reconcile differences through cultures and the safety of their cultural ways and that everyone embraces everyone's world views and belief systems.

- Limited to no cultural awareness within schools
- Lack of responsiveness of services to community needs
- Limited or no acknowledgement of Aboriginal people, culture and practices
- Lack of historical information available within the community regarding Aboriginal traditional owners and culture

"… Aboriginal community of Dalby have got to feel that there is a place for them

"…Aboriginal people feel that they belong to Goondir because it's their centre, their program". Aboriginal flags are on the wall but they also have Aboriginal stories, they feel they belong to that place.

"…They've got to feel they belong, there's something that they can identify with that's really important. Students have got their place, they've got their special room, they go in there do their homework, that's their place.

"…Centrelink in Dalby, where are the Aboriginal identification in that office. They don't feel that they belong there but they've got to go there to get a job (and welfare assistance). (Hence), they are not told that you (or where to go for assistance) can help with their resumes.

"… Non-Indigenous white people, they're never around our community, they're never around in the homes with our struggling mum's who's got eight children"

"They won't access those places. They go to other townships where people don't know them because they don't trust the people here that work in those medical centers' or the hospital"

When services and people in the community don't want to help they stand behind the hurdle so as to make it harder for Aboriginal people. It's almost as though it's not that there's a lack of solutions but it's just hard to put those solutions into practice. Aboriginal people are confronted with these terms because of who they are, their Aboriginality their identity. These themes have negative connotations that offend some people, make them feel put down, no good or even unworthy at times. Some people believe that their colour impacts on how they access services, and how people are treated when accessing services.

Social justice means not having equality across the community when accessing any type of service. Participants stated that even though their community is small in comparison to urban cities their problems or issues are more prominent: The above statement is in relation to a number of private General Practitioners closing down their practices over the years and now Non-Aboriginal people are told to access the local Aboriginal medical service because of bulk-billing services being available. Aboriginal men don't have the same access to services as Non-Aboriginal people. The reasons for this occurring are: *"there is no Aboriginal male health worker who visits the local men in the community to discuss any health issues or concerns; there is not enough known about various health checks available to men and other groups and the local men are difficult to engage"* and hence it is well-known that the Aboriginal medical service does provide this service, there appears to be a definite gap in this particular service required by the Aboriginal community.

In relation to the elders of the community participants' state: "Tara is situated approximately two (2) hours north west of Dalby and provides a limited number of services". For the Aboriginal men and boys within the community there are little to no services provided outside of the clinic setting or specifically targeting these groups. There are issues regarding effective engagement of men generally within the community: This last statement was in relation to men having access to prostate checks. The Aboriginal community are fully aware of Mental Health services being available through Queensland Health. Aboriginal people believe that services are not being fully accessible to the extent that they should be because of the attitude of the local Aboriginal liaison person currently. "They believe that she disrespects the

Aboriginal people; she doesn't get out in the community and promotes the service". What is known is that she does not originally come from the community and does not have a good relationship with the local community.

There is a lot of stigma attached when accessing mental health services and historically issues for the Aboriginal people all impact on how they access services and how they are provided. There are issues for the Dalby community there is a high rate of crime locally occurring and often the youth are seen to be caught in this area and often presenting at court for arraignment. There is also the issue of the racism and discrimination being portrayed towards Aboriginal people regularly regardless of their age or statue in the community and where they are within the community, meaning walking around; at the local hospital or down the river. The local police station does not employ an Aboriginal or Torres Strait Islander police liaison officer even though the rate of crime is high and people being locked up overnight without their rights being respected and more so in relation to the recommendations of 'Black Deaths in Custody Report'.

The Aboriginal legal service provides a service to the Aboriginal people of Dalby by employing an Aboriginal legal aid person. There are issues for the community when accessing this service too. Many other issues relevant to suicide and self-harm were discussed such as family members released from prison institutions. From an Aboriginal perspective, "the people of Dalby believe they live in 'real red neck territory' and they face racism in the past and present times". The township of Dalby is well-known for its

racism towards Aboriginal people and racism is felt at different levels and sectors within the community:

In relation to Aboriginal people having the same opportunities as Non-Aboriginal people regarding employment and how major corporate bodies incorporate this into their employment strategies, participant's stated: *"Culture from an Aboriginal perspective means who you are; your identity; your colour; your connections; your family; your heritage; your traditional owners; your traditional practices and ways".* It also means being recognised and acknowledged by Non-Aboriginal people; embracing cultural practices within today's society and showing respect. One of the major problems in Dalby is the massive disengagement by Aboriginal kids from school. There are too many hurdles that Aboriginal people have to go through continually to get what they want. If they want to run programs there are too many people preventing this from occurring they need to change community people's attitudes and policies?

Even locally if communities want to tap into funding through the council to run small programs there's hurdles to go through, you have to be incorporated, you have to be in partnership with other services which is a hurdle in itself. When services or people don't want to help they stand behind the hurdle so as to make it harder. I It's not that there's a lack of solutions but it's just hard to put those solutions into practice. What came out of the research with the Aboriginal community of Dalby was that even though there is a vast range of health and counselling services available locally participants from the focus groups only identified local Aboriginal and mainstream services that they accessed. It is not evident what, why and how this is this case but what is apparent is

that these services identified are the most prominent ones accessed when required however, there are major issues and barriers around accessing these services more effectively and efficiently.

The Aboriginal people in the Dalby are seen as a minority group in comparison to the whole community, encompassing a diverse range of cultures and traditions. The majority of Aboriginal people residing in Dalby currently and who return to the community have lived there for quite a while off and on as well as a number of Aboriginal families and non speaking English background families moving into the town from other communities and countries. Dalby is well-known for being a 'red neck town', and it appears the Aboriginal people don't have established close knit community it appears to be torn apart by racism, discrimination, prejudice, divisions, and no sense of Aboriginal and Torres Strait Islander people having connectedness that they are in this together. There is a lack of solidarity across the community they don't have established tradition/s and traditional owners are not included or committed at the local level. According to the Aboriginal community there is a high level of racism and discrimination being experienced at various levels and sectors across the community.

CHAPTER 8

DISCUSSION OF THE THEMES

Prior to undertaking this research, I was aware that there were gaps in services in particular mental health services. I was also aware that partnerships were important and useful for developing good working relationships in this case between mainstream and Aboriginal services. My main concern regarding this research topic was that even though Goondir had counselling services established in the community through their Stolen Generation office there were no services of a mental health nature being provided through the clinic (location separate to Stolen Generation office) in as much as being able to assess clients initially as well as providing follow-up care and treatment. Aboriginal Health Workers didn't have any training or qualifications in mental health at all and issues of recruitment within this discipline were difficult.

Currently clients who did go through the clinic were referred to Stolen Generation counselling services via the General Practitioner. Staff at stolen generation as a result would refer onto other appropriate mainstream services as required. Therefore, this thinking led me to develop my research question 'What services are available and accessible to the Aboriginal people of Dalby community who have been affected by suicide or self-harm?' In practice I engaged with the local Aboriginal people to find out if they accessed services and how were these services delivered or available to the Aboriginal people in the community. This is what I have found: across the focus groups majority of the participants was Aboriginal except for three who were non-Aboriginal and living within the township of Dalby. Non-Aboriginal participants currently work for

Aboriginal and Torres Strait Islander services locally and age groups across these focus groups varied from twenty (20) years up to seventy (70) years of age. Most of the Aboriginal participants from the research identified as local community people who were unemployed. All of the participants stated that they currently lived in Dalby, have lived in the community as a child and recently moved back as an adult. Majority of the participants had connections within the community (family, friends etc) both past and present. Across the focus groups participants had seen a number of changes occurring within the community regardless of their length of time as residents.

A number of the changes occurring within the community were: community dynamics changing such as a variety of Aboriginal groups residing in the community, families moving to Dalby from other communities who identified with their own land, tradition, culture, issues and the support and network of individual families; increase in employment opportunities; increase in different cultural groups taking up residency particularly from non English speaking backgrounds; structural changes largely seen across the whole community in the way of new buildings, services and organisations trying to accommodate for the influx of new people ; increase in retail, construction and industrial development. The local community of Dalby is growing fast with more opportunities, more competition and more people. These developments have had a huge impact on the local Aboriginal people and are proving difficult to handle because they have to compete more with other local people and new residents for jobs, services, and support.

On the other hand there are a number of community and health issues that participants have also identified which are seen as barriers for Aboriginal people locally. Across all of the focus groups the community issues identified were: no Aboriginal or Torres Strait Islander people employed in identified positions as liaison officers (hospital, police, centrelink); limited dental services; no mental health services within the local Aboriginal medical service. (However) at the time of this research there has been some progression in this area between Goondir Health Services and the local hospital regarding the provision of mental health services; no Aboriginal and Torres Strait Islander women counsellors; difficulty getting employment; high rate of disengaged kids; high incidence of racism, discrimination and prejudice all being experienced by Aboriginal people in Dalby.

In relation to health issues these were seen to be: alcohol and drug abuse; mental health issues such as depression and anxiety; self-harm; dental issues and removal of children. The participants identified that a high level of racism, discrimination and prejudice is experienced when accessing health and counselling services within the community of Dalby including other services. When approaching the local hospital Aboriginal people feel they are being stereotyped because of their identity as in their 'Aboriginality'. This was supported by one participant who accessed the local hospital in saying…. *"It's like you're an Aboriginal person you go there if you are sick, you've either been drinking or taking drugs"* and the hospital *"when the old section was open was very, very prejudice and will refuse to treat you if you have been drinking or taking drugs".* This is a huge issue because a lot of Aboriginal people access mainstream services either in the early hours of the morning or after hours and they often present

with injuries from fighting and under the influence of either alcohol or drugs. The focus groups repeatedly suggested that they feel they are discriminated against in their access to health services; often seeking help results in them being locked up and being exposed to further acts of racism and discrimination such as *"being put up on assault, refusing and resisting arrest"*. There is a level of prejudice occurring when Aboriginal people are also accessing services generally within the community, a view shared by participants across focus groups. There is the belief by Aboriginal people that community health services are for the *"out of town people, like the cockies (non-Aboriginal people from properties)"* and people from smaller towns surrounding Dalby; Aboriginal people further admitting that they don't use this service often. This view is reinforced when accessing Stolen Generation counselling services, some people are aware that these services are for those who are from the community and/or have a relationship with Link-up services in relation to finding their family connections and identity.

There is an association with Stolen Generation and welfare services in that emergency relief funding is available through Stolen Generation to an extent. However, participants from focus groups suggest "*they (stolen generation/emergency relief staff member) will give you like a $40 or $50 dollar (where is the rest of the money going?) voucher, now they're starting to write out $100 or $200 dollars and they do the shopping and you're getting home brand food" Participants from the focus groups repeatedly suggest* that even though services exist and there is plenty of these being provided across the community, however, they are not available to everyone how they are portrayed and services should be more available. Aboriginal people state that when they are seeking

help there is a sense of rejection and refusal by those being approached to assist people in accessing the right services at the right time. When participants were asked about health and counselling services available, participants stated "*when asked for help no-one is there to help, nobody is willing and no-one will do it or help us do it?"* Although, there is a sense of hope being expressed by some of the Aboriginal community in saying that *"this community will change and combine together"*.

It was repeatedly suggested by the focus groups that there is also a level of prejudice amongst Aboriginal people particularly those who are employed within Aboriginal and mainstream services being prejudice towards other Aboriginal community people requiring services. Leadership within these services is perceived by the Aboriginal community as not wanting to assist or help the local Aboriginal people. There appear to be issues around identity with Aboriginal people employed in services who obviously don't originate from the community resulting in people not accessing the services they require effectively and efficiently. On the other hand when local people have been employed in positions more effective access has been evident because firstly, these people are known in the community, secondly people identify with the worker and each other and thirdly they provide assistance and guide people when in need or crisis. Aboriginal people feel they can't trust many people and services within the community because of bad relationships from the past.

People tend to rely on each other for moral support hence, when accessing services people are confronted with no-one wanting to help them or the services don't know how to talk to Aboriginal people. People feel services are available to an extent but are

lacking in how services are being provided in the community and to community people who require those services but also to those groups who the service specifically targets. Historically Aboriginal services have always been separate and the Aboriginal people believe that services are too spread out for community to access effectively and efficiently and one of the issues for community in accessing services is having a vehicle or the financial means of getting there. A lot of people rely on taxis and public transport yet this can be expensive.

It was evident across the focus groups that if your skin colour is dark you are more inclined to experience racism and discrimination than if your skin colour is lighter. This appears to occur when accessing any services in particular health, housing, financial assistance services and in retail shops. Community don't access private General Practitioners because they don't possess private medical insurance and there are no Aboriginal or Torres Strait Islander people working within these services. There were a number of General Practitioners closing their doors and now there are only a few left within the town. Due to this shortage and the demand from the whole community, non-Aboriginal clients are now accessing the Aboriginal medical services too because of the availability of bulk-billing services.

It was repeatedly suggested through the focus groups that it is a lot "*harder for them (Aboriginal people) to get into the Aboriginal medical service for the reason that it is always booked out and white people are taking advantage of it, they're taking the privileges away from the Aboriginal people and their community"* According to the local Aboriginal people a lot of young ones with depression are suicidal and this increases

when a family member passes away, there are a lot of financial worries and they feel there is no way out. Dental services are limited in the community because services not only service the Dalby community but also visit other smaller communities surrounding Dalby resulting in limited days left for local people to access and compete for appointments. Availability of appointments are determined by seriousness of problems, which usually results in teeth being removed, there is little preventive treatment and education occurring. The Aboriginal medical service did provide dental services but currently have no dental services available. The local Aboriginal people support this in saying that if they need dental services urgently they often have to travel to Toowoomba for treatment which is approximately one (1) hour's drive from Dalby.

Within the community there is very little acknowledgement of Aboriginal and Torres Strait Islander history and/or culture available, the only time this is recognised is at National Aboriginal and Islander Day of Celebrations (NAIDOC) occurring once a year as well as other smaller events or activities with an emphasis on culture and history. . A Small number of representatives from the community both Aboriginal and non-Aboriginal people attend events or activities being held. Some community members have been working towards 'Reconciliation' within the town by creating awareness as one participant says and actively states *"reconciling with the Aboriginal people"* since the 'Apology' This participant further states it's about *"building bridges between black and white, we're not about just building bridges for Aboriginal people. The bridge has to go somewhere and people have to go back and forth"*.

A high level of racism is still present today and is impacting on Aboriginal people getting jobs, connecting with the wider community, accessing appropriate services and being treated equally. Racism, discrimination and prejudice is experienced by Aboriginal people when accessing welfare payments for instance if your skin colour is dark you are more inclined to be asked to identify, prove aboriginality, and produce proof. I speculate if this is because a lot of Aboriginal people don't have access to documents demonstrating proof and people may already know this and/or assume this to ensure they don't have access, putting up another barrier making it even harder for Aboriginal and Torres Strait Islander people to access services. Aboriginal and Torres Strait Islander peoples today still do not have the equal opportunity to be as healthy as non-Indigenous Australians.

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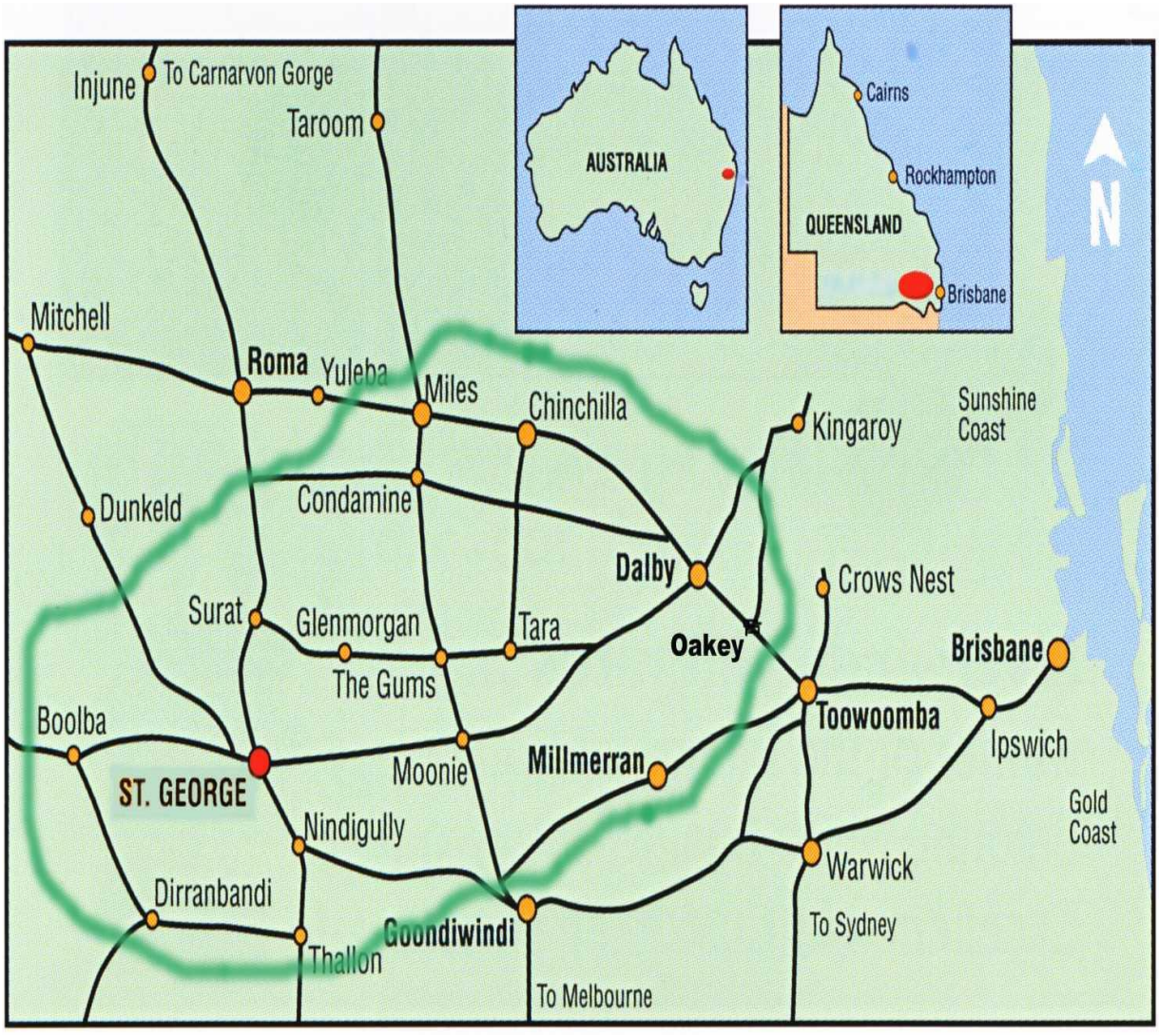
APPENDICES

APPENDIX 1

REGIONAL MAP OF DARLING DOWNS AND PARTS OF SOUTH-WEST QUEENSLAND

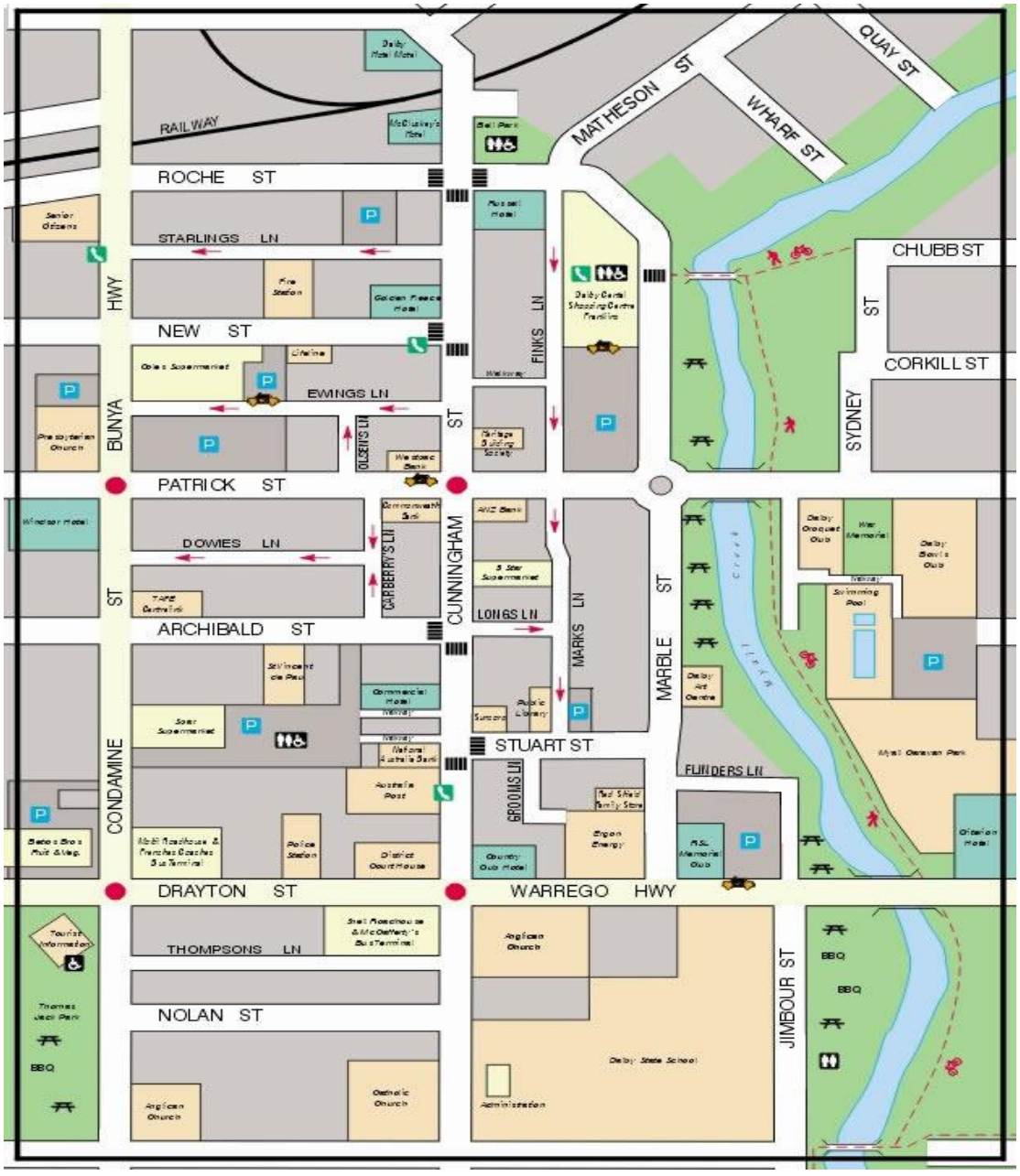


Regional map of South-West Queensland. The map illustrates where Dalby is located and the distance between larger towns and the city of Toowoomba.

This map also illustrates the boundaries of Goondir Health Services ***green circle*** *and the communities to whom they provide services too.* www.goondir.org.au

APPENDIX 2

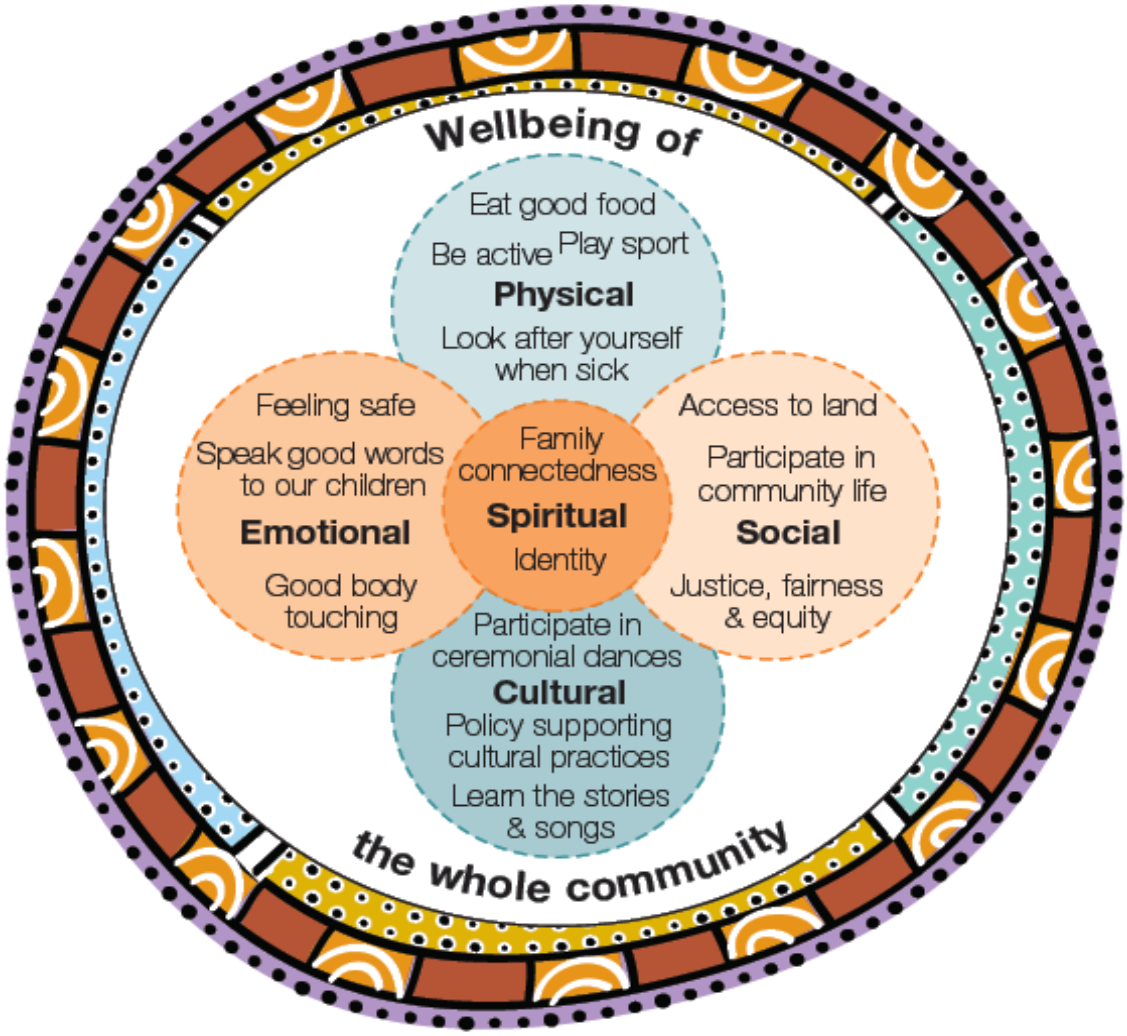
MAP OF DALBY TOWNSHIP



Map of Dalby Township, illustrates the main business area of town with some identified streets

APPENDIX 3

SOCIAL AND EMOTIONAL WELLBEING DIAGRAM
'Indigenous understanding of holistic health'



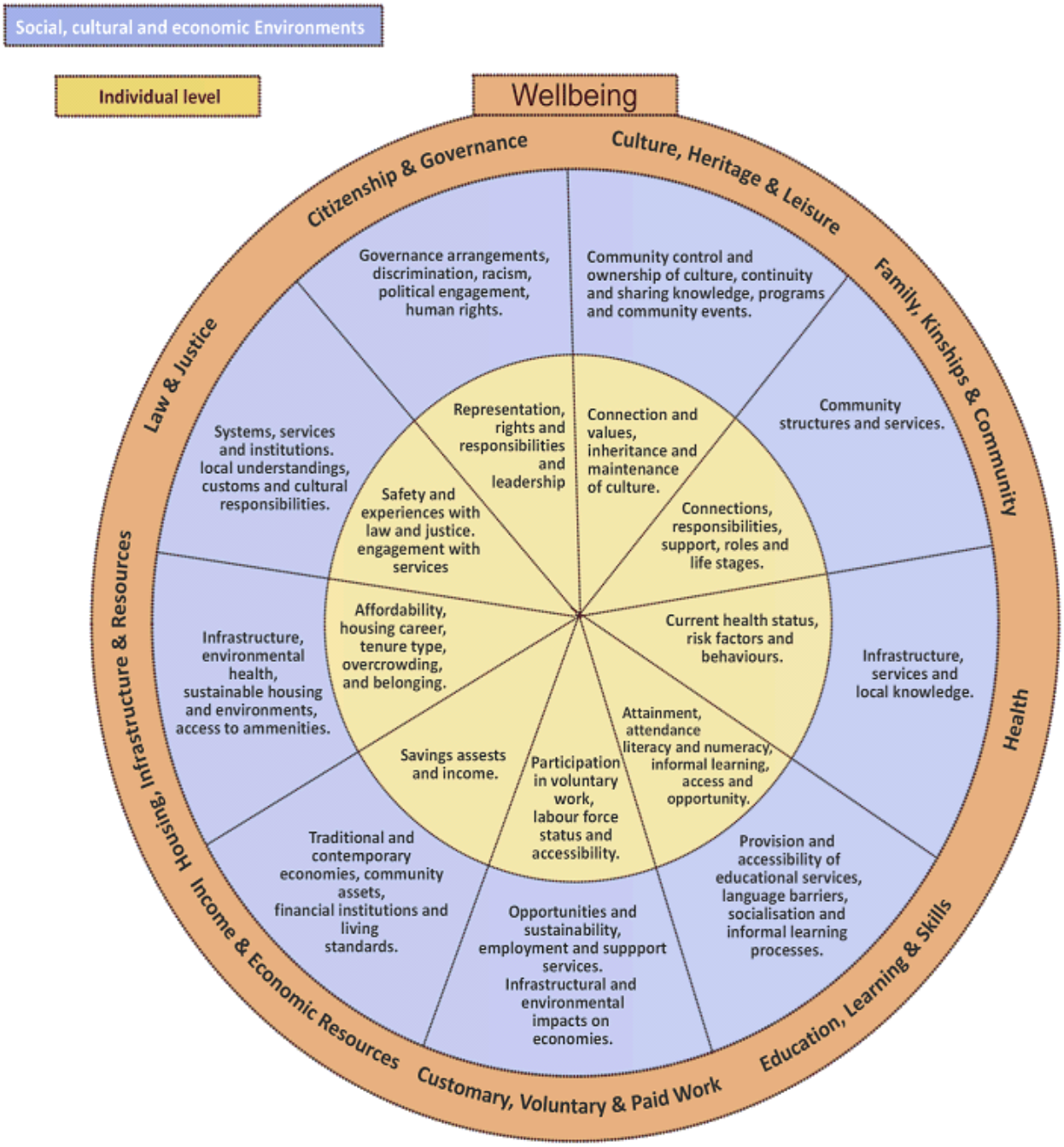
(Living is For Everyone (LIFE) – Fact Sheet 16: Suicide Prevention In Indigenous Communities (2007). Commonwealth Department of Health and Ageing: Canberra).

Diagram adapted from artwork by Ted Watson - Yudin Dally, Murrie artist from the Bigumbul language group in south west Queensland, reproduced by Queensland Health. Additional artwork by Sista Girl Productions.

The above diagram demonstrates how Indigenous people view health incorporating a holistic understanding of health and wellbeing that not only affects the individual, but the community as a whole. Wellbeing includes all aspects of health, including mental, physical, social, cultural and spiritual health

APPENDIX 4

INDIGENOUS WELLBEING FRAMEWORK

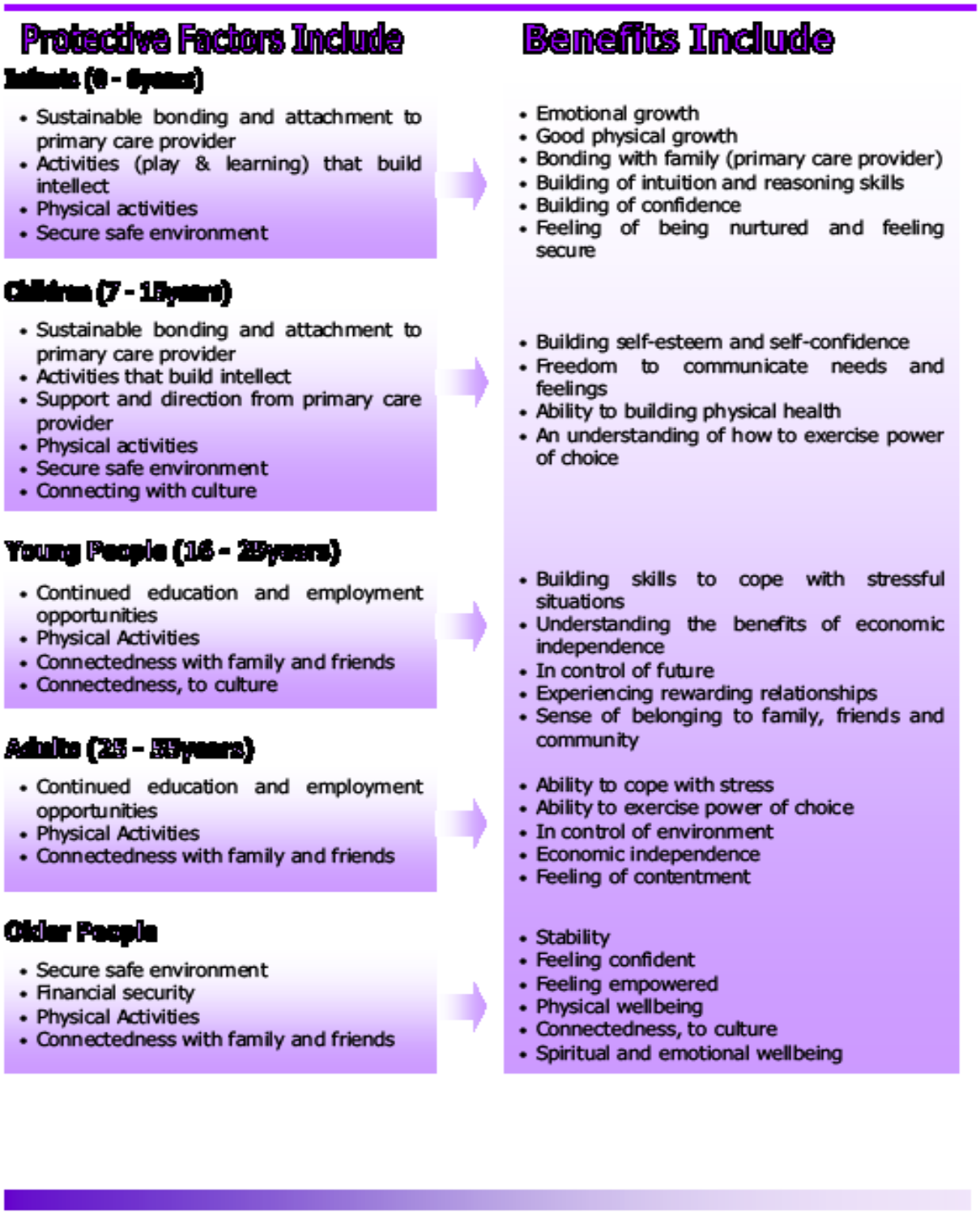


The nine domains of the framework for Indigenous wellbeing

http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/145F764BD98F0355CA2576DC001437FE?opendocument

Appendix 5

PROTECTIVE FACTORS AND BENEFITS MODEL



(South Australian Health Partnership 2004 pp 5)

APPENDIX 6

COMMUNITY PRESENTATION

My Research Question

"What services are accessed and available to the Aboriginal community of Dalby who have been affected by Suicide and/or Self-harm"

Why focus on this question?

The idea for the above research question came from my previous employment with 'Goondir Health Service', an Aboriginal & Torres Strait Islander Medical Service

Through my employment one of my main roles was to monitor, maintain and update the Service Delivery Reporting Framework (SDRF) document, and reporting this to the funding body

Overtime I began to question the capacity of this service in relation to its service delivery and to identify what partnerships this service had in relation to local health service providers

Through this I identified that Goondir had some partnerships in place yet at this particular time there was no record of any partnership with Queensland Health (such as mental and community health services) or with any other service providers locally for the delivery of mental health services which were being accessed and available to the Aboriginal community

What I have found in the literature?

- limited research done in this area with an emphasis on the Aboriginal population in South-West Queensland
- research articles that have been published have focused on Aboriginal communities in Northern Queensland, for example Yarrabah and Cape York communities and other States and Territories
- In 1988 Indigenous people who were living in rural areas had a higher rate of suicide than their counter parts living in urban areas or capital cities. Factors contributing to these high rates were: isolation, rural poverty and availability of firearms.
- It has been suggested that communities who have a large population of Aboriginal & Torres Strait Islander people found an increase in the rate of suicides among males, this being predominately high between the ages of 15-34 years

Aboriginal and Torres Strait Islander Population

- Suicide and self-harm used to be rare in traditional Aboriginal and Torres Strait Islander communities but has become more common in recent years
- Combined 2004 data for five states and territories indicated that suicide accounted for 4.2% of deaths for Aboriginal and Torres Strait Islander people compared to1.5% of deaths for other Australians in those states
- Rates are significantly higher for Aboriginal and Torres Strait Islander men (2.8 times) and women (1.9 times) than for their counterparts in the general population
- In recent years the death rate from suicide for Indigenous males was highest in the 15-34 year age group. For females, the rates have generally been highest in the 15-24 year age group
- People in any form of custody have a suicide rate three times higher than the general population. From 1990 to1995 Aboriginal and Torres Strait Islander people were 16.5 times more likely to die in custody than other Australians

("Mindframe 2007).

Access to Services

- Aboriginal & Torres Strait Islander people are more likely to access mainstream services in the event of a crisis instead of other community based services, which are unevenly and poorly distributed in rural and remote settings (Brown 2005).
- Access to health services, the ability to act on health advice, and the capacity to modify health risk factors are all influenced by the circumstances in which people live and work.
- Studies have shown that those most needing care are least likely to receive it. The quality of care received by people with higher socioeconomic disadvantage is different from those with lower levels of disadvantage (Harper 2004).
- Queensland Health published a report called '(Harper 2004), based on the Indigenous population throughout Queensland which identified factors contributing to the low socioeconomic status for Indigenous people. At the time of this report they identified the following: Indigenous status and level of socioeconomic disadvantage and to a lesser extent living in a rural or remote location have all impacted on the overall health of these people.

  However, with current data, the effect of each of these factors is unable to be separated out. This is because Indigenous peoples throughout the state often live in areas of socioeconomic disadvantage and 55% live in rural and remote areas of Queensland

Social & Emotional Wellbeing

The Social & Emotional Well Being Framework 2004-2009, recognises the strengths, resilience, and diversity of Aboriginal and Torres Strait Islander communities. It acknowledges that Aboriginal and Torres Strait Islander peoples have different cultures and histories, and in many instances different needs, the Framework recognises that supporting Aboriginal and Torres Strait Islander families to effectively deal with, and triumph over, the effects of past policies and practices is a priority.

From an Aboriginal perspective, social and emotional well-being problems can result from: grief; loss; trauma; abuse; violence; substance misuse; physical health problems; child development problems; gender identity issues; child removals; incarceration; family breakdown; cultural dislocation; racism; and social disadvantage.

The high levels of mental illness, of substance abuse, and suicide all testify to the challenges faced by Aboriginal and Torres Strait Islander peoples. The financial stress in which the majority of Aboriginal and Torres Strait Islander households survive indicates not only that they are severely limited in their ability to cope with a crisis, but also unable to accumulate resources (Mouse 2004).

Profile of Dalby Community

Profile generated 7th April 2009 www.oesr.qld.gov.au

- As at 30 June 2007, the estimated resident population of Dalby Regional Council was 30,230 persons
- There were 10,423 persons resident in the urban centre of Dalby
- At the time of the 2006 Census of Population and Housing there were 1,195 persons in Dalby Regional Council who stated that they were of Aboriginal or Torres Strait Islander origin
- Approx 500 Aboriginal & Torres Strait Islander people reside in the Dalby community

The Aim of this study is to:

Identify what services are available, and determine if these services are being accessed by the Aboriginal community

The Objectives of this study are to:

1. Identify existing professional health and counselling services available in Dalby
2. Map how services are delivered and accessed
3. Identify the types of community programs and/or support groups available in the community of Dalby

Methodology and Methods

Recruiting Participants

Services/Organisations

- Commonwealth Care-link Centre via their database
- Yellow Pages via the phone book
- Dalby Community Directory via internet access
- Other databases and information gathered from other existing studies performed
- Toowoomba City Council Community Directory

Cont…

Aboriginal participants from the community of Dalby:
(Objective 2)

- Networking and liaising with local Aboriginal services in the community of Dalby
- Networking and liaising with Aboriginal staff in identified positions who are employed via mainstream services such as Queensland Health
- Attending and participating in local community meetings/programs/events/functions/gatherings
- Identify who the Aboriginal population are and where community people congregate

Identify existing professional health services available to the Dalby community

(Objective 1)

- Goondir Health Services
- Myall Medical Practice
- Ozcare Asthma Foundation of Qld
- Branch Blue Nursing Service
- Coeliac Support Group & Information
- Dalby Community Health
- Dalby Health & Liveability Group
- Dalby Physiotherapy Centre
- Dalby Wambo Care Association
- Dalby Health Services
- Jandowae Health Services
- Disability Services
- Hearing Aid Specialists (Toowoomba)
- Home Healthcare
- ATSI Mental Health Worker

Identify existing professional counselling services available to the Dalby community (Objective 1)

- Salvation Army Family Store & Welfare Office
- Dalby Crisis Support Association Inc
- Gambling Help Toowoomba & South West
- Ozcare
- St Vincent De Paul Society Store
- Bonnie Babes Foundation
- Australian Heritage Funerals
- Burstows Complete Funeral Care
- Queensland Transport
- Lifeline Darling Downs & South West
- Lifestyle Support Service
- Queensland Cancer Fund Branch
- Joan Saunders
- Tricia Stewart
- Alateen Dalby
- PCYC
- Dalby Rural Youth Club
- Stolen Generation Counselling services
- Drug Arm Services
- AOD Clinical Worker Drug Arm
- Regional & State Manager

Arrange and hold information sessions within the community inviting all stakeholders and Aboriginal & Torres Strait Islander people (Objective 2)

If you relate to one of the following categories:

- Resident of the Dalby Community
- Aboriginal & Torres Strait Islander (ATSI)
- Provides services to ATSI community
- Health Service Provider
- Counselling Services
- Crisis Support & Intervention
- Welfare Support
- Advocacy Support
- Mental Health
- Crisis Relief
- Provide outreach services to Dalby

Then attending one of the following information sessions on new research being conducted in Dalby will be beneficial to you and your Community.

INFORMATION SESSION 1

Venue: MYCNC
Date: Thursday 30th October 2008
Time: 10am – 12md

INFORMATION SESSION 2

Venue: MYCNC
Date: Friday 31st October 2008
Time: 10am – 12md

Data Collection

The process for gathering information for the purposes of this study will occur through:

- Face to face interviews
- Focus groups
- Community meetings
- Health promotional activities and education programs

Establishing focus groups within the Dalby community

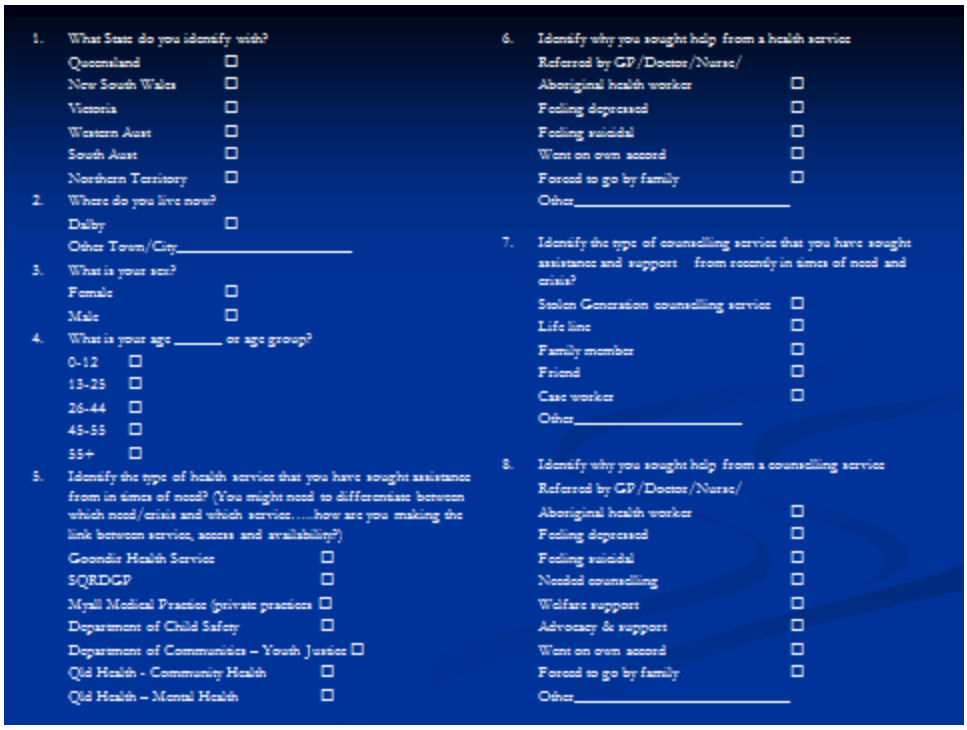
- Initially work closely with local services to recruit local people & build rapport with community people
- 4 focus groups comprising of ATSI community people who reside in the Dalby town
- From the information sessions establish first **1st focus group** for **November 2008**
- Arrange **2nd focus group** for approximately **January 2009**
- Arrange **3rd focus group** for approximately **February 2009**
- Arrange **4th focus group** for approximately **March 2009**

Focus Group demographics

- Recruit approximately 5-8 people for each group
- Mixture of male and female, young and elderly people
- Age ranging from 18yrs+ and up
- All participants identified as either Aboriginal &/or Torres Strait Islander
- All participants are current residents of Dalby

The following slides contain two questionnaires, first one developed for service providers and the second developed for the Aboriginal and Torres Strait Islander community

1. Briefly describe the main role that your service or organisation provides to the Aboriginal community?
2. Describe how often your service visits Dalby community?
3. What age group in the Aboriginal community does your service or organisation target?
4. What population group does your service/organisation target when providing a service i.e. youth, women, men etc
5. How many Aboriginal clients access your service/organisation?
6. Do you have any Aboriginal clients who do not identify?
7. How does the Aboriginal community access your service
8. Where is your service/organisation located in Dalby, do you feel it is easily accessed by Aboriginal people?
9. How many Aboriginal people who use your service have voiced concerns/issues about suicide?
10. How many Aboriginal people who use your service have self-harmed/suicide them-selves?



1. What State do you identify with?
   - Queensland ☐
   - New South Wales ☐
   - Victoria ☐
   - Western Aust ☐
   - South Aust ☐
   - Northern Territory ☐
2. Where do you live now?
   - Dalby ☐
   - Other Town/City_____
3. What is your sex?
   - Female ☐
   - Male ☐
4. What is your age _____ or age group?
   - 0-12 ☐
   - 13-25 ☐
   - 26-44 ☐
   - 45-55 ☐
   - 55+ ☐
5. Identify the type of health service that you have sought assistance from in times of need? (You might need to differentiate between which need/crisis and which service.....how are you making the link between service, access and availability?)
   - Goondir Health Service ☐
   - SQRDGP ☐
   - Myall Medical Practice (private practice) ☐
   - Department of Child Safety ☐
   - Department of Communities – Youth Justice ☐
   - Qld Health - Community Health ☐
   - Qld Health – Mental Health ☐
6. Identify why you sought help from a health service
   - Referred by GP/Doctor/Nurse/ Aboriginal health worker ☐
   - Feeling depressed ☐
   - Feeling suicidal ☐
   - Went on own accord ☐
   - Forced to go by family ☐
   - Other_____
7. Identify the type of counselling service that you have sought assistance and support from recently in times of need and crisis?
   - Stolen Generation counselling service ☐
   - Life line ☐
   - Family member ☐
   - Friend ☐
   - Case worker ☐
   - Other_____
8. Identify why you sought help from a counselling service
   - Referred by GP/Doctor/Nurse/ Aboriginal health worker ☐
   - Feeling depressed ☐
   - Feeling suicidal ☐
   - Needed counselling ☐
   - Welfare support ☐
   - Advocacy & support ☐
   - Went on own accord ☐
   - Forced to go by family ☐
   - Other_____

Data Collection

- Consent forms provided to all participants
- Conversations recorded on a digital recorder
- Conversations transcribed for analysis

Data Analysis

- Thematic analysis
- NVIVO
- Write up results

APPENDIX 7

PARTICIPANT INFORMATION SHEET & CONSENT FORM

Consent Form for Interview

Full Project Title: "What services are accessed and available to the Aboriginal community of Dalby who have been affected by Suicide and/or Self harm"

Researcher: Raelene Ward

Purpose and Background

The purpose of this study is to explore and identify the different types of health and counselling services available in the community of Dalby and to see if the local Aboriginal people of Dalby use these services when in crisis of need. We already know that there is a lack of health services and resources available to Aboriginal people living in rural and remote communities in the South-West regions of Queensland. At the end this study will give the Aboriginal people of Dalby a list of the services and resources available to them so that they can become empowered (stronger) and self-resilient (build inner strength) through their own gains and successes of knowledge and self-awareness programs.

1. The first part of the study will be to inform the local community of this study by having community information sessions locally in Dalby so we can explain to the Aboriginal people what we aim to do and how we intend to do it. This will help us to see and talk to community people one on one and to see how we can involve the Aboriginal community.

2. The second part of the study will focus on interviews, the type of things we will be using in the interviews are questionnaires' these will be given to local health and counselling services, so that we can identify who these services are and what types of services they deliver and to what people.

3. The third part of the study will be to set up focus groups locally in Dalby and invite local Aboriginal people to come along and join in a focus group, this means that you will sit in a group and talk to other people, while I (Raelene Ward) listen and record you talking so that I can study it later.

Your participation in this study will help us to inform the wider community of Dalby of the types of services that Aboriginal people will use and how they intend to use them more openly and safely.

What we are asking you to do

Participation in the study will involve you being interviewed, one on one with me, as well as coming along to a focus group session, this will allow me to find out from the local Aboriginal people how much they know about health and counselling services in Dalby, identify if they use these services and if they don't use these services and why?

If you say yes to participate in the interview it will be held in a location that is suited for you and it would go for about 1 hour.

The interview will be recorded so that I can study it later and no names will be shared with anyone outside of the project, this information will be de-identifiable, meaning that I will use numbers to recognise people's answers and/or comments in any future publications.

Your choice to participate in this study is voluntary and you can withdraw at any time you wish.

Privacy, Confidentiality and Disclosure of Information

Any information obtained in this project that could identify you will remain confidential. Any publication/s or information arising from this study will be provided in such a way that neither you your family, your community nor your health service can be identified.

Results of Project

The results of the project will be submitted for publication to relevant journals

Further Information or Any Problems

If you require further information or if you have any problems concerning this project, you can contact myself Raelene Ward on (07) 4631 5442 or my supervisor at the University of Southern Queensland, Professor Don Gorman on (07) 46315456. Alternatively you may contact the Secretary, University of Southern Queensland Human Research Ethics Committee on (07) 4631 1438.

Participant's Name (printed)
_____Signature_____

Date / /

APPENDIX 8

DEFINITIONS

For the purposes of this study the following terms will be defined to ensure that readers and participants have an excellent and thorough understanding of the whole question being researched.

Health Services

For the aim of this study, the term health services will include only those services which identify as a professional health service, which provide a service to any group/population for general health reasons.

Counselling Services

For the aim of this study, the term counselling services will include only those services which provide advocacy, crisis support, crisis intervention, crisis relief and counselling to Aboriginal people within the community of Dalby.

Dalby Township

This study will only concentrate on the Township of Dalby community, which will exclude all those smaller communities and towns surrounding the Dalby region. Due to the timeframes overall for this study and the short period of time allocated for engaging and consulting with the Aboriginal community I will only have the time and resources to examine the township of Dalby. According to the Local Government Area Profile, as at 30th June 2006, the estimated resident population of the Dalby (T) region was 10,536 persons, representing 0.3 per cent of the States population (LGA May 2007). "At the time of the 2001 Census, there were 544 persons in the Dalby (T) region who stated that they were of Aboriginal or Torres Strait Islander origin. These persons comprised 5.6 per cent of the total population" (LGA May 2007).

Social & Emotional Wellbeing

This *Social and Emotional Well Being Framework* is based on the Aboriginal definition of health (NAHS, 1989) recognising that achieving optimal conditions for health and well being requires a holistic and whole-of-life view of health. Referring to the social, emotional and cultural well being of the community (Mouse, 2004)

Aboriginal Health

This broader understanding of health is also outlined in Ways Forward (Swan and Raphael, 1995), 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 harmonised interrelations which constitute cultural well-being. These inter-relating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical. It is essential to understand that when harmony of a personal inter-relation is disrupted, Aboriginal ill health will persist (Swan, 1995).

Mental Health

Aboriginal concepts of mental health are holistic and are defined as follows: Health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well-being of their communities. This is an evolving definition. Cited in Ways Forward (Swan, 1995).

Suicide

"Suicide can be defined as the deliberate taking of one's life. To be classified as a suicide a death must be recognised as being due to other than natural causes. It must also be established by coronial enquiry that the death resulted from a deliberate act of the deceased with the intention of ending his or her own life" (Australian Bureau of Statistics 2005 pg 3; Butterworth's Concise Australian Legal Dictionary, 1997, Butterworth's Sydney; Healey, J 2002 pg. 1). There has been minimal research which has been inclusive and incorporated Aboriginal understandings and definitions of self-harm behaviour and suicide. Suicide in the general population is often debated against arguing against the 'element of intent' (Allen 2000).

Intentional self-harm is also a controversial issue, in that the person may not have deliberately intended to end their life as such. Reser (1991) identified that in an Aboriginal setting this kind of behaviour is often described as a 'release' with the intention to succumbed to this feeling after their wrists were severed, these people would feel 'at peace' and 'calm'

Attempted Suicide

Instances of attempted suicide and self-mutilation are inclusive in the definition of self-harm often reflecting self-inflicted harm where the intention may or may not have been to die. Not only is self-harm a significant problem in it's own right, research has demonstrated that those who have previously attempted suicide are at an increased risk of committing suicide (Auseinet, 2007).

Self-harm

"Self-harm is when people deliberately inflict physical harm on themselves directly or indirectly" (Healey, 2002). In relation to the Aboriginal context, several writers as documented in this article by Procter state that all self-harming behaviours should be identified as a radical response to specific risk factors and violence in the wider

context of emotional and social meanings, socioeconomic conditions, cultural identity and historical themes (Proctor, 2005).

Aboriginal Community Controlled Health Services (ACCHSs)

ACCHSs are primary health care services initiated by, and based in a local Aboriginal community and governed by an Aboriginal body elected by the local Aboriginal community to deliver holistic and culturally appropriate care to people within their communities. A service that contains these elements represents true community control and best practice. However, it is acknowledged that there are a variety of existing governance structures that may be considered stages along a process that can lead over time to the development of a fully community controlled best practice service (NATSIHC 2002). Cited in Social & Emotional Wellbeing Framework document, Aust Health Ministers Advisory Council 2004-2009 pg. 67

APPENDIX 9

DEMOGRAPHICS OF EACH FOCUS GROUP

APPENDIX 10

EXCERPTS OF TRANSCRIPTS

Dalby Focus Group 1 of 5

10 November 2008

Facilitator: This focus group is largely working with the Aboriginal community of Dalby, so first of all I would like to welcome everyone and thank you for coming today and participating in this focus group. So the purpose of the focus group is to get you guys opinion and perception around services that are currently in Dalby and also services that visit Dalby on a regular basis, for instance from Toowoomba so it's really just looking at if you think that services are accessible and if they are available in the local community for the Aboriginal people.

So there are a few things I will just mention around the focus groups. Everyone has an opportunity to participate and everyone is important when they do participate in a focus group. There are no right or wrong answers, so feel free to say what you feel and wrong answers won't be the negative side of it either. So if you disagree with someone, that's fine, just keep talking and we will just go around the circle.

So, as I said before, once everyone has signed the consent form that just lets me know that everyone's happy to participate, all information will be maintained confidential so no one won't be able to identify who said what in the conversations and the information collected on the recordings, and even on the paper trail will all be shredded after five years and they will all be locked in my filing cabinet at USQ, so no one else has access to this information.

There hopefully will be published articles from the end of this research, so that's really just to inform service providers locally as well as getting the local community to inform policy makers and even government bodies about what services are appropriate and what's more accessible for them.

Participant: That's very good because like we haven't got much help up here. I mean like Government probably thinks because we're a smaller community than the cities, if you know what I mean, but we've got the same problems as they have in the cities, but ours are very noticeable because a lot of us do walk around in the community because lots of us don't own cars and most of us are Commission housing or private dwellings. We've got housing,

like Aboriginal Housing here in which we have built out forms like years ago and still to no avail that we sort of have one of them. They tell you it's a priority, housing, especially for sick and elderly and things like that, families with a lot of children, you know families, but I mean myself, you know I've got six children and I've got about 13 grand children, our families, and five of them in my family do have large families living in Dalby and they're still in Housing Commission. They get hassled by the Housing Commission, harassed and they've only got to miss one payment, not through their own fault, but through Centrelink. You know there might be a late payment or something could have happened in that family – they could have done a few hours work somewhere, and Centrelink fits hold to it and next minute they're being cut off and then they will miss out and straight away they get this form out of Housing you know.

Participant: To be evicted.

Facilitator: So how long have you lived in Dalby?

Participant: Oh, I lived here for what? I came up here in 1998 and first off my grand children came with me, like the older ones and the older boy actually lived on the riverbank which they didn't mind, you know what black fellas are and they lived on the riverbank under Myall Creek and I was doing a bit of cultural heritage work out here and so I had a little bit of money there. Got two flats like one for myself and the younger children, the younger grand children, and the boys got a flat next door. I got it for them anyway. So like the money I was making it sort of covered it you know and even with the rent I sort of paid two rents.

Participant: That would have been $50 a week rents then wouldn't it? She was paying $200 a fortnight.

Participant: A week for the two flats.

Participant: Since then my daughter and her and her other half, they had a bit of an argument down Moree so she come up. She had about three children then and stayed with me and from there everything sort of went like I wouldn't say really good, but we tried like to survive in the one house, this three bedroom house and everybody was just getting in each other's road, you know what I mean?

Facilitator: Yeah.

Participant: There's a lot of kids and a lot of adults there.

Facilitator: So how long did you say you lived here?

Participant: Oh, since 1998.

Facilitator: So you would have seen a change in the local community?

Participant: Well, yes, you know I mean a lot of us now, like us older community now, well we've got older of course and our grand children – well my grand children have grown up, most of them. A lot of them have still got little tiny ones. One of my daughters is partly deaf. She reads lips more than anything else. She was living in a Housing Commission home but it wasn't big enough and she asked Housing Commission for transfers and like out of the one place now because her children…

Participant: Were getting sick.

Participant: Were getting sick all the time with the constant close to the stable sort of thing and I think the Bluff then was probably an old place where they – it was more like a swamp sort of thing and it still is. I mean the Council – complained to them, they didn't take much notice you know because of all the water still – and even today it still sits there and kids still get sick. Like boils and sores and runny nose and we…

Participant: Constantly sick.

Participant: We had spoken to some Aboriginal health workers, can't remember names, about the situation. You know they said, "Oh we will see what we can do." But it was to no avail.

Participant: Nothing come around about it.

Participant: So anyway we decided to go private and me on my Old Age Pension now, I'm feeble you know and…

Participant: My daughter.

Participant: And she's on a disability and her other half, he works and doesn't make enough money to sort of keep them sort of going you know what I mean.

Participant: Cover everyone.

Participant: My little bit of money comes in handy, especially with the electricity bill and the rent and food. She's got five children, three of them in school. Eldest one of hers goes to high school next year and the other two are in year four and two – no one and another little fellow, he starts off school next year in 2009 and then she will just have the one at home. So we sort of

busied ourself around and just lately we've had so much alcohol and drugs and I mean we're sitting on the main highway if you know what I mean. You know it goes all ways – north, down south, Northern Territory. You can get to any destination you want to coming through where we live.

Facilitator: So with – you were talking about some of the health problems…

Participant: The health problems here, it's an ongoing thing. There's not enough – well we do have a medical centre, Aboriginal Medical Centre Goondir but the staff aren't trained. You know it's not to – I mean I'm a diabetic myself and I need my blood pressure taken and that.

Participant: They're not medically trained in a sense where they don't go to university or go to the hospitals to be trained. They're physically actually at the medical centre which is wrong. They're hardly sent away to train and a lot of them people think they know everything because they just work in the medical centre but they're not fully qualified.

Participant: Exactly.

Participant: They're not qualified to do the job.

Facilitator: So with that comment do you think – what are your thoughts around other services, health services in the community?

Participant: Are they health services? I think that's the only health service apart from Dalby Hospital for the Aboriginal people. There's not enough training in the Dalby Hospital on Aboriginal culture and how to talk to Aboriginal people. It's like you're an Aboriginal person you go there if you're sick, you've either been drinking or you've taken drugs if you know what I mean?

Facilitator: Yeah.

Participant: And I mean if you get a sexual disease you can't go to the Goondir Centre…

Participant: Confidentiality is a big thing in a medical centre and they tell everybody in this town what you've got.

Facilitator: Ok. So what do you guys – what are your thoughts around what's just been shared around the community, health problems with the services?

Participant: Needle service.

Participant: Oh well with the service anyway, don't care if they've got a sexual disease they've got no rights to go through their files and tell everybody because that's confidential. They can get fired for that, that's wrong.

Participant: But they do, they do do it.

Participant: Yeah. We had a big thing like that in Moree too like when we were young.

Participant: Mm.

Facilitator: So where are you from initially?

Participant: I'm from New South Wales, Moree. We had this sort of problem down there when we were young. When you went down [inaudible] *13:35 they knew that you had a sexual disease. They don't broadcast it over radio telling us why you are wrong, they shouldn't even do that. That's your business, that's your personality, you're the one that got to tell the person what you got, not them, that's wrong.

Facilitator: Yeah.

Participant: Yeah and like for us oldies we come up town shopping and I mean I don't mind in the winter walking, but in the summer I've got to keep money for a taxi which I can't afford and what not all the time.

Participant: And to go 2.5 kilometres costs $12 [laugh].

Participant: Exactly.

Facilitator: So access to services is difficult.

Participant: Very, very…

Facilitator: Or limited.

Participant: Yeah.

Participant: Very limited, very – I think – you know I mean when I go to the doctor they know when I go to see the medical centre, the Goondir Medical Centre, it's like I'm sick because I know my blood pressure is up. They come there, they sit outside and blow the horn.

Participant: Instead of getting up, knocking on the door.

Participant: And I think, “I’ve got to be sick, why can’t they come and see how I am?”

Participant: See if you are alright. “Oh you need a help out to the car.”

Participant: That’s why I can’t live on my own because of what – I would love to be on my own, there’s just too many children for my liking, I need a bit of a break now because I’m an old age pensioner. I love my grand children, I love my great grand children too you know, but I mean it’s not every day that I want to put up with them because I need my rest. I know that sometimes it cause my – worrying about the kids when they’re not home at such and such a time and things like that and that’s when he said, “Mum you need to be on your own now.” I said, “I realise that you know but I don’t think I could live on my own, you know what I mean.”

Participant: You’re frightened to.

Facilitator: Yeah.

Participant: I mean if they’re going to sit out the door and beep the horn you know and I mean if I do go and have a sugar black out, they’re going to drive back to Goondir and say, “Oh no she’s not home.”

Participant: Lillybell not home.

Participant: I could be dead there.

Participant: The old girls not home. She could be laying there in a sugar black out coma.

Participant: That’s it.

Participant: Unbeknowns to the driver because the driver refused to get out of the car.

Participant: They won’t get out of the car.

Participant: To be polite and that’s their natural job to do it, it says so in the manuals and everything they get when they go to sign up with Goondir or the medical services here. They refuse to get out of their car, they expect a crippled person to walk out to the car instead of them going in to your house and saying, “Hey would you like a hand lady or man? I’ve come to pick you up?” Not sit outside and toot the horn, “Toot, toot, toot” and expecting you hear over four or five screaming kids.

Facilitator: So we’ve talked a little bit around access so they – transport is available.

Participant: Transport is available from the Medical Centre.

Participant: Only school buses you know. There is transport from the Medical Centre, the Aboriginal Medical Centre, to the hospital, then they drop you off there, they give you the phone number to contact them when you're finished whatever you've got to do inside and I thought, "Now, how rude is that?" We shouldn't have to ring them because we've got to use our own money to ring them when they're supposed to provide all these services for us elders and the young people. I mean there's ears, eyes, every sort of problem here you know and the kids don't get to see that unless you ring up and make an appointment. When you ring up, because they've got – what do they call it now?

Participant: Bulk billing now.

Participant: Bulk billing now you know, it's always booked out.

Facilitator: Yeah.

Participant: The Aboriginal community can't get in to see their normal doctor now.

Participant: Exactly.

Participant: Because they brought the bulk billing service into the Aboriginal Medical Services and the white community has taken advantage of it…

Participant: Oh yeah.

Participant: You know when they found out that the Aboriginal Medical Centre…

Participant: They use the bus, they use the Medical bus, and I see flash cars they drive around town in but they use the Medical Centre's bus you know.

Participant: They're taking the privileges away from the Aboriginal community.

Facilitator: So what about you guys down the end there? Do you have a similar view around health services in the community?

Participant: Yeah.

Participant: They've got more complaints about the Police services in this township.

Participant: Yeah.

Facilitator: Ok.

Participant: That's what's their complaints mainly about.

Facilitator: So do you men access health services very often?

Participant: Kevin does.

Participant: I don't, not really.