Success Stories:

Environmental, Social, Emotional and Spiritual Health of Aboriginal and Torres Strait Islanders

Report of the Indigenous Health Workshop

Australian Health Promotion Association

IUHPE

Cooperative Research Centre for Aboriginal Health

QAIHC
Queensland Aboriginal and Islander Health Council

Success Stories:

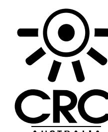
Environmental, Social, Emotional and Spiritual Health of Aboriginal and Torres Strait Islanders

Report of the Indigenous Health Workshop

© Australian Health Promotion Association, International Union for Health Promotion and Education, Cooperative Research Centre for Aboriginal Health and Queensland Aboriginal and Islander Health Council, 2009

ISBN 978-0-7340-4144-9

First printed in December 2009



This work has been published as part of the activities of the Cooperative Research Centre for Aboriginal Health (CRCAH). The CRCAH is a collaborative partnership partly funded by the Cooperative Research Centre Program of the Australian Government Department of Innovation, Industry, Science and Research. This work is joint copyright between the Australian Health Promotion Association, the International Union for Health Promotion and Education, the CRCAH and Queensland Aboriginal and Islander Health Council. It may be reproduced in whole or in part for study or training purposes, or by Aboriginal and Torres Strait Islander Community organisations subject to an acknowledgment of the source and no commercial use or sale. Reproduction for other purposes or by other organisations requires the written permission of the copyright holder(s).

Electronic copies of this report are available from:

Australian Health Promotion Association
W: www.healthpromotion.org.au

International Union for Health Promotion and Education
W: www.iuhpe.org

Editors: Rosmarie Erben, Jenni Judd, Jan Ritchie and Louise Rowling

Managing Editor: Jane Yule

Copy Editor: Cathy Edmonds

Design and Print: InPrint Design

For citation: Erben, R., Judd, J., Ritchie, J. & Rowling, L. (eds) 2009, *Success Stories: Environmental, Social, Emotional and Spiritual Health of Aboriginal and Torres Strait Islanders. Report of the Indigenous Health Workshop,* Cooperative Research Centre for Aboriginal Health, Darwin.

Table of Contents

Acronyms	**iv**
Executive Summary	**v**
Introduction	**vi**
SECTION A Success Stories: Comprehensive Case Studies	**1**
Well Women's Service—Opening Health Promoting Doors	2
Aboriginal and Torres Strait Islander peer support in a Queensland correctional centre	6
Traditional Aboriginal and Torres Strait games: a culturally appropriate program for school settings	11
SECTION B Success Stories: Brief Project Reports	**19**
Improving diabetes care in a rural Victorian Aboriginal Community Cooperative	20
Men's Health	22
Applied research tools to record success stories in Aboriginal communities	24
Smokers Program	26
Ifi ni gulanga—The house of healing	29
SECTION C Success Story: The Workshop	**31**
The workshop processes	32
Planning	32
Workshop format	33
Workshop outcomes	33
Guidelines for the group work	33
The program for the day	34
Key learnings from the success stories	38
Evaluation feedback	38
Appendix	**40**

Acronyms

AHPA	Australian Health Promotion Association
BADAC	Ballarat and District Aboriginal Cooperative
BSPHU	Brisbane Southside Population Health Unit
CEO	Chief Executive Officer
CRCAH	Cooperative Research Centre for Aboriginal Health
GP	general practitioner
IUHPE	International Union for Health Promotion and Education
NAIDOC	National Aborigines and Islanders Day Observance Committee
NRT	nicotine replacement therapy
PHAA	Public Health Association of Australia
QAIHC	Queensland Aboriginal and Islander Health Council
SEWB	social and emotional wellbeing
TIGs	Traditional Indigenous Games
WHG	Women's Health Grampians

Executive Summary

In July 2008 in Brisbane, Australia, an Indigenous Health Workshop was conducted in conjunction with the Population Health Congress. A collaboration of four partner organisations—Australian Health Promotion Association, International Union for Health Promotion and Education, Cooperative Research Centre for Aboriginal Health, and Queensland Aboriginal and Islander Health Council—the workshop aimed to consolidate recent success stories and innovations undertaken in Indigenous health by identifying critical success factors to inform future health service delivery and policy. The expected outcomes from the workshop included sharing information about these success factors, capacity building for knowledge transfer, strengthening the interface between research and practice, and promoting networking and future collaboration.

This report contains detailed case studies and brief reports that were presented, discussed and documented at the workshop. Additionally, the carefully planned workshop process is documented as an example of successful quality health promotion practice. Respecting individuals and communities for the assets they bring to improve health was an underpinning principle of the workshop. Key processes identified included: capacity building through personal relationships that facilitate dialogue about cultural protocols; community experiences and expectations (including formal introductions and endorsement between partners, Elders and community members); collaborative ongoing support for activities between partners and project staff; authentic engagement; and a focus on strategies to maximise sustainability for creating and embedding new practice in settings.

Introduction

This report documents the outcomes of a workshop that concentrated on Indigenous health success stories and that was conducted with a number of partners: the Australian Health Promotion Association (AHPA), the International Union for Health Promotion and Education (IUHPE), the Cooperative Research Centre for Aboriginal Health (CRCAH), and the Queensland Aboriginal and Islander Health Council (QAIHC). A common purpose and philosophy was reflected in the work of these partners for the advancement of Aboriginal and Torres Strait Islander health and wellbeing. The workshop was held at the Population Health Congress 2008, Brisbane Convention and Exhibition Centre, Queensland, on Sunday 6 July.

Dr Ian White, Workshop Chair and National President of AHPA, welcomed delegates. The focus of the workshop was to bring people together to identify what makes health programs and projects 'successful' and to investigate how we might pass on the important messages to others so that they might learn and build on that learning to enhance future programs and projects. It was hoped that a good deal of what could be learned in the workshop would be as a result of sharing ideas and thoughts; building individual capacity through communication and networking; and providing opportunities for collaboration and partnerships. This form of communication was seen as fundamental to good health promotion practice.

All workshop participants—experienced practitioners and novices alike—were encouraged to network, share, communicate and enjoy this great learning opportunity.

Dr Rosmarie Erben introduced IUHPE as a global non-governmental organisation with a mandate to address and defend social justice issues globally. During the IUHPE World Conference in 2004 in Melbourne, the global membership agreed on a number of resolutions concerning Indigenous health. These included giving specific support to Australian Government developments that would recognise the specific Indigenous population needs that have resulted from losses experienced over many generations; support would also be given to programs led by community members that are linked to the normal daily life of communities and that build on local traditions. These resolutions were reinforced at the 2007 IUHPE World Conference in Vancouver. In the South West Pacific Region of IUHPE a working group was established to support action on Indigenous resolutions. In response to ongoing debates about the health status of Indigenous Australians, the group had called upon the Australian Government to draw on experiences from health promotion success stories when developing programs. Respecting individuals and communities for the assets they bring to improve health was seen as a fundamental underpinning health promotion principle of the workshop.

The CRCAH, one of the workshop partners, is committed to research that makes a difference to Aboriginal health. It takes a holistic view of health that includes social and emotional wellbeing, and creates partnerships for Aboriginal communities, researchers and governments to work together.

QAIHC, another workshop partner, is Queensland's peak body representing, advocating and supporting the State's community-controlled health services sector in delivering comprehensive primary health care solutions for communities. Through partnerships with government, corporations, community bodies and other health service providers, QAIHC's vision is to eliminate the disparities in health and wellbeing experienced by Aboriginal and Torres Strait Islander people in Queensland.

Vision and spirit

The vision and spirit of this special one-day workshop was to enhance the design and implementation of policies and programs to close the life expectancy gap between Indigenous and non-Indigenous Australians.

The workshop aimed to consolidate recent success stories and innovations undertaken in Indigenous health by identifying critical success factors in order to inform future health service delivery and policy. This was a unique opportunity for those with experience and an interest in health service delivery and design to highlight exemplary approaches for extending the Australian Government's 2008 'Apology to Australia's Indigenous People' into action and healing.

The success stories that emerged from the day are presented in three sections in this report. They are examples of the projects that were discussed and showcased. Section A details three comprehensive case studies that have each been extended from the short pro forma to a more detailed narrative for the purpose of this report. Section B contains five brief reports of projects (in short pro forma versions) as presented at the workshop. Section C describes the program and process that resulted in achieving the aim of the workshop—to bring people together to identify what makes health programs and projects 'successful', to highlight exemplary approaches to extending the federal government's recent apology into action and healing, and to identify messages that might be passed on to others so that they might learn and build on that learning to enhance future programs and projects. This document continues the process of passing on the messages.

Three case studies are presented in this section:

- Well Women's Service—Opening Health Promoting Doors
- Aboriginal and Torres Strait Islander peer support in a Queensland correctional centre
- Traditional Aboriginal and Torres Strait games: a culturally appropriate program for school settings.

Well Women's Service—Opening Health Promoting Doors

Key words: Women's health; Grampians; well women; health service; Aboriginal women.

The storyteller: Sandy Anderson, Women's Health Grampians.

What is the story about?

In mid-2007 a trial partnership was formed between Women's Health Grampians (WHG) and the Ballarat and District Aboriginal Cooperative (BADAC) to introduce a regular Well Women's Service to be held within the Baarlinjan Clinic, a general practice located within BADAC.

Introducing a Well Women's Service within an Aboriginal Community-Controlled Health Service was part of a collaborative process to open doors to engage the local Aboriginal and Torres Strait Islander women in health promotion activities related to women's health.

The Baarlinjan Clinic, a general practice based within BADAC, provides a considerably extended support role to engage with the local community.

Why was the project conducted?

An annual audit of WHG clients indicated that we were not seeing any Aboriginal or Torres Strait Islander women in the regular weekly clinic based at WHG, or no women who identified as Aboriginal or Torres Strait Islander. WHG has a long history of connecting with BADAC but largely for specific health promotion activities rather than for ongoing services. Although specific activities provided an opportunity to build a relationship with the local Aboriginal and Torres Strait Islander community, they did not increase our clinic services.

The management and Board of WHG have always been committed to partnership work with the Aboriginal and Torres Strait Islander community. Recognising the lack of Aboriginal and Torres Strait Islander women accessing the service, they were supportive of trying a new and innovative approach.

The timeframe

The planning for the work commenced in September 2007 and has continued since this time.

Where was the project conducted?

Ballarat, Victoria.

Project aims

To build and continue to maintain an ongoing relationship with the local Aboriginal and Torres Strait Islander community and BADAC to ensure opportunities to work collaboratively on health promotion programs.

People targeted by the project

The Aboriginal women in the community in the Ballarat and district area.

People involved in the project

BADAC staff: Chief Executive Officer (CEO), Karen Heap; Baarlinjan Clinic practice nurse, Katrina Hishon; Aboriginal women's health worker, Carmel Marshall; and other BADAC staff.

WHG staff: CEO, Patty Kinnersly; the WHG Board member; and the Women's Health Nurse and Health Promotion Coordinator, Sandy Anderson.

What was done during the project?

The WHG CEO and Board made an ongoing commitment to provide 25 per cent of all clinical hours of the Well Women's Service to provide a women's clinic at BADAC.

The relationship and trust were built through providing a Well Women's Service that enabled women from the community to become familiar with the WHG women's health nurse. This service provided pap tests, breast checks and breast awareness, and other women's health information. Long appointment times ensured there was time to discuss all health issues. The promotion of the service occurred by word of mouth and via BADAC staff.

At the same time, the staff of the Baarlinjan Clinic wanted to work together to undertake some women's health promotion activities, and through our collaboration a planning process was developed. This resulted in a creative consultation process to determine a plan for future health promotion work that was driven by the local Aboriginal and Torres Strait Islander women.

Community consultation is never an easy issue but there can be even more challenges with the Aboriginal and Torres Strait Islander community. In March 2008 an afternoon women's event was held to talk to Aboriginal and Torres Strait Islander women from the community. Of the 12 women who had indicated that they would attend, only six were present. However, lively discussion was held and a starting point was developed to then gather more feedback. Other Aboriginal and Torres Strait Islander women were asked to contribute to the consultation when they accessed the Baarlinjan Clinic for health assessments and other issues; also, women's groups that were held at BADAC, such as the Elders group and the Young Mums' group, provided feedback.

From this consultation, health promotion strategies were planned and implemented for local Aboriginal and Torres Strait Islander women. The consultation process informed the approach for a women's health day held at Kirrit Barreet, the BADAC-developed local Indigenous art gallery. The health day included health promotion activities for healthy nutrition, mental health and stress coping strategies, cervical screening and human papilloma virus immunisation, and breast health and correct bra fitting for the more than 30 women who attended the event.

The evaluation from the day provided another opportunity to direct further health promotion. A BreastScreen women's afternoon was the next event on the agenda; in September 2008 a bus took 11 Aboriginal and Torres Strait Islander women for an afternoon of laughter, massage and breast screening. Many of the women had never been screened and had their first mammograms that day.

The creative and ongoing consultation and evaluation feedback continued to play a critical role in the planning of future programs.

During all of this time the Well Women's Service continued to operate at the Baarlinjan Clinic in a flexible way so as to increase the opportunities for women to attend the service. Times were made accessible so that appointments could be arranged soon after the need for an appointment was identified. A waiting time of three weeks for a routine pap test may work for non-Indigenous women (as experienced in the WHG centre-based clinic) but was not appropriate or desirable for Aboriginal and Torres Strait Islander women. This approach ensured that more unscreened and under-screened Aboriginal and Torres Strait Islander women were seen.

What happened?

The successes were in the relationships and although there was an investment of time to build the relationship and maintain the collaborative work, one result was an increase in the opportunities for further work together.

Although the provision of a regular Well Women's Service was not without challenges, the opportunities ensured the numbers of Aboriginal women screened increased and some women returned with further health issues.

From this work, our understanding of the issues of working with the Aboriginal and Torres Strait Islander community increased at WHG and the learnings assisted with other work with the community.

Learnings that came from the work included always being ready to work in a very flexible way and recognising that the timelines and priorities of the Indigenous community and non-Indigenous organisations need to find common ground rather than trying to apply the expectations that a non-Indigenous organisation may have.

There was also an increased understanding by the Baarlinjan Clinic staff about the value of health promotion strategies.

What worked well? (critical success factors)

The commitment from both BADAC and WHG management was critical; without either, the work would not have succeeded.

A pilot of six months of co-locating the Well Women's Service at BADAC grew into an ongoing service model in which both services continued to think of creative ways to provide the best opportunities for Aboriginal and Torres Strait Islander women.

A further critical success factor was having the time to invest in the collaborative work and in relationship building.

The consistency of staff from both locations was key to the success. As the relationship continues to build with other BADAC staff, the potential for staff changes threatening ongoing work is diminished.

The creative consultation and ongoing conversations about community needs have been critical to keep all plans for work community driven.

What did not work well?

At the start of the work, some of the clinic doctors were resistant to the Well Women's Service but once they found the process was working and client information was shared, with client consent, resistance was resolved.

The evaluation process that worked well for non-Indigenous women was not always as successful for Aboriginal and Torres Strait Islander women in the clinical setting, and depended on literacy levels and level of disability. The evaluation form has been adapted to make feedback easier for any client with a lowered literacy level, whether accessing the service at BADAC or at the Ballarat office.

What can others learn from this work?

Approaches for a collocated service provide additional challenges and work, but the success is evident from the benefits of relationship building and increased access to services and health promotion for women.

The commitment of time, consultation, relationship building and continuing work on the partnership, despite any challenges, are crucial.

Maintaining flexible and creative approaches is best, if possible.

Without the clinical work, it would have been more challenging to open doors for broader health promotion work.

Suggestions to policy makers

It is hard to apply targets (i.e. breast screening targets) that work for non-Indigenous women but are not as easily applicable for Aboriginal and Torres Strait Islander women.

This model of practice is transferable to other practice and health promotion settings, which should allow adequate and realistic time for both clinical and health promotion activities.

There are challenges with one-off funding cycles such as short clinic extension grants for cervical screening. A more sustainable approach is required and evaluation models need to be designed for the spectrum of client needs.

Creative and ongoing consultations will keep programs current to client needs.

So what?

This collaborative work has also provided opportunities to include other organisations that want to undertake work with the Aboriginal and Torres Strait Islander community in health promotion activities.

Keeping the partnership strong will provide more health promotion program opportunities.

The challenge is to also find time to share success stories with other organisations.

People to thank

None of this work would have been possible without the women of the local Aboriginal and Torres Strait Islander community; the staff and CEO (Karen Heap) of BADAC; and the staff, CEO (Patty Kinnersly) and Board at WHG.

Storyteller details: Sandy Anderson, Women's Health Grampians, <sandy@whg.org.au>; Tel: 0407 190 207.

Aboriginal and Torres Strait Islander peer support in a Queensland correctional centre

Keywords: peer support, Aboriginal and Torres Strait Islander, men.

The storyteller: This information is provided on behalf of peer support project workers and is the result of an independent external evaluation of the project conducted by Megan Williams, Indigenous Health Unit, School of Population Health, Faculty of Health Sciences, The University of Queensland.

What is the story about?

This information is about a well-developed peer support project that was funded by Queensland Health, in partnership with Queensland Corrective Services.[1] In itself, this cross-government relationship targeted a holistic health care need and highlights the importance of government departments combining resources to develop responses to complex issues.

The peer support project detailed here was developed to provide hepatitis C prevention education, particularly to Aboriginal and Torres Strait Islander men in a Queensland correctional centre. In this centre, Aboriginal and Torres Strait Islander men constitute around 60 to 80 per cent of the population. Prison is considered a high risk factor for hepatitis C infection because of the number of people incarcerated for drug-related offences, including injecting drug use, which in Australia has been the major hepatitis C infection risk. Other infection risks in prison are related to sharing hygiene equipment such as razors, as well as blood-to-blood contact through tattooing and fighting.

This story shows the utility of informal and formal peer support to increase access for Aboriginal and Torres Strait Islander and other prison inmates to health services and supports in a correctional setting.

Why was the project conducted?

'Gold standard' hepatitis C prevention strategies that are accessible in the general community—access to sterile injecting equipment and sterile tattooing—are not accessible in correctional settings in Queensland. The onus is on the education of individuals to prevent infection. Research and policy frameworks about hepatitis C education clearly recognise that information about hepatitis C cannot be provided in a vacuum—it must be in relation to health risk behaviours and drug use more broadly.

> *There is a fine balance between hepatitis C education and other general lifestyle education. Peer support was both general about lifestyles and specific about hepatitis C* (Peer Support Project Officer).

Projects addressing the health and wellbeing of Aboriginal and Torres Strait Islander people must be locally developed and inclusive, and must build capacity for empowerment—and must avoid the pitfalls of further top-down approaches that have been applied since Australia's colonisation and the ensuing dispossession that underlies the generally poor health status of Aboriginal and Torres Strait Islander people and the high incarceration and recidivism rates. As the following quote highlights, there has long existed a gap in appropriate health education for Aboriginal and Torres Strait Islander people in prisons, but there are key solutions:

> *If professionals are not available enough to provide that support, or the relationship does not facilitate the sharing of personal or vital information, there is either a gap, or there is peer education. There should be another option, rather than a gap* (Correctional Centre staff member).

Programs targeted at improving the health and wellbeing of men are few in number and are generally underdeveloped. There are numerous challenges to providing education in this field. It is difficult to talk about 'peer education' or 'peer support' as specific strategies because of the many differences among peer education models and the way in which peer education is used (Mitchell & Rosenthal 1994:19). Essentially, peer engagement focuses on using social relationships to reduce the possible harm associated with drug and alcohol use (Moore 1993:62) and other health risk behaviours. Des Jarlais and Friedman (1988:865), for example, reported that the 'strongest predictor of behaviour change' among people who inject drugs was the 'belief that their behaviour was changed through friends'—as opposed to social workers, community workers or educators (Davis 1990:37).

The timeframe

The peer support project operated with funding in 2006 and 2007. Evaluation occurred throughout 2007. Since the end of funding availability, peer support has continued but without dedicated coordination by a paid employee as formerly occurred.

Where was the project conducted?

The peer support project operated in a high-, medium- and low-security correctional centre in Queensland. A similar project had operated in a different correctional centre and was regarded as successful.

Project aims

The peer project aimed to increase the number of Indigenous and non-Indigenous prisoners accessing health services and participating in programs, as well as to support men in reducing health risk behaviours. To achieve this, a small number of long-term prison inmates were recruited, trained and supervised as peer support workers. This role was voluntary. A paid Queensland Corrective Services Project Manager had responsibility for professional supervision and management of the peer team. Design of the peer support project was formalised through consultation meetings with a number of officers and inmates within the centre.

The evidence base on which to plan, design and deliver services for Aboriginal and Torres Strait Islander people in prison is theoretically and empirically underdeveloped (Walsh 2005), considering the enormous social and economic costs associated with imprisonment and recidivism (Western 2006). Improving outcomes for released prisoners not only rests on improving referrals and linkages to services, but also on improving the number and quality of services available (Ross 2003). Evaluation is an important aspect of improving the quality of services that are implemented.

This comprehensive process evaluation gathered information primarily through group interviews with peers, key staff and inmates about their experiences of the peer program.

People targeted by the project

Peers were selected according to a range of criteria including benevolence shown towards others; credibility with a significant group of prisoners; availability to fulfil tasks; completion of appropriate core prison programs including numeracy and literacy; security/intelligence clearances; and identification that they were not a threat to the good order of the prison.

> *These are the kind of people who on the outside train as social workers and human service workers to support others and bring about personal and social change…* (Correction Centre Officer).

People involved in the project

The peers were in contact with both inmates and staff. Aboriginal and Torres Strait Islander men (inmates) were particularly targeted, including those with low access to health services, support and employment. These men are relatively isolated and considered at risk of ongoing depression, self-harm, suicide, reoffending and prolonged disconnection with others.

Staff in contact with the peer support workers included:

- Indigenous Liaison Officers
- industry supervisors
- centre management
- administration
- counselling staff and psychologists
- health team members
- other correctional officers.

What was done during the project?

The peer project undertook formal peer education and support sessions, and informal peer support at several levels in the correctional centre. After recruitment and training, structured activities and unstructured opportunities for peer support were undertaken.

Some of the peers' messages to others included:

> *I'm not your mum, I'm not going to hold your hand and pat you on the back. We are here to talk to you man to man.*
>
> *We are confidential and private, except for self-harm and suicide. We will not mention what is said exactly but we have to report when someone talks to us…*
>
> *Getting a job is not hard. Put in applications, and take whatever gets offered to you. Do it because it will help you later to get a better job. The idea is, you get out of your unit.*
>
> *If you are doing a short time, get out and don't come back. You're away from your loved ones… This is not a place to live.*

Peers participated in regular training and supervision sessions, and reflected on their own personal development and engagement with others.

What happened?

The main strategy used in the peer support project was listening support, which often resulted in an informal assessment of inmates' needs. At least 1500 instances of peer support were recorded. This included assisting individual inmates, as well as staff. Activities with inmates included:

- informal contacts in mutual residential unit/ blocks anytime
- weekly unit visits in which contact was most often with inmates not employed or engaged in courses—i.e. those thought to be of poorest health and wellbeing, and most in need of support
- weekly shopfront contacts supervised by the project officer
- weekly supervised education sessions for other inmates, including new prisoners
- follow-up.

Staff had differing levels of contact and roles in peer support. Some had direct and at times close contact with individual peers through:

- distribution of information
- movement around prison performing duties
- assisting in education sessions
- mediation, to diffuse conflict between staff and inmate/s
- information about referral sources
- provision of local community knowledge.

The peer project provided a 'layer' between corrections staff and inmates. Staff at times served as cultural and language translators.

What worked well?

Listening support and peer-based assistance is low cost, non-invasive and culturally sensitive, and also fills a concerning area of need within the correctional setting. On many occasions, each peer provided support to an individual who otherwise would not have had such support within usual correctional programs or services. As a result of many of the peer contacts, a potential crisis or worsening of wellbeing for inmates was averted.

Other unique elements of the peer support project included:

- traditional Aboriginal and Torres Strait Islander languages used at times
- awareness raising of historical context of health and wellbeing
- peers could go to areas where those most in need were—e.g. those who stay in their units and do not work in the prison
- rapport, relationships and trust as a basis for information provision, listening support and referral
- utilisation by the corrections officers and centre managers of the peer support workers
- an increase in knowledge and skills of peer support workers (as illustrated by the comment, 'Had I known more I could have helped, looked for the signals. I wasn't in peer support then, I didn't know enough like I know more of now.')

A small number of staff who had regular contact with peers believed the training and peer support role was an integral part of developing future Aboriginal and Torres Strait Islander leaders. One commented this would have a 'positive ripple effect' on the lives of the peers beyond prison—because of the way the peer training and activities changed and reinforced positive behaviours, thinking and knowledge of the peers themselves.

What did not work well?

As with many projects not embedded in policy and standard practice, funding is short term and not ongoing. This affects capacity to continue innovations put in place, to retain staff and to demonstrate impacts on health behaviour. The peer support project detailed here is currently unfunded, despite a comprehensive process and outcomes evaluation indicating its applicability for extension.

What can others learn from this work?

Provision of support by the peer workers was multi-dimensional. For example, the peer workers provided practical support including information giving, referral to other health services in the prison setting and assistance with letter writing. The peer workers also provided emotional support, including time for listening and talking and follow-up with inmates after legal or health appointments, for example. The peer workers provided support that may have been instrumental in inmates setting goals, identifying solutions to problems and developing better relationships with themselves and others.

The multi-dimensional model of support identified above, including employment of a dedicated Project Officer, appointment of several peer support workers, regular training and supervision, and formal and informal activities, is useful and adaptable for implementation in other correctional centres and organisations that engage with marginalised populations.

Suggestions to policy makers

The role of peer support is evidently early intervention—assisting inmates before their immediate issues escalate into more complex needs that require an intensive multi-sectoral response. Improving the health and wellbeing of inmates and meeting criminogenic or rehabilitative goals will undoubtedly cost more if undertaken solely by professional services within the correctional centre, or if left until crisis point.

Peer education and support complements services available within the correctional centre and could reduce demand and burden on these. This could represent a significant cost saving to government and tax payers, both in the prison setting and in the community if commitment is on enhancing capacity of individuals to seek and utilise support and reduce health risk behaviours.

The evaluation material described here indicates the peer project was delivered accountably—without any trouble associated with drugs, crime, power or violence stereotypically associated with those imprisoned. The project was delivered on a small budget, and through culturally sensitive processes that build capacity of Aboriginal and Torres Strait Islander people to respond to health and wellbeing issues within and beyond release from correctional centres.

So what?

Projects such as peer support are well positioned to have an impact on the culture of correctional centres. Connections with peer support workers can improve accessibility of formal services, as well as informal caring. Peers are well positioned to assist centre staff engagement with inmates and respond earlier to issues they are experiencing. This is crucial in meeting rehabilitative objectives of imprisonment, including developing and maintaining healthy lifestyles. The successful contribution of peers in this project was a combination of personal skills, background, empathy, commitment, training and weekly supervision—wonderful developments sure to have a ripple effect throughout imprisonment terms and beyond community re-entry.

People to thank

The peers, the Project Officer, Cultural Liaison Officers and Elders.

Storyteller details: Megan Williams, Indigenous Health Unit, School of Population Health, Faculty of Health Sciences, The University of Queensland, <m.williams@sph.uq.edu.au>.

Note

[1] Funding arrangements were prior to the transfer of responsibility for Correctional Centre health services to Queensland Health as at 1 July 2008.

References

Davis, M. 1990, 'Peer Education and a Framework for Change in Queensland', *National AIDS Bulletin*, August, pp. 37–40.

Des Jarlais, D. & Friedman, S. 1988, 'The Psychology of Preventing AIDS Among Intravenous Drug Users: A social learning conceptualisation', *American Psychologist*, vol. 43, no. 11, pp. 865–70.

Mitchell, A. & Rosenthal, D. 1994, *Report of the National Workshop on the HIV/AIDS Needs of Homeless Young People*, Centre for the Study of Sexually Transmissible Diseases, La Trobe University, Melbourne.

Moore, D. 1993, 'Social Controls, Harm Minimisation and Interactive Outreach: The public health implications of an ethnography of drug use', *Australian Journal of Public Health*, vol. 17, no. 1, pp. 58–67.

Ross, S. 2003, *Bridging the Gap: A Support Program for Victorian Prisoners: Final Evaluation Report*, Melbourne Criminology Research and Evaluation Unit, The University of Melbourne, Melbourne.

Walsh, T. 2005, *Incorrections II: Correcting government*, TC Beirne School of Law, University of Queensland, Brisbane.

Western, M. 2006, *Punishment and Inequality in America*, Russell Sage Foundation, New York.

Traditional Aboriginal and Torres Strait games: a culturally appropriate program for school settings

Key words: physical activity, cultural understanding.

The storyteller: Craig Dickson.

What is the story about?

Traditional Indigenous Games (TIGs) have been used in one-off projects and at special events throughout Australia for a number of years now. Whenever the games have been played, there has been an enthusiastic response from all participants. However, little has been done to encourage sustainable use of the games in mainstream settings.

TIGs is a program that schools and communities can use to deliver culturally relevant physical activity to Aboriginal and Torres Strait Islander children and young people and the broader Indigenous community. It may also strengthen cultural identity within these settings and may play an important role in school retention rates. TIGs provide children and young people (both Indigenous and non-Indigenous) with essential training in social interaction and physical skills, and increased opportunities for enjoyable and inclusive play.

Why was the project conducted?

Aboriginal and Torres Strait Islander populations are priority target groups for health intervention. According to the *Strategic Policy for Aboriginal and Torres Strait Islander Children and Young People's Health 2005–2010 Discussion Paper* (Queensland Health 2005), the level of inequality and weight of disadvantage in the health status of Aboriginal and Torres Strait Islander people, and the intergenerational effects of poor health and wellbeing, gives us no option but to invest heavily in evidence-based, targeted interventions for Aboriginal and Torres Strait Islander children and young people.

In recent times, along with Australian trends that show falling physical activity levels among school children, retention of Aboriginal and Torres Strait Islander students in school has been a serious concern. There is considerable evidence that a child's sense of connectedness to school plays a protective role against the development of problem behaviours that may lead to disengagement with the education system, unemployment, social alienation, alcohol and drug misuse, and long-term mental and physical disorders (Hunter & Garvey 1998). This is particularly relevant for Aboriginal and Torres Strait Islander children and young people who attend mainstream schools (Vicary & Westerman 2004). There is an identified need for targeted programs for Indigenous children to bring about a sense of belonging within the school environment (Edwards 1999).

One primary goal of 'The National Goals for Schooling in the Twenty-first Century' is that 'all students understand and acknowledge the value of Aboriginal and Torres Strait Islander cultures to Australian society and possess the knowledge, skills and understanding to contribute to, and benefit from, reconciliation between Indigenous and non-Indigenous Australians' (Department of Education, Employment and Workplace Relations 1999). In alignment with this goal, the implementation of TIGs can provide Aboriginal and Torres Strait Islander students and non-Indigenous students with the opportunity to learn about, appreciate, and experience aspects of Aboriginal and Torres Strait Islander history, culture and language.

Aboriginal and Torres Strait Islander communities have a rich history of games and pastimes that helped improve social bonding, as well as:

> *hand-eye co-ordination, agility, fitness, [and to] perform ceremonies, and for story-telling, role-modelling and enjoyment. Most of these training and recreational activities were suspended when these societies came under threat, and until recently it appeared many had disappeared, even in remote areas* (Edwards 1999).

Incorporarting TIGs in primary schools that have high numbers of Indigenous students is an opportune holistic strategy that addresses factors such as improving physical activity, building capacities through training and facilitation, building collective self-esteem in Indigenous children, and creating greater understanding and engagement (Commonwealth Department of Education Training and Youth Affairs 2000) of Aboriginal and Torres Strait Islander culture by non-Indigenous students. Evidence also shows increasing success in retention rates for Indigenous children in schools that have culturally relevant programs (Steering Committee for the Review of Government Service Provision 2005).

Building the capacity of school communities and the broader community is an important health promotion strategy for TIGs to be sustainable. Capacity building is 'an approach to the development of sustainable skills, organisational structures, resources and commitment to improvement in health and other sectors, to prolong and multiply health gains many times over' (Hawe *et al*. 1997).

The *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013*-reviewed implementation plan (Commonwealth Department of Health and Ageing 2007) focuses specifically on physical activity and social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islander people. TIGs is a program that can contribute to achieving some of the objectives within the strategic framework by using a whole-of-government approach.

The timeframe

Dr Ken Edwards investigated Indigenous games across Australia as part of doctoral studies at The University of Queensland. Over time the games were utilised in a number of school settings and cultural celebrations. In 1999 Dr Edwards published a resource book called *Choopadoo: Games from the Dreamtime*, which documented a large number of games and how to play them.

In 2000–01 Dr Edwards and colleagues from Brisbane's Queensland University of Technology, including Beryl Meiklejohn, Elizabeth Parker, Carla Patterson, Patricia Shuter, Cilla Preece and Trish Gould, implemented *Back to the Future: Our Games Our Health*, a TIGs project for the Indigenous communities of Cherbourg and North Stradbroke Island. The project was funded by Health Promotion Queensland (Queensland Health) for $200,000 over 15 months. Significant community consultation occurred before the project, and continued during its implementation.

Queensland Health continued to show an interest in TIGs following the positive outcomes of the *Our Games Our Health* project. In 2004 the Gold Coast Population Health Unit (Queensland Health) funded the Active Eagleby Project, which incorporated TIGs as one of five targeted physical activity initiatives for the local community. In May 2005 the Brisbane Southside Population Health Unit (BSPHU) (Queensland Health) formed partnerships with Brisbane City Council and seven Brisbane-based Indigenous community organisations to train and implement TIGs within their communities. This project occurred over a 12-month period, with its evaluation overlapping with the planning for a number of school-based TIGs interventions coordinated by BSPHU.

BSPHU assisted with the implementation of TIGs at schools within Bayside (11 schools), Logan (12 schools) and Inala (13 schools) from 2005 to 2007. An Indigenous respite centre within Logan also implemented the games. In 2007 and 2008 uptake of the games was encouraged within high schools through demonstrations to the School-based Youth Health Nurse employees.

The Tropical Population Health Unit in north Queensland implemented and evaluated TIGs in 2007 and 2008 at four Townsville primary schools. Brisbane Northside Population Health Unit funded a training day for Indigenous kindergarten teachers in January 2008.

Dr Edwards worked with the Australian Sports Commission to publish *Yulunga: Traditional Indigenous Games*, which contains 262 pages of TIGs. *Yulunga* was released in July 2008 and can be downloaded from the Australia Sports Commission's website (http://www.ausport.gov.au/participating/indigenous/games/traditional_games).

Since the release of *Yulunga*, Queensland Health has formed a state-wide TIGs group to develop a sustainable framework for the ongoing training and delivery of TIGs across the State. This group meets on a regular basis and has had a number of successes to date.

Project aims

The focus on schools came about following the successful involvement of Dunwich State School as part of *Our Games Our Health*; a few schools within the Inala district were also involved in the 2005 Brisbane project (their involvement was opportunistic at the time). Participating organisations reported cultural value in the TIGs, including increases in cultural identity and strength, gains in respect for the Aboriginal and Torres Strait Islander culture, and improvement in reconciliation. Mark Saran (Indigenous Advisor) saw great value in improving the capacity of schools to deliver TIGs, so alongside Kevin Zielke (Principal, Dunwich State School) and Susan Plater (Health Promotion Officer, BSPHU), they strongly advocated Education Queensland to conduct the Bayside project.

The school programs implemented by Queensland Health shared the following objectives:

- to offer culturally relevant programs to Aboriginal and Torres Strait Islander students
- to offer a greater variety of physical activity programs to all students, aimed predominantly at those disengaged from mainstream activities
- to link TIGs to key learning areas within the school curriculum (e.g. health and physical education, history, art)
- to increase cultural identity, pride, self-esteem, knowledge, skills and leadership among Aboriginal and Torres Strait Islander students, school staff, and family and community members
- to increase awareness, respect and appreciation for Aboriginal and Torres Strait Islander history, knowledge, traditions and culture among non-Indigenous students and school staff
- to enhance relationships between Aboriginal and Torres Strait Islander family and community members, non-government agencies, school staff and Queensland Health
- an increased number of facilitators, particularly Aboriginal and Torres Strait Islander people with the knowledge and skills to deliver culturally relevant programs in school and community settings
- the opportunity to explore the transferability of the school projects to other settings (e.g. kindergartens, aged care and alternative schools)
- the opportunity to explore, develop and/or strengthen partnerships with key agencies to improve Aboriginal and Torres Strait Islander health.

The ongoing work of the TIGs state-wide sustainability group aims to make delivery of the games sustainable, and to ensure cultural heritage and respect is maintained by everyone who delivers them. There is also an element of quality control that needs to be considered as part of the games delivery.

The Queensland Government's Reconciliation Action Plan 2009–2012 demonstrates a commitment to embed Aboriginal and Torres Strait Islander perspectives across all areas of school practice in all state schools to promote a greater understanding of the histories, cultures, values, beliefs, languages, lifestyles and roles of Aboriginal and Torres Strait Islander people. Queensland Health is a key advocate for making TIGs part of this process.

People targeted by the project

The predominant setting for TIGs to date has been within schools because of the variety of curriculum areas in which TIGs can be incorporated. Aboriginal and Torres Strait Islander students were the primary audience to improve engagement and promote physical activity. Inherent in this project, however, is the benefit across the school environment to non-Indigenous students, teachers and community.

The capacity building component of the project ('train the trainer' facilitation workshop) was open to teachers from participating schools (maximum two teachers per school, space permitting). Aboriginal and Torres Strait Islander parents and community members were also invited to participate. The invitation was extended to those involved with the kindergarten project on Brisbane's northside.

People involved in the project

TIGs has had involvement from a number of individuals, community organisations, businesses and government departments since Queensland Health's initial funding commitment. Each key stakeholder has played a significant role in the continuing development and delivery of TIGs. The following list provides a brief account of the significant key stakeholders:

- Dr Ken Edwards—research and development of *Yulunga: Traditional Indigenous Games* with assistance from Troy Meston
- Queensland Health—funding body, partnership development, liaison and consultation between stakeholders
- Queensland University of Technology, Faculty of Health—conducted games within communities and facilitated training and support to communities and schools (Beryl Meiklejohn)
- Department of Local Government, Planning, Sport and Recreation (former)—provided advice and assistance during programs through an Indigenous Sport and Recreation Advisor
- Department of Education, Training and the Arts (former)—the schools and respective principals allowed the games to be conducted and released teachers to participate in training
- Blackbase (no longer operating)—facilitated TIGs training
- Indigenous organisations and community members—assisted with communication between community Elders and stakeholders, attended training to introduce TIGs to their local communities
- Department of Housing (Community Renewal) (former) and Brisbane City Council—funding bodies
- HART Sport—primary supplier of TIGs equipment kit, and donation of one kit for every ten kits sold
- Australian Sports Commission—a new partner in the local delivery of TIGs through the Active After School Community Program.

This list is by no means exhaustive, but articulates the primary players in the school-based projects conducted by Queensland Health.

What was done during the project? (Queensland Health)

Queensland Health provided initial funding towards the first major TIGs project and subsequent funding towards a number of additional TIGs projects and community training. The other major role that Queensland Health played was the ongoing assistance with, and facilitation of, dialogue between the Indigenous community and project partners.

As part of the school projects, schools were provided with funding for teacher relief to enable two teachers to attend a two-day 'train the trainer' workshop facilitated by Blackbase. The workshop provided participating teachers with the knowledge, skills and motivation to deliver TIGs to students in a culturally safe and appropriate manner. Schools were encouraged to send additional teachers to the workshop (at their own expense). Teachers were encouraged to train other school community members to deliver TIGs and to incorporate them within the school curriculum as a sustainability measure for the games.

Each school was supplied with a TIGs kit to the value of approximately $1500. Additional curriculum resources were developed by Blackbase (with input from Education Queensland and Queensland Health) to guide lesson planning and were linked to key outcome learning areas. TIGs was officially launched at each participating school. Blackbase attended each launch to mentor the newly trained facilitators in delivering the games appropriately. Many of the schools chose NAIDOC Week for their launch dates. All projects conducted within schools have incorporated an evaluation component, including questionnaires, follow-up surveys and interviews.

Queensland Health's state-wide TIGs group meets on a regular basis to collaboratively plan for the ongoing sustainability of TIGs. A number of members continue to liaise with key stakeholders that can assist with TIGs planning and delivery, particularly the Department of Communities (Sport and Recreation Services), the Department of Education and Training, universities and Indigenous organisations.

What happened?

Evaluation results from all school projects have showed that TIGs are appropriate for the school setting. Similar findings have been seen in kindergartens, aged-care facilities and at community events. Everyone who has attended the two-day TIGs facilitator workshop has reported an improvement in the capacity to deliver TIGs.

Within all the school projects involving TIGs, the games have been incorporated into the school curriculum, with Health and Physical Education featuring prominently. The Study of Society and Environment and after-school activities have also been very popular. Schools, along with other settings and community groups, have consistently utilised TIGs during celebrations such as NAIDOC Week and cultural awareness days.

Along with reporting successful inclusion of the games in the school curriculum, the surveys indicated improved relationships between key stakeholders.

What worked well?

It has been evident from school launches, cultural celebrations, community events and participant feedback that both Indigenous and non-Indigenous students have truly embraced and engaged with TIGs. Ongoing requests to Queensland Health for information on how to implement TIGs recognises a strong community desire to conduct the games.

The 'train the trainer' workshop is an important component of TIGs implementation to ensure quality-controlled delivery of the games and ongoing sustainability. Providing each school with a TIGs kit allows the school to implement the games straight away with all the appropriate equipment.

A number of relationships were developed and enhanced as part of the program. These relationships often enhanced community involvement, including assistance with facilitating TIGs within the school.

Having an Aboriginal Health Worker assist the non-Indigenous project officer was a vital component of building positive relationships. The health worker is highly regarded by the local community and helped form an integral part of the consultation process. He provided information and advice about cultural protocol and community experiences and expectations to the project officer and participating schools, and personally vouched for the project officer and provided formal introductions to Elders and other key community members. He also facilitated community forums to share information and discuss the project. Without his active support and participation, the project would not have been successfully implemented and sustained.

The number of schools that have embedded the games into the school curriculum reflects the enthusiasm to participate and the realisation of the benefits that TIGs can deliver to all sections of the school community. As the mainstream embraces the games, this provides a great opportunity to celebrate cultural strengths and to improve relationships with, and develop respect for, Aboriginal and Torres Strait Islander communities and their cultures.

What did not work well?

There were many cases where teachers attending the 'train the trainer' workshop did not have time to train non-attendees within their schools. This is particularly problematic if the trained teacher moves to a new school, leaving nobody to continue TIGs.

One barrier to implementing the games is the time issue in a full school curriculum. Sustainability within schools would benefit greatly from inclusion in the state-wide curriculum.

Since the initial facilitator workshops, the training has become significantly expensive, with costs of up to $7500 for thirty people over two days. This is unsustainable for community groups and schools, added to the cost of purchasing a TIGs kit at approximately $1500.

In working on long-term sustainability options, engagement with Sport and Recreation Queensland and Department of Employment, Training and the Arts was proving difficult. Since the State election in March 2009 and work of the Queensland Health state-wide sustainability group, the new Department of Communities (Sport and Recreation Services) has positively engaged to work collaboratively on the sustainability of TIGs.

What can others learn from this work?

This project illustrates a health promotion approach that strengthens ties within communities rather than endangering them, thereby reinforcing the factors that support the wellbeing of communities and individuals (Parker *et al*. 2006). The collaborative approach with the local Aboriginal and Torres Strait Islander community has been significant in the success of these local projects.

It should be noted that consultation takes time, and this does not always fit with funding timeframes. Any funding provided towards the implementation of TIGs needs to be mindful of this to ensure a respectful consultation process is undertaken.

Engaging local Aboriginal and Torres Strait Islander community members alongside non-Indigenous teaching staff in delivering the games would help alleviate the anxiety that this is another form of cultural appropriation. Even though this view is in the minority, there were and still are some influential community people who are opposed to non-Indigenous people teaching the games.

The enthusiastic uptake of TIGs by schools and other communities indicates its potential for transferability, something already being explored by Queensland Health. With an increase in the number of partners willing to assist with TIGs sustainability, there are improved opportunities to further enhance resources and training that is specific to individual settings.

Despite schools being very enthusiastic, they were constrained financially. The only way Queensland Health could get them to participate was to pay for everything, including the Teacher Relief Scheme. While schools had no financial interest, they showed their commitment by sending teachers to the training and then incorporating TIGs within the school.

Suggestions to policy makers

There are a number of recommendations to promote and enhance the sustainability of TIGs across all settings. The key recommendations are provided below.

Education:

- incorporate TIGs training into teacher education, particularly the health and physical education stream (however, recognise its relevance in a number of curriculum areas)
- train a select number of Indigenous organisations across the State to train and facilitate TIGs within all settings and provide information to potential TIGs users
- include regular updates about TIGs in Education Queensland newsletters, health and physical education newsletters, education conferences and through professional bodies such as the Australian Council for Health, Physical Education and Recreation and the Australian Sports Commission
- utilise the Education Queensland Learning Place Curriculum Exchange website to host example lesson plans, teaching ideas and units of work that incorporate TIGs
- form local networks or working groups to share ideas and explore enhancement and sustainability of TIGs.

Training and development:

- provide update/refresher training for original TIGs workshop participants to improve their ability to deliver the games with confidence, and continue to train additional teachers, parents and community members in TIGs delivery
- conduct evaluation on an ongoing basis to review successes and make further recommendations for sustainability
- with key partners, further assess the feasibility of implementing TIGs into other community settings such as aged care, respite services and rehabilitation and, if appropriate, adapt the program for these settings.

Expenses:

- promote use of a modified TIGs kit as a cost-efficient way to begin delivery of TIGs into a variety of settings
- create a resource kit/template for organisations to apply for grants aimed solely at TIGs implementation.

So what?

Given the acceptance and relevance of TIGs for the school community, it is vital to build on the recommendations and learnings from Queensland Health projects and to work with key agencies to create a sustainable program for all schools to access. Planning how this happens will be important in coordinating an approach across all key agencies. This will include building the program into existing structures and in relevant systems that schools can access. Education Queensland, in partnership with other agencies, will be key in driving this program into the future. Support from state-wide strategic policies including Smart Moves, Tomorrow's Queensland (Toward Q2) and the Queensland Government Reconciliation Action Plan should help influence greater investment in TIGs.

People to thank

Dr Ken Edwards (formerly of Queensland University of Technology), Beryl Meiklejohn (Queensland University of Technology), Blackbase Youth Development Organisation (no longer trading), Mark Saran (former Sport and Recreation Queensland), Kim Rallah (Queensland Health), Suzanne Plater (formerly of Health Promotion Queensland), Kevin Zielke (former principal, Dunwich Sate School), Raelene Baker (Brisbane City Council), communities who contributed and participating schools.

Storyteller details: Craig Dickson, Acting Senior Health Promotion Officer—Physical Activity, Brisbane Southside Population Health Unit, Southern Population Health Services, Queensland Health, <Craig_dickson@health.qld.gov.au>; Tel: +61 7 3000 9112.

References

Commonwealth Department of Education Training and Youth Affairs 2000, *Positive Self-identity for Indigenous Students and its Relationship to School Outcomes*. Accessed 3 October 2006 at: <http://www.apapdc.edu.au/IndigenousEd/downloads/DETYA/PSI_synth.pdf>.

Commonwealth Department of Health and Ageing 2007, *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013—Australian Government Implememntation Plan 2007–2013*. Accessed 9 July 2009 at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-healthstrategy.htm>.

Department of Education, Employment and Workplace Relations 1999, *The Adelaide Declaration on National Goals for Schooling in the Twenty-first Century—Preamble and goals*. Accessed 18 September 2009 at: <http://www.dest.gov.au/sectors/school_education/policy_initiatives_reviews/national_goals_for_schooling_in_the_twenty_first_century.htm>.

Edwards, K. 1999, *Choopadoo: Games from the Dreamtime*, University of Technology Publications, Brisbane.

Hawe, P., King, L., Noort, M. & Jordens, C. 1997, 'Multiplying Health Gains: The critical role of capacity-building within health promotion programs', *Health Policy*, vol. 39, pp. 29–42.

Hunter, E. & Garvey, D. 1998, 'Indigenous Mental Health Promotion: Mind over matter?', *Health Promotion Journal of Australia*, vol. 8, no. 1, pp, 4–11.

Parker, E., Meiklejohn, B., Patterson, C., Edwards, K., Preece, C., Shuter, P. & Gould, T. 2006, 'Our Games Our Health: A cultural asset for promoting health in Indigenous communities', *Health Promotion Journal of Australia*, vol. 17, no. 2, pp. 103–08. Accessed 12 December 2007 at: <http://eprints.qut.edu.au/9452/1/9452.pdf>.

Queensland Health 2005, *Discussion Paper—Strategic Policy for Aboriginal and Torres Strait Islander Children and Young People's Health 2005—2010*, Queensland Government, Brisbane.

Steering Committee for the Review of Government Service Provision 2005, *Overcoming Indigenous Disadvantage: Key Indicators Report*, Productivity Commission, Canberra.

Vicary, D. & Westerman, T. 2004, 'That's Just the Way He Is: Some implications of Aboriginal mental health beliefs', *Australian e-Journal for the Advancement of Mental Health*, vol. 3, no. 3. Accessed 29 September 2009 at: <http://auseinet.flinders.edu.au/journal/vol3iss3/vicarywesterman.pdf>.

SECTION B

Success Stories: Brief Project Reports

This section provides brief reports of the following five projects presented at the workshop:

- Improving diabetes care in a rural Victorian Aboriginal Community Cooperative
- Men’s Health
- Applied research tools to record success stories in Aboriginal communities
- Smokers Program
- *Ifi ni gulanga*—the house of healing.

Improving diabetes care in a rural Victorian Aboriginal Community Cooperative

Key words: diabetes.

The storyteller: Jason Hahne.

What is the story about?

Healthy for Life funded Goolum Goolum Aboriginal Cooperative to assist community members to receive best practice diabetes care.

Why was the project conducted?

Diabetes was identified as an issue through an audit of medical records and discussions with the Community Board of Management.

The timeframe

The work started in January 2006 after *Healthy for Life* provided the project funds. The project team was given six months to do the audit, to consult with the Community Board of Management for approval, to establish a steering committee and to organise the involvement of facilitators to get the program up. The project is ongoing.

Where was the project conducted?

Horsham, western Victoria (the largest service area in Victoria), from the South Australian border to Stawell, and from Rainbow to Hamilton.

Project aims

To address the reasons why Aboriginal people were not managing their diabetes and why they do not access and use allied health care services appropriately.

People targeted by the project

Aboriginal people who were diagnosed with diabetes. We were also trying to increase and conduct screening, and provide diabetes education to all community members.

People involved in the project

The Board of Management, Aboriginal Health Workers, general practitioners (GPs), community members, a podiatrist, dietician, diabetes educator, optometrist, psychologist and health promotion worker.

What was done during the project?

An audit, community consultation, employed allied health professionals, collected ongoing data, promoted the service to the community, employed a community health promotion officer.

What happened?

Results indicate that community members are managing blood sugar levels.

Increased access to allied health professionals.

Identified clients with diabetes, and conducted education and promotion of diabetes. The Aboriginal Health Worker encouraged clients to get a plan/ongoing management.

Continuing monitoring/screening to identify new clients—continue education.

Identify other key health risk factors.

What worked well?

- Education and care that meets community needs within the Aboriginal setting instead of the mainstream.
- Community collaboration and working from the ground up.
- Allied health professionals learning cultural issues.

What did not work well?

- Addressing potential risk factors like diet, exercise and smoking.
- Getting clients to address such issues when they also have other social and economic issues.

What can others learn from this work?

- To address care plans and how to engage with community members.
- To understand the data and what it is telling you.
- To work *with* people, not *on* people—to learn and understand what people want.

Suggestions to policy makers

Understand and recognise the importance of the Aboriginal workforce and adequately pay for their experience and expertise.

So what?

- Diabetes is only one of many issues associated with Aboriginal people's health.
- Balance acute care and immediate and future needs.

People to thank

Goolum Goolum Board, Horsham Aboriginal Community, GPs, Aboriginal Health Workers and allied professionals.

Storyteller details: Jason Hahne, <Jason@goolumgoolum.org.au>, +61 3 5381 6318.

Men’s Health

Key words: community involvement; discussions; sustainable; well-respected men; ownership; partnerships/networks; empowerment.

The storyteller: Karl Briscoe.

What is the story about?

Men’s group.

Why was the project conducted?

The men identified a need and the leaders were part of this.

The timeframe

June 2007 to November 2007.

Where was the project conducted?

In a small community in North Queensland.

Project aims

Allowing the men to identify problems within the community and themselves.

People targeted by the project

Aboriginal and Torres Strait Islander men.

People involved in the project

Men in the community.

Personal network members.

What was done during the project?

Weekly meetings with identified topics.

What happened?

The group met regularly and set the agenda as to what issues they would like to talk about.

What worked well?

The agenda was driven by the group, with appropriate consultation occurring. There was a sense of self-empowerment, allowing community to take ownership, and suitable partnership formation.

What did not work well?

I had to move to another town because of work commitments; with low levels of trust in the impending facilitators, the sustainability of the men’s group was not forthcoming.

What can others learn from this work?

Set and reinforce ground rules before each meeting.

Build trust and respect among the group.

Allow participants to take ownership.

Ensure appropriate partnerships and consultation.

Source facilitators with whom the community can engage.

Suggestions to policy makers

Funding is not always necessary and at times it can hinder the process from going forward when funding guidelines need to be abided by. As this project was driven by the community, the people involved established a commitment to make changes in their lives and community. The need for extensive consultation has to be considered. Also, the concept that the community will take ownership of the issue, program, project etc. has to be recognised and accepted.

So what?

The notion of community participation has been around for many years, but for true participation to occur appropriate consultation is a prerequisite. However, do not forget the community needs to take ownership for any intervention to be either sustainable or have the desired outcome.

People to thank

I would like to thank the men who participated because without them this activity wouldn't have been possible. As well, I thank the Douglas Shire Indigenous Family Support Service for its efforts in co-facilitation, Relationships Australia for its valuable contribution, and the Department of Families, Community Services and Indigenous Affairs for giving me the opportunity to undertake the community activity as part of its leadership program.

Storyteller details: Karl Briscoe,
<karl_Briscoe@health.qld.gov.au>.

Applied research tools to record success stories in Aboriginal communities

Key words: applied research tools; success stories; Aboriginal communities.

The storyteller: Peter Waples-Crowe.

What is the story about?

Victorian Aboriginal Communities Working for Health and Wellbeing: Success Stories from the Aboriginal Community Controlled Health Organisation Sector in Victoria, a booklet published by the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) to celebrate the success of the member organisations over ten years.

Why was the project conducted?

To promote our Aboriginal Community Controlled Health Organisation sector and successful stories within it.

The timeframe

The work of collecting the stories was begun in 2006 by a student, Sarah Fletcher, and the booklet was published in July 2007. The booklet is available from VACCHO and a second book is on its way. (Telephone VACCHO on +61 3 9419 3350 for details.)

Where was the project conducted?

Victoria.

Project aims

To promote good news stories about the member organisations of VACCHO. The project looked at successful programs/projects.

People targeted by the project

The general population.

People involved in the project

A Canadian student studying for a Masters degree researched the stories during her time at VACCHO and at nine Aboriginal health services.

What was done during the project?

We identified the need to publicly promote success stories from the Victorian Aboriginal community-controlled sector and to use this as an advocacy tool.

What happened?

We published 700 copies of the booklet in 2007, which was supported by the CRCAH. The publication was launched during NAIDOC Week at a VACCHO open day. We reprinted 1000 copies in 2008 due to an overwhelming demand.

What worked well?

The student had the time to do the research work, which was invaluable and provided great reciprocity for her time at VACCHO. It was practical and the project had an outcome that the community could use. The publication is a great advocacy tool for VACCHO and the sector.

What did not work well?

The project did not include all of VACCHO'S member organisations (nine out of twenty-four).

The project needs to be repeated with new success stories.

What can others learn from this work?

There are ways to make the most of students and volunteers, to create a useful product.

Take a strength-based approach to promote what is good in the Aboriginal community-controlled sector etc.

Suggestions to policy makers

Provide some funding to allow organisations to promote successful projects.

So what?

It's important for the Aboriginal community-controlled health sector (or any Aboriginal organisation) to be promoting positive stories to counteract the negative portrayal of Indigenous organisations and people.

People to thank

The CRCAH funded the publication, and Sarah Fletcher collected the stories.

Storyteller details: Peter Waples-Crowe, <peterw@vaccho.com.au>.

Smokers Program

Key words: stop smoking; frontline health workers deliver smoking cessation.

The storyteller: Ashleigh Buckland.

What is the story about?

The need for a program was derived from adult health checks where the majority of people who smoked said they wanted to quit. We needed to provide follow-up support to the people who wanted to quit, but health workers in our region were not trained to deliver evidence-based smoking cessation interventions and there was no program in place. In response, we organised smoking cessation training for frontline health workers (including Aboriginal Health Workers and registered nurses); implemented a smoke-free workplace policy; developed a 12-week Quit program to be delivered as an ongoing program by all local health services across our region; and commenced an evaluation of the program.

After some feedback from community members and smoking cessation experts, we changed the name of the program from the Quit program to the Smokers Program. The term 'quit' was off-putting and we found the 'set a quit date' approach not to be very helpful. 'Smokers Program' implies that you can join the program while you are still smoking and access support to manage your smoking, cut down and then stop.

Why was the project conducted?

Training health workers in smoking cessation was necessary because we wanted to deliver an evidenced-based program. To do the work, health workers needed knowledge and skills to deliver effective brief interventions and to case manage a client in the program (e.g. how to use nicotine replacement therapy (NRT) to manage nicotine dependence and withdrawal).

The workplace smoke-free health care policy was important because we wanted to encourage all workers who smoked to quit. Under the policy, the Smokers Program was offered to staff and family members. The policy encourages all staff to model healthy behaviour.

The development of the 12-week program was necessary because health workers needed a package of evidence-based tools to work with. The program includes everything a worker needs to case manage a client attempting to stop smoking. It includes a client management plan, guidelines for weekly support session, NRT, a carbon monoxide monitor and education material to give to clients

The timeframe

It began in 2005 and is ongoing. The Smokers Program continues to be delivered by health services in seven communities across our region.

Where was the project conducted?

At all health service sites across our region, but particularly Broken Hill, Menindee and Wilcannia, New South Wales.

Project aims

Ultimately, to offer a sustainable, accessible, evidence-based smoking cessation service delivered by frontline health workers who are confident and competent in their smoking cessation work.

People targeted by the project

Originally we screened to detect smokers through the adult health checks. However, we now also ask clients about their smoking status in the chronic disease program and the GP clinics, and at the child and family clinics we talk with parents about their smoking.

People involved in the project

NSW Health (Tobacco Branch) came to Broken Hill and provided us with our initial training. From this training we gained enough information to be able to develop the 12-week program and put together a four-hour in-service session to train local health workers to deliver the program and case manager clients.

What was done during the project?

We packaged up the 12-week program and provided each health service with all the resources required to deliver the program (including the NRT, carbon monoxide monitors); we delivered the four-hour in-service session to health workers at each health service; and we provided follow-up health worker training. We supported workers to access additional training over the next three years (e.g. Smokecheck, accredited smoking cessation training delivered by NSW Health via Telehealth, and a certificate in smoking cessation delivered by Renee Bittoun from The University of Sydney).

What happened?

Over the past three years, many staff at seven health services have received the case management training, of which fifty are still current employees; there has been approximately 230 community quit attempts made by 215 people (some people with numerous quit attempts).

What worked well?

Having 'champions' within the organisation to drive the development and implementation of the program and approach. Having a 'packaged program' for workers to implement. Tailoring the program for each individual client—e.g. some clients start on Champix or Zyban, some on NRT. Twelve weeks is offered initially, but clients can stay on if required or withdraw and rejoin to allow for multiple quit attempts. Focus on people who say they want to stop smoking. Evaluating the program as we go is important as we learn what works and what does not and can improve the program. Having a position solely dedicated to evaluation is important, otherwise we would not have the time to do the evaluation work (e.g. file audits, data analysis, client interviews, focus groups).

What did not work well?

Integrating smoking cessation into the day-to-day practice of frontline health workers takes time. There were some barriers to address (e.g. workers who smoked were reluctant to case manage a client on the program; workers were busy and felt they could not deliver a 'new' program; we would train staff and staff would leave, so we would need to train staff again). However, over time we are addressing the barriers, but it has taken four years and we still have a lot more work to do.

What can others learn from this work?

Training health workers in smoking cessation is important; however, we have found that training on its own is not effective. There is a big gap between workers having the technical knowledge about smoking cessation and workers actually being able to case mange a client who is trying to stop smoking. Workers need access to an evidenced-based program that clearly articulates the case management role, the details of the weekly support offered to clients, the nicotine dependence treatment guidelines and so on. The program needs to be built into the day-to-day work of the health service (now that smoking cessation involves treatment like Champix and Zyban, GP involvement in the program is also necessary). The program approach is what makes it sustainable. If workers leave, new workers can be orientated to deliver the program.

Suggestions to policy makers

NRT is an essential component in smoking cessation. NRT is expensive and is not always readily available in all communities (especially remote communities). We are lucky because a grant enables us to buy NRT and provide it to clients on the Smokers Program at a subsidised price. However, in the long term, NRT would be more accessible if it was available on the Pharmaceutical Benefits Scheme.

People to thank

Thank you to all the frontline health workers in our region who case manage clients in the Smokers Program as part of their day-to-day work role.

Storyteller details: Ashleigh Buckland, <Abuckland@gwahs.health.nsw.gov.au>, is a recent public health graduate from La Trobe University, and works as a Project Officer, Smokers Program Evaluation, in Broken Hill.

Ifi ni gulanga—The house of healing

Key words: culturally appropriate, community action, Solomon Islands.

The storytellers: Esau Kekeubata and David MacLaren.

What is the story about?

Community action that led to the construction of a modest building at a remote hospital in the Solomon Islands for people who practice ancestral religion.

Why was the project conducted?

Despite being one of the best hospitals in the Solomon Islands, Atoifi Adventist Hospital presents significant cultural barriers to people in the area who practice ancestral religion. This project was to increase access to modern medical care to those unwilling or unable to access mainstream services.

The timeframe

In 2000 Esau Kekeubata asked David MacLaren to work with him and community leaders at Atoifi Adventist Hospital to document the barriers faced by people who practice ancestral religion. In 2002 action was initiated—through a participatory action research approach—to plan a culturally appropriate health facility for both men and women. In 2005 construction of the facility started, and in 2006 the facilities were opened.

Where was the project conducted?

Atoifi Adventist Hospital, East Kwaio, Malaita Province, Solomon Islands.

Project aims

Increase access to health services for all people in the Kwaio community.

People targeted by the project

People who live in the mountains who practice ancestral religion and choose not to access mainstream health services.

People involved in the project

The project involved hospital leaders and community leaders coordinated by Esau Kekeubata and supported by David MacLaren as a research student.

What was done during the project?

We worked with hospital and community leaders to analyse the situation and establish a modest culturally appropriate health facility.

What happened?

Community action supported the planning and construction of two buildings. Both have timber floors and walls, and sago palm roofing. One building is for women and one building is for men.

What worked well?

The community supported the initiative because the idea came from within the community.

What did not work well?

Some community leaders continue to question the initiative, as only a small number of people are using the facilities and it challenges both the biomedical model and Christian systems that have informed practice for the forty years of the hospital's operation.

What can others learn from this work?

Disparate groups are able to work together to improve the health choices available to minority and/or Indigenous groups in remote locations.

Suggestions to policy makers

Support bottom-up initiatives that are initiated and led by the community.

Engage people in the community with knowledge to assist in policy making.

So what?

People who have been unable to access health services in the hospital's 40 years of operation now have an option to use the *ifi ni gulanga*

People to thank

Atoifi Adventist Hospital staff, Atoifi Support Committee, and Kwaio community chiefs and leaders.

Storyteller details

Esau Kekeubata, Kafurumu Health Centre, East Kwaio, c/- Atoifi Adventist Hospital, PO Box 930, Honiara, Solomon Islands.

David MacLaren, James Cook University, Cairns Campus, <David.maclaren@jcu.edu.au>,
Tel: +61 7 4042 1658.

Success Story: The Workshop

Working with the leadership in communities through partnerships has been demonstrated to be a powerful tool for enhancing health and a legitimate public health goal. Health promotion strategies that strengthen community action and involvement in planning, policy making, delivery and evaluation have produced positive results in many countries.

The workshop processes

From the initiation of the workshop to its implementation, evaluation and documentation, key processes have purposefully been employed to facilitate an experience for participants that would allow them to share their work experiences in a safe, supportive environment, to network and learn, and to bring back to their own project work a better understanding of health promotion principles. These key processes have been:

- capacity building personal relationships that facilitated dialogue about cultural protocols, community experiences and expectations, including formal introductions and endorsement between partners, Elders and community members
- collaborative ongoing support for activities between partners and project staff
- authentic engagement
- a focus on strategies to maximise sustainability for creating and embedding new practice in settings.

Planning

Contributions had been invited about positive, proactive health promotion programs for Aboriginal and Torres Strait Islander people, including recent capacity development innovations for applied research. Participants were asked to identify:

- What is currently happening to improve the environmental, social, emotional and spiritual dimensions of Indigenous health?
- What can be done to strengthen responses aimed at the improvement of environmental, social, emotional and spiritual conditions impacting on Indigenous health? (It could be expected that the audience was already well informed about the health status of Aboriginal and Torres Strait Islanders, and the environmental, social, emotional and spiritual conditions that impact on health. Therefore, the workshop emphasis was on describing positive stories of health promotion projects, capacity development and research.)

Workshop format

Within the Aboriginal and Torres Strait Islander health workshop, participants had the opportunity in small group sessions to share and discuss specific success factors within their current projects or programs. Groups worked together to:

- identify one or more exemplary projects that have achieved success in improving the health of Aboriginal and Torres Strait Islander people
- identify critical inputs, processes and outcomes of the project/s to shape future knowledge transfer about the exemplary project, including planning for public presentations, papers and policy briefs
- present exemplary projects back to the workshop plenary. In addition, the Aboriginal and Torres Strait Islander health workshop provided an opportunity for participants involved in various facets of Indigenous public health and health promotion to meet and caucus around specific issues such as capacity development, policy, research and evaluation.

Workshop outcomes

Expected outcomes of the Aboriginal and Torres Strait Islander Health Workshop included:

- sharing information about critical success factors
- capacity building for knowledge transfer
- strengthening the interface between research and practice
- promoting networking and future collaboration
- developing strategically focused briefings for policy makers.

Guidelines for the group work

During the first workshop session (10.30 am to 11.30 am) participants worked in small groups and had the opportunity to talk briefly about an area of their work in Indigenous health that showed some successful outcomes. By the end of the hour, each group had identified one project they thought needed to be more widely appreciated. Groups then supported the person involved in the project to collaboratively identify critical success factors and plan for a more public presentation of the project.

The program for the day

Indigenous Welcome to Country

The workshop chair, Dr Ian White, introduced Aunty Delmae Barton, Aboriginal Cultural Advisor at the Office for Community Partnerships, Griffith University, Brisbane, to give the traditional Welcome to Country. Her exceptionally beautiful chant touched the hearts of all participants and—as keynote speaker Ian Anderson said later—expressed the very core of the workshop.

Opening presentation

In her opening presentation, 'A spotlight on progression/regression—Where to from here?', Professor Boni Robertson, Professor of Indigenous Policy at the Office for Community Partnerships, Griffith University, Brisbane, highlighted the many unresolved issues that need to be addressed if the environmental, social, emotional and spiritual health of Australia's Indigenous people is to be improved, and if the government's goal of closing the gap in life expectancy between Indigenous and non-Indigenous Australians is to be reached. She acknowledged the progress made with regard to policies, services and research, and she created for the audience a lively picture of the scenes in 2008 in Canberra when Prime Minister Kevin Rudd presented the government's apology to Aboriginal and Torres Strait Islander people. The sentiment in both Indigenous and non-Indigenous people had been one of hope to see a wave of change, the hope that a new set of circumstances in the lives of Indigenous people would be developed through processes of mutual respect and consultation, and the hope that it could be possible to raise the level of integrity of the entire country by working on the unfinished problems in a spirit of partnership between Indigenous and non-Indigenous people.

But with a note of despair Professor Robertson made it very clear that much of that hope was dwindling and much more needed to be done to address the many unresolved issues as, ironically, despite some improvements, there was regression and deterioration with regard to many factors that influence social, emotional and spiritual health.

The Queensland Welfare Reform was one of the examples Professor Robertson mentioned to show how even after Rudd's apology Indigenous people's integrity was undermined by measurements that would imply that they were all neglecting and abusing their children, drinking, using violence etc. instead of applying mutual respect and understanding and taking into consideration the unique characteristics and culture of Indigenous Australians. As a forward-looking strategy to deal with the many unresolved problems, she called for the application of the 'the art of human compassion'.

Plenary presentation

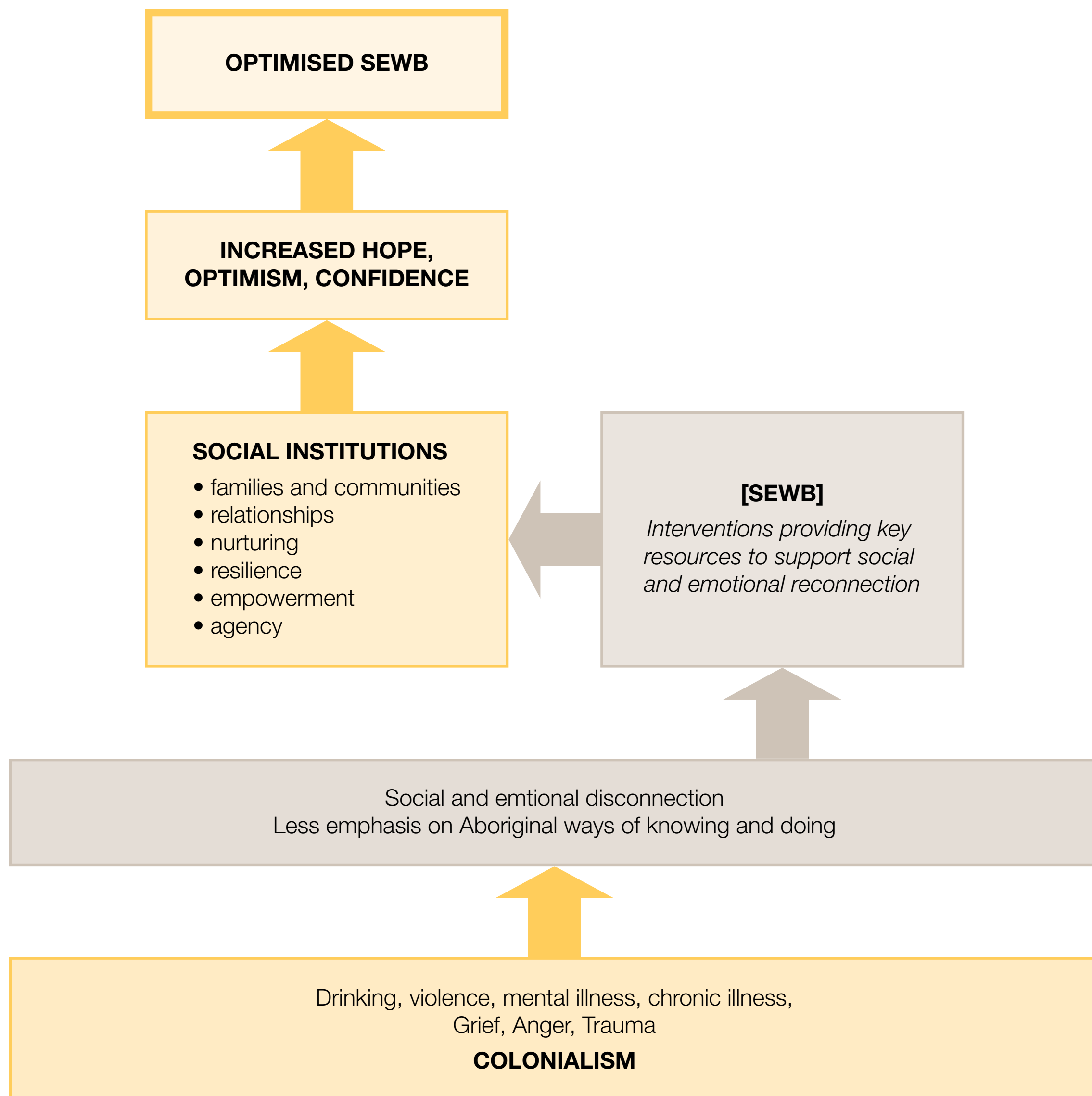
The keynote speaker was Professor Ian Anderson, Inaugural Chair of Indigenous Health and Director of *Onemda* VicHealth Koori Health Unit, in the School of Population Health at the University of Melbourne. He set out to discuss the links between spirituality and health, and to describe the necessary holistic approach required for improving the health status of Aboriginal people and Torres Strait Islanders. He contextualised this broad field by focusing on social and emotional wellbeing (SEWB).

He first introduced some key SEWB concepts, and then discussed the way the CRCAH approaches research, including the development of the CRCAH's SEWB program and the priorities within it, including spirituality.

Professor Anderson explained Hunter's (2004) four levels of intervention with regard to SEWB; i.e. society, community, family/clan, and individual. He explained the CRCAH's approach to understanding the factors influencing SEWB by understanding and providing resources to support SEWB with social interventions, within families and communities. This is reflected in Diagram 1.

Professor Anderson explained that research coordinated by the CRCAH is focused on building capacity to improving outcomes. Projects are developed with a focus on promoting and transferring the research findings into policy and practice. A *facilitated development approach* is used within the five CRCAH programs, including

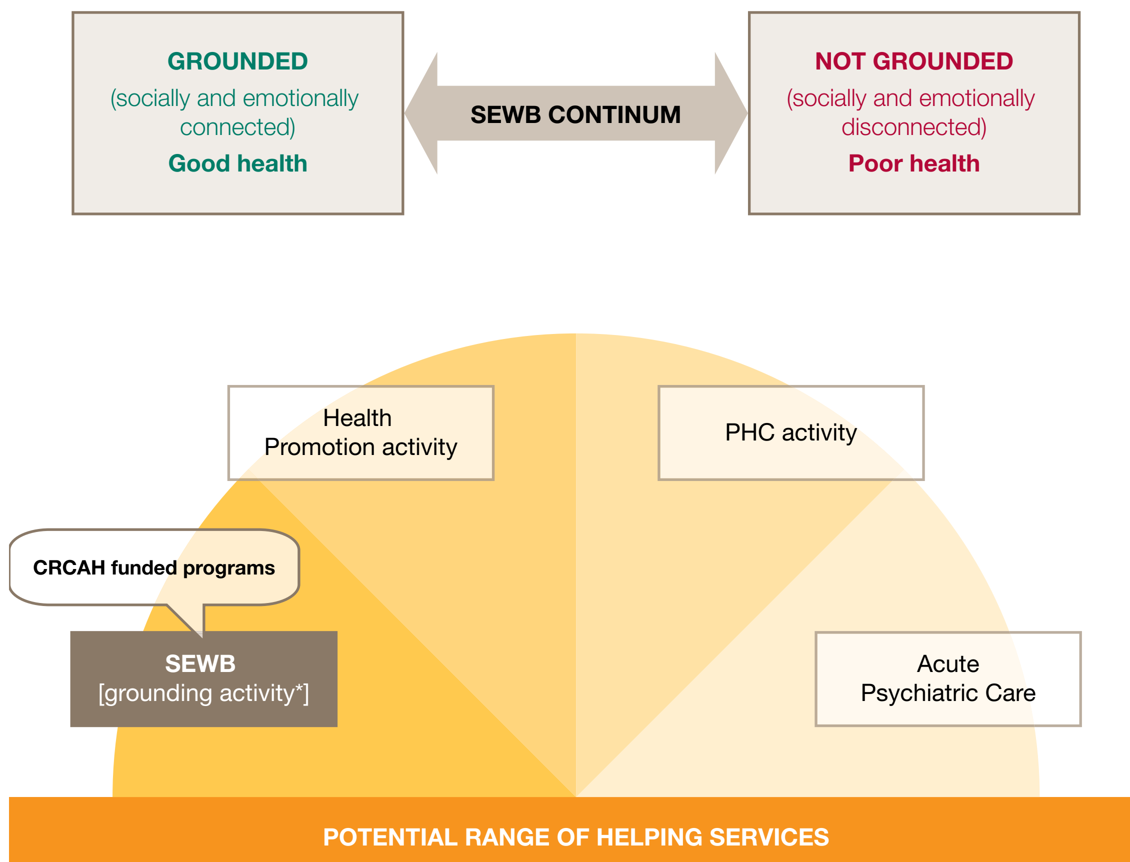
DIAGRAM 1: Pathways to optimising social and emotional wellbeing



Aboriginal Social and Emotional Wellbeing. The CRCAH determines research priorities through consultation and roundtables with key stakeholders from the Aboriginal-controlled sector, universities and governments both at a State and federal level.

The SEWB program statement and priorities were developed around a need to understand the social aspects of SEWB. There is research and work around the acute stages of mental illness and the SEWB program was keen to do some work at the grounded end of the SEWB continuum, as described through Diagram 2.

DIAGRAM 2: The SEWB continuum



***Note:** Grounding activities - contribute to building rich and productive families and communities and embody the underlying principles of good SEWB to inform programs. But it is noted that the potential range of helping services are closely linked.*

The priorities developed from a roundtable meeting in September 2006 and endorsed by the CRCAH Board include:

- families (the resilience of people)
- resourcing and service provision around SEWB
- activism/advocacy
- workforce—key issues around the workforce that supports SEWB interventions
- research transfer and capacity development
- evaluating what is currently working and why
- spirituality.

Spirituality was also a very strong theme that came out of the roundtable meeting, and several SEWB projects have links to spirituality and health. To illustrate some of the thinking around spirituality, Professor Anderson quoted Vicki Grieves: '*spirituality*; the basis of our existence and way of life that informs our relationships to the natural world, human society and the universe' (Grieves in press).

He highlighted the importance of links to the past and the future to understand the 'now'. In this context, he introduced two projects he was proud to be connected with: Mibbinbah—Indigenous Men, Health and Indigenous Men's Space; and the Empowerment and Family Wellbeing Project (a poster presentation was given during the tea break). He suggested that participants should get further information about these exciting projects on the CRCAH website (www.crcah.org.au).

Morning tea

Morning tea provided the opportunity for a poster presentation, 'Empowerment as a strategy for health and wellbeing', at the invitation of the CRCAH. Melissa Haswell and Lyndon Reilly presented on:

- the empowerment programs seek to encourage people to take control of their own lives
- the Empowerment Research Program is a ten-year program of work that includes:
  - implementation and evaluation of empowerment interventions with Indigenous communities
  - development of evaluation tools to better understand and measure the empowerment processes and the results.

Sharing success stories

The next session focused on sharing success stories. In small groups (six to eight participants), all participants had the opportunity to talk briefly about an area of their work in Indigenous health and particular factors that have enabled success in a specific project. At the end of the hour, each group identified one project they thought needed to be more widely appreciated.

Critical success factors in exemplary projects

Each small group identified one project and agreed to work with the person involved in the project to collaboratively plan and develop a public presentation of the project following a pro forma. Groups worked with the person involved in the project, and collaboratively identified, analysed and outlined the logic of the work—what worked and didn't work well, including project outcomes.

Lunch

Plenary presentations from small groups

Each group provided a five-minute overview of the success story framework it had developed.

Networking

A. Discussion in network groups

Possible networking opportunities included:

- Indigenous public health capacity development network (curriculum, teaching and learning/Public Health Education and Research Program)
- advocacy groups

- exploring personal stories—an opportunity for people to share their stories of positive change in social and emotional wellbeing, led by one or two identified people

- population and issue-based themes, e.g. maternal and child health, drugs and alcohol, chronic illness, social and emotional wellbeing.

B. Group work on briefings for policy makers

No groups actually worked on the briefings for policy makers.

Plenary conclusion

- Feedback from group work.

- Sharing learning experiences.

- Completion of evaluation forms.

Farewell and concluding remarks

Peter Waples-Crowe, Public Health Association of Australia (PHAA) (Indigenous Special Interest Group).

Key learnings from the success stories

- The process adopted in this workshop and utilised in the success stories takes time for project implementation, evaluation and sustainability.

- In teaching situations Indigenous and non-Indigenous team teaching allows cultural understanding to be improved.

Evaluation feedback

From the 92 participants, 55 evaluation responses were received in a structured questionnaire and were combined in a report to the organising committee. This evaluation report can guide the planning of future Indigenous health workshops.

The following two comments focus on what was intended with the workshop:

- 'Really good overall, a good step in the beginning of making the apology practical, thanks.'

- 'Great to have a workshop to celebrate successes and build on these.'

The answers to the open-ended questions highlighted that:

- critical success factors for engaging and working with Indigenous communities have been addressed

- sharing positive stories/case studies can empower others

- networking and learning from others in different states can improve and reinforce other projects

- 'linking more with community controlled health services and get[ting] money to support this' is important

- networking and building partnerships are crucial.

Most respondents felt there were no barriers or challenges faced and considered the workshop environment as supportive and inclusive. Time constraints were mentioned as hindering factors to making full use of the wealth of knowledge and experiences that participants brought to the workshop and to work together on policy briefs.

Responses to the evaluation questions

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
The workshop was useful to my work	0	0	69% (38)	23% (13)
The workshop was relevant to me	0	2% (1)	73% (40)	24% (24)
The structure of the workshop (e.g. speakers and interactive sessions) was appropriate	0	5% (3)	65% (36)	22% (12)
My confidence in sharing my experience has increased	2% (1)	13% (7)	65% (36)	7% (7)
I have had opportunity to network with people working in the same field	0	15% (8)	60% (33)	25% (14)
I have had further opportunity to strengthen the interface between research and practice	2% (1)	25% (14)	49% (27)	16% (9)
Overall, I was happy with the standard of the workshop	0	4% (2)	76% (42)	18% (10)
In the future I would recommend this workshop to others	2% (1)	7% (4)	67% (37)	24% (13)

References

Grieves, V. in press, *Aboriginal Spirituality: A Baseline for Indigenous Knowledges Development in Australia: Building the Capacity to Enhance Social and Emotional Wellbeing for Indigenous People Living within a Colonial Regime*, Discussion Paper No. 11, Cooperative Research Centre for Aboriginal Health, Darwin.

Hunter, E. 2004, 'Commonality, Difference and Confusion: Changing constructions of Indigenous mental health', *Australian e-Journal for the Advancement of Mental Health*, vol. 3, no. 3. Accessed 5 October 2009 at: <http://www.ausienet.com/journal/vol3iss3/huntereditorial.pdf>.

Appendix

Persons involved in the workshop

Group facilitators

CRCAH: Vanessa Harris
Deakin University: Janice Jessen
IUHPE (South West Pacific Region): Rosmarie Erben, Jan Ritchie
James Cook University: Jenni Judd
Menzies School of Health Research: Leanne Ramsamy
Onemda VicHealth Koori Health Unit, The University of Melbourne: Paul Stewart
QAIHC: Paul Durante, Bronwyn Fredericks
The University of Queensland: Megan Williams

Facilitation support

Griffith University: Boni Robertson
La Trobe University: Penny Smith
PHAA Indigenous Special Interest Group: Peter Waples-Crowe

Workshop Steering Committee members

AHPA: Ian White, Jenni Judd, June Redman and Marguerite Sendall
CRCAH: Vanessa Harris
Deakin University: Janice Jessen
IUHPE (South West Pacific Region): Rosmarie Erben, Boni Robertson
Menzies School of Health Research: Kate Senior
PHAA (Indigenous Special Interest Group): Peter Waples-Crowe
QAIHC: Bronwyn Fredericks, Lindsay Johnson, Karen McPhail-Bell (previously with QAIHC)
Queensland Institute of Medical Research: Gail Garvey
The University of Melbourne: Bill Genat
The University of Queensland: Megan Williams

Special invitees

Aunty Delmae Barton, Aunty Valda Coolwel
Uncle George Couchy, Nguyun Frank Hollingsworth

Workshop volunteers

Karen McPhail-Bell, Samia Goudie and Kym Kilroy

People involved in compiling the workshop report

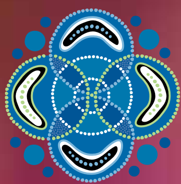
AHPA: Jenni Judd
IUHPE (South West Pacific Region): Rosmarie Erben, Jan Ritchie, Louise Rowling

Evaluation report

APHA: June Redman

Sensitivity clause

Please note: the views expressed by presenters at the meeting are the views of individuals who have presented or participants in small or large group discussion. They do not represent the views of the organising committee. Without prejudice the organising committee takes no responsibility for any third party misunderstanding in this report.



Cooperative Research Centre for Aboriginal Health
PO Box 41096, Casuarina
NT 0811 AUSTRALIA
T: +61 8 8943 5000
F: +61 8 8943 5010
E: admin@crcah.org.au
W: www.crcah.org.au