

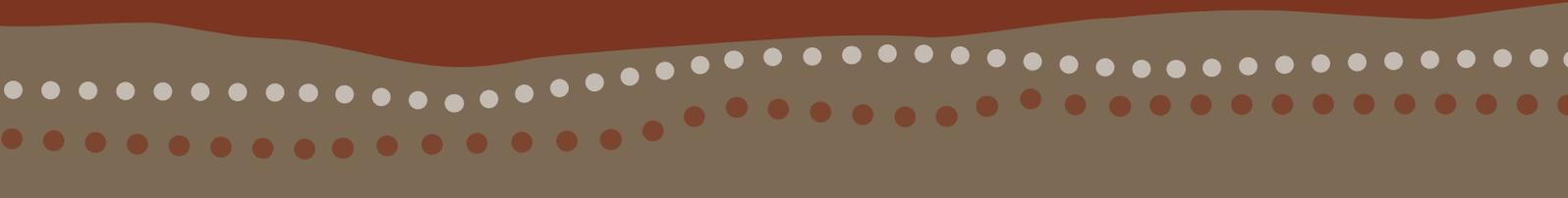
HealingFoundation

Strong Spirit • Strong Culture • Strong People



Aboriginal and Torres Strait Islander Healing Programs

A Literature Review



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Defining our healing: a literature review

Executive Summary

This review summarises existing research on healing internationally and nationally, highlighting what constitutes an effective Aboriginal and Torres Strait Islander healing process. This evidence enables the identification of what constitutes an effective healing program and the gaps in our knowledge that can inform future evaluation and research priorities.

The literature revealed that to be successful, a healing program needs to be created within the local context; respond to needs identified by local community members and be supported by the local community. Sustainability needs to be multi-level and include development and transfer of knowledge and resources. This includes strong evaluation frameworks that are consistent with an Aboriginal and Torres Strait Islander world view.

The literature review has provided an inter-country context for healing that clearly demonstrates what constitutes an effective healing program; the interface between healing and health and the need for quality evaluations that incorporate Aboriginal knowledge systems. The depth of this material enables the Healing Foundation to identify a clear pathway to building and developing the evidence of healing into the future.

Background

Colonisation has had a profound impact on Aboriginal and Torres Strait Islander peoples resulting in unresolved trauma, which continues to be passed down through the generations. This is seen in community through lives marked by poverty, lack of educational opportunity, unemployment, poor health, shorter life expectancy, lack of access to services, racial discrimination, and ongoing marginalisation.

Aboriginal and Torres Strait Islander communities are healing themselves through the incorporation of traditional practices and aspects of western methodologies in healing programs.

Effective healing programs

Effective healing programs show positive impacts on individuals, families and communities in terms of self-worth and identity. The evidence in this review demonstrates that these have had a positive impact on health status and health disparities (Wallerstein 2006). There are also positive impacts in terms of knowledge and skills acquisition by community members and the development of individual, family and community capacity.

To be most effective healing programs must be sustainable from the beginning. This is achieved by ensuring there is intra- and extra-community capacity, that intra- and extra- community networks are in place, and that there are adequate resources and funding provided to enable long term support.

Consistent evidence of the characteristics that result in effective healing programs are those:

- ◆ developed to address issues in their local community
- ◆ driven by local leadership
- ◆ based upon well-developed evidence and theory base
- ◆ combining both western methodologies and traditional healing in their treatment theory base
- ◆ informed about and understand the impact of colonisation and intergenerational trauma and grief
- ◆ building upon individual, family and community capacity through the acquisition of knowledge and skills
- ◆ incorporating strong evaluation frameworks
- ◆ With a proactive rather than reactive focus

Healing programs and Aboriginal and Torres Strait Islander systems of health

Achieving optimal conditions for Aboriginal and Torres Strait Islander health and wellbeing requires a holistic and whole-of-life view. This must consider the social, emotional, cultural, spiritual and physical wellbeing of the whole community. This is in contrast to Western medical systems which have a focus on the individual and are disease focused.

Indigenous healing programs from the United States of America, Canada and New Zealand have more in common with each other than with western health programs. All draw on elements of their Indigenous cultures including the underpinning values and concepts, traditional Indigenous healing practices and the essence of what it means to live a 'good' life.

Common aims of the healing programs include increasing social and cultural identity and self-esteem, cultural knowledge and skills and cultural connectedness. The focus of the programs is not limited to the individual but extends more widely to the family and the community, with community ownership of programs and building of community capacity.

Evaluation of the efficacy of Aboriginal and Torres Strait Islander healing programs

Theorists and practitioners agree that current clinical and biomedical methods are not appropriate for the evaluation of community based healing programs, and this is supported by the literature pertaining to community based primary prevention programs. The most common method used is participatory action research (PAR) which values the knowledge systems of the community in which the program is conducted. Unfortunately rejection of the biomedical model and case control studies of efficacy raises some issues around acceptance of the findings of the PAR evaluations.

Despite the debate about methodology of evaluation, the findings of evaluations using methods grounded in local Indigenous knowledge together with participatory action research and other qualitative methods are remarkably consistent across programs, tribal groups and countries, making them difficult to reject. Similarly the factors found to be associated with successful healing programs are similarly consistent across contexts.

There is still a need for ongoing development of new methods for the assessment of the efficacy of healing programs. It is recommended that innovative methods of evaluation be developed to assess early and intermediate success of healing. These methods should incorporate:

- ◆ a range of definitions of efficacy
- ◆ a range of methodological approaches
- ◆ local social and cultural processes of decision making
- ◆ communities developing their own indicators of success
- ◆ sensitive measures of efficacy such as subjective attitudinal and behavioural changes. Such changes are subtle and occur over time and are not be detected by the relatively coarse clinical measures of efficacy currently available.

If Aboriginal and Torres Strait Islander people are to have access to best practice healing programs further research is imperative. This is evident in the areas of the sustainability of the programs, the transferability of knowledge, and the adaption of programs successful in one locality to other regions. Methodological development is also urgently required using both Aboriginal and Torres Strait Islander and Western knowledge.

The future

The development of healing centres is emerging as an important approach towards addressing the healing needs of Aboriginal and Torres Strait Islander communities. In the evaluation of the Canadian Aboriginal Healing Foundation, healing centres were shown as one of the most effective investments towards positive outcomes for those suffering from the impact of intergenerational trauma and grief. Experts in the field of mental health and wellbeing are calling for an investment in healing centres in Australia. These investments would seek to address the social and emotional wellbeing needs of Aboriginal and Torres Strait Islander peoples.

The evidence presented in this critical review of the literature pertaining to Indigenous healing and healing programs indicates that the establishment of community based Indigenous healing programs/centres established according to the principles discussed would have positive outcomes for Aboriginal and Torres Strait islander people, families and communities.

Aboriginal and Torres Strait Islander communities are looking for ways to facilitate individual and community healing. At present there is insufficient infrastructure and investment in programmatic design to allow communities to establish effective long-term programs/centres. The emergence of adequately resourced healing centres within the Australian context would enable communities to develop healing and social emotional well being responses driven from Aboriginal and Torres Strait Islander world views.

Conclusion

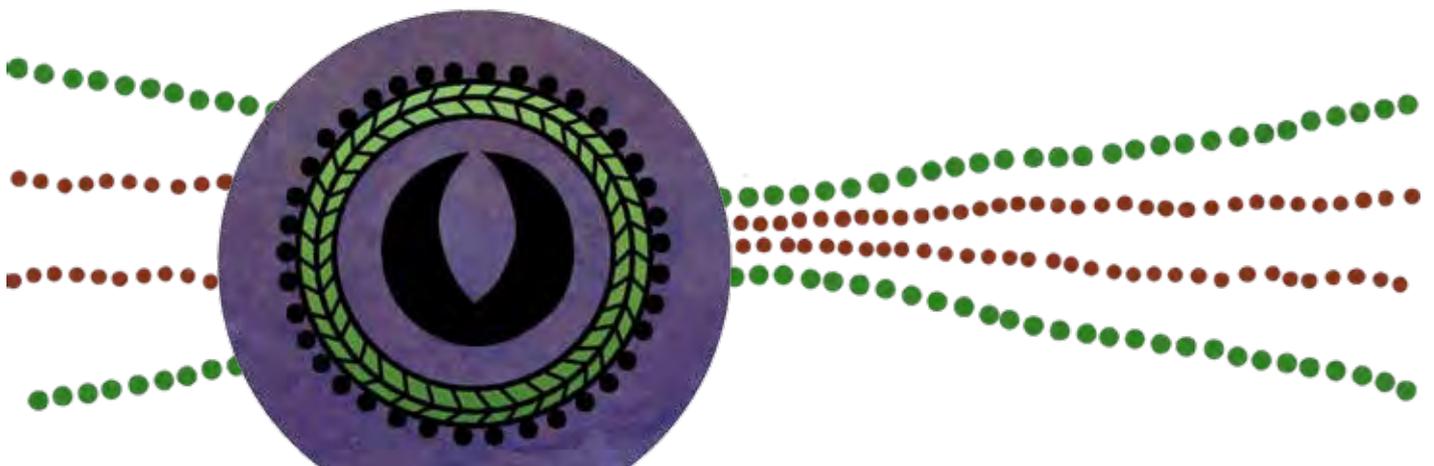
This review points to:

- ◆ the importance of long term sustainable funding for healing
- ◆ the development of effective evaluation strategies and methodologies as critical to understanding what works and the long term impact of healing
- ◆ the need for quality programmatic design and theories to guide and develop healing work nationally

This review creates a framework for change by contributing to:

- 1) the evidence base for healing;
- 2) program logic development;
- 3) principles and resources needed to establish viable healing programs;
- 4) guidelines for business development of healing programs and
- 5) the development of methods of evaluation to assist communities across Australia to build on their knowledge base in this area and use this knowledge to address issues pertaining to program operation.

This work will assist the Healing Foundation and others to assist communities create quality healing environments that achieve long term change for individuals, families and communities, including quality systems required to support healing activities.



Aboriginal and Torres Strait Islander Healing Programs

A Literature Review

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CHAPTER ONE: BACKGROUND

Introduction

Indigenous peoples around the world have suffered from the impacts of colonisation. Here we discuss the impacts of colonisation on Indigenous peoples of New Zealand and North America (Canada and the US). These countries, like Australia, were colonised by Britain. There are similarities and differences in the experiences of colonisation of Māori, Aboriginal Canadians, Native Americans and Aboriginal and Torres Strait Islander peoples. All groups had their lands stolen, were murdered by settlers, and were reduced to starvation and illness through their inability to follow traditional ways – for example, providing for their families, conducting healing practices and speaking their languages. Consequently, all continue to suffer the impact of colonisation.

The differences include a longer duration of colonisation for Native Americans and Aboriginal Canadians; Māori being the only groups with a common language; and the Aboriginal and Torres Strait Islander peoples having no treaty. These structural differences are in addition to basic differences in cultural understandings, explanations for life and ways to relate and engage with each other and the environment.

Today the lives of members of each of these Indigenous peoples are marked by social suffering. Indicators include poverty, low levels of education, unemployment, poor health, lack of access to services, racial discrimination, and ongoing marginalisation. The collective memory is said to result in transgenerational or intergenerational trauma. Thus there are substantial symptoms of unresolved loss and grief and post-traumatic stress (Brave Heart and DeBruyyn 1998; Whitbeck, Adams et al. 2004). Indigenous peoples' contemporary literature, poetry, song, art and film often bears testament to the current suffering due to past traumatic experiences and enduring grief.

Box 1.1: Naming

Indigenous refers to the first peoples of the world, of which there are many groups. The Indigenous peoples of Canada, the US and Australia comprise diverse groups with different language and traditions. Indigenous people refer to themselves by names that tell of kinship and links to land.

Collective names such as *Māori* (which means normal) are used in this report which, while recognising diversity, also aims to highlight principles for practice which can be modified for local conditions. Thus we refer to:

- the Indigenous peoples of Canada (First Nations, Inuit and Metis) as **Aboriginal Canadians**
- the Indigenous peoples of the US, consisting of many language and cultural groups with different peoples, as **American Indians** (mainland US), **Alaska Natives** and **Hawaiians**
- the Indigenous peoples of New Zealand as **Māori**, while recognising hapu and iwi.
- the Indigenous peoples of Australia as **Aboriginal and Torres Strait Islander peoples**.

In recent decades Aboriginal and Torres Strait Islander peoples, like Indigenous peoples around the world, have been striving to heal themselves from the impacts of historical and present-day traumas. To improve their wellbeing they have developed healing programs based on Indigenous knowledge and Indigenous ways of seeing and being in the world and the cosmos. The healing programs are as diverse as the peoples. Within countries the nature of the programs differs by region, tribal affiliation, remote/rural/urban settings and so on. Unfortunately many healing programs are not well documented, often because the work of healing is all-consuming both for healers and for participants. The lack of documentation not only has implications for ongoing funding of programs but also means that model programs that work well are not available to be adapted in other settings, and programs that are not working well, do not have the necessary information to be able to make corrections. Indigenous healing programs in Canada, the US and New Zealand have been more thoroughly documented than those in Australia (Williams, Guenther et al. 2011).

In this review we:

- ◆ present an analysis of these international programs (Chapter 2)
- ◆ use this, together with the general literature pertaining to healing and the evaluation of healing programs, to develop a method of assessing Australian healing programs reported in the black and grey literature (Chapter 3)
- ◆ present an analysis of those Australian Aboriginal healing programs we have identified as being examples of good practice (Chapter 4).

The appendices contain a detailed description of the method of the literature review (Appendix 1) and a brief description of all the Aboriginal healing programs identified in the black and grey literature (Appendix 2).

In this chapter we present an overview of the history, current circumstances and traditional healing practices of the Indigenous peoples of Australia, the United States and Canada. Box 1.1 examines the names used when talking about different Indigenous peoples in these countries.

Colonisation, historical trauma and the relationship to wellbeing

Colonisation impacted on the whole way of life of the Indigenous peoples and, in the context of this review, particularly their spiritual and healing traditions. They were prevented by various means from following their spiritual and healing practices. The greatest suppression of spirituality and healing seems to have occurred at times of great suffering when they were most needed. The outlawing and suppression of healing practices has an ongoing impact in the present day. Although they are no longer outlawed, the fact that they were prohibited and driven underground has meant that over time some knowledge that is passed down from generation to generation has been lost. Furthermore, the loss of language through prohibition and forced movement of people often means that many Indigenous people are uncertain about the spirituality and healing practices of their tribes. At the same time most Indigenous people do not have full access to Western health services and, when they do, often find them difficult to understand and confusing, leaving people with inadequate access to care.

Box 1.2: Colonisation

Colonisation is marked by:

- *Conflict, introduced diseases, starvation*
- *Losses – life, land, sources of food, shelter, spiritual connection to place*
- *Assimilation – more losses of language, cultural practices including healing, identity; physical, sexual and emotional abuse.*
- *Ongoing impact in the present day*

The stories of colonisation and its impact on the first peoples of the United States and Canada have been told by people themselves in biographical works, novels, poetry, song, and the visual arts. Sherman Alexie's stark novels, including *Reservation Blues* (1995) and *Indian Killer* (1996), tell the stories of contemporary Native Americans in the United States and bear testament to the wreckage of the lives of many. On the other hand the Canadian First Nations writer Thomas King uses humour in his short stories and novels including *Green Grass Running Water* (1993). The songs of Archie Roach and the late Ruby Hunter evocatively bring forth the lives of the Stolen Generations and their families, while Jimmy Chi's musicals, *Bran Nue Dae* being the best known, use humour and pathos. Māori author Witi Ihimaera's, immense body of work (novels, plays, short stories and most recently songs) poignantly tells the stories of Māori from the times of the Treaty of Waitangi and the Land Wars (*The Matriarch* (1986) and *The Parihaka Woman* (2011)) to the present day (*Bulibasha* (1992)).

These stories have been told in different ways by academics, Indigenous and non-Indigenous (anthropologists, medical anthropologists, psychologists, sociologists, and psychiatrists), and it is the academic literature that we focus on here. Strengths of academic literature include the review processes, the accumulation of knowledge over time and the broad range of approaches taken to understand the issues. However, no one piece of research on its own allows us to draw strong conclusions. For example the association between psychological distress, poverty, and childhood abuse, initially poorly understood and disputed, is now so strongly supported by many different studies using different methods that the relationships are not questioned anymore, although many individual studies in this area are weak and quite limited. Similarly, the sheer weight of the literature from different perspectives all reaching similar conclusions demonstrates that the impacts of historical trauma are persuasive in individual and community lives.

Australia



Colonisation, historical trauma and loss and grief

It is estimated that Aboriginal people have lived in Australia for tens of thousands of years, probably more than sixty thousand years. They came to terms with the often challenging environments in which they lived in ways that enabled the development of ways of life rich in spirituality, art and dance, with the practice of medicine interwoven with the lore. Furthermore:

Aboriginal people evolved a series of successful, varied economies. These broadly based economic systems allowed them to survive in a wide range of environments where European agriculture proved to be an abysmal failure ... by 10000 years ago Aborigines had mastered the sophisticated aerodynamic principles of boomerangs ... Society was organised so there was ample leisure time ... The achievements of early Australians are constantly underestimated by those who judge a society solely by its material possessions. (Flood 1983)

The arrival of British colonists had a devastating impact on the lives of Aboriginal people throughout Australia. In south-eastern Australia, colonisation was so rapid and so destructive that:

Anthropological and historical analysis of Victorian clans is extra ordinarily difficult because of the rapidity of European usurpation ... By 1861 fewer than 2,000 of the original owners had survived what eyewitness accounts called 'wanton slaughter' starvation and the effect of European-introduced diseases. (Barwick 1984)

The parents were massacred and it happened down around those areas ... yeah they just slaughtered them left right and centre down there. They say they used to push 'em back into the water, there's a lot (of bodies) down there you know. (McKendrick 2001a)

Dispossession, destruction of traditional lifestyles, rapid cultural change, disruption of families and communities, discrimination, cultural exclusion, poverty, lack of educational opportunity, and poor health have been the legacies of colonisation (Dodson 1991; McKendrick 1993; Dodson 1995).

Assimilationist policies were adopted by Australian state and federal governments until the middle of the 20th century. Initially, the theory of eugenics was applied to 'breed' the Aboriginal race out by marrying 'part Aboriginal' children to Europeans. It was expected that the 'full blood' Aboriginal people would rapidly 'die out'. However, by the end of World War II the prevalent international view was that eugenics was responsible for or allowed the Holocaust to occur. This led to a change in policy from a biological solution to the 'Aboriginal problem', to a cultural solution according to which Aboriginal people would cease to exist as a distinct cultural group – they would be made to assimilate (McKendrick 2011).

The removal of Aboriginal children from their families has been an insidious feature of the assimilation policies throughout Australia since colonisation. The practice was at its height during the 1950s, 1960s and 1970s. Under the law Aboriginal children could be taken from their families with no court order being necessary. Aboriginal people were not counted as citizens of Australia until 1967. Thus the parents of children who were taken away had no right to take court action. Generations of Aboriginal people have lived in fear of 'the welfare'. Stories abound of mothers sending their children to hide in the bush whenever a strange car was sighted. A few escaped but many were taken, never to see their parents or siblings again.

The systematic removal of Aboriginal children from their families was an act of genocide as defined by the United Nations Genocide Convention (1948), to which Australia was a signatory:

In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, such as ... (e) Forcibly transferring children of the group to another group

The removal of Aboriginal children is clearly documented in public documents which show that the removals were both forcible and had the ultimate aim that Aboriginal peoples would cease to exist as distinct cultural groups:

... the pure-blood Aborigines were rapidly decreasing in numbers. Many people ... accepted the idea that this group was becoming extinct and should be 'left alone to pass in peaceful ease' the half caste were increasing in numbers ... they were expected to merge into the white community. One obvious way of providing a solution to the 'Aboriginal problem' was to move the 'half castes' off the stations (and forbid them to associate with 'full bloods'). In a short period of time, the pure blood Aborigines would become extinct. (Read 2006, p.38)

Assimilation was enshrined in official policy in all Australian mainland states and territories by 1940 (Wilson 1997). The removal of Aboriginal and Torres Strait Islander children from their families is clearly both systematic racial discrimination and genocide as defined in international law. Sadly, the removals continued even after being prohibited by treaties to which Australia willingly signed (Wilson 1997).

The present day – loss and grief

Today Aboriginal people are the most socioeconomically disadvantaged group in Australia and their health status is well below that of the general community, with an average life expectancy 10-20 years less than that of other Australians. Assimilationist policies such as the forced removal of Aboriginal children from their families have disrupted the fabric of Aboriginal family and community life. Aboriginal people are incarcerated up to 20 times more than the general Australian community, high school retention rates are many times lower and unemployment rates many times higher than for the general population. Chronic psychological distress has been shown to be associated with both longstanding environmental difficulties and intermittent acute stressors, such as physical illness in self and significant others, frequent bereavement, poverty and lack of educational opportunity (Mann, Jenkins et al. 1981; Kessler, Cleary et al. 1985).

The impact of colonisation and subsequent events has resulted in many Aboriginal people living in circumstances that promote the development of depression and mitigate against the resolution of such depression. The early to mid 1990s were a time of positive change engendering hope for a better future and true self-determination among Aboriginal people, including the establishment of the Aboriginal and Torres Strait Islander Commission (ATSIC), through which Aboriginal people were formally involved in the processes of government, and the Mabo decision of the High Court of Australia, which recognised Native Title and paved the way for more Aboriginal land claims throughout Australia. However, a new government elected in 1996 reversed these changes over the next 10 years. ATSIC was disbanded and the Native Title Act 'watered down', and in 2007 the Northern Territory Intervention (the Intervention) began. The Intervention and subsequent acts of parliament occurred in response to the report *The Little Children Are Sacred*, which detailed the spectrum of social suffering in remote communities in the Northern

Territory. The government of the day chose to focus on the sexual abuse of children by a few. Military troops were sent into remote Aboriginal settlements, and the Racial Discrimination Act was dismantled. The government took control of all aspects of Aboriginal people's lives, including finances, health, housing, and care of children, rendering them little more than wards of the state. The 2007 Intervention continues (McKendrick 2012).

The special case of healing for victims of sexual abuse:

The trauma of sexual abuse experienced by so many Aboriginal women and children since colonization, has been neglected by history and warrants consideration in its own right. Prior to colonization, Aboriginal women's and men's roles in society were clearly defined. Colonisation brought a change in the relationships between Aboriginal women and men, which gradually became more akin to those of the dominant patriarchal society, the built-in protections for women and children in Aboriginal society being lost. Over more recent decades, the impact of sexual abuse of women and children across the generations has become a cause for concern, with both non-Aboriginal and Aboriginal men as perpetrators.

Aboriginal people are deeply concerned about the sexual abuse of their women and children. Dr Hannah McGlade, an Aboriginal human rights lawyer and academic, believes that the starting point for healing in Aboriginal sexual abuse must be the recognition of i) the human rights of Aboriginal women and children, and ii) sexual abuse as a violation of the human rights of women and children. Healing is thus a matter of justice. Successful healing programs for the victims of sexual abuse established by Indigenous people in the United States and Canada utilise similar concepts. In West Australia, 'Sister Kate's Home Kids', a healing centre, is in the early stages of its development, with key themes being redress, reparation and healing for those who suffered abuse and trauma as children. Intergenerational trauma will also be addressed, including the strengthening of individuals, families and communities

Indigenous views of mental health and wellbeing

Australian Aboriginal people have very different views of health and illness to those of Western medicine. While the cultures of Aboriginal people around Australia are diverse, there are similarities in the knowledge systems on which Aboriginal concepts of health and illness and their associated healing systems are based. These are very different to the knowledge system on which Western medicine is based. The person is seen to exist in a world in which they have interrelationships with other people and the environment (the land, the animals, the plants and the meanings given to them by the ancestral beings) but also with the cosmos and the ancestors. Illnesses can be caused by simple means (sick from eating food; headache), from the spirit moving from its normal place in the body causing a person to become anxious and restless, from harmful spirits and through sorcery (whereby people can cause sickness in others) (McCoy 2006).

Interviews and focus group discussions were conducted with Aboriginal people from the Kimberley and Perth to determine their views about mental health, Western practitioners and strategies for improving mental health services. The information obtained was analysed for main themes. Despite sociopolitical, cultural and environmental differences between the city and the remote group, their responses were similar. Over 70 per cent of respondents said that depression, which they described as 'just the way he is' was not a state that could be addressed through medical treatment. It was said to be a weakness in wellness, involving a person's environment and social relationships. Once a person became unwell they were open to the influence of malevolent spirits who could influence them to take a certain course of action. Such unwellness needed to be addressed through traditional means, although once people became very ill (crying in public, suicidal) they were usually referred to mental health services. The traditional way of treating such a problem is to build a person's resilience to spirits and to make changes in the social world and the environment. Most people believed that a combination of Western and traditional treatments would provide the best opportunity for a person to become well again.

Westerman, (2004) found a condition termed 'longing for, crying for, or being sick for country' which had similar symptoms to clinical depression. The cause is the removal of the person from their country, dreaming place or spirit for extended periods of time. The resolution involves a combination of traditional treatments and Western psychotherapy (Vicary and Westerman 2004).

Towards healing

It has been shown that a strong sense of cultural identity can be protective against the development of psychiatric morbidity. It is likely that Aboriginal people who have strong family connections, know about their Aboriginal heritage, including their tribal group and traditional lands, and continue to live an Aboriginal lifestyle (the nature of which varies between Indigenous groups) are similarly protected. Despite the near fatal impact of European contact on Aboriginal societies, the richness and durability of Aboriginal cultures has continued and can continue to enable Aboriginal communities to overcome the problems that continue to be imposed upon them (McKendrick 2001a).

Healing methods

Traditional healing

Aboriginal traditional healers still practice in most regions of Australia, although they are more visible in remote regions. Many Aboriginal people will consult traditional healers at the same time as being treated by a Western physician (McKendrick 1997; McCoy 2006). In Central Australia traditional healers are the Ngangkari, while in the Kimberly region of Western Australia they are the maparn. Traditional Aboriginal healers can be women or men; however, women and men usually have different ways of healing (McCoy 2006).

Blended healing

There are diverse initiatives in healing for Aboriginal people being developed throughout Australia. Most of these use a combination of traditional healing techniques and cultural practices and techniques drawn from Eastern or Western therapies, including psychotherapy, group therapy, empowerment strategies, massage and meditation. Narrative Therapy based on storytelling has been shown to be acceptable to Aboriginal people and to have positive outcomes.

Aboriginal community-based mental health services and some mainstream mental health services have Aboriginal traditional healers and/or Aboriginal cultural consultants working alongside Western-trained practitioners.

These programs are described in detail and assessed in Chapter 4.



Canada and the United States

Colonisation, historical trauma and loss and grief

The process of colonisation in North America has been likened to the Holocaust (Brave Heart and DeBruyyn 1998; Whitbeck, Adams et al. 2004; Whitbeck, Walls et al. 2012). The initial contact with the Europeans resulted in epidemics of infectious diseases from which many Indigenous people died. There followed the movement of colonists into the continent in search of land. Many battles were fought but inevitably the Indigenous people were defeated, leaving many dead. Those remaining were forced from their tribal lands, and made to walk long distances to the inferior country set aside for them – the ‘reservations’. More people died during these enforced marches from starvation and disease (Brave Heart and DeBruyyn 1998). Even the new lands were not safe, however, and well into the 20th century legislators took land from the reservations (O’Neill 1993).

The story of the Flathead, who live on a reservation in the plateau region of Montana, is typical of that of other North American tribes. Prior to colonisation they had lived a life of hunting and gathering on their bountiful lands, and were known for their many horses and their horsemanship, as well as for being pious and humble. They were, however, often in dispute with their Blackfoot neighbours. The advent of Europeans saw the Flathead forced from their lands, harassed and murdered by the settlers, sick from introduced diseases, and starving from lack of food due to loss of their hunting grounds and fertile land:

The years were bitter ones for the tribe. On the reservation and in the Bitterroot Valley small pox and tuberculosis ravaged the people at times destroying whole families ... Hunger was rampant as wild meat became more difficult to obtain ... In 1881 the same year the BIA (Bureau of Indian Affairs) officially prohibited Indian ceremonies, war dancing and stick games and 36 years after the creation of the reservation the Flathead left the Bitterroot Valley. The Flathead Culture Committee details Char’s (the Chief) desperate decision and mournful emigration. (O’Neill 1993, p. 450)

We discuss the impact of this history on the present day Flathead in the section ‘Views of mental health’ below.

The 19th century saw the beginning of the assimilation policies. These included taking back reserve land previously set aside for Native Americans, forcible relocation of men to cities where they were separated from their tribe and often from their families, and the Native School system, which forcibly removed children from their families. All these policies had the effect of separating the people from their culture, from their spirituality, from their elders and from their languages. The Report of the Canadian Royal Commission into the Residential Schools (Aboriginal Healing Foundation) revealed that children were abused physically, sexually and emotionally in the residential schools:

Spiritually and emotionally, the children were bereft of culturally integrated behaviors that led to positive self-esteem, a sense of belonging to family and community, and a solid American Indian identity. When these children became adults, they were ill-prepared for raising their own children in a traditional American Indian context.' (Brave Heart and DeBruyyn 1998, p. 63-64)

The process of colonisation of North America fits the definition of genocide adopted by the United Nations (Whitbeck, Adams et al. 2004) and has been referred to a devastating act of ethnic cleansing (Duran and Duran 1995; Brave Heart and DeBruyyn 1998; Brave Heart 1999; Brave Heart 1999a; Whitbeck, Adams et al. 2004).

The present day – loss and grief

Today the First Peoples of North America suffer disadvantage compared to others in all areas of their lives – in health, housing, education, employment and justice:

We suggest these social ills are primarily the product of a legacy of chronic trauma and unresolved grief across generations. It is proposed that this phenomenon, which we label historical unresolved grief, contributes to the current social pathology, originating from the loss of lives, land, and vital aspects of Native culture promulgated by the European conquest of the Americas. (Brave Heart and DeBruyyn 1998, p. 60)

Deaths occur more frequently and at much earlier ages than for the wider population. The causes include accidents and premature death from treatable illnesses including diabetes, hypertension and pulmonary disease:

Present generations of American Indians face repeated traumatic losses of relatives and community members through alcohol-related accidents, homicide, and suicide ... Many times deaths occur frequently, leaving people numb from the last loss as they face the most recent one. (Brave Heart and DeBruyyn 1998, p. 60)

This is compounded and perpetuated by racism (personal and institutional) and social injustices so that Indigenous people are effectively marginalised from the wider society (Duran, Firehammer et al. 2008).

It has been hypothesised that the first generation of First Peoples colonised would have suffered from post-traumatic stress disorder in a similar way to survivors of the Holocaust (Brave Heart and DeBruyyn 1998) and that subsequent generations have experienced transgenerational transmission of trauma for which they have unresolved historical grief.

The layers of present losses in addition to the major traumas of the past fuel the anguish, psychological numbing and destructive coping mechanisms related to disenfranchised grief and historical trauma. (Brave Heart and DeBruyyn 1998, p. 69-70)

In a qualitative study conducted to determine the nature of historical loss, the team found that between 20 and 30 per cent of Native American adults had thoughts about historical traumas daily, some several times a day (Whitbeck, Adams et al. 2004). This was followed by a quantitative study of the relationship between historical loss and symptoms of depression among American Indian and First Nations adolescents aged 13 to 15 years and their female caregivers. The frequency of thinking about historical loss was significantly different for the young people compared with their carers; however, a high proportion of both groups had at least daily thoughts about aspects of historical loss:

20.5% of the adolescents reported daily or more thoughts about loss of land compared to 12.4% of their adult female caretakers. (Whitbeck, Yu et al. 2008, p. 26)

The types of losses thought about were similar for the adolescents and the female caregivers:

... daily or more thoughts about loss of land, loss of language, loss of traditional spiritual ways, loss of culture, losses due to alcoholism, losses from early death, and loss of respect for elders. (Whitbeck, Yu et al. 2008, p. 27)

Using factor analysis (which is a powerful statistical tool requiring a great deal of quantitative data), it was found that thoughts of historical loss and depressive symptoms in adolescents were separate constructs in the study sample. The relationship between depressive symptoms and thoughts of historical loss was examined, with historical loss being shown to be associated with depression even when more proximal stressful events and other causes of adolescent depression were controlled for. The authors state that their findings indicate that historical loss may have a negative impact on the development of Native American adolescents:

Historical loss represents a response to a profound denial of a culture's right to exist and the attempt to eradicate cultural identity. These findings also suggest that the effects of historical loss may have early demoralizing effects on the development of adolescents. (Whitbeck, Yu et al. 2008, p. 35)

Indigenous views of mental health and wellbeing

Indigenous peoples have beliefs, values and concepts that are based on Indigenous epistemologies, or knowledge systems. Indigenous knowledge systems are very different from the Western epistemology that informs psychiatry, psychology and indeed all of the Western health disciplines (Bennett 2009; Bennett and McKendrick 2010). The differences between Indigenous and Western epistemologies are discussed further in Chapter 3. Given the differences, it is not surprising that Indigenous views of mental health and wellbeing differ from those of Western medicine. Here we discuss some examples.

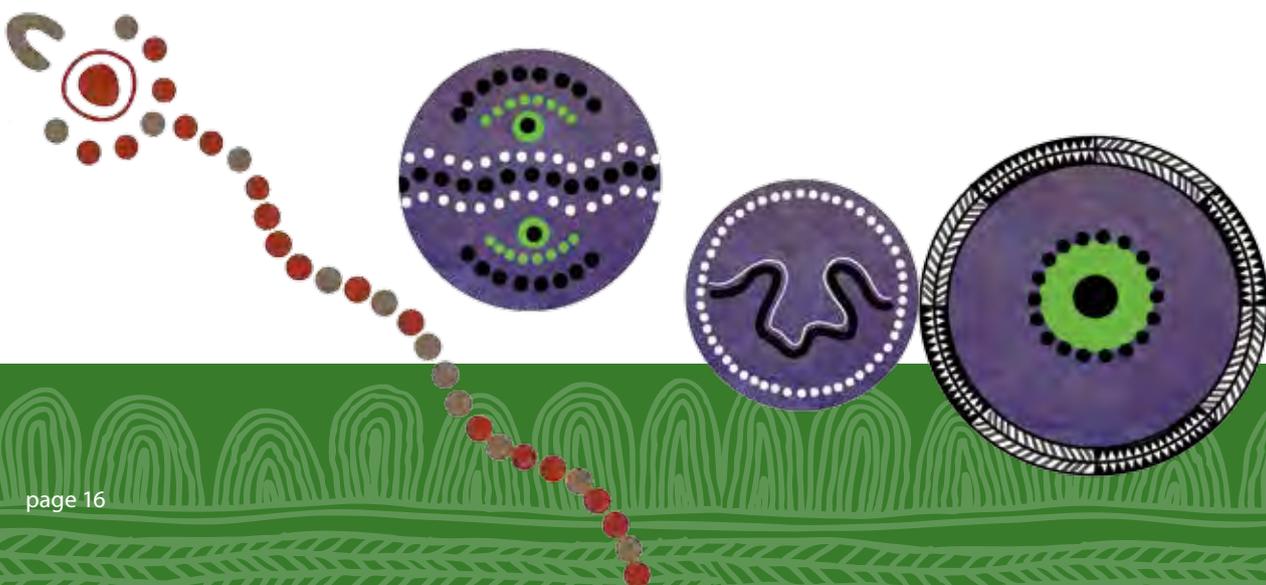
O'Neil (1993) began working with the Flathead to determine the relationship between Flathead notions of depression and the Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of depression. However, she found the Flathead did not speak of depression or sadness but of loneliness and that the types of loneliness described by the Flathead did not align in any way to DSM depressive disorder. Sometime after her work with the Flathead, O'Neil worked with American Indian Vietnam War veterans from the Northern Plains. She notes that:

Among some American Indian tribes, there have existed, both traditionally and in contemporary times, curing rituals designed for persons exposed to combat, for example, the Enemy Way among the Navajo. (O'Neil 1993, p. 449)

The Northern Plains veterans were referred to by others in their communities as 'not having come home yet' and as having a 'lost and faraway look in their eyes' (O'Neil 2000, p. 446).

O'Neil revisited the Flathead community following her experience with the Northern Plains tribe. The Flathead wanted to talk about developing an intervention that would heal the loneliness. Through talking with the elders and others, O'Neil realised that loneliness was in fact a respected position to take within the tribe because it meant the person was taking seriously the losses and terrible things that had happened to the tribe since colonisation. Thus loneliness was not a personal position, not an illness but a social position taken because one cared about the tribe and what had happened:

an esteemed elder who feels profound loneliness, who has trouble sleeping and eating, but whose sad and resigned demeanor is understood within her family and the community as a moral and mature response to the losses that she and her tribe have suffered and endured. Her loneliness is not a sign that something is wrong with her; it is in fact an embodied memorialization of the Flathead response to their history of loss. (O'Neil 2004, p. 224)



Box 1.3: The present day – trauma, loss and grief

The impact of colonisation continues in the present day with ongoing losses and trauma:

- *Social injustices, social suffering and marginalisation (poverty, poor housing, poor health, frequent deaths at an early age, high rates of incarceration, racism, violence)*
- *Poor sense of identity, low self-esteem*
- *Depression, high rates of suicide among young people, substance misuse.*
- *Hope: reclaiming language, culture, development of healing programs, self-determination, treaty*

Duran and colleagues (2008) write about liberation psychology to treat 'soul wound' that results from historical trauma. To practice liberation psychology one must use Indigenous metaphors, which the patient can understand, not the metaphors of, for example, the DSM. Duran himself uses the term 'soul wound' to explain sadness to people who are depressed. This is drawn from the spirituality of the Plains Indians, who believe that if a person experiences severe trauma or loss the spirit will leave the body and be replaced by another spirit – the spirit of sadness. Ceremonies are then required to bring the person's own soul back. A distinction is made between the healing that occurs in the practice of liberation psychology and Western mental health.

Western mental health practitioners aim to cure the patient of the disease so that the patient can become a productive, obedient member of the dominant society. The patient is a passive receiver of the treatment. In the healing process of liberation psychology the one seeking help is an active participant in the process, which is characterised as helping the person find their own place in the cosmos:

Being a productive member of society has a very different meaning in traditional Indigenous cultures, which are mainly concerned with the person's relationship to the universal cosmology versus curing a culturally defined psychological disorder. From an Indigenous liberation psychology perspective, individuals can be very depressed and still have a relationship with their soul and the way their soul harmonizes with the universal life force. (Duran, Firehammer et al. 2008, p. 293)

Towards healing

Gone (2008), an American Indian psychologist, studied the provision of mental health services on Indian reservations in the US. He found that the American Indian people themselves saw the mental health services as extensions of the process of colonisation and believed that they would start thinking like white people if they attended those services: 'So I can be like a white man' (Gone 2008, p. 382).

He also notes that other assessments of Indian health services by American Indian people found that they were sites of colonial invasion by white health professionals who continued to 'force their white ways and white beliefs' onto their patients.

Duran (Duran, Firehammer et al. 2008), another American Indian psychologist, also views Western mental health practice as a means of making Indigenous people fit into the dominant society and continuing the process of colonial suppression of Indigenous peoples, their spirituality and their culture. Duran and his colleagues propose a way of healing that draws on Indigenous spirituality and healing practices, on the work of Brave Heart, and also on the work of Friere. The ability to practice liberation psychology involves coming to an understanding of the traumatic history and current social suffering due to social injustices and cultural oppression of Native people in the US. According to proponents of liberation psychology, which draws on the work of Friere, current Western psychiatric and psychological treatments perpetuate the dominant hegemony and in doing further oppress Indigenous people. Practitioners, in addition to becoming aware of the historical trauma and current social injustice that mark the lives of their Indigenous clients, must also be familiar with the culture of the people they are treating – as it is practiced, not in theory. The spiritual plays a big part in liberation psychology and the goal of this mode of working with clients is not to cure but to heal, not to fit people into the dominant society but to allow them to live in the cosmos.

Brave Heart and DeBruyn have developed a method for healing the distress caused by historical unresolved grief (Brave Heart 1999; Brave Heart, Chase et al. 2011), drawing on First Peoples' healing practices and on the literature pertaining to the treatment of Holocaust survivors and their children. Whitbeck and his team are the first to take the concepts of transgenerational trauma, historical unresolved grief and soul loss and develop scales to measure what they refer to as historical loss and to conduct quantitative research to determine the relationship between historical trauma and symptoms of depression. This work adds force to that of the qualitative researchers, and is additional evidence of the need for healing programs to address the issues.

Healing approaches developed

The Indigenous people of North America use a range of spiritually based healing systems for healing the ongoing impacts of colonisation, historical loss, historical trauma and soul loss. Most draw on Indigenous spirituality and healing, whether from their own tribe or borrowed from other tribes. Many also draw on elements of Western psychology and psychiatric practice but usually in modified form. We have divided the healing practices described here as traditional or blended.

Traditional healing

The Navajo have three spiritual healing systems that they use today – traditional healing, Christian healing, and the Native American Church (Csordas 2000). The Navajo believe that the elements of traditional healing were passed down from the gods in ancient times. Traditional healing has been used by many generations of Navajo and remains relevant today:

Traditional healing is that of the hataalii, who performs intricate chants and sand paintings, and of the diagnostician who works by methods such as crystal gazing, hand trembling or coal gazing. (Csordas 2000, p.464).

The Native American Church (NAC) has some aspects of healing in common with traditional healing, in particular the diagnostic system; however, treatment methods differ:

NAC healing is that of the road man who prays at an earthen alter or fireplace and administers the sacramental peyote. (Csordas 2000, p. 464)

The Christian faith healing ranges from Pentecostal to Roman Catholic. Navajo use all three forms of spiritual healing, and Western biomedicine is seen as the alternative system. Begay and Maryboy describe the life of a Catholic nun whose father was a traditional healer and later in life also took on some elements of the NAC healing system. The nun herself lived for many years away from the reservation; however, when she became very ill in late middle life she returned and used traditional native healing together with faith healing. At the time the paper was written she was alive and well in her eighties and was herself a well-known Navajo healer (Begay and Marybody 2000).

Gone (2004) retells the story of a traditional healer, Bull Lodge, a Gros Ventre of the late 19th and early 20th centuries. Bull Lodge's daughter originally told the story to Gone's father. The story tells us a great deal about Indigenous spirituality and healing in North America and the beliefs of ordinary Indigenous people. Bull Lodge was born of a humble family but was determined to do well in life and he prayed constantly to the Feathered Pipe as a child. Eventually his prayers were heard and he became a great healer and leader of his people:

suffering in the context of personal religious devotion was crucial to Bull Lodge's success as a healer and leader ... His unique boyhood relationship to the Feathered Pipe during which he prayed in anguish to the Pipe to 'have pity on me' inaugurated a healers training that depended directly upon an impressive series of supernatural encounters providing the requisite 'professional knowledge' to perform supernatural acts of healing. (Gone 2004, p. 132)

Gone goes on to say that healing practices were meaningless to the Gros Ventre unless accompanied by the ceremonies of ritual smudging, singing, smoking and supplicating. Furthermore these beliefs are maintained by Gros Ventres of today, who have a high regard for spiritual healing and a belief in supernatural power, which makes acceptance of Western forms such as counselling extremely difficult for them:

Gros Ventres are culturally committed to a view of personhood that encompasses personal relationships with a wide variety of Spirit Beings and the resultant potential for accessing sacred power for the purposes of sustaining life 'in a good way'. (Gone 2004, p. 133)

O'Neil, working with the Plains Indian Vietnam Veterans, found that although the men had spoken to people in their own age groups about the war, usually when drunk, they had not participated in the tribal ceremonial way of talking about such things:

Waktoglaka is characterized by restrained sadness, and is characterized overall by a more formal style of speech, such as the incorporation of native language kinship terms. Perhaps most importantly, waktoglaka is performed before an intergenerational audience, such as at pow wows or memorial giveaways, where infants are cradled on the laps of aunties and elderly prayer leaders are at hand to conduct opening ceremonies, and where veterans' words evoke tears, respectful silence, and feelings of pride among listeners.' (O'Neil 2000, p. 456)

In the process of talking in this formal way and sharing their experiences with the tribe the men could truly come home from Vietnam and take their place again as members of the tribe:

... waktoglaka war memories undergo a semiotic transformation within which they are detached from combat-based meanings of death and survival, and become reattached to the sense and flux of ongoing intergenerational and transhistorical tribal life. (O'Neil 2000, p. 458)

Similarly, loneliness experienced by the Flathead (see above) could only be healed through interrelationships and participation in meaningful ceremonies with the whole tribe. Medical intervention or psychological intervention would be inappropriate (O'Neil 2004).

Blended healing methods

Duran and his colleagues have developed a form of healing they call liberation psychology. In order to practice liberation psychology the practitioner must come to understand the oppression and social injustices that Indigenous peoples face in the present and the legacy of historical loss and trauma. The person seeking help must be seen in their sociocultural context. One of the important elements of Liberation Psychology is to help the person seeking help understand the nature of the historical and present-day trauma and to come to understand that they are not defective Indians because they do not speak the language or have traditional knowledge but that this is something that has happened to them as a result of the process of colonisation. Friere calls this a change in consciousness conscientisation (Duran, Firehammer et al. 2008). Once one has freed oneself from the impacts of colonisation one can also change the coloniser and free the coloniser as well as oneself. To practice liberation psychology one must also use Indigenous metaphors that the patient can understand, not the metaphors of, for example, the DSM. Duran himself uses the term 'soul wound' to explain sadness to people who are depressed. This is drawn from the spirituality of the Plains Indians, who believe that if a person experiences severe trauma or loss the spirit will leave the body and be replaced by another spirit – the spirit of sadness. Ceremonies are then required to bring the person's own soul back.

Duran and his colleagues also make the point made by many others cited in this review that Indigenous healing programs cannot be assessed using Western biomedical models as the Indigenous and the Western epistemologies run parallel to each other and do not intersect or overlap.

A joint Canadian–Norwegian research project (Bastien, Kremer et al. 2003) examined the views of three separate Indigenous groups, two from Canada and a Sami group, on healing from historical loss and trauma. The main theme that came from their work was that stories of survival balanced those of trauma and were seen to have the greatest healing potential. They concluded that there were four critical factors in healing from colonial violence – remembering, reconnection with ancestors' healing methods, reaching out to others with love, and reconstruction of Indigenous notions of community.

Brave Heart and DeBruyn (1998) describe a model of healing they have developed to address historical unresolved grief. It combines traditional Native American ceremony and spirituality with techniques from Western psychology, and draws on the work done with Holocaust survivors. This model also has similarities with the liberation psychology model (Duran and colleagues). Groups are held in communities facilitated by local community members (including those expert in spiritual matters), and local

clinicians trained in the model help participants come to terms with historical trauma through expressing their own feelings and listening to others, and through presentations about historical traumas, including battles such as Wounded Knee and the boarding school.

The participants in the groups are kept safe and brought together through traditional ceremonies such as the purification ceremony at the beginning and the wiping of tears at the end (Brave Heart and DeBruyin 1998). The participants form close bonds through the group work and support each other outside the group. The training for the group facilitators emphasises cultural awareness, knowledge of historical trauma and historical unresolved grief, and being aware of and coming to terms with one's own unresolved grief. The Takini Network for Lakota Holocaust Survivors was established in the 1990s to provide the training for this model of healing (Brave Heart and DeBruyin 1998; Brave Heart 1999).

A Native American healer and spiritual leader (Barlow and Thompson 2009) who works with Native American prisoners uses a model of healing that draws on aspects of those developed by Brave Heart (1998) and Duran et al. (2008). The model blends Western methods with elements of traditional healing and liberation practice (Barlow and Thompson 2009). The focus is on healing historical trauma and understanding what has happened in one's own family history so that energy can be used to move forward rather than continually fight the system by breaking the law and being sent to jail:

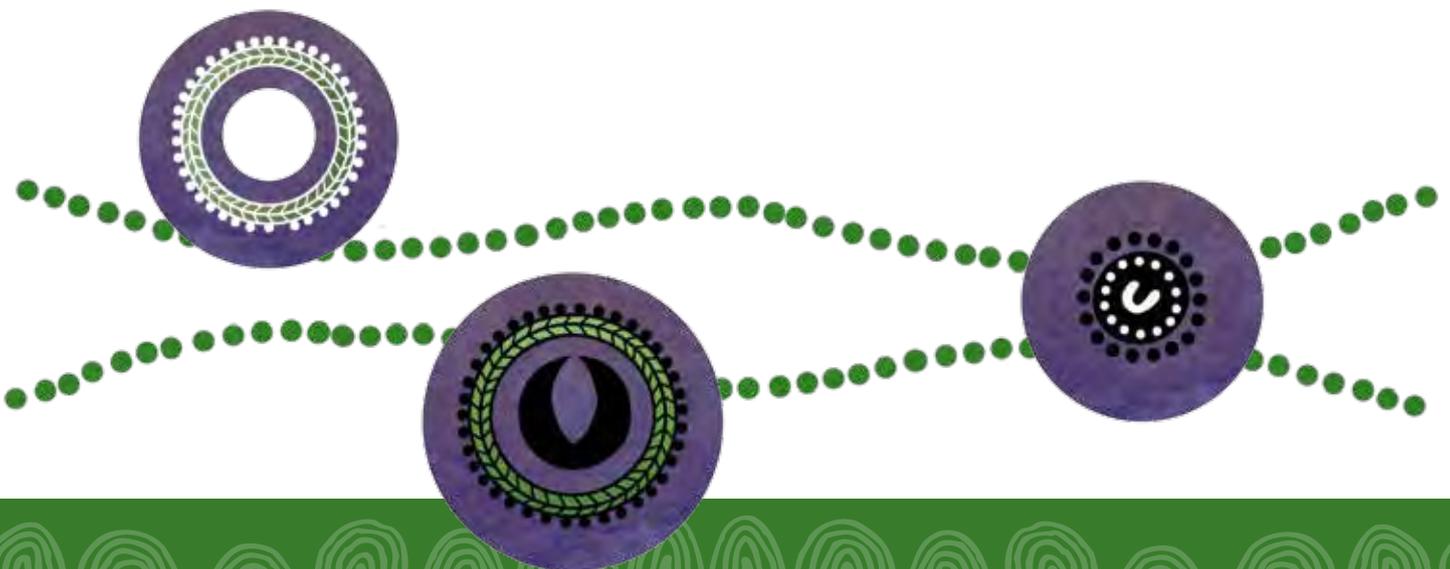
Warriors provide, protect and make things happen and do all of this as peacefully as possible (Barlow and Thompson 2009, p. 117)

Box 1.4: Views of mental health and illness

Indigenous and Western knowledge systems are very different.

Indigenous views of mental health and illness are based on Indigenous knowledge passed down through the generations.

- *Health is related to the relationships between people, the environment and the cosmos.*
- *Different views of the nature and cause of illnesses – there is a prominent spiritual element.*
- *Effective treatment is usually felt to require both Indigenous and Western methods.*



New Zealand



Colonisation, historical trauma and loss and grief

History prior to colonisation

Māori, the Indigenous people of New Zealand, are Polynesian. Māori arrived in New Zealand around 1000 CE having undertaken long voyages across the Pacific (Durie 2005; Durie 2010). It is not known exactly where in the Pacific the Māori came from; however, the original homeland is called Hawaiki in the stories of the voyages of the ancestors.

The settlement of New Zealand by the Māori is told in the waiata (songs) and pakiwaitara (stories). Prior to settling permanently, Māori made voyages to Aotearoa. Then followed the permanent settlers, the first of whom settled in the areas now known as Auckland, Hawkes Bay and Taranaki. Family and extended family groups settled on particular areas of land and tribal boundaries began to be laid down. At the same time the Māori developed rules and values for living (tikanga) and a system of knowledge (mātauranga Māori), both based on an intimate knowledge of and connection to the land. Traditional Māori healing has its basis in Māori rules for living and Māori values (tikanga) and Māori knowledge (mātauranga Māori) (Durie 2005; Durie 2010).

History since colonisation

The history of colonisation in New Zealand has followed a similar path to that in other countries. The lands and waterways on which Māori were dependent for food, shelter and all the necessities of life that are central to Māori spirituality and culture were stolen. Māori were forced onto smaller and smaller areas of land. Concerned about the risk to Māori lives and livelihood, the British Crown negotiated a treaty with Māori – the Treaty of Waitangi. The Treaty of Waitangi has three articles. Article One states that Māori will retain rangatiratanga, or governorship, over New Zealand. Article Two states that Māori will have ownership of all their toanga (treasures), including the forests and the waterways. Health is considered a toanga, or treasure. Article Three gave Māori the same rights as British citizens. However, there were two versions of the Treaty of Waitangi – one in English and the other in te reo Māori (the Māori language) and there has been and still is debate between Māori and non-Māori (pakeha) as to the meaning of key words, including rangatiratanga.

Needless to say, the Treaty of Waitangi was not honoured and the lands continued to be stolen. When Māori protested, the governor, the Crown's representative, went to war with Māori to protect the British settlers as they continued to steal the land. Many atrocities were committed against Māori during the land wars – one example is of women and children attending a church service in a rural village. Soldiers attacked the church, burning it down with all the women, children and elders inside. All were burnt to death. In another region, a tribal group who lived in the village of Parihaka on Mount Taranaki undertook peaceful resistance against the theft of their land – for example they would take down fences put up by settler farmers. In retaliation the governor had his soldiers attack the village of Parihaka (none of the villagers were armed). After the attack the leaders of the peaceful resistance and many of the men of the tribe were arrested and sent to jail thousands of miles away, leaving the woman, children and elderly to fend for themselves. Following the land wars, tribes had land confiscated by the Crown, as did the peaceful protestors of Parihaka. Māori suffered terribly over this time and, as more and more land was taken over and introduced diseases and effects of starvation took their toll, the Māori population reached dangerously low levels.

The present day

Until the mid 20th century most Māori lived in papakainga (villages) away from major urban centres. Whānau (family) lived largely through farming the land, working the mara (gardens) and gathering kaimoana (sea food). Changing socioeconomic conditions in the 1950s and 60s led to a migration to the large cities, where there were better opportunities for jobs and education (Metge 1995). This meant that whānau (families) were living away from the supports of their extended whānau, their traditional land, and their marae. This was difficult, but urban Māori soon established whānau relationships with neighbours and work colleagues. Over time urban Māori authorities and marae were established that provided support to local Māori who were living away from their families and traditional lands.

By 1976 over 80 per cent of Māori were living in urban settings (Durie 2005). Increasingly Māori children were born and raised away from their ancestral land and extended whānau and surrounded by mainstream institutions. By the mid 1980s Māori concern about the resultant decline in fluency in Māori language and understanding of Māori cultural practices was translated into action through the establishment preschool centres (te kohanga reo, or language nests), Māori schools and Māori health services, including mental health programs operating in accordance with Māori cultural values and practices. These and similar innovations continue to provide Māori, particularly those living in urban settings, with a renewed sense of identity and pride.

The Waitangi Tribunal was established in 1975 to hear tribal grievances pertaining to breaches of the Treaty of Waitangi, including confiscation of land. Although there have been some settlements with tribes, the process has been slow.

Māori Marsden (2004), an Anglican minister, spoke about the impact of colonisation on Māori:

... continued and persistent deprivation/oppresion/intrusion/manipulation/exploitation of the tangata whenua (Indigenous peoples) by the dominant culture/society/government (which) poses a serious threat to the self-esteem/humanity/identity which leads to serious disorders – social/organic/mental/spiritual ... social disorders are but symptoms of mental/spiritual dis-ease ... In the contemporary New Zealand situation the Māori is the major client/victim of the colonization process as is demonstrated by the high incidence and gross over-representation of Māori in ... crime/unemployment/violence/mental health (Marsden 2003, p. 87)

Tariana Turia, a prominent Māori politician who has been an associate health minister in several governments, came under severe criticism from non-Māori in 2000 for stating that Māori mental illness was related to 'postcolonial stress disorder' (Kingi 2005).

Different views of health and illness

Māori views of health and illness are very different from those of Western medicine. This has been shown in studies of Māori views of mental health. Māori community members relatively naive to mental health issues and Māori Western-trained mental health professionals were shown videos depicting Māori suffering from depression and psychosis exhibiting the symptoms required for a diagnosis under the DSM (Bennett and McKendrick 2010). Responses were similar for the community members and the mental health professionals. Māori preferred not to name the conditions, believed them to be similar in nature and cause, and believed they were associated with spiritual issues and relationships, especially family relationships. Furthermore the appropriate course of action in the first instance was felt to be to call upon a kaumātua (elder) known to the family and, if necessary, a traditional healer, and to call the whole family together to determine the exact cause of the problem. If it was a problem related to spiritual matters or a transgression, a traditional healer would be required to put things right. However, it was acknowledged that in many instances Western treatment would also be required.

Healing

Māori history across the ages from the voyages, to settlement in Aotearoa, to the coming of the Europeans and to modern times shows that Te Ao Māori (the Māori world) is central to the achievements and endurance of Māori over time (Hiroa 1949; Biggs 2006). Central to Te Ao Māori are whānau (family), whenua (land), tikanga (values) and wairua (the spiritual), and the maintenance of balance between the people, the environment (earthly realm) and the heavenly realm (Hiroa 1949; Durie 2005; Biggs 2006). The whānau is the source of wellbeing. Tikanga provides the values and wairua (the spiritual aspect that connects people to the cosmos) and the processes (through practices including karakia (prayer) and the use of wai (water)) that maintain balance and harmony in people's lives, environments in which creativity and achievement can occur and the capacity to maintain wellbeing and overcome challenges. Mātauranga Māori (Māori knowledge) underpins the activities of the whānau and tikanga Māori (Durie 2005; Durie 2010).

Māori systems for the maintenance of health and wellbeing were overseen by the rangatira, the political leaders, and the tohunga, the professional experts, whose roles were both inherited and ascribed (Durie 1998). Both had expertise in spiritual matters. Tohunga were educated in whare wananga, specialised houses of learning, and became the carriers of tribal knowledge, of which they were guardians rather than disseminators. The concepts of tapu, and noa were central to the belief systems of Māori healers, who used an ecological model based on the intimate relationships between people and the land. Events, places, actions and the environment were classified according to whether they were safe or prohibited, tapu being prohibited and noa being safe. Illness could occur as a breach of tapu – where community conventions of social codes were breached, illness was thought to be the likely result (Durie 2010).

The Tohunga Suppression Act of 1906 made tohunga and their practices illegal. This had a severe impact on Māori healing practices. The whare wananga and the tohunga were forced underground. With the repeal of the Suppression Act in 1964, tohunga were able to practice openly again. However, today's healers are not so closely aligned to tribes, and their selection and training are not so well defined. Recognition of expertise and credibility by Māori communities is now more based on the recognition that a person has a special gift coupled with personal qualities (Durie 2011).

The report of an inquiry into the mental health system in New Zealand conducted by Māori psychiatrist Dr Henry Bennett and Māori lawyer Judge Ken Mason commented on the impact of colonisation on the wellbeing of Māori:

[prior to colonisation] Very few Māori would have been in need of psychiatric care. If so they were cared for within their whānau (family) hapu (subtribe) or iwi (tribe) ... At that time the tangata whenua (the people of the land) were culturally strong. Almost all would have known their whakapapa (genealogy) and their turangawaewae (place to stand and an economic base) ... Most would have also had access to their own healers and herbal medicines. The rules of tapu and noa would have helped to provide and maintain social order. Through everyday practices such as karakia (incantations) most would have known ways of promoting and maintaining their health and if they were sick they would have known of a remedy. The maintenance of good health was an individual, whānau and iwi responsibility. (Mason, Ryan et al. 1988, p. 226)

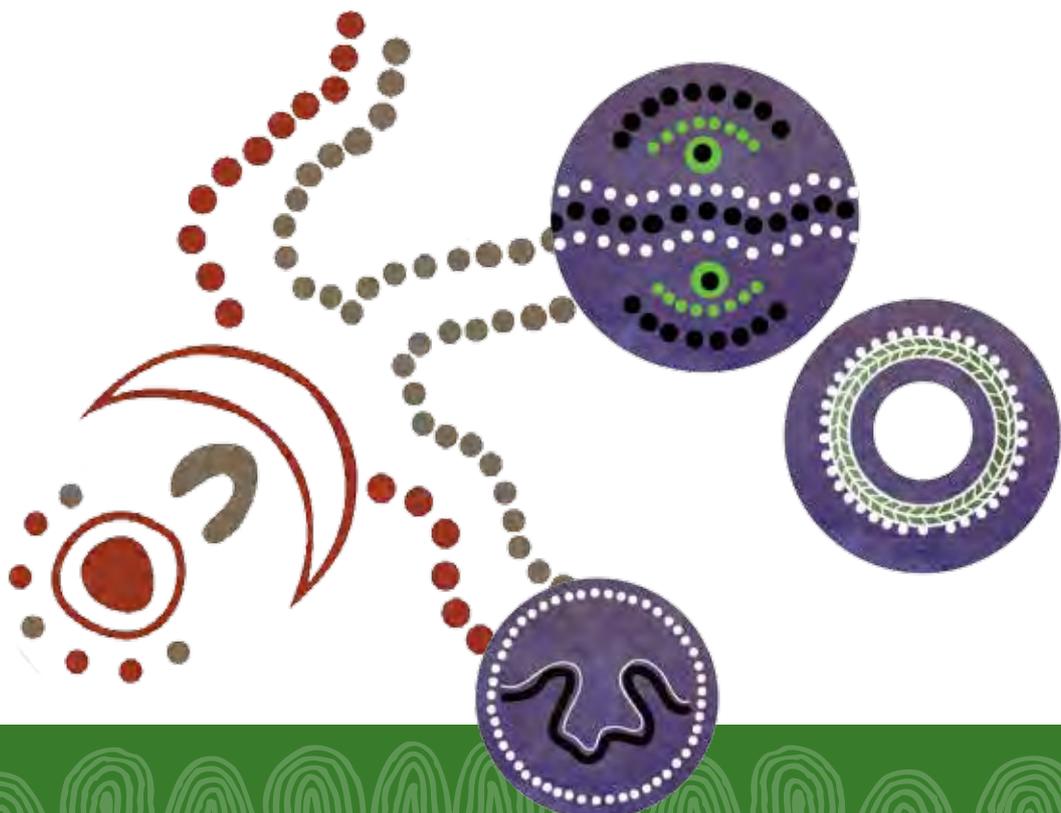
Box 1.5: Healing

Traditional:

- *Based on Indigenous systems of knowledge*
- *Spiritual*
- *Relationships between people, the environment, the cosmos*
- *Externalises*

Blended:

- *Elements of traditional healing and other traditional cultural practices (dance, song, ceremony)*
- *Elements from Western and Eastern healing systems – psychotherapy, narrative, massage, meditation, empowerment*



CHAPTER TWO: HEALING PRACTICES AND PROGRAMS – CANADA, THE UNITED STATES AND NEW ZEALAND

Introduction

This chapter explores the healing of Māori, Canadian and US First Peoples. These peoples have similar colonial histories as Aboriginal and Torres Strait Islander peoples. This chapter thus provides learning from international Indigenous peoples to support and explore the Aboriginal and Torres Strait Islander approaches to healing.

Box 2.1 shows the key findings from this review of first peoples healing programs.

Box 2.1: Key findings

- *Healing takes time*
- *Programs are most often blended using traditional healing techniques, ceremonies and practices together with techniques from Western methods*
- *Spiritual component is central*
- *Programs delivered by members of the same cultural group*
- *Careful to do no harm*
- *Staff need support because of the stressful nature of the work*
- *Recognise the diversity of those seeking healing*

Canada and the United States

Most of the documented healing programs are from Canada. This is a function of the literature – there is very little literature about specific healing programs in the US, in contrast to healing practices (Chapter 1), where most of the literature pertains to the US. It may be that some programs are not documented at all in the black or grey literature (Williams, Guenther et al. 2011). Gone (2011) has noted that in a recent search of the literature he could find no detailed descriptions of how Indigenous cultural practices and processes had been incorporated into specific healing programs.

The programs described are from remote, rural and urban areas and were selected on the basis of the information available in the literature.

The Lodge

The context

The Lodge (Gone 2008; Gone 2011) is a First Nations community controlled healing program on a remote Canadian reservation and is funded by the Aboriginal Healing Foundation (AHF). The Lodge program is for survivors of residential schools and other reservation residents and addresses issues of substance abuse.

Program description

The program runs in 10-week cycles with up to 15 participants in each cycle. It employs 24 staff, all of whom are First Nations and most local band members. The program consists of:

‘structured lectures’ usually accompanied by associated therapeutic activities for 2–4 hours on four evenings per week, as well as one-on-one counseling by appointment as desired. Additional therapeutic activities included coordinated field trips, sponsored cultural events, or participation in ceremonies. Beyond formal client services, community education and outreach activities were a crucial component of the healing mission of the program (Gone 2011, p. 189).

The lectures were conducted by the counsellors and included psychoeducational, expressive and applied components and aimed to increase the awareness of and engage participants in the therapeutic process. Lectures included Aboriginal cultural orientation and mainstream life skills instruction. The Aboriginal content of the lectures exposed participants to history and culture from which many had been alienated through the residential school system and its intergenerational effects:

‘I learned a lot there, too, [about cultural ceremonies such as] Sundance, sweats. I made [Native crafts, like] dream catchers. It was alright’. (Gone 2011, p. 191)

One-to-one counseling sessions, at least one per week, were encouraged. Counsellors were also available on call for participants. This was important during times of crisis when, for example, a participant craved a drink and felt they could not control the craving. Having the counselor available gave the person an alternative to taking a drink.

Workshops of several days duration were also held. They covered a range of issues, including grief. In addition there were field trips to Aboriginal conferences, and a healing journey back to the residential school. All community members were encouraged to take part in field trips and cultural activities. Cultural activities included powwow dances, pipe ceremonies and an annual fasting camp.

Healing modalities

The treatment modalities used at the Lodge were Western and Aboriginal. The Western modalities included the Alcoholics Anonymous (AA) Twelve Steps and a range of ‘New Age’ and alternative therapies including inner child exploration, guided imagery, reiki, meditation and acupuncture.

Aboriginal approaches included prayer, smudging, talking circles, tobacco offerings, pipe ceremonies, sweat lodge rituals, fasting camps and other blessing rituals. A full-time ‘traditional’ counsellor was employed by the Lodge to formulate and facilitate the cultural activities. The Aboriginal activities highlighted the emphasis of the program on Aboriginal identity and the promotion not just of individual wellbeing but of community wellness in spiritual and cultural terms. The healing effect of the traditional Aboriginal methods is described as follows:

‘It’s a sacred ceremony. And it addresses all four areas of our being. It cleanses physically, mentally, and emotionally and spiritually. Because in our cleansing ceremonies we have that opportunity to share with one another whatever it is that’s bothering us ... It gives us that opportunity to release that there If we’re sincere about the ceremony itself, we come out of there feeling refreshed ... That kind of relief. Mentally, you feel okay ...’ (Gone 2011, p. 193)

The medicine wheel (which derives from stone structures built by the ancients and whose original purpose is not known) is a pan-Indian symbol which formed the basis of the Lodge healing program. The medicine wheel links space and time with the four sacred directions (directional space) and the four seasons of the year (cyclical time). Any element considered in detached isolation from the other three distorts reality, with resulting disharmony and disintegration:

*'The red, white, black and yellow (quadrants) in the medicine wheel, it each symbolizes something. There's an animal that sits in each direction and it symbolizes that love, humility and other values ... And then there's a plant associated with each direction. So it shows that everything is interconnected ... that we are all equal'.
(Gone 2011, p. 194)*

In the context of the program the medicine wheel represents the holistic and cyclical aspects of people's experience, the four quadrants being associated with the physical, emotional and spiritual aspects of human experience.

Impact

The Lodge program officially caters to 15 participants for each 10-week cycle. However, its community outreach means that in addition to individual treatment the program promotes community wellness and renewal. Its efficacy (it seems a good proportion of participants graduate from the program and remain sober, although there has been no formal evaluation) cannot be measured in terms of the individual or in the short term.

The Lodge: lessons learnt

Target group: Residential school survivors and family members who have problems with substance abuse.

Healing: Program based on the medicine wheel; spirituality incorporated in all elements; traditional methods blended with Western and Eastern; delivered by local First Nations staff.

Key tools: Cultural orientation (including history and culture); life skills; counselling (one on one); AA; talking circles; prayer; smudging; pipe ceremonies; sweat lodge.

Impact: Not formally evaluated; however, a high proportion of participants graduate from the program and remain sober.

Traditional healers and telepsychiatry

The context

Shore and colleagues (Shore and Manson 2004; Shore, Shore et al. 2009) describe mental health service delivery to remote American Indian reservations in the US in which traditional healers and psychiatrists collaborate in treating American Indian war veterans suffering from post-traumatic stress disorder (PTSD). American Indian veterans have higher rates of PTSD than other veterans, and this is probably because they see much more combat action.

Program description

Teleconferencing – live interactive videoconferencing – has been established to link veterans who live on remote reservations with psychiatrists. To support this work, clinics are established on the reservations and a community outreach worker, a member of the local tribe, is appointed to liaise with veterans and traditional healers. Initially the psychiatrist will make several visits to the reservation to establish clinic protocols with the staff on the ground. During the visits the psychiatrist also becomes known to and gets to know the community through attending and participating in community meetings and powwows, and meets local healers. The process of getting to know the healers has to follow tribal protocols, and the community outreach worker guides the psychiatrist in these protocols. Once they get to know each other the psychiatrist and healer stay in regular contact with both face-to-face meetings and videoconferencing.

Healing modalities

This program brings Indigenous and Western methods of healing together in a way whereby each maintains integrity. The psychiatrists and the healers refer patients to each other, and collaboration between the psychiatrists and healers also occurs through patients. In some cases the healers ask the psychiatrists to participate in healing rituals including talking circles, sweat lodge ceremonies and smudging. The most important factor involved in developing a good working relationship between the healers and the psychiatrists is the establishment of good informal relationships and networks between them and the community. In some communities formal relationships are not even established. A very important aspect of this program is that the healer and the psychiatrist do not interfere in each other's work.

Impact

It has been shown that only a small proportion of veterans with PTSD consult traditional healers or psychiatrists (between 10 and 20 per cent); however, veterans who participate in tribal ceremonies and healing rituals both before and after their service are significantly less likely to suffer from PTSD and less likely to require help for emotional problems, and those who do are more likely to benefit from a combination of Western and traditional methods of healing.

Traditional healers and telepsychiatry: lessons learnt

Target group: *Native American Vietnam veterans living on a remote reservation.*

Healing: *Traditional healers, psychiatrists, cultural facilitator.*

Key tools: *Making traditional and western practitioners available in a way whereby each maintains their integrity.*

Impact: *Not formally evaluated; however, the available information suggests that veterans who have access to cultural modes of healing are less likely to have PTSD and those who do are more likely to benefit from psychiatric treatment.*

Medicine House and the Forensic Centre

The context

Medicine House and the Forensic Centre are described in research conducted by Greg Brass (2008) and Jim Waldram (1993) respectively. The two programs are considered together because they provide similar healing programs. Medicine House is a residential facility located in a major city, which takes referrals of men who have been paroled and men awaiting sentencing. The men have been heavy users of alcohol and drugs at different times of their lives and have experienced suffering as a result of their criminal behaviours. The Forensic Centre takes prisoners from a jail located near a large city. The men are sent there from prison for psychiatric and/or psychological treatment.

The men in both programs come from diverse backgrounds. They are from different tribal groups. Furthermore they have different life experiences. Some are traditional in that they speak an Aboriginal language as their first language and have relatively little proficiency in English and little proficiency in non-Aboriginal settings. Others are relatively bicultural, comfortable in both the Aboriginal and non-Aboriginal worlds. Yet others have been raised exclusively in the non-Aboriginal Euro-Canadian culture, having been raised in foster homes or institutions or adopted.

Detailed ethnographic interviews were conducted with program participants, focusing on the participants' experiences of the programs.

Program description

The Medicine House healing program is delivered via group and individual psychotherapy and intensive therapy sessions held off site at a rural camp retreat. Group psychotherapy sessions are held three times a week and last for three or four hours, while the intensive therapy sessions are conducted over a week spent in camp. The Forensic Centre officially runs two streams, a spiritual stream, which the authorities consider a religious program similar to the services of other religions, and a cultural and academic education program. However the two streams overlap (Waldram 1993).

The healers are Aboriginal men referred to as elders. The elders offer sweats and individual counselling and provide cultural and spiritual knowledge in group settings. Elders do not report to the psychiatric or the psychological teams. They are not the 'traditional' elders, who are older, tend not to leave their homes and do not offer their services to institutions, although they do conduct healing sessions in their home country. The elders who work at these two institutions have usually had difficulties with alcohol and drugs in the past and have been taught by the traditional elders, whom they visit on a regular basis. They may or may not be traditional healers. They need to be effectively bicultural in their orientation, as in addition to their healing roles they have to negotiate contracts and the culture of the institution.

Healing modalities

Medicine House and the Forensic Centre use symbolic healing approaches and a rhetoric of healing based on pan-Indian spirituality. Brass describes pan-Indian spiritual healing as:

... a culturally generalised representation of Indigenous identity, particularly in terms of religious beliefs and spiritual practices; it lacks a specific reference or boundedness to any one Aboriginal cultural tradition. (Brass 2008, p. 358-359)

The practices associated with pan-Indian healing are the sweat lodge, the healing circle, smudging, and deference to and honouring the wisdom of the elders. The symbols of healing are the sacred pipe, the use of tobacco and sweat grass, the sweat lodge and the medicine wheel. These symbols are related back to the Creator, whose assistance is needed for healing to occur. The clients/patients and healers tell their stories during sessions. The symbols and their associated rhetoric encourage:

... integration of the sufferer within a therapeutic community, and the transformation of one's problems from a source of despair and suffering into a source of revitalisation and strength. (Brass 2008, p. 359)

The elders/healers have a difficult task as a result of the diversity of their clients/patients. If healing is to be successful, the healers and their clients/patients must share a similar cultural base, a similar world view, and similar meaningful symbols. pan-Indian spirituality may not be culturally compatible with the spiritual orientations of all clients/patients. Thus the first step in the healing process is for the healers to educate the clients/patients so they can identify with the healing symbols:

(the Elders) ... enhance the common themes and discredit the difference (between Pan-Indianism and specific Aboriginal cultures) as a mythic base for healing to occur. The interaction between the healer and patient seems to be, in part, a search for the lowest common denominators linking their cultures and experiences, so the therapeutic encounter has some hope of success. And both the healer and the patient take on the responsibility of redefining the essential elements of their own cultures to arrive at a common base. Brass (2009) sees the healers as 'homogenising the cultural identities of residents and constructing a sense of Aboriginal community among residents'. (Brass 2008, p. 375)

The principles of this surrogate community are 'caring, sharing, honesty and respect' (Brass 2008, p. 375). The community is sustained by the rhetorical devices 'the circle', 'the community', 'the medicine', 'the medicine wheel' and 'the sacred fire' which, in addition to laying the ground for the therapeutic interventions, give the residents a sense of common spiritual purpose.

Impact

Brass and Waldram did not undertake an evaluation of the programs they studied. However, through their observations of the programs and interviews with healers and participants both concluded that where the participant found they could speak about their suffering and their losses and where they embraced the pan-Indian spirituality they were able to make personal changes, some to the extent of breaking their cycle of alcohol and drug abuse and staying out of prison. However, in both studies a significant number of individuals could not relate to the pan-Indian spirituality, symbolism and rhetoric. These were in the main men who were 'traditional' – who had been raised in their own specific tribal culture and taught by their own elders and were knowledgeable about the 'medicines' that grew on their country: 'Real medicines are inseparable from particular knowledge of a local world or landscape' (Brass 2008, p. 361).

Brass and Waldram both found that Inuit men did not relate to the pan-Indian spiritualism, coming as they did from country hundreds of miles away, and from a very different culture. The Inuit men did not even see themselves as Indian. The participants who had little or no knowledge of their Indian culture, having been separated from it at an early age, were much more receptive to the pan-Indian spirituality and healing. Furthermore, whereas men from more traditional or bicultural backgrounds were concerned about the fact that the healers came from a different cultural or tribal group, the culturally alienated men were not concerned about the cultural identity of the healer.

It is important to note that some participants found involvement in such intensive spiritual healing techniques to be 'emotionally and behaviorally disorganising' (Waldram 1993, p. 358) and that this can have serious consequences, including the development of a major psychiatric disorder, attempted suicide and suicide.

Medicine House and the Forensic Centre: lessons learnt

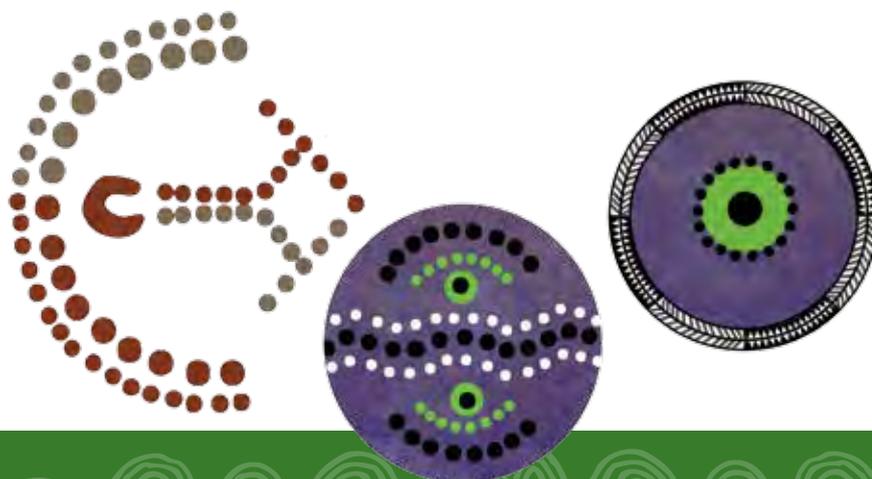
Target group: *Men in prison, on parole, awaiting court appearance. The men have been traumatised by prison experiences and events in their everyday lives. The program addresses issues of identity, self-esteem, substance abuse, incarceration.*

Healing: *Based on pan-Indian spirituality. Program delivered by 'elders' who have usually been through their own recovery and are usually supported by traditional elders from their own tribes.*

Key tools: *The medicine wheel, the sweat lodge, the talking circle, the sacred fire, the sacred pipe, smudging, tobacco.*

Impact: *The men who responded to the healing method tended to be those more alienated from their own culture. Men from more traditional backgrounds, and especially Inuit men, could not relate to pan-Indian spirituality and often not to healers from a different cultural background.*

It is important to be aware of the potential of such intensely spiritual healing techniques to have adverse impacts such as the development of a psychiatric disorder, suicidal thoughts and suicide attempts.



Youth Initiative Project

Participants and staff of the Youth Initiative Project (YIP) were interviewed about the program (Adelson and Lipinski 2008; Vukic, Gregory et al. 2011).

The context

The Youth Initiative Project was established by the Aboriginal community in response to a series of suicides of young people. The project aimed to 'provide youth at risk with opportunities for self development in the areas of self esteem, responsibility, respect, and empowerment to develop personal, social, mental and physical well-being that is so needed to combat the destructive effects of unresolved traumas originating primarily from the Legacy of Residential Schools and its Intergenerational Impacts'. (Adelson and Lipinski 2008, p. 10)

The community, located in a rural setting near a city and close to a small town, has a population of 2,000. There are three convenience stores, a petrol station, a school, a church a health centre, a recreation centre, a restaurant and the band office. The YIP was initially housed at the school; however, in 2002 it moved to a new building reserved solely for young people. The building is large and has a computer room, a games room (with widescreen TV, ping-pong, computer games and a pool table) and space to hold dances and presentations. Outside there is a park for skateboarding, biking and rollerblading.

Program description

The YIP is open to young people aged between 10 and 19 years. All the young people grew up in the community, although some were preparing to leave to attend college or university. All were fluent in the local Aboriginal language and in English. Most had experienced their parents or other adults close to them drinking heavily and taking drugs. They had also often been the victims of physical, sexual and/or emotional abuse or had witnessed other being severely abused. Many were heavy users of alcohol and other drugs. There was a consensus that the reserve was a difficult place to live. However although some young people wanted to leave and never come back, most said they wanted to stay and raise their own children on the reserve. The reasons for wanting to stay included being able to speak their language and practice their culture and the fact that they were fearful of losing these things if they left – they are very proud of who they are and their culture: 'because it made me strong, I want my kids to know the Native ways and the language' (Adelson and Lipinski 2008, p. 18).

The project provides a safe, neutral space, services, activities and staff specifically for the young people. It is seen within the community as offering young people a place to go other than the street and therefore having the potential to help them stay away from drugs and alcohol, to see that there are other, better things in life that they can aspire to.

YIP staffs include elders, healers, counsellors, managers and youth workers. The elders from the local community are frequent visitors to the YIP centre, attending specific activities, talking with and teaching the young people. All of the Aboriginal staff were members of the local tribe and fluent in the local Aboriginal language as well as English. Most grew up in the community and were thus familiar with local histories and current issues. Many had experience of violence and abuse and had been heavy users of alcohol and/or drugs as young people. They felt that this was an advantage when it came to helping their young clients. In contrast, the non-Aboriginal counsellors were not from the community, lived off the reserve and did not speak the local language but were fluent in English and French. None of these counsellors had histories of trauma and abuse or substance misuse.

The Aboriginal healers and Western therapists all spoke of the high levels of stress associated with working with the troubled young people:

'it's really hard work and very easy to get burned out. I don't think I would have been able to cope if I didn't have my healing too'. (Adelson and Lipinski 2008, p. 27. Quoting an Aboriginal Healer)

Many consult a psychologist or participate in talking circles to deal with the stress.

The people interviewed (staff and young people) believed that healers should be sober and undertaking their own healing journey. They should be empathetic and understanding, otherwise the young people would not want to attend. They should be trustworthy (confidentiality is a major issue in a small community). They should be good listeners and communicators and be easygoing and approachable. These qualities applied to both the Aboriginal and Western healers. The qualifications felt

to be important for Aboriginal staff were having received their knowledge, wisdom and teachings passed down through the generations, from the elders to the young people. On the other hand it was felt that Western therapists should have a degree.

Healing approach

The staff and clients of the YIP view the healing program as being a uniquely Aboriginal approach to healing, even though Western therapies are used and there are Western therapists working with the program. Healing is seen to be a lifelong process that is active and involves finding a balance between the good and the bad things in one's life. Aboriginal healing was seen to be more based in spirituality than Western ways. The point is made that traditional healing takes time. The Aboriginal healers were of the view that for true healing to occur the community had to heal, not just individuals:

'true healing needs to come from the community itself. If it doesn't heal itself it will constantly breed sickness ... we need to stop blaming ... need to take control of our own lives'. (Adelson and Lipinski 2008, p. 29)

Healing is central to all the activities of the youth centre, albeit largely indirectly, as it is believed that the young people would be more reluctant to participate if the healing aspects were more overt. The activities are geared towards building self-esteem and confidence. The programs are educational, recreational and spiritual. The young people are divided into two age groups for activities – 10 to 13 and 14 to 19. Some activities are for young women and young men together while others have separate groups for young women and young men.

The YIP offers both Aboriginal and Western healing. The traditional Aboriginal healing includes talking circles, sweat lodges, smudging, drumming, traditional crafts and dancing. The participation of elders is a key to the healing, and they come to the centre to talk with the young people, with storytelling and walks through country identifying native plants and discussing their uses.

Western counsellors offer one-on-one sessions and also group sessions covering problems at school and at home, peer pressure, anger management, and sexual abuse.

Outcomes – successes and failures

Young people who attended the YIP were interviewed about their lives (Adelson and Lipinski 2008). Most said they felt as if they were on the right track. They felt that overall both the Aboriginal and the Western healing were effective and helpful to them, even though some preferred the Aboriginal healing and others the Western healing. A young man who preferred Aboriginal healing explained it in this way:

'a healer uses natural things, he prays, he talks about the creator and smudges with you, while a therapist just uses big words'. (Adelson and Lipinski 2008, p. 25)

Those who preferred the Western healers (therapists) felt that the therapists were more educated and thus could 'fix the problem'. Another reason why some young people preferred the therapists was that they lived off the reserve, didn't know everyone's business and were not likely to talk about their clients to community members.

Impact

The suicides and attempted suicides in this community stopped with this and other interventions, including a week of mourning; community members going away to do courses in suicide intervention and prevention and returning to train others including teachers and police; a youth crisis line; and community awareness programs (McFarlane 1997).

An issue of concern about the YIP was that many of the young people, especially those in the older (14–19) age group were not participating in the activities offered. It was felt that more community members, families and parents should become involved in the program. Many in the community saw the program as a means of keeping young people off the street and away from drugs, which is one of the roles; however, the other, deeper aspects of the program were not necessarily clear to the community members.

Youth Initiative Project: lessons learnt

Target group: Young people living on a remote reservation that had experienced a high rate of youth suicide.

Healing: Program based on providing a safe space for young people. Uses a combination of traditional and Western methods delivered by local Aboriginal people and non-Aboriginal Western counsellors.

Key tools: Youth activities organised by youth workers. Traditional methods (talking circles, sweat lodges, smudging, drumming, traditional crafts and dancing). Elders talk with the young people and have storytelling sessions and walks through country identifying native plants and discussing their uses. Counsellors offer one-on-one and group sessions.

Impact: Suicides and attempted suicides ceased. Some concerns that older youth are not participating and families are not involved. Healing takes time.

Building a Nation healing program

Waldram et al. (2008) interviewed therapists and clients about their experiences of the program and what healing meant to them.

The context

The Building a Nation healing program (BAN) is located in a storefront near the centre of a large city. It occupies two floors of the building and has several counselling offices and large meeting rooms for group therapy and traditional Aboriginal ceremonial activities. BAN provides clinical counselling and psychotherapy services and fellowship for the residents of the central city. It has two waiting rooms – inner and outer – so that people who do not participate in the therapy/healing can nevertheless have a cup of coffee and chat with others. There is the smell of sweat grass on entering the reception area. The atmosphere is usually calm, unless there is a crisis or someone is angry and/or intoxicated. Community feasts are held at the BAN premises as part of outreach to the community.

Program description

BAN aims to provide direct crisis intervention and lifestyle support for survivors of the residential schools and their family members and descendants, including non-Aboriginal people, in order to restore the sense of trust, strength, pride and honour taken away by the residential schools. BAN is about assisting people to live good lives as part of a family and community. There are services available for women, children, men and couples. All are welcome at BAN; however, in practice most of the clients are Aboriginal and most of the Aboriginal clients are Cree. Cree is the most common Aboriginal language spoken by the clients, and several of the staff are of Cree heritage.

Clients come from diverse backgrounds and the majority are disconnected from their Aboriginal culture, having been separated from their families and communities during childhood. Clients who spent more time with their communities growing up have retained more of their language and culture. The problems experienced by BAN clients are related to having been abused and neglected as children and sometimes as adults. Others are trying to recover from the abuse and trauma experienced while at residential school. Alcohol and drug misuse and sexual abuse are common among clients. Many BAN clients are totally alienated from their families and communities and present with multiple problems – emotional, social and spiritual.

The staff of BAN are Aboriginal and non-Aboriginal men and women. All staff have undertaken the medicine wheel training (see 'Healing modalities'). There is a traditional Aboriginal healer who performs traditional ceremonies and counselling. Aboriginal crisis intervention counsellors do crisis intervention work. A registered counselling psychologist and a certified mental health therapist also work at BAN. Many of the BAN staff have had similar life experiences to their clients. BAN does not have an elder on the staff but brings elders in to speak with clients and also for ceremonies. BAN has difficulty finding and keeping elders in the urban environment as they often move to their home country.

BAN therapists will see their clients wherever and whenever needed. This, together with the nature of the problems their clients face, places a great deal of stress on the therapists. There is a weekly debriefing circle for BAN staff and all BAN services are available to staff. Staff under stress may see a co-worker for counselling. Others use the medicine wheel to determine the locus of their stress and take steps to diminish this. They may have their own elder to consult and they also take part in Aboriginal healing activities, including smudging, sweats, use of sweet grass, and prayer.

Healing modalities

The therapy programs include both Western and traditional Aboriginal methods.

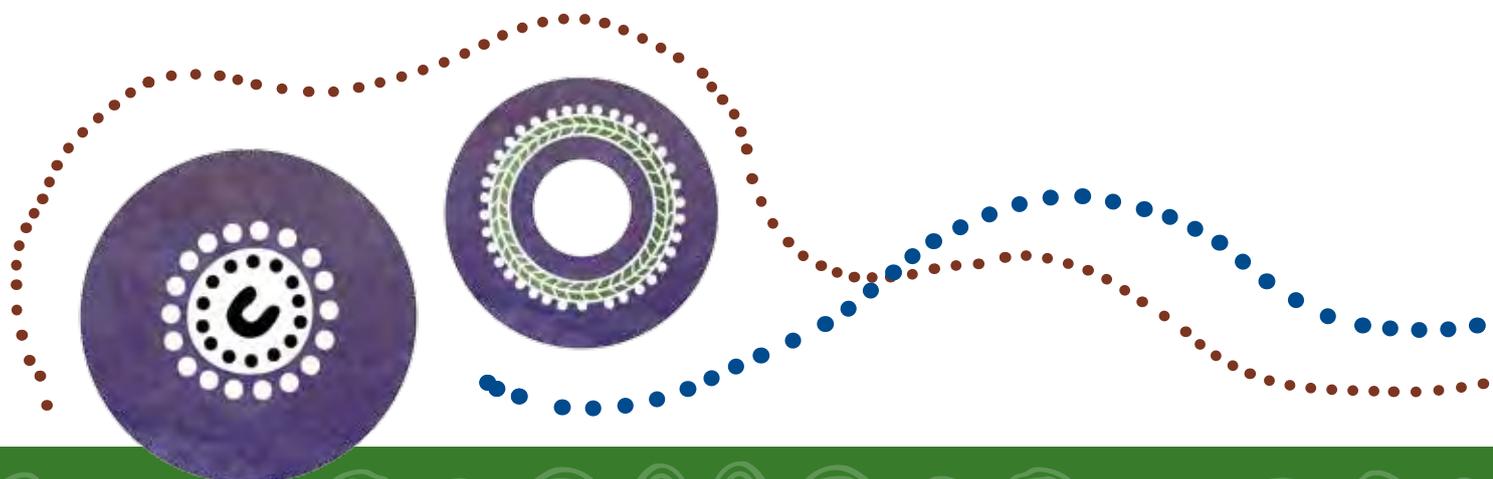
The overall healing approach of BAN is perceived by the staff and the clients as being Aboriginal, and in fact the medicine wheel informs all healing activities. However, in practice it is eclectic, the medicine wheel being used to integrate the mix of Aboriginal and Western methods. Individual and group therapy is practiced. Groups take the form of healing, talking and sacred circles. Therapy for couples and families is offered and there is an Aboriginal parenting program. Healing is not seen as time limited but as lifelong, developmental and never complete.

The medicine wheel (the Cree medicine wheel is used because most of the clients and some staff are Cree; however, other medicine wheels are acknowledged and clients can choose to use another version) is used conceptually and visually to help clients understand how to lead a balanced lifestyle. Using the medicine wheel model means that clients must focus on individual responsibility for change. The four directions of the medicine wheel – north, south, east and west – broadly represent the physical, the spiritual, the social and the emotional aspects of life with respect to the individual and connectedness to family and community. The medicine wheel model links childhood experiences with adult behaviours and is used by BAN therapists to explain the connection between current behaviour – for example alcohol misuse – and childhood experiences such as growing up in the residential school.

The use of the medicine wheel in all healing activities means that there are not many other therapists, Aboriginal or non-Aboriginal, with whom the BAN therapists can work easily, as other therapists tend to have a Western model as the basis of their work. However, BAN does liaise with other services, including drug and alcohol services, child protection services, legal services, and social services.

Impact

While there is no formal evaluation as such, the use of the medicine wheel allows therapists to follow the progress or otherwise of their clients, who often visit the BAN centre with their families or a new partner, or come in to talk about their jobs. Furthermore, clients usually return if things are not going well for assistance to deal with new or recurrent difficulties. When clients do not return, therapists assume they have failed.



Building a Nation program: lessons learnt

Target group: *Urban-dwelling Aboriginal people who were survivors or family members of survivors of residential schools and had multiple problems; most had been abused sexually, emotionally or physically.*

Healing: *All healing methods used have the medicine wheel as their basis (all staff are trained in its use). Aboriginal and non-Aboriginal staff deliver Western-style and traditional healing programs.*

Key tools: *Medicine wheel. Staff make themselves available when their clients need them.*

Impact: *BAN therapists keep in touch with their clients. Only a few clients do not keep in touch and these are considered to be failures by the staff. Staff undertake their own healing because of the high stress levels in their work.*

A Nunavut case study – healing in an Inuit community

Fletcher and Denham (2008) conducted a study of an AHF-funded healing project in an Inuit community. This community and its healing programs differ from the others we have considered here in many respects, which are discussed below.

The context

The Inuit underwent rapid, intense social and political changes during the 1950s in moving from Inuit political and cultural autonomy to incorporation into Canada. Although this brought benefits, there were many negative impacts leading to a high degree of social suffering. Under the influence of the Canadian state the Inuit were forced to give up their own principles and practices of social organisation and adopt those supported by the state. As a result, in less than a generation their housing style, mobility, subsistence, reproduction, child-rearing, practices, political structure and familial authority have been profoundly impacted. The resulting powerlessness, disenfranchisement and cultural diminution have resulted in much trauma, with attendant spiritual, emotional, physical and behavioural impacts. The Nunavut community healing program addresses these issues, linking the collective, often subtle experiences with the overt violent experiences of individuals.

The community is a relatively large remote Inuit settlement. Family is central to all things, with elders being very influential. Food, goods and cash are circulated through sharing networks. Of the 52 per cent of the community who are employed the majority work in jobs categorised as 'arts, culture, recreation and sport'. The population is young. Ninety-two per cent of people have Inuit as their first language and are fluent. In many First Nations communities English has become the language of interaction. However, in this Inuit community Inuktitut is the language used in everyday life in communication and social interaction. Thus the Inuit show cultural continuity and are living their traditions, with language being an indicator of identity.

Unlike those of the First Nations, Inuit tradition is not found in ceremonies or texts but in the way the people live their lives; in the landscape; in the social organisation, which encompasses everyone; and within the language. There is cultural continuity in social, cultural family and intellectual life in Inuit communities – there has not been an absolute break. The state is ever present through health, police and education services. The community is marked by high rates of suicide and interpersonal violence. The people suffer from multiple traumas, many ongoing.

Program description

A meeting of community members to discuss the impact of trauma on the community and in people's lives resulted in the expression of extreme pain and grief. This initial meeting caused people to organise a series of workshops facilitated by non-Inuit from the south. The people preferred active involvement in workshops, including role-play, rather than sitting and listening to 'lectures'. However, there were long gaps between workshops and it was recognised that workshop facilitators were needed from the local community. Thus people who had begun to understand and gain mastery over their experiences were brought into a healer role, although they neither referred to themselves nor were referred to as healers. The focus was on helping those who were suffering as a result of trauma and abuse verbalise their pain and speak publically about their own experiences.

The model of healing is called 'heal the healer'. There is no real distinction between clients and healers. Healers are undergoing their own healing journey. When people reach a certain stage in their healing such that they have begun to understand and gain mastery over their own experiences, they are brought into the healer role. People in need would approach others recognised for their ability to overcome and heal from similar experiences. They would then talk – usually spontaneously in one or the other's home or over the phone. This model is in keeping with normal Inuit social action characterised by gradual consensus building. Healing is for individuals, the community, women, teens, elders and men.

The healing model

The healing approach combines Inuit notions of selfhood and society with methods from Western psychology and popular psychology, and methods from First Nations healing. This embracing of techniques from other cultures is not new – Inuit have always been ready to borrow aspects of other cultures if they are beneficial to Inuit. (Fletcher and Denham 2008)

The healing model 'heal the healer' has developed gradually over time. Its goals are to work towards a balanced community; to work to heal from the effects of physical and sexual abuse in the residential schools, including intergenerational impacts; to develop individual self-knowledge and self-care skills; to foster health relationships within families and within the community; and to ease transitions for offenders from correctional facilities.

Healing activities include individual healing, community healing, workshops and training programs, community awareness programs, and healing gatherings held on the land at least once a year for targeted groups. Healing is seen as a journey, as ongoing. It is seen as an active process that has to be undertaken by the person seeking healing.

'I have to be careful about this healer thing or who does my healing. It has to be me; I have to take responsibility for me. Somebody might show me something or might say something that helps me to understand me, or make me see me. And then ... something might come clear to me that I need to make some changes in my life, but I' m the one who has to do it. Nobody can change my life, only me.' (Fletcher and Denham 2008, p. 102)

This, however, does not imply that healing is an individual process – healing is seen as occurring with the community and with family; it is not an isolated activity.

Impact

The community has taken ownership of this program, which has continued to grow. Other programs have been developed and operate alongside each other.

A healing in an Inuit community: lessons learnt

Target group: *Members of an Inuit community that has undergone rapid change in recent decades. Issues dealt with include sexual abuse and substance misuse.*

Healing: *Heal the healer model. Uses a combination of traditional and Western methods.*

Key tools: *The people of the community helping each other.*

Impact: *The community has taken ownership of this program, which continues to grow.*

New Zealand

New Zealand differs from Australia and North America in that, although there are a number of iwi (tribes) and hapu (subtribes) Māori identify as belonging to, there is one Māori language (albeit with regional variations) and Māori cultural practices across tribes and subtribes are more similar than different. Furthermore the incorporation of Māori models and practices alongside mainstream health services has been facilitated by the fact that the Treaty of Waitangi is a document of health that emphasises the principles of partnership, participation and active protection of Māori cultural treasures, including healing practices and knowledge. There is not such a diversity of Indigenous healing programs in New Zealand as in Australia and North America. Here we present Māori models of healing, health and wellbeing and describe Māori health and wellbeing services that illustrate the ways the models work in practice.

Māori models of healing, health and wellbeing

Since the mid-1970s, Māori have been emphasising the benefits of traditional health belief systems to health. Models representing contemporary Māori views of health have been developed. These include Te Whare Tapa Wha (Durie 1998), Te Wheke (Pere 1991) and Te Pae Mahutonga (Durie 1999). The first two emphasise the centrality of Whānau (family) and the interconnectedness of taha wairua (the spiritual), taha tinana (the physical) and taha hinengaro (the mind), all of which are essential to health and wellbeing.

In developing Te Pae Mahutonga, Durie (1999) has related the key elements of Te Ao Māori (the Māori world) to the maintenance of health and wellbeing through allegory. The four central stars of Te Pae Mahutonga (the Southern Cross) – Mauriora, Waiora, Toiora and Te Oranga – are said to describe four pillars of health promotion for Māori. Mauriora relates to the secure cultural identity of a person resulting in internal strength as a result of access to the Māori language, Māori knowledge, marae (the meeting place), the land and family. Waiora pertains to the environment. Toiora is to do with the minimisation of risk to health, which is enhanced or limited depending on access to the Māori world and factors pertaining to the ongoing impact of colonisation, such as poverty. Te Oranga depends on the ability to have full access to the society and its institutions, including health services, education, and employment opportunities. The two pointers Nga Manukura represent Māori leadership and self-determination respectively, both of which are essential to the attainment of Mauriora, Waiora, Toiora, and Te Oranga.

Māori models of health are used as a means of introducing Māori health concepts, values and perspectives into health and wellbeing services, especially in the area of mental health, the ultimate aim being that Māori and Western systems of health work side by side. Durie (2007 and 2010) is clear that Māori healing methods, values, and practices cannot and should not be assessed using a Western biomedical model as the two are based on separate systems of knowledge. Māori healing is based on tradition, and the remedies, techniques and knowledge, having stood the test of time, are accepted. Māori healers do sometimes incorporate new knowledge from other systems (for example Eastern massage techniques) but overall are guided by the traditions handed down from the ancestors. In contrast Western biomedicine is based on positivism and new knowledge is continually sought and verified, so that medical knowledge is always changing.

Māori health and wellbeing programs

Tohunga (Māori healers)

Māori healers today practice in both urban and rural settings. The methods they use include the use of medicines derived from plant materials (rongoa), massage (mirimiri and romiromi), prayer, incantations (karakia), water, suffusions and heat applications. These are combined with:

... ritual, interpretation of symbols and signs (such as dreams, prognostication and an understanding of human interaction including contact with the environment. (Durie 2009, p. 239)

In the first stage of healing the tohunga (traditional healer) makes a detailed assessment of the problem (tending to focus on breaches of protocol) and also focuses on the relationships within the family and the wider community. It is understood that the problem is related to a breakdown in relationships. Once the healer has formulated the problem the family is invited to comment and to be part of the healing process. The next stage usually involves karakia and then specific remedies are recommended.

Some Māori healers are now beginning to work with mainstream health services. This makes sense in terms of the Māori model of health discussed above, as Western medicine addresses the disease but most practitioners lack the skills to address the illness. Māori healers, on the other hand, are expert in addressing the cultural, spiritual and psychosocial dimensions of wellbeing (Jones 2000). However many Māori healers are reluctant to have a formal arrangement with health services. This is because they want to protect the integrity of their knowledge and their skills, which have been passed down through the generations. Thus Māori healers who see patients within hospitals usually do so on a private basis. It is important for Māori that they know the healer, and Māori usually prefer healers who come from their own tribe.

Whai Ora

In 1981, Māori mental health professionals from Tokanui psychiatric hospital developed a nine-part Māori framework to guide psychiatric nursing, and established a Māori cultural unit called Whai Ora (to foster, nurture and seek wellbeing) within Tokanui Hospital. The psychiatrist superintendent at the time was Māori, as were a psychiatrist in training and senior members of the nursing staff. The Whai Ora model incorporated taha wairua (spirituality), taha whānau (family), taha hinengaro (wellbeing), taha tinana (physiology), taha whenua (environment), taha tikanga (compliance), Māoritanga (old world), Pakehatanga (new world) and taha tangata (self) (Te Roopu Awhina o Tokanui, 1987).

Dr Jennifer Rankin (1986), a Māori psychiatric registrar at Tokanui during the establishment of Whai Ora, discusses the reasons for the establishment of the unit. These included the differences in presentation of Māori patients, which often impacted on the interaction between the patient and the non-Māori psychiatrist; the necessity of going beyond the needs of the individual and into Māori support networks and resources; the importance of one's taha Māori; and the disproportionately high number of Māori being admitted to psychiatric hospitals. She states:

'These problems apply to all of us. We are all in some way alienated. Māori culture has a structure to decrease this.' (Rankin 1986, p. 40)

Whai Ora was a group, a whānau (family) that consisted of the people in the wards, the patients and the staff. The Whai Ora family observed Māori cultural ways of doing things, protocols (kawa and tikanga). Te reo Māori (the Māori language) was spoken. At the beginning and end of each day the Whai Ora whānau gathered together for karakia (prayer).

Visitors were welcomed to the ward with a ceremony called a powhiri in the same way as visitors to the marae. So that people could get to know each other, speeches (in the Māori language) were made on both sides. This form of speechmaking is an art, and both patients and staff developed their expertise in this area. Once the speeches were finished, everyone from the visitors' side moved across to the home people's side and hongis (pressed noses with) the home people. This was followed by a cup of tea and food and then the business of the day was conducted.

A method of gathering patient information by the staff was developed that followed Māori protocol. In operating in this way, both staff and patients developed an increased pride in their cultural identity and increased cultural knowledge and skills, with resultant increased self-esteem.

Whai Ora was staffed by Māori psychiatrists and nurses but also incorporated conventional methods of treatment. A senior nurse describes the way the two systems of health, Māori and Western, worked side by side, using the example of a kaumātua (elder) admitted with depression. The kaumātua was prescribed medication and treated for his depression by the ward psychiatrist in the morning. In the afternoons he was visited by his tohunga (healer) and the two sat outside under the trees speaking in the Māori language, and having karakia (prayer and incantation) sessions (Coleborne, Graham et al. 2012).

Mason Durie has commented on the unique aspects of Whai Ora:

The distinctiveness arose from the observance of customary ceremonies to receive new patients and their families, the incorporation of spiritual encounters into patient management, the inclusion of families in aspects of treatment and the employment of tribal elders to oversee the cultural milieu. While western treatment methods, including standard pharmacological regimes were used, much emphasis was placed on relationship building and strengthening cultural identity. (Durie 2009, p. 246)

Māori mental health programs

There are now Māori mental health programs operating in most regions of New Zealand. It is well documented (Huriwai 2001) that Māori have poorer outcomes than others in terms of wellbeing following mental health treatment. It is also well documented that Māori have very different concepts of mental health (Bennett and McKendrick 2010) than that of psychiatry. Thus although there are differences in the way they operate, Māori mental health services have a common goal – to improve outcomes in terms of wellbeing for their mental health consumers through Māori cultural practices (Kingi 2005). A number are located within or attached to mainstream services, while others are more closely aligned with tribes (iwi). All, however, utilise both Māori and Western psychiatric methods.

The cultural interventions undertaken by Māori mental health services (and some mainstream services) include:

- ◆ cultural assessment
- ◆ powhiri (formal Māori welcome)
- ◆ employment of kaumātua or cultural advisors
- ◆ use of te reo Māori (the Māori language)
- ◆ whānau (family) participation
- ◆ Māori arts and crafts and leisure activities
- ◆ incorporation of kawa and tikanga in all aspects of the service's functioning.

Cultural assessment has been described by Mason Durie (1995) as 'the process through which the relevance of culture to mental health is ascertained', thus providing a basis for a better understanding of the patient and of the person's presentation from a cultural point of view.

Formal Māori welcome (powhiri) has been found to be therapeutic. Although the powhiri can be seen as a simple process of encounter or welcome, it can also have a profound effect on the tangata whaiora (person seeking wellbeing) and their whānau, putting them at ease in an often stressful situation. The powhiri is guided by the wish to establish a platform for ongoing care, for all involved to come to a common understanding, and to offer reassurance.

Kaumātua (elders) or cultural advisors provide support on issues of custom and protocol. However, they also have close connections to the community from which the tangata whaiora (person seeking wellness) comes and can often identify solutions to problems previously thought insoluble. They are also sometimes better able to engage with the tangata whaiora (person seeking wellness), creating an open dialogue allowing for a better understanding of the issues.

Te reo Māori (the Māori language) is important because tangata whaiora and their whānau are often more comfortable speaking in the Māori language, and using the language can offer broader and deeper understanding of the issues. Māori tend to reveal much more when speaking in te reo Māori (Kingi 2005).

Family (whānau) involvement is important because the family is the basic unit of Māori society and provides the basis for all cultural interactions. It is through family that cultural information and knowledge is transferred from one generation to the next. Whānau contribute to the process of attaining wellness through active participation in therapeutic activities.

Māori leisure pursuits such as flax weaving, painting, wood carving, taniko (fine weaving), kite making and flying, singing and playing musical instruments all contribute to attaining wellbeing.

Programs for Māori with problems associated with alcohol and drug use

Māori cultural programs for people with problems of substance misuse incorporate:

- ◆ customary Māori views of wellbeing as existing in the context of whānau (family) and hapu (subtribe)
- ◆ Māori descriptions of wellness, which include a sense of identity and self-esteem as Māori; confidence and pride; spiritual awareness; personal responsibility; and knowledge of Māori language and culture
- ◆ Māori processes, including the powhiri (the elements of the formal welcome); poutama (the steps of learning); and whānaungatanga (shared relationships and experiences, especially relating to family but also to groups coming together for other purposes (Huriwai 2001)).

Huriwai (2002) notes that Māori with alcohol and drug problems have been described as ‘detrribalized and deculturalised’. Cultural programs contribute to increased self-esteem and sense of identity through facilitating the relearning of skills and knowledge and through reconnection with family and tribal groups (which is in turn facilitated by the relearning process). In essence the Māori cultural programs are instilling Māori values and principles for living healthy and balanced lifestyles.

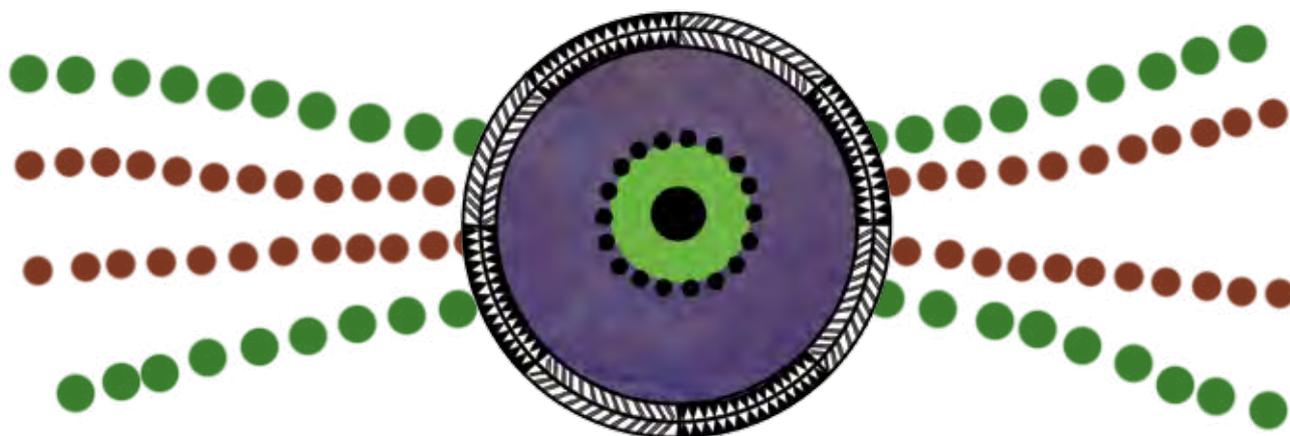
Māori healing: lessons learnt

Target group: *People experiencing psychological distress.*

Healing: *Programs based on Māori values and concepts, delivered by Māori for Māori. Western methods used at the same time, delivered by Māori practitioners where possible.*

Key tools: *Kaumātua; Māori ceremony; Māori language; all activities conducted according to Māori values, concepts and processes; family; Māori activities (e.g. weaving, wood carving).*

Impact: *Improved outcomes for Māori with psychological distress.*



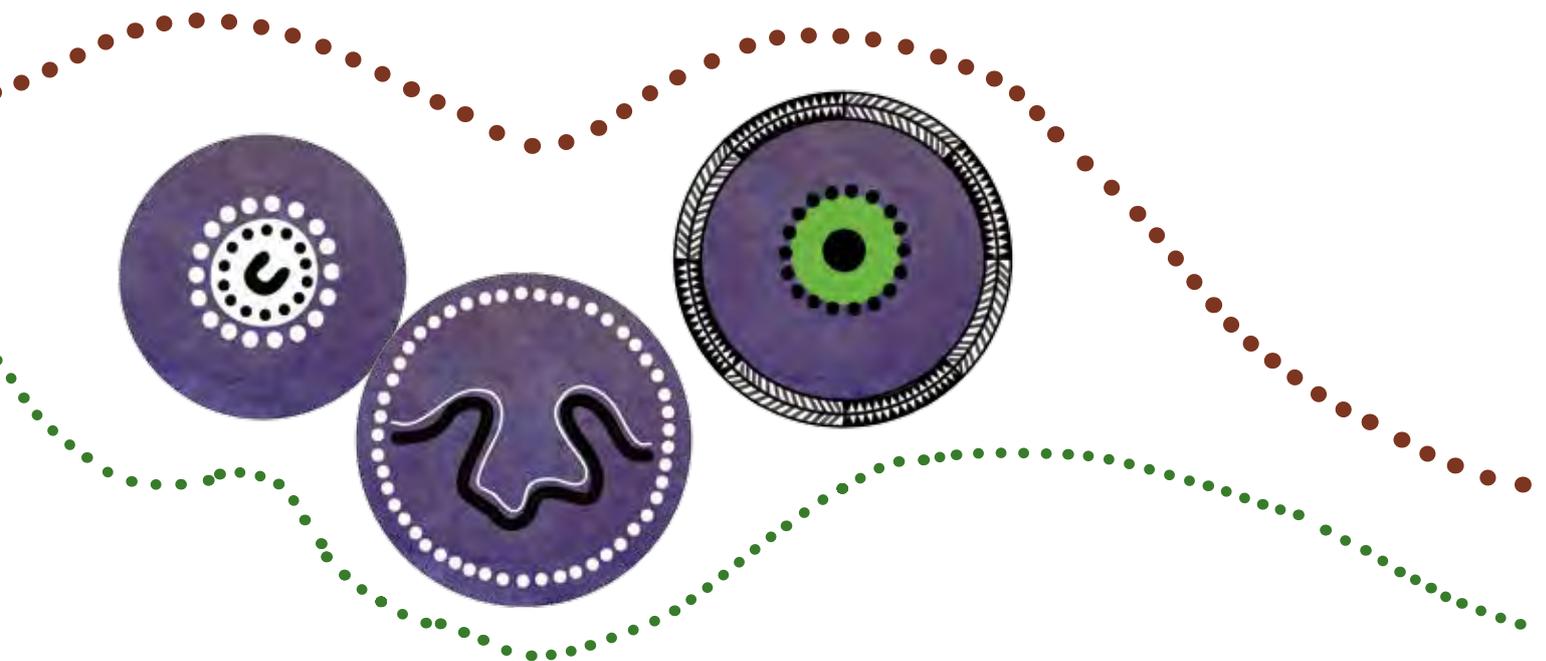
Conclusions

There are similarities and differences between the Indigenous healing programs in Canada, the United States and New Zealand. The similarities are:

- ◆ All draw on elements of their Indigenous cultures – including the underpinning values and concepts, traditional Indigenous healing practices and the essence of what it means to live a ‘good’ life – in order to help people in their healing journey to move towards wellbeing.
- ◆ All prefer to conduct the healing / wellbeing / path to wellness activities in groups, not as individuals.
- ◆ The issues/problems people experience are not seen as being only within themselves (although each person must take responsibility for their own healing journey) but are also related to history, life experiences and the sociopolitical context.
- ◆ Increased cultural identity, self-esteem, cultural knowledge and skills, and cultural connectedness are seen as being very important to being able to move towards wellbeing.
- ◆ It is important that the programs are delivered by people from the same culture as oneself.

The differences relate mainly to cultural factors, the sociopolitical context, and geographical factors. The Indigenous peoples of Canada and the United States are very diverse; their lands cover regions that differ markedly from each other, from the subarctic regions to the Pacific and from the east to the west coast of the continent. Consequently there are many different languages and cultures among the first peoples of the United States and Canada. New Zealand, on the other hand, is an island nation with a relatively small area.

Although there is diversity among Māori, there is a common language and cultural differences between tribes are small. Thus there is not as much diversity among the wellbeing/wellness programs for Māori. New Zealand also has the Treaty of Waitangi, which both protects Māori knowledge, culture and treasures (the waterways, the land, the forests, health) and makes New Zealand a bicultural country where the Māori language is an official language. Thus Māori wellbeing programs are often situated within or alongside mainstream services, although some are closer to tribal and subtribal entities. The programs we have reviewed from the United States and Canada were more likely than those from New Zealand to be associated with tribal groups and communities.



CHAPTER THREE: ASSESSMENT/EVALUATION OF INDIGENOUS HEALING PROGRAMS

Introduction

The assessment or evaluation of Indigenous healing programs is a contentious issue. Most healing programs use a combination of traditional healing techniques and methods drawn from Western therapies, modified to suit Indigenous needs (Gone 2011). Traditional Indigenous healing and Western therapies are drawn from two different knowledge systems that run in parallel to each other. Sir Mason Durie, eminent Māori psychiatrist, has said:

(Indigenous peoples have) a way of thinking within which health and illness are conceptualised as products of relationships – between individuals and wider social circles and between people and the natural world ... the search for knowledge, especially in connection with the human condition requires an outward flow of energy ... (whereas) for the most part modern psychiatric practice has promoted diagnostic and therapeutic methods where answers are sought within the individual. (Durie 2009, p. 241)

Other Indigenous practitioners trained in Western methods warn against adopting only the methods of assessment/evaluation of Western biomedicine:

When it comes to testing the effectiveness of a new therapy or counseling intervention, it is crucial that the testing process include research methods and ways of knowing that characterize the diverse populations that will ultimately become the recipients of such helping services. (Duran, Firehammer et al. 2008, p. 293)

While it is true that most healing programs adopt some Western methods, the focus of healing programs is very much directed towards the spiritual, which is ignored in most Western therapies (Durie 2009). Gone (2008, 2011) in his examination of a Canadian First Nations healing program that addresses substance abuse noted that the Western therapies employed in that program were chosen for their spiritual aspects and actually incorporated into an Aboriginal world view:

Effective treatment in general was understood to require a 'spiritual program' ... (counsellors) engaged in the incorporation of Aboriginal approaches and practices into their more conventional treatment approaches, effectively institutionalizing several of these. (Gone 2011, p. 193).

Box 3.1: Indigenous systems of health and illness

- *Indigenous people think about health and illness in terms of relationships between individuals and the wider society and between people and the environment.*
- *Healing requires examination of the person in relation to their environment (spiritual, social, cultural, physical) in contrast to Western medicine, which seeks answers within the individual.*
- *Thus an understanding of Indigenous healing methods needs to be grounded in Indigenous knowledge.*

In our search of the black and the grey literature we have not found any evaluation of an Indigenous healing program that used a clinical trial methodology (comparing the program with another evaluated program or a placebo intervention). Other authors (Wallerstein 2006; Wallerstein and Duran 2006; Gone 2012) comment on the lack of such evaluation methods, which is evident not only for Indigenous healing programs but also for health promotion programs for women, young people, and other at-risk populations. Among the issues affecting the evaluation of such programs and their impact on health and wellbeing are the fact that programs need to be developed to suit local contexts and are not strictly comparable, the relatively long period of time required for evidence of improved health and wellbeing to be exhibited, and the fact that many Indigenous practitioners and communities do not accept that such methods of evaluation are required (Wallerstein 2006; Duran, Firehammer et al. 2008; Gone 2012).

In this chapter we examine the evaluation/assessment of Indigenous healing programs, drawing on the international and local literature. We conclude with a discussion of the main issues and outline a method for assessing the Indigenous healing programs reported on in the literature.

Theoretical aspects of the assessment of healing

Terminology

In discussing the assessment of healing it is important to be sure what we are talking about, and so we begin with some definitions. Henderson (2009) is an American Indian physician. He distinguishes between traditional medicine and complementary and alternative medicine:

Traditional medicine is a collective term used to describe the systems of medicine and healing that were developed before scientific medicine, largely by Indigenous peoples, and are still in use today the traditional medicine system derives from language, behaviours and beliefs of the people with whom the system is associated Complementary and alternative therapies have been created more recently and generally by individuals or small groups of clinicians or scientists often in opposition to western medicine. (Henderson 2009, p. 15)

Box 3.2: Definitions

- **Traditional medicine** – systems of medicine developed by Indigenous peoples before biomedicine and alternative medicine and based on Indigenous knowledge and world views.
- **Healing** – psychosocial process of repair in the social, spiritual, cultural and affective dimensions. Patient is an active participant. Ongoing process.
- **Cure** – the removal of disease. Patient is usually passive. Time limited.

Tradition and healing are central to Indigenous efforts to overcome the injustices and social suffering resulting from colonisation. Kirmayer and colleagues (2003) view healing traditions as a metaphor with several potential meanings:

- ◆ The recovery and application of traditional methods of healing embedded in spiritual and subsistence activities that serve to integrate the community and provide meaning to make sense of suffering.
- ◆ The recovery of traditions that have been actively suppressed by ongoing colonisation can be seen as healing. For example, the recovery of language is seen by Indigenous peoples as a healing process.
- ◆ The land and the activities that traditionally took place on the land, including hunting and fishing, were and remain associated with Indigenous spiritual practices. Thus making claim to traditional lands with the ultimate purpose of return to those lands may be viewed as crucial elements of healing. The mental health problems experienced by Indigenous people are socially derived and thus require social solutions. Psychiatric and mental health interventions must operate together with traditional healing and focus not on the individual but on family and community. There is evidence that individual identity and self-esteem draw strength from collective identity (Kirmayer, Simpson et al. 2003).

Waldram (2000) points out that in assessing the efficacy of any system of medicine it is important to distinguish between curing and healing. Curing refers to the removal of the pathological process, the removal of disease, while:

Healing refers to a broader psychosocial process of repairing the affective, social and spiritual dimensions of ill health or illness. (Waldram 2000, p. 604).

In Western medicine the patient or client is often relatively passive, the cure being something that is done by the doctor; it is also time limited, having a start and an end point. However, in traditional systems of medicine the patient or client is an active participant in the process of healing. Healing is said to be a lifelong process that never ends (Waldram 2008).

Efficacy and its assessment

Efficacy, another concept crucial to understanding the assessment/evaluation of healing programs, is an elusive concept. Efficacy is judged against the ability to achieve goals, which vary widely according to context. The definition of efficacy raises epistemological, ethical, and aesthetic questions. Success can occur at different levels:

- ◆ the level of the individual (change in behaviour, better quality of life, restoration of harmony of the soul)
- ◆ community level (restoration of social harmony, restoration of harmony of the soul)
- ◆ in the cosmos (affirmation, restoration of harmony) (Kirmayer 2004).

In addressing the issue of efficacy, it is also necessary to take into account the cultural diversity of healing, although diverse practices and forms of healing have common concerns – to alleviate suffering, decrease disability and prolong life. Kirmayer (2004) divides healing into the physiological processes of biomedicine and the symbolic aspects of traditional systems, which have psychological, spiritual and social effects. In this model traditional healing uses ‘the metaphoric logic of transformation processing, wholeness, balance and wellbeing’ (Kirmayer 2004, p. 39).

Waldram (2000) is clear that biomedical theory and research techniques – the clinical trial – are not suited to examining the efficacy of traditional medicine because the different systems are based on totally different epistemologies. This means that if healing programs are assessed using biomedical techniques they will usually be shown not to be efficacious, which is not necessarily true: ‘Scientific inquiry often leads to biomedical artefacts masquerading as facts’ (Waldram 2000, p. 619).

Gone and Alcantara (2007) found that mental health treatment outcomes have not been empirically assessed or reported for American Indian or Alaska Native people suffering debilitating psychological distress. Despite being advocates of evidence-based clinical practice they are sceptical that approaches based on randomised clinical trials (RCT) are appropriate for the assessment of outcomes of Native American mental health service delivery. The first issue they raise is that the context of the RCT is artificial and unlike the actual clinical interaction that occurs in ‘real world’ service delivery, and so the RCT is not measuring what occurs in clinical practice, raising serious issues of external validity.

It has been suggested that in order to address such limitations of RCT a 'local clinical science' is required that does not depend on 'nomothetic outcome evidence' (Stricker and Trierweiler 1995). There is also concern that while the RCT is the gold standard for the evaluation of pharmacological therapies in medicine, it is not valid when extended to psychotherapeutic interventions. It has been found that it is the nature of the therapeutic relationship, not the particular therapeutic technique, that accounts for therapeutic change in psychotherapy (Norcross 2002).

Gone and Alcantara conclude that:

... the complexities of cause and effect in the context of psychotherapeutic interventions remain irreducible to overly simplistic technique to disorder outcomes. (Gone and Alcantara 2007, p. 361).

The final argument from Gone and Alcantara (2007) for caution when applying RCT to determine the efficacy of outcomes in mental health for American Indians and Alaska Natives is the fact that for most Native communities the status of American Indian mental health is bound closely to history, culture, identity, spirituality and the devastating impact of colonisation. The Indigenous people themselves do not see the solution as being mental health services (which many refuse to use) but a return to sacred tradition and practice (see also Kirmayer et al., 2003).

In a more recent paper Gone (2012) returns to the assessment of efficacy in treatment, this time in relation to substance abuse treatment. He points out that many Native people actively dismiss the need for scientific inquiry in the assessment of efficacy, with 'culture as treatment' meaning the results of our methods are self-evident and scientific methods will not add anything. The key here is the difference between Indigenous traditional knowledge (ITK) and Western knowledge. ITK is said to be personal and experiential (it does not involve general and abstract truth claims about the world, which Western knowledge does), holistic, and narratively conveyed. ITK is characterised by collective analysis and consensus rather than direct contradiction and argument:

eye witness accounts based on experience are privileged over abstract and second hand [and] individuals are expected to formulate their own interpretations of the narrated experiences of others, experience being valued over words or the words being valued as constellations of experience'. (Gone 2012, p. 494)

In terms of assessment of efficacy there is total epistemic divergence between ITK, which holds that 'inferences based on personal experience may be all that recommends a given treatment in terms of its purported efficacy' (Gone 2012, p. 495), and Western science, which equally strongly holds the view that 'inferences based on personal experience are utterly inadequate for discerning cause-and-effect relationships between interventions and outcomes' (Gone 2012, p. 495).

The focus on traditional knowledge has been challenged in the anthropological and psychological literature (Weibel-Orlando 1989; Brady 1995a; Brady 1995b) on the basis that evidence of efficacy is lacking; however, so too has Western knowledge. A review of 49 highly cited intervention studies in medicine (Ioannidis 2005) found that the original positive findings from RCT are more likely to be attenuated or overturned on replication, especially if the original samples were small (range of subjects 403 to 1,500), which would make a fair test outcome for Indigenous communities where population numbers are small unlikely. Gone (2012) recommends pluralism as the best way to negotiate epistemic divergence between ITK and Western knowledge, quoting Durie:

... Indigenous knowledge cannot be verified by scientific criteria nor can science be adequately assessed according to the tenets of Indigenous knowledge. (Durie 2004, p. 1138)

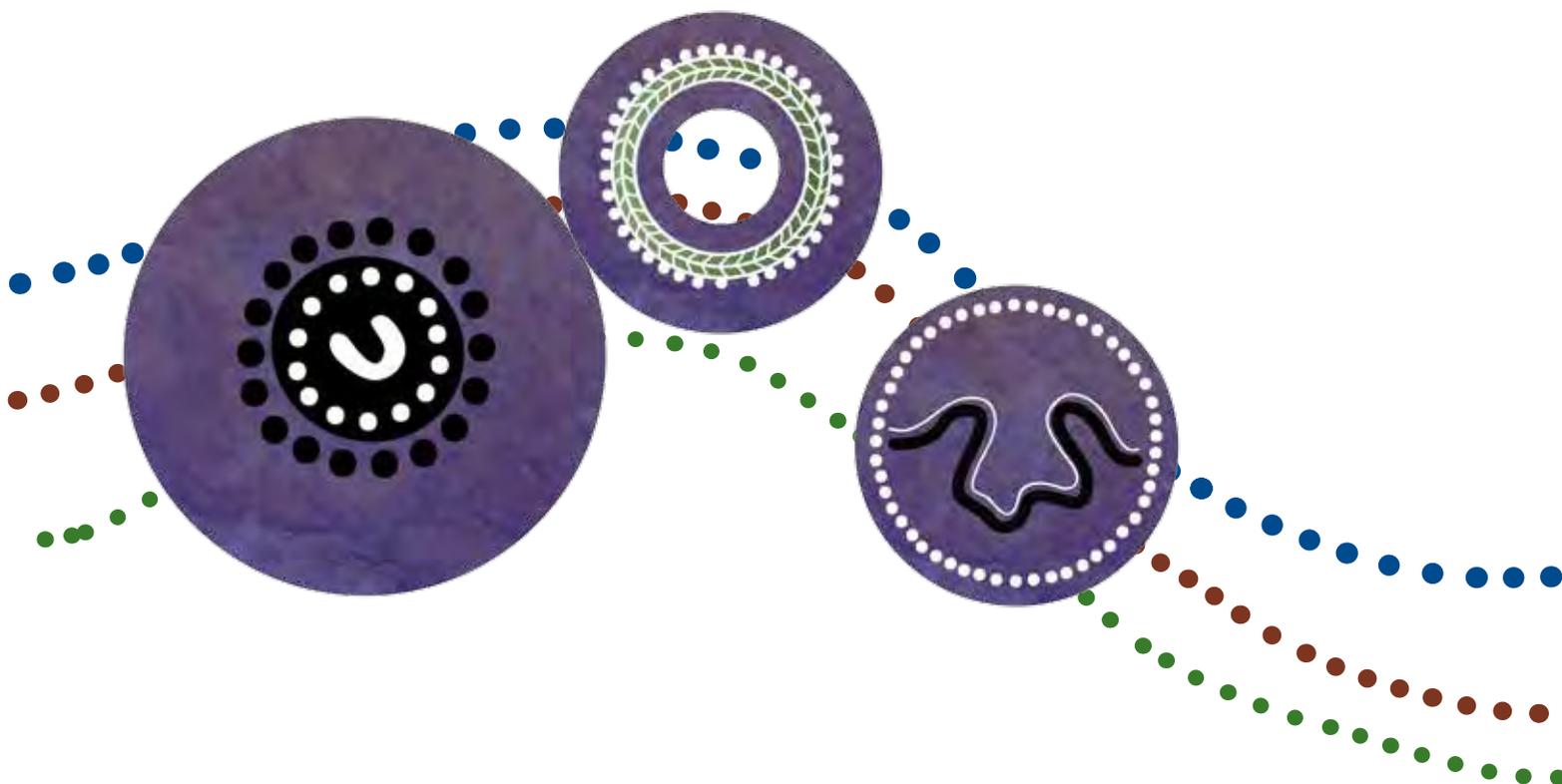
Waldram (2000) asks the question 'How is efficacy understood in traditional healing systems themselves?', which is similar to asking what efficacy means to the community running the healing program.

Box 3.3: Efficacy

Efficacy is an elusive concept because:

- *healing practices are diverse*
- *the goals of healing are diverse*
- *clients have diverse reasons for seeking healing*
- *success can occur at different levels – individual, community, environment, cosmos*
- *healing is ongoing and long term by nature.*

Gone (2012) believes there needs to be a dialogue between scientific knowing and ITK that occurs initially between those with the knowledge. Wallerstein and Duran (2006) and Macaulay (2003) are of the view that the Indigenous communities in which the healing program is being run should develop evaluation/assessment strategies based on their needs. They advocate the use of community-based participatory action research (CBPAR) in which community members and academics work together (see below). Wallerstein (2006) shows that multilevel CBPAR research shows that empowerment programs have positive impacts on long-term health status and decrease in health disparities, but that research methods that examine specific outcomes need to be developed.



Box 3.4: Important characteristics of an effective healing program

- *Is based on local culture and values*
- *Recognises the ongoing impacts of colonisation, including transgenerational trauma and grief, and examines local and family history of such*
- *Provides community empowerment*
- *Acknowledges diversity*
- *Is based on the principles of social justice and human rights*
- *Has an evidence or theory base*
- *Responds to needs identified by the local community*
- *Is supported by the local community*
- *Involves elders*
- *Builds individual, family and community capacity through knowledge and skills acquisition*
- *Provides training, peer support and mentoring*
- *Provides a safe place for healing to occur*
- *Incorporates spirituality*
- *Is flexible*
- *Is proactive rather than reactive to specific incidents*
- *Provides networks within and external to the community*
- *Is sustainable, having sufficient long-term resources*
- *Incorporates ongoing reflective evaluation from the beginning*
- *Has the aim of 'researching ourselves back to life'*

Characteristics of effective healing programs

The characteristics that many effective healing programs have in common are documented in the literature pertaining to evaluations of healing programs, and general reviews of healing programs. These characteristics should be borne in mind when developing or assessing a healing program and in the evaluation of healing programs. The Assembly of First Nations (1997) outlines the key factors that a successful Indigenous healing program should incorporate. The program should be tradition and values based. The focus should be on the entire family, and the drawing together of individuals and families within the tribal community. All therapists should have an intimate knowledge of the tribal community and its cultural traditions so that links are made between spirituality and therapy. Healing projects should respond to needs identified by communities. The healing project should be supported by community members. The skills needed to establish and conduct a healing program need to be present within the community, and the healing program should be integrated with other community services and use holistic strategies.

A review of programs that aim to reduce suicide among Australian Aboriginal and Torres Strait Islander peoples (Krysinska, Martin et al. 2009) notes the importance of healing models being specific to regions and groups. The principles of good practice for healing programs are identified as:

1. Community empowerment (where empowerment is described as: 'a social action process by which individuals, communities and organizations gain control and mastery over their lives in the context of changing their social and political environment to improve equity and quality of life' (Krysinska, Martin et al. 2009, p. 860).
2. The recognition of human rights, transgenerational trauma, loss and grief.
3. The development of individual, family and community, social and emotional wellbeing.
4. Acknowledgement and recognition of the diversity of Aboriginal and Torres Strait Islander people and the importance of the local context.
5. Direct involvement of community members and the development of a local workforce.
6. Ensuring program sustainability and organisational capability.
7. An evidence or theory base for the program.
8. Appropriate program evaluation (participatory action research (PAR) is recommended, where PAR is 'a systematic methodology for studying social action processes. It is based on continuous cooperation between researchers, practitioners and clients and invests in the recruitment, training and support of the main change agents with ongoing improvement as the goal' (Krysinska, Martin et al. 2009, p. 860).
9. The aim of 'researching ourselves back to life'.

A review of violence prevention programs for Australian Aboriginal peoples (Memmott, Chambers et al. 2006) found the key elements of good practice to be cultural and community grounding of projects; ensuring elders were involved; engaging men in the projects; individual capacity building (increasing self-esteem and self-empowerment); the examination of intergenerational family history and colonial experience as a feature of healing; group approaches rather than individual; community capacity building and capacity building through networks and partnerships; collecting information and disseminating the information; skills acquisition; and flexibility and adaptability of projects. Factors mitigating against success of projects included inadequate resourcing; inadequate support; inadequate training and support for staff (staff can suffer burnout and can be vulnerable to violence themselves from clients); being reactive to violent incidents rather than proactive in violence prevention; lack of sectoral partnerships and lack of local level coordination; and fragmentation between state and Commonwealth governments with respect to the goals of the program.

An Australian research group comments on the proliferation and diversity of groups for Indigenous men (McCalman, Tsey et al. 2006) and notes there is evidence that programs that aim to enable Indigenous people to take charge of their own lives and those that result in enhanced sense of self-worth, resilience, problem-solving techniques and increased hope for the future do have an impact in terms of wellbeing and also in the prevention of crime. Where the underlying historical, social and economic issues involve return to country and have strong spiritual components, benefits have been shown for individuals and communities in the long term (10 to 15 years). However, if a program is to have ongoing benefits funding, resourcing and support are required.

Cripps (2007) discusses the difficulties and constraints Australian Aboriginal and Torres Strait Islander communities face when developing their own healing programs. She then outlines ways in which these could be overcome to facilitate the development of healing programs and offers an eight-step framework for the development of effective programs:

1. Acknowledgement of family and kinship relations
2. Definition of the problem to be addressed
3. Community leadership in initiating and sustaining the program
4. Assessment of the capacity of the community to respond to the specific problem being addressed
5. Development of responsive projects in consultation with the community
6. Negotiation of partnerships and development of strategic plans
7. Implementation in partnership with the community
8. Evaluation of the response.

These are similar to the factors required for the success of a community-based healing or preventative program as described by Macaulay (2003) and Wallerstein and Duran (2006).

Macaulay et al. (2003) stress the importance of incorporating local social and cultural processes into decision-making and the development of healing strategies. They also warn against using only health outcomes in assessment/evaluation because this may mask the important but more sensitive positive program impacts. Macaulay et al. (2003) and Wallerstein and Duran (2006) believe that it is important that communities identify their own indicators of success and examine them using participatory evaluation methods. They believe that such an approach will lead to evaluation methods that will have a good fit with the community and will be able to identify early and intermediate successful outcomes, which may be missed if biomedical methods are used or health outcomes are the indicators. They note some indicators of success, including sustainability, empowerment, self-efficacy, participation and the reach of the program (that is, its ability to engage community members across the board), increases in knowledge and attitude changes.

Macaulay and her colleagues (2003) and Salsberg et al. (2004) also note the importance of having the appropriate skills and resources within a community to efficacy in healing programs.

Methods, processes and principles of evaluation

Participatory action research incorporating local Aboriginal ways of knowing (ITK)

The Hollow Water Community Holistic Circle Healing (CHCH) for the victims and perpetrators of crimes, especially sexual abuse but also other crimes, is one of the longest standing and most successful Indigenous healing programs. The CHCH is situated in the remote Anishnabe (Ojibwe) village of Hollow Water in Manitoba. The healing program was established in 1984 at a time when the community and its people were at a very low point in terms of health and wellbeing. Today the health and wellbeing of both the community and the people have improved considerably.

Couture and his colleagues (2001) conducted an evaluation of the Hollow Water program. The process and the method were developed with sensitivity to Aboriginal ways of knowing and ways of being and to the highly charged nature of the problems the victimisers and victims of sexual abuse bring. A participatory action research approach was used incorporating the knowledge and expertise of the CHCH, the community workers, the community members and the researchers, thus maximising the involvement of the community and resulting in benefits to the community as well as producing new knowledge. Couture and his team (2001) point out that involvement of the wider community in the project also broadens the perspectives and interpretations, improves the credibility of the oral and written results, and guards against inadvertent stigmatisation of the community by the researchers.

In developing the protocol the researchers were aware of the need to make the participants in the research feel safe to share their experiences. Thus relationships were built with the community through observance of the rituals of the community, including those related to entry to the community, permission to undertake the research, and the development of relationships that would allow the research data to be collected (knowledge taken from the community) – but also benefits to the community such as information, the development of expertise, and new opportunities to be left with the community when the research was completed. Relationships were built through four days of opening circles:

These free flowing discussions were aimed at developing trust, understanding workers needs, interests, sensitivities, cultural and community issues, as well as issues surrounding CHCH work. Weaknesses and strengths of previous evaluation studies were openly discussed as they voluntarily arose ... as were surfacing issues such as interviewing fatigue or saturation experienced by CHCH workers (who are usually in demand from various people studying and researching them). (Couture, Parker et al. 2001, p. 4)

Qualitative data was collected through interviews, group discussions (formal and informal), participation in meetings, ceremonies and the day-to-day life of the CHCH team. Questionnaires aimed at determining the 'dynamics underlying the healing activity and the criteria by which local success can be and is gauged' (Couture, Parker et al. 2001, p. 5) were also completed. CHCH staff, community members in general and community leaders, as well as victims and victimisers, participated in the research.

Key elements of the CHCH healing program are:

- ◆ meeting the needs of the person, which requires confronting the repercussions of individual difficulty upon family and community members;
- ◆ Anishnabe tradition, from which emerge the insights, skills, and approaches for effective intervention, enabling helpers/healers to advance the healing of a damaged People;
- ◆ being/becoming an Anishnabe, that includes an expanding awareness of, and sustained commitment to, living a way of life that profoundly recognizes the equality of all life-forms, and the inter-connectedness of human beings who are persons-in-family-in-community. (Couture, Parker et al. 2001, p. 12)

Community-based participatory research

Wallerstein and Duran (2006) believe the use of a community-based participatory research (CBPR) model is important in the development and ongoing functioning of an effective healing program. They define CBPR as follows:

... a collaborative approach to research, (CBPR) equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities. (Minkler and Wallerstein 2003, p. 4)

CBPR focuses on the interrelationships between the partners in the research project – the community partners and the partners from academia – and uses multiple methods, usually qualitative but also quantitative. It is not merely a vehicle for community outreach:

CBPR ... represents a systematic effort to incorporate community participation and decision making, local theories of etiology and change, and community practices into the research effort. (Wallerstein and Duran 2006, p. 313)

Box 3.5: Key principles of community-based participatory research

1. *Genuine partnership between community and academic partners so that each learns from the other.*
2. *Community capacity building that includes knowledge transfer and skills acquisition.*
3. *All partners commit to long-term involvement.*
(Wallerstein and Duran 2006)

Capacity building, lateral transfer of knowledge and readiness to implement a healing program

The interrelationships between capacity building and readiness and intercommunity knowledge translation in participatory action research (PAR) were examined in the context of three First Nations communities in Canada (Salsberg, Louttit et al. 2004). Two of the communities had longstanding primary prevention programs for type 2 diabetes established through PAR. The communities were in control of the programs and worked in partnership with researchers and clinicians from local academic institutions. The third community wanted to establish its own type 2 diabetes primary prevention project.

Box 3.6: Community capacity

→ *Capacity – objective and environmental*

→ *Objective capacity involves community members having the*

- *skills*
- *tools*
- *knowledge*

to develop and institute a healing program

→ *Environmental capacity – the infrastructures and environments needed to maintain objective capacity are in place*

Capacity is described as having objective and environmental components. In building objective capacity, the community members gain skills, tools and knowledge to address health and social issues. Building environmental capacity ensures the infrastructures and environments required to support objective capacity are fostered and maintained.

Community readiness has both internal community factors, especially the degree of mobilisation, and external factors that enable the success of a program within a community. It was concluded that a community that is ready to address a public health issue has both external and internal capacity and readiness. External support came from other communities, federal funding or interventions, research funding, academic institutions and researchers, graduate students interested in working with the community, networking with national and international organisations. Internal support and community-based readiness included a well-developed health delivery system, interested and committed community leadership, and skilled and well-supported community researchers.

Lateral transfer of knowledge from the two established community prevention projects to the third community so that they could establish their own prevention project was found to involve a number of important factors (Box 3.7).

Box 3.7: Lateral transfer of knowledge

- *Culturally acceptable messengers*
- *The researchers learned from the community through focus group discussions*
- *Workshop-style delivery of knowledge*
- *Members of the third community participated in the collection of data required to plan and establish the program*
- *Ongoing dialogue of all partners (in this case achieved through writing a paper for publication)*
- *External support*

Longitudinal research and evaluation

Another key element of research and evaluation is taking a long-term view of healing, as indicated in the understanding of healing as a lifelong process. Tsey and his colleagues (2007) describe a 10-year evaluation of the Family Wellbeing Program (FWB) using participatory action research (PAR). The FWB program in Alice Springs received long-term funding and FWB programs were commenced in three rural Aboriginal communities in Queensland with funding for several years. This allowed longitudinal evaluation, and modification of the program based on the evaluation. The programs were judged to be successful based on their ability to

... help individuals, their families and communities to move on from the distress, chaos and barriers of the past to taking greater control and responsibility for issues such as violence and abuse, suicide and incarceration. (Tsey, Wilson et al. 2007, p. 564)

Box 3.8: Keys to success of a PAR process

- *Strength focus*
- *Solutions come from within (individual, family, community)*
- *Researched area is determined by the community*
- *Long-term mutually trusting relationship between the community and the external researchers*
- *Evaluation approach is clear to the community*
- *Evidence base is established to support long-term funding*

(Tsey, Wilson et al. 2007)

Use of mixed methods (qualitative and quantitative)

The Northern Adelaide Family Violence Prevention Program was evaluated after six months and 24 months (Kowanko and Power 2008; Kowanko, Stewart et al. 2009). The project aimed to address issues of family violence within the local community. The evaluators (from the academy) worked with the leaders of the programs to develop an evaluation strategy. A combined qualitative and quantitative methodology was used, with interviews with project participants and staff and examination of project records for qualitative data. At six months the project was evaluated against the funding objectives and found to be achieving these. The two-year evaluation adopted a participatory action research approach. Program clients reported increased self-esteem, confidence and cultural connection. They felt they had gained the skills and knowledge to move away from a life of violence towards healing and that their own experiences had a positive impact on their family and friends.

Local researchers and feedback processes

Poelina and Pedrisat (2004) evaluated a project for adolescents focused on the prevention of family violence in a remote region of Australia. The team used mixed qualitative methods and engaged Aboriginal researchers to conduct the study. Participant observation was used in community and organisational activity, in formal and informal interviews and in attendance at meetings related to the project. Information was collected using case study methodology to describe the various organisations and elements of the project. A film was made to show the community the impact of the project. In conducting the evaluation the team ensured the evaluation was meaningful for the local community; promoted social justice and equity and advocacy; and enhanced and empowered the participants.

The evaluation showed that the adolescents who took part in the program understood the reasons against violence and were committed to preventing violence in their lives. However the project was also shown to have wider positive impact, increasing the capacity and skills within the community and the programs in the community and also enhancing the lives of people throughout the community, not just the adolescents who were the participants. The project was characterised by a close working relationship between the community involved and outside agencies and by being embraced by most of the community.

Box 3.9: Beyond the individual

Healing programs judged to be successful are shown to have had a positive impact on individuals participating in the program, who in turn have had a positive impact on those in their families and immediate social circle and beyond that to the wider community

A range of methods

The medical anthropologists and clinicians who conducted assessments of Canadian healing programs funded by the Aboriginal Healing Foundation (Adelson and Lipinski 2008; Fiske 2008; Gone 2008; Waldram, Innes et al. 2008; Gone 2011) used interviews and group discussions with staff and clients of the programs and participant observation to assess program efficacy. They recommend that the following be developed to assist in the evaluation of healing programs (Box 3.10):

Box 3.10: Recommendations for evaluation

- *A range of definitions of efficacy*
- *A range of methodological approaches*
- *Sensitive measures of efficacy, as subjective attitudinal and behavioural changes (noticed by individuals and those around them) are subtle and occur over time and would not be detected by the relatively coarse clinical measures of efficacy available*
- *New approaches to the evaluation of efficacy*

Discussion

Kirmayer has said that healing programs using traditional and modified Western therapeutic approaches do not necessarily result in 'the grand sweep of healing transformation' but 'small turns of thought and feeling' (Kirmayer 1993a, p. 176).

This is clearly illustrated by the papers reviewed in this chapter where the measures of success are at individual, family and community levels and include empowerment; increases in self-esteem and feelings of self-worth; increased efficacy; increased subjective feelings of wellbeing; community ownership of and ongoing participation in programs; the attainment of long-term funding and the development of internal and external resources. Other programs have seen decreases in community violence, decreases in recidivism and decreases in incarceration.

The theorists and practitioners (researchers and clinicians) agree that current clinical and biomedical methods are not appropriate for the evaluation of community-based healing programs, and this is supported by the literature pertaining to community-based primary prevention programs. The most common method used in the evaluations of healing programs is participatory action research, which values the knowledge systems of the community in which the program is conducted. Various qualitative methods are used in the evaluations; however, in a few cases quantitative data was also collected, still under the auspices of PAR. Unfortunately rejection of the biomedical model and its case control type studies of efficacy raises some issues around acceptance of the findings of the PAR evaluations. Despite their widespread use over the past 10 to 20 years these methods are still not fully accepted by biomedicine, and the findings of evaluations may be rejected by elements of the medical profession and others. This has implications in terms of funding and resources because the practitioners of biomedicine have great power and influence:

'Thus in the postmodern state biomedicine has come to serve a major political mission ... (it) has outstripped its own professional autonomy and become inseparable from the state'. (Kleinman 1995, p. 216)

These power inequities, most clearly seen in the active suppression of traditional Indigenous practices since colonisation, are the main reason why there has not to date been a pluralistic approach to the development of research methodologies to assess the efficacy of Indigenous healing programs. Many of the authors cited in this review acknowledge the necessity of developing new methods to assess efficacy that encompass both ITK and Western scientific and biomedical knowledge (Kirmayer 2004; Wallerstein 2006; Gone 2007; Durie 2009; Gone 2012). However, with current Western methods unsuitable for the task of assessing the efficacy of Indigenous healing (Durie 2004; Wallerstein and Duran 2006; Gone 2007; Duran, Firehammer et al. 2008; Gone 2012), the process of community-based participatory action research (CBPAR), although not accepted as sufficiently rigorous by biomedical researchers, has revealed positive aspects of Indigenous healing programs.

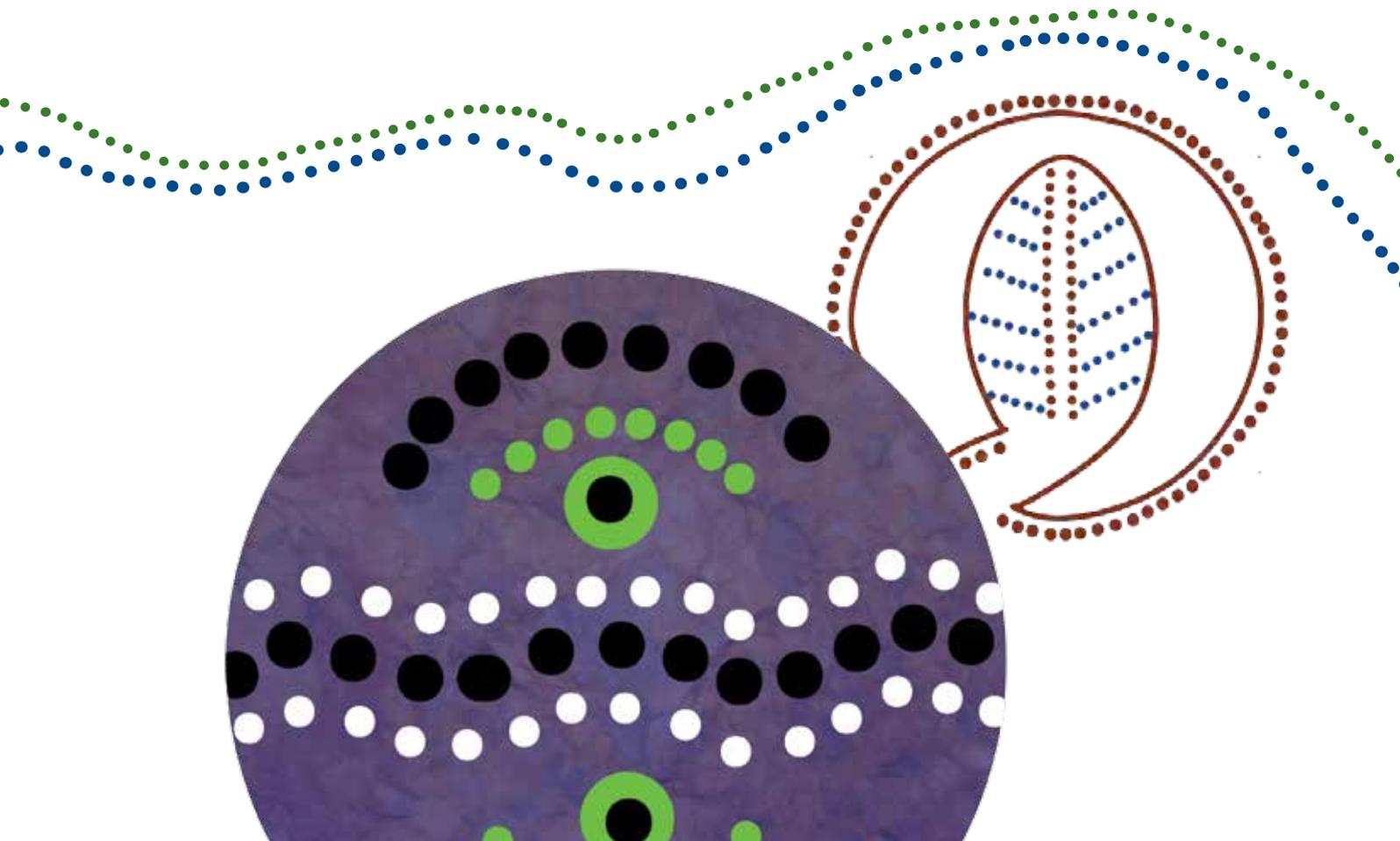
These positive findings from the evaluations of healing programs are remarkably consistent across programs, tribal groups and countries, making them difficult to reject. Similarly the factors found to be associated with successful healing programs (and primary intervention programs) are similarly consistent across contexts. The consistency of the findings across time, space and cultural and academic context allows the development of a method for the evaluation of healing projects reported in the black and grey literature. However, there is still a need for ongoing development of new methods for the assessment of the efficacy of healing programs.

Conclusion

To assess the Aboriginal and Torres Strait Islander healing programs we examined the way the healing program was established, the key elements of the program and the evaluation of the project.

The literature reveals that to be successful a healing program needs to be created within or modified for use in the local context, respond to needs identified by local community members and be supported by the local community. It needs to be sustainable, with interconnected internal and external networks, and have sufficient objective and environmental capacity and sufficient long-term resources. These in turn depend on there being a strong evidence base for the efficacy of the healing program. Programs that are developed and run using CBPAR by definition have evaluation built in from the beginning of the process.

The elements of a successful Indigenous healing program include, in addition to the above, incorporation of spirituality through local cultural practices and values; aims to empower individuals, families and communities through various mechanisms, including increased self-esteem, sense of identity, good relationships and problem solving; incorporation of knowledge and skills development; provision of a safe place for healing to occur; provision of peer support, training and mentoring for healing program workers; and impacts beyond those on the individual to include the family, the community and their interaction with wider systems.



CHAPTER FOUR: ABORIGINAL AND TORRES STRAIT ISLANDER HEALING PROGRAMS

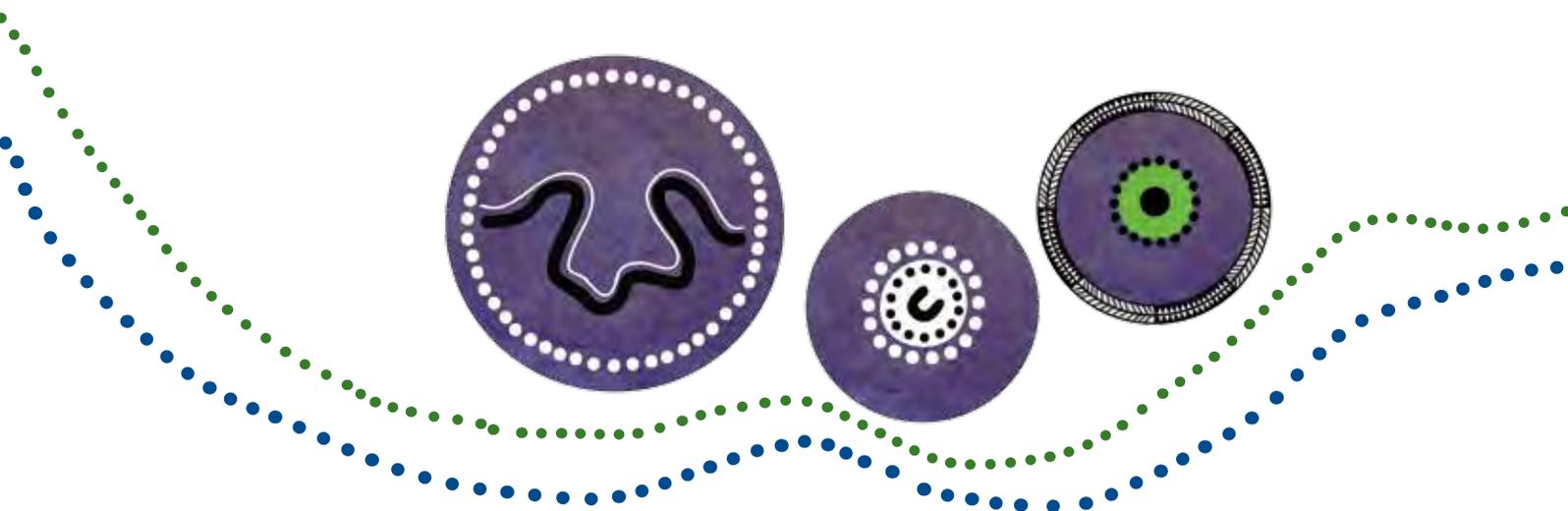
Introduction

In conducting this review of the literature we have found that only a few of the many healing programs for Aboriginal people are well documented in the black or the grey literature¹, and even fewer have been systematically evaluated. In this chapter we describe and present the available evidence for the efficacy of those programs that have been evaluated to some extent. There is not enough information to make a judgment about the efficacy of many healing programs that are not well documented; however, these are briefly described in Appendix 2. Some programs were considered to present a risk to people taking part. These were programs that were isolated in terms of access to health and social services, provided little back-up support for participants or staff, and had only a few staff with little training or experience. This information is also available in Appendix 2. Perhaps not surprisingly, the healing programs for which the most useful information is available are those where the host community works in partnership with an academic institution.

Table 4.1 sets out the characteristics of the healing programs selected for discussion in this chapter as models of good practice. The criteria were developed through detailed examination of the national and international literature on the evaluation of healing programs and community-based health promotion programs (see previous chapter). The programs listed are the few that meet a reasonable number of the criteria. Programs with fewer indicators of good practice are briefly described in Appendix 2².

We have included the projects funded under the auspices of the social and emotional wellbeing (SEWB) programs of the Office of Aboriginal and Torres Strait Island Health (OATSIH). These programs have not been well evaluated; however, they are included as they form the largest group of healing programs for Aboriginal people. They encompass the Bringing Them Home counsellors, the Link Up program, clinical SEWB services operating through Aboriginal community controlled health services, and the regional centres for social and emotional wellbeing.

The social and emotional wellbeing programs not discussed are not included because, in our opinion, there is inadequate information to assess whether they fulfil the criteria for good practice. The SEWB program itself avoids the 'good practice debate' by identifying programs said to be examples of 'promising practice' (Wilczynski, Reed-Gilbert et al. 2007)³.



- 1 Black literature is that published in peer-reviewed journals. This means that the work is examined by others knowledgeable in the area of work and often improved substantially by the time it is published. This provides additional confidence that the work is of good quality. Grey literature does not have a formal peer review process, and thus confidence in the work presented is lower.
- 2 It is noted that these criteria do not contain a clinical trial. This is where the program is tested against either a placebo or another program of known efficacy. This is the criterion required for programs in non-Indigenous health. Further it is noted that no healing program meets this standard or has attempted to meet this standard, for the reasons explained in the previous chapter. New methods are required to assess the efficacy of Indigenous healing programs.
- 3 Programs can only remain 'promising' for a short period. 'Promising' indicates that they have some evidence – just not yet enough. After that they should establish evidence of efficacy or not, and consequently be continued, ceased or modified depending on the evidence. Thus it is incumbent upon the social and emotional wellbeing programs to develop the evidence base shortly or cease functioning, as a lack of supportive evidence suggests the programs are at best harmless, not beneficial.

Table 4.1: Characteristics of programs selected for description

Program	Local context and address local needs	Local social and cultural processes, values and spirituality	Supported by the community	PAR-type evaluation from start	Environmental and objective capacity	Sustainable?	Empower, participate, self-efficacy, inclusive, knowledge transfer
Family wellbeing	Yes	Yes	Yes	Yes	Yes	Yes	Yes
We Al-Li	Yes	Yes			Yes	Yes	Yes
Men's groups	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adelaide family wellbeing	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ngangkari	Yes	Yes	Yes		Yes	Yes	Yes
Deadly Vibe	Yes		Yes	Yes	Yes	Yes	Yes
Marumali	Yes	Yes			Yes	Yes	Yes

Description of the healing programs

Central Northern Adelaide Health Service Family and Community Healing

Family and Community Healing (FCH) is a healing program for Aboriginal families and the local Aboriginal community run through the Central Northern Adelaide Health Service (CNAHS) (Kowanko and Power 2008; Kowanko, Stewart et al. 2009). Established in 2006, the program aims to develop effective responses to family violence and is built around community engagement. FCH aims to engage women, men and youth and targets three main strategic areas: social and emotional wellbeing, substance misuse, and diabetes. Programs aimed at community, family and individuals are run for each strategic area and align with regional health plans and priorities. FCH has internal linkages within the CNAHS and external linkages with other agencies. The objectives of FCH are:

1. To build community capacity to support safe families
2. To equip Aboriginal people with effective skills for communication and conflict resolution
3. To support families in crisis
4. To build the capacity of mainstream agencies and services within the region to address Aboriginal family violence issues in the community context
5. Workforce development
6. To collect data about the FCH program and to evaluate the program (Kowanko and Power 2008).

The CNAHS was contracted through the federal government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) to establish and run the FCH program, which is an integral part of South Australia's Regional Aboriginal Health Plan, developed from the work of the South Australian Aboriginal Health Partnership (Kowanko, Stewart et al. 2009).

The program was evaluated at six months and two years after establishment by a team from Flinders University invited to do so by the CNAHS. The description of FCH presented here is drawn from these evaluations, which are documented in the black (Kowanko, Stewart et al. 2009) and grey (Kowanko and Power 2008) literature. Table 4.3 summarises FCH projects (Kowanko, Stewart et al. 2009).

Evaluation

FCH was formally evaluated by a team consisting of two external evaluators from Flinders University and two Aboriginal co-evaluators chosen by the FCH team. The Aboriginal co-evaluators had been clients of FCH. The method chosen (by the evaluators in collaboration with the FCH team) for the evaluation was participatory action research using both qualitative and quantitative techniques. The evaluation began six months after the program was established, and finished at the two-year point.

A strength of the evaluation is that it was not retrospective but followed the course of the program as it developed. In the initial stages of the evaluation the FCH projects were mapped (see Table 4.3). Although it is a prospective study, a limit was commencing the evaluation six months after the program started. Data was collected through individual interviews (22 in total) and focus group discussions (with 27 staff and 19 clients); participation in a number of FCH activities, including men's and women's groups; and examination of the FCH records.

It was established that both clients and workers had 'journeys' through the program. Workers experienced many of the same issues as their clients in their own lives and with their families; however, their experiences or journeys were fundamentally different due to their different roles in the program. The client's journey and the worker's journey are compared in Table 4.2, which is drawn from the findings of the evaluation:

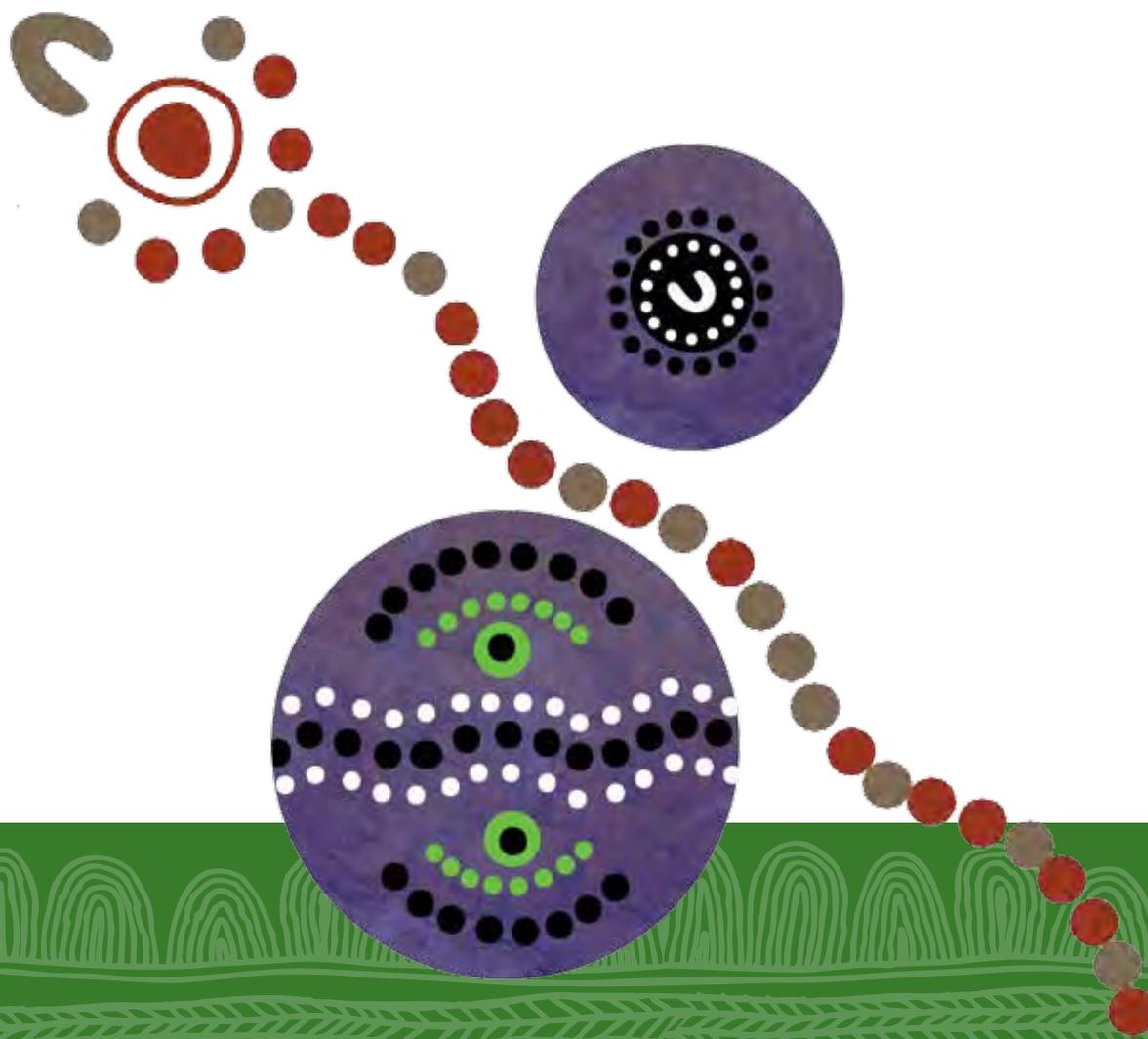


Table 4.2: Comparing the client and worker journey in the FCH program

Experience	Client journey	Worker journey
Care and support	Assessment after crisis	Team building
	Participation in program	Self-care
	Individual counselling	
	Access to clinical services	
	Access to ongoing integrated care with continuity	
	Support while accessing outside services	
Healing and personal development	Empowerment	Holistic versus Western
	Peer support and friendship	Challenge of delivering FCH in a primary health care setting
	Reduction in social and cultural isolation	Challenge of integrating Aboriginal community health services into mainstream
	Wellbeing and healing	
	Becoming a role model	Gaining cultural respect
	Reconnection with family and culture	Working with clients no other agency wants to work with
	Valuing existing survival skills	
New knowledge and skills	New skills	Formal and informal education
	Increased knowledge of own history and culture	Working on making interagency collaboration work
	Employment or further education	Managing organisational restructuring
		Managing changing funding models
Negative	May experience racism in interaction with mainstream services	Concerns about ongoing funding
		Living in two worlds resulting in conflict with oneself

Source: Kowanko, Stewart et al (2009).

The FCH program was evaluated on the basis of its objectives (see above). The objectives were found to have been achieved, although with variable success.

Objective 1 (to build community capacity to support safe families) was achieved with a great deal of success. A large number of diverse programs for young people, women, men and the community were highly valued by both the workers and the program clients. The benefits to program clients – including increased self-esteem, confidence and cultural connection – equip them

with skills and knowledge to move out of a life of violence⁴ and on to a journey of healing, and were found to have flow-on effects to family members and peers of the clients. The key program elements leading to success were determined to be:

- ◆ peer support and mentoring
- ◆ cultural focus
- ◆ long-term commitment
- ◆ intersectoral linkages
- ◆ sharing information
- ◆ holistic approach
- ◆ organisational support
- ◆ adequate resources.

The clients of FCH successfully developed communication and conflict resolution skills (Objective 2) through their participation in groups and counselling sessions. Essential elements in the development of these skills were peer support, learning to trust within the safety of the groups, role modelling, respectful communication and formal and informal learning.

FCH was found to provide effective support for families in crisis (Objective 3) using both formal arrangements with services and the informal connections of FCH staff. Both were felt to be essential. FCH built many relationships with a range of services for the purposes of referrals, sharing resources and follow-up. These linkages were also essential for the success of the program overall (Objective 4).

Informal on-the-job learning was the most common workforce development for the staff of the FCH program (Objective 5). Some workers already had qualifications, while others undertook courses. Peer support and mentoring by experienced staff and community elders were identified as the most effective forms of learning. However, ongoing funding and institutional support were the main concerns of the workers. Limited quantitative data was available for the program at the time of this evaluation (Objective 6).

The difficulties faced by the FCH program included that it:

- ◆ operated a large number of programs from three primary care sites with a relatively small staff (usually 25, mostly women, with men working solely with men's programs)
- ◆ had a high turnover of staff
- ◆ worked with the regional state plan – while this had some advantages, the disadvantages were that there was ongoing restructuring with changing responsibilities and changing funding formulae
- ◆ did not have ongoing funding guaranteed.

The evaluators and the FCH team managers together made the following recommendations aimed at overcoming these difficulties:

- ◆ The FCH program should continue and expand.
- ◆ The Aboriginal health teams should be adequately resourced to deal with complex health and social issues and manage crises.
- ◆ Systemic data collection and information management protocols should be introduced.
- ◆ There should be sustainable funding.
- ◆ Ongoing organisational support is required.

The last two recommendations are beyond the control of the FCH team and need to be addressed at the highest level.

.....
 4 The program did not measure the levels of violence – only some of the potential precursors to violence. This is a major limit to determining its effectiveness in creating safe families. Accurately measuring violence is very difficult in many circumstances; hence it is understandable that this has not occurred. However, it is still a limitation of the findings.

Table 4.3: FCH program projects and partnerships

Work with women	Work with young people	Work with community	Work with men
Women's healing group	Leadership and wellbeing in schools	Community peer support initiatives	Men's group
Structured 8-week group program	Kids connecting with community	Nunga nutrition luncheons (coincide with weekly Nunga clinic)	Bush Mechanic
Women's shelter	School Expo events		Peer support
Individual counselling (brief intervention)	Young people's drop-in centre (computers)	Clinic services – adult and child health assessments	Boystown
Boystown			Licence for Life
Women's wellness camps	Young Nungas Yarning		
Nunga Women U R Special	Holiday program	Lifestyle/living skills	Young Nungas Yarning
Weekly art group with peer-led talking circles		Mini conferences: Family Violence, Life Improvement Plan	Kinship program
PLANNED ACTIVITIES	PLANNED ACTIVITIES	PLANNED ACTIVITIES	PLANNED ACTIVITIES
Peer support across all areas	DECS: interagency initiative to go into schools with big Aboriginal enrolments		
Women's group activities – trips, excursions			
PARTNERSHIPS	PARTNERSHIPS	PARTNERSHIPS	PARTNERSHIPS
Kura Yerlo, Kurruru	DECS Families SA		Nunkuwarrin Yunti of SA – bridge between Aboriginal and mainstream health services and between primary health care and acute care services
Families SA: Strong Families, Safe Babies Women's health	ADAC		Men's Aboriginal Youth and Family Support
Nunga Childsplay	Young women's and young men's dance groups		Disability SA, Aboriginal Unit
Disability SA	MAYF		
Aboriginal Family Support Services	TWIG (young Aboriginal mums outreach group)		DECS: Aboriginal Western Districts Unit

Deadly Vibe

Aboriginal students are the most educationally disadvantaged in Australia. They are less likely than non-Aboriginal students to achieve adequate academic standards, more likely to not attend school, more likely to not finish high school, less likely to pursue university education and less likely to find employment on leaving school. Aboriginal students have also been shown to have poor sense of self-esteem and self-concept, be less healthy and be more likely to misuse substances (Purdie, Ellis et al. 2006). *Deadly Vibe* is a magazine for Indigenous school students (primary and secondary) that aims to counter this disadvantage using a range of techniques.

The magazine, which is published monthly, features high-profile Aboriginal people (from music, the arts, sports, education and entertainment) as well as people who are working at the ground level to improve the lives of people and their communities and to promote Aboriginal culture. *Deadly Vibe* covers a range of issues including health and nutrition, education and career opportunities, legal aid, Aboriginal culture, and sport. It promotes regular school attendance, the completion of secondary schooling and the advantages of ongoing education and training. Competitions and worksheets are used to develop literacy, numeracy and internet skills as well as engage the students. The magazine caters for a wide range of reading skills.

Evaluation

In 2004, Vibe Australia (an Aboriginal media, communications and events agency) contracted the Australian Council for Educational Research (ACER) to conduct an evaluation of *Deadly Vibe* magazine (Purdie, Ellis et al. 2006). The evaluation examined the effect of the magazine on improving educational outcomes for Aboriginal students and on increasing school attendance rates of Aboriginal students; the value of the magazine as a tool for teachers; and the views of students, teachers and principals on the continuation of the magazine and the consequences of discontinuing the magazine.

Two surveys were developed, one for students and one for teachers. The surveys sought students' and teachers' views on each of the key evaluation areas (see above). The surveys were sent to 1,979 schools in all states and territories. Government, Catholic and independent schools were included. Four hundred and forty-three students from 61 schools across Australia responded (290 Aboriginal students and 145 non-Aboriginal students). Forty-five per cent of students were from capital city metropolitan areas and 55 per cent were from rural, regional and remote areas. Thirty-eight per cent were primary school students and 62 per cent secondary. There were 91 responses to the teachers' survey from the same 61 schools.

The students and the teachers who responded to the survey were all very positive about *Deadly Vibe* magazine. Their responses to the survey indicated they believed that *Deadly Vibe* has a positive impact on literacy, numeracy, career aspirations, and Indigenous culture. Both students and teachers reported that students interest in reading increased as a result of *Deadly Vibe* and that this has resulted in better literacy outcomes. Teachers reported that *Deadly Vibe* was an important teaching resource, and most kept back copies for that reason. Forty-seven thousand copies of *Deadly Vibe* magazine are distributed each month not only to schools but also to detention centres and Aboriginal organisations, including health services.

The positive outcome of the evaluation and the wide distribution and enthusiastic uptake of *Deadly Vibe* are encouraging. There are methodological issues with the evaluation. In particular, this was a three-month study and only a few of the schools targeted responded. A longitudinal approach would provide definite information on outcomes. However, such a study would be expensive and may not provide any more information than this survey response. We feel confident that *Deadly Vibe* is a valuable resource for improving the wellbeing, self-concept and life opportunities of Aboriginal students. However, there is also a need for school and system based programs developed to suit the needs of specific groups of students in their environmental/community context. These need to be available for the range of Aboriginal students in urban, rural and remote settings.

Family Wellbeing Empowerment Program

The Family Wellbeing Empowerment Program (FWB) was developed through the Aboriginal Education Employment Development Branch (AEEDB) in 1993. The first stage of the program came about in response to a request from an Aboriginal community member from the Riverlands region of South Australia for training in how to deal with loss, grief and other trauma that community members were dealing with on a day-to-day basis.

The program consists of five stages, with stages two to five including further training related to loss and grief and family violence, and training for program facilitators. All stages are accredited certificate courses, with each stage consisting of 30 hours of group learning. Stages one to four are Certificate II courses; stage five, which enables people who have completed the first four stages to become facilitators, is a Certificate III course (McCalman, McEwan et al. 2010a)

The FWB Program is designed to support group and community advocacy efforts in areas including land rights, housing, health, employment and education. It provides a framework that encourages participants to talk about issues of concern to them, identify their strengths, build relationships and acquire new skills. The five stages of the FWB Program are outlined in Table 4.4.

The FWB Program has been used as the basis of healing programs in Aboriginal communities throughout Australia. Programs in Alice Springs, Cairns, Yarrabah and Cape York have been conducted through partnerships between the local communities and a regional academic institution (Tsey and Every 2000a; Tsey and Every 2000b; Peeters 2007; Tsey, Whiteside et al. 2010; McCalman, McEwan et al. 2010a). These programs have been thoroughly evaluated throughout their lifespan and are presented as examples of good practice.

Table 4.4: Stages of the Family Wellbeing Empowerment Program

FWB stages	Content
Stage 1 Human Qualities	Introduction to core concepts including human qualities, basic physical, mental, emotional and spiritual needs, exploring values, analytic tools for self-reflection, self-care skills, skills to provide counselling and support to others
Stage 2 The Process of Change	How change affects people, change as an opportunity to grow and develop through inner qualities and strengths, frame difficulties as challenges for which there are solutions rather than as problems
Stage 3 Changing the Patterns	Applying the FWB approach to issues including violence, abuse and other social dysfunction
Stage 4 Opening the Heart	Reinforcing messages of self-development, healing and healthy relationships
Stage 5 FWB Participation	Practice-based training for FWB facilitation

Source: Tsey, Harvey et al (2009, p. 171).

Alice Springs

The first FWB program was conducted in Alice Springs in 1996. The Tangentyere Council invited the Adelaide developers (from the AEEDB) to conduct the program as a targeted response to a number of suicides of young people. Stage 1 of FWB was delivered as a successful pilot program. Subsequently 31 local people participated in all five stages. Participants included family members and young people affected by the suicide crisis, and service providers (who could, it was assumed, deliver the program to others). A researcher, who was also a participant, evaluated the project (Tsey and Every 2000a; Tsey and Every 2000b).

The FWB has continued to be delivered in Alice Springs. A train the trainer approach was used from 2001 to 2003, and since 2004 over 300 people have participated in the FWB program (approximately eight per cent of suburban dwellers and five per cent of town camp residents). The program is popular and, after a decade of being run on short-term grants, is now supported and delivered by the four key Aboriginal education and health providers in Alice Springs (McCalman, McEwan et al. 2010a).

The FWB was modified for use in three other communities, all in North Queensland. Pilot programs were evaluated in each community.

Yarrabah, Cape York

The Yaba Bimbi men's group workers were trained as facilitators of the FWB and delivered the program at the weekly meetings of the group. (For the aims and objectives of the men's group, see 'Yaba Bimbi Indigenous Men's Support Group' under 'Men's Groups' below.)

The Apunipima Cape York Health Council (Apunipima) and the University of Queensland adapted the FWB Program to engage and support individuals to take greater control of their health. The program as delivered in the Cape York communities is a two-step participatory action research process that helps people explore priority issues affecting their daily lives, recognise their own strengths and resources, generate knowledge and take action to improve their situation, often in collaboration with external facilitators (Tsey, Whiteside et al. 2005). Step one consists of 30 hours of structured personal development workshops that focus on personal empowerment and growth. Step two involves follow-up with community development processes aimed at supporting groups to collectively address community issues identified during the personal development training.

The program was piloted with both adults and school children. Community members asked that the program also be delivered in the schools in order to build the self-esteem and confidence of the children. The content of the school children's program was the same as that for adults; however, the delivery method differed, with key elements of the adult program being translated into hands-on activities that would engage the children's interest. In the leadership topic, for example, the children (with the help of a parent) interviewed a favourite community person they looked up to. They then shared the information they had obtained in small groups. In the relationships and basic human needs topics each student was given a disposable camera to photograph their family, friends, pets, favourite places, food and activities they enjoy to compile an album called 'Me and My Family'. Students also undertook group projects involving planning and action to address issues of importance to them, including the need for a larger playing field; decreasing the danger of injury by stopping 'the drunks' from drinking on school grounds after hours; and avoiding broken glass in the playground. These activities were designed to encourage the children to learn more about themselves and their basic needs, and to think positively about their future and about people, places and things they connect with, including role models (Tsey, Whiteside et al. 2005).

Evaluation

Alice Springs

Three peer-reviewed papers and a community report have been published that evaluate the Alice Springs FWB project from its beginning in 1996 to 2008. The first paper (Tsey and Every 2000a; Tsey and Every 2000b) evaluated the FWB as a youth suicide prevention program through literature review; participant observation; and analysis of the FWB evaluation forms, personal narratives of participants and focus group discussions. There were 31 participants (family members, young people and professionals from the 1998 program), of whom 80 per cent were Aboriginal. The evaluation focused on self-reported changes in attitudes, belief and behaviour.

It was found that the FWB course enhanced the sense of self-worth and resilience of participants, their ability to reflect on the root causes of problems and their ability to solve problems. There was also an increase in the general sense of wellbeing of the participants and those around them. However, there was no evidence from this evaluation of wider organisational and community empowerment such as stronger social networks.

The community report (Tsey and Every 2000b) focused on reflective personal empowerment narratives. Nine FWB participants and four family members were interviewed and the interviews and draft reports were given to the participants for comments. The report found participants used the skills learned from the FWB program to bring about significant change in their social and emotional health. In particular, participants had a greater awareness of the needs of young people and a greater capacity to support them; skills to bring about conflict resolution in the family and community settings; enhanced ability to deal with grief and loss; greater assertiveness; stronger sense of cultural and spiritual identity; greater sense of self and their own abilities; and an ability to reflect on the past in order to make sense of the present.

The second paper (Rees, Tsey et al. 2004) reported on the findings of in-depth interviews conducted with 28 of the 52 Aboriginal people aged 30–50 years who participated in one of the 1996, 1998 or 2001–2002 programs; interviews with eight significant others; participant observations; and diary entries of 10 participants. The interviews were analysed for self-reported changes in attitudes, beliefs and behaviour in relation to addressing violence. It was found that participants experienced increased personal control and empowerment, awareness of self and personal needs, enhanced capacity to deal with emotions and feelings, and ability to reframe personal and community problems in terms of the political and historical context. The evaluation also found that participants had greater self-esteem and personal strength; had developed the capacity to help others; and advocated for structural change within their community, taking positive action, for example, against violence, unemployment and educational disadvantage. Others participated in community-level and organisation-level politics for the first time⁵.

5 Again the key objective of violence reduction was not directly measured/examined but covariates only. This is particularly important in the area of violence, as evidence suggests most violence programs fail to reduce violence behaviour and some make the violence worse.

The third peer-reviewed paper (Tsey 2008a) reports on the secondary analysis of 24 of 73 previous interviews and focuses on addressing substance abuse. Analysis of the data showed participants to have a greater sense of self, greater ability to provide and receive constructive support, and the ability to meet challenges and take opportunities to maintain change when the social environment is resistant to change. Thus the changes in the individual also impacted on those around them and the environment.

The impact of the FWB program over time on individuals and their communities has been examined (McCalman, McEwan et al. 2010a) through analysis of the three papers and the report of evaluations and interviews with key facilitators and evaluators. The analysis focused specifically on the contribution of the FWB program towards the social sustainability of the Alice Springs Aboriginal community. A meta-synthesis of this work was conducted by summarising and then comparing the interpretations, themes and explanations from the original studies. The identified themes were found to describe key influences important to the social sustainability of Alice Springs:

- ◆ personal empowerment
- ◆ the ability to identify priority community issues and goals
- ◆ the ability to influence community development outcomes (for example, ongoing delivery of FWB in Alice Springs as a result of the efforts of previous participants and trained local facilitators)
- ◆ the ability to ensure effective governance through community control
- ◆ the ability to influence national policy development and implementation through working together (McCalman, McEwan et al. 2010a).

Yarrabah and Cape York

The evaluations were conducted as for the Alice Springs programs by the same teams of researchers, and the findings were similar to those of the Alice Springs program (Tsey, Patterson et al. 2004a; Tsey, Wenitong et al. 2004b).

The Cape York children's program was delivered in two schools by three facilitators (two Cape York women and one non-Aboriginal woman) in 12 one-hour sessions every two to three weeks over two school terms. Fifty-nine 12-year-olds in years five to seven participated from one school, and 20 students in year seven at the other. There were approximately equal numbers of girls and boys. The teachers helped in the delivery of the FWB program and incorporated elements of it in the curriculum.

The evaluation of the children's program focused on the relevance and adaptability of the FWB program to schools and the extent to which participation in the program resulted in personal empowerment for the children. A set of semi-structured qualitative interview questions were developed to elicit in-depth narratives. Two people previously unconnected with the project conducted interviews with eight teachers and 22 students (Tsey, Whiteside et al. 2005). No information was forthcoming after a quarter of each class had been interviewed, so no further interviews were conducted – it having been judged that saturation had been achieved.

The program was seen by the teachers as a 'good fit' for school children. The overall outcomes for children included greater ability to think for oneself, ability to set goals, less bullying and teasing at school, enhanced friendships and social relatedness, greater self-esteem, and more confidence in the school environment. The children interviewed showed the effect of the program in their capacity to initiate problem solving and in their learning skills (Tsey, Whiteside et al. 2005). The students enjoyed the project, with the family/friends activity being their favourite. They also liked the way the facilitators presented the program, enjoyed the activities and learned a lot about themselves, their place in the community, leadership (what is involved) and relationships:

The way you think, the [relationships] trees, it's not something you take for granted; If you have best friend and fight you can go and talk and make up; If someone argues with you, you walk away and cool down. (Tsey, Whiteside et al. 2005, p. 115)

Meta-synthesis

Meta-synthesis aims to integrate the findings from a number of different but interrelated qualitative studies to produce deeper understandings of the contextual dimensions of programs. Its purpose is interpretive, as distinct from the aggregating purpose of meta-synthesis of qualitative studies (Walsh and Downe 2005). The seven discrete evaluation reports of the FWB program (Tsey and Every 2000a; Tsey and Every 2000b; Daly, Tsey et al. 2004; Rees, Tsey et al. 2004; Tsey, Whiteside et al. 2005; Whiteside, Tsey et al. 2006) were synthesised in order to develop a deeper understanding of the contribution of community empowerment education programs to improving Indigenous health. The findings sections of each document were collapsed into one document and coded line by line.

Consistently recurring themes were identified pertaining to the nature and benefits of empowerment in the context of Indigenous health (Tsey, Whiteside et al. 2010). Table 4.5 shows the main themes and subthemes identified using this method. Changes occurred at the individual level and at the relationship level (individuals impacting on others). At the individual level, people’s attitudes changed so that they became less judgmental of others and had greater hope for the future. People developed skills in dealing with anxiety, anger and conflict, including impulsive actions that might in the past have led to violence. They adopted healthier lifestyles through an ability to understand the reasons for doing things differently, and they showed more active participation in community life. The changes in individuals influenced the people around them. Some children spoke of having more friends; cross-cultural relationships improved; people began actively helping others; parents showed increased awareness of children’s needs; and families began spending more time together. At the same time the program allowed participants to realise that in order for things to change in their communities they needed to have a greater role in leadership and also needed to maintain hope and a positive attitude to change. However, any changes that did occur did so in environments of severe social constraint. Despite this the FWB participants maintained their hopeful outlook, which was reinforced by the changes they were able to bring about in their lives and in their communities.

Table 4.5: Themes and subthemes in the impact of the FWB program on Indigenous health

Themes	Relevant to Indigenous people	Transformation and change	Social connectedness and support
Subthemes	Indigenous developed	Self-reflection and awareness	Parenting
	Practical and holistic	Hope and vision	Empathy and ability to help others
	Identity and respect	Dealing with emotions	Collective action
	Sharing stories	Self-care and healing	Reconciliation between black and white
		Intellectual curiosity and further studies	
		Addressing alcohol and violence	

Source: Tsey, Whiteside et al (2010).

A separate meta-synthesis of FWB program evaluations was conducted using meta-ethnography (McCalman, McEwan et al. 2010a). Meta-ethnography is a seven-step process of deciding the research question; deciding on the scope of the synthesis; reading the studies; determining how the studies are related; translating the themes into one another; synthesising the translation; and expressing the synthesis (Noblit and Hare 1988).

The aim of this study was to understand the ways in which community empowerment programs such as the FWB influence participants to work towards social sustainability. The method involved one researcher reading and rereading the individual studies to identify the main themes, concepts, and metaphors. These were workshoped with the team of authors until there was confidence in the trustworthiness of the identified themes. Common and recurring themes were then clustered by the co-authors.

In developing more personal strength the participants were able to identify priority issues for their communities and take action to address them. Thus FWB participants identified family violence as a key priority and personal, family and community healing as a way of combating such violence. The organisational and community outcomes of the FWB program include the founding of a healing centre and the delivery of the FWB to town camp residents, prisoners, alcohol rehabilitation clients, and school children.

Marumali

The Marumali program has been identified as a model of promising practice by the Office of Aboriginal and Torres Strait Islander Health SEWB program (SEWBMH 2001). Its developer, Aunty Lorraine Peeters, herself a member of the Stolen Generations, notes that Marumali has been endorsed by Professor Beverley Raphael (Peeters 2007). Aunty Lorraine in 2011 received the Sigmund Freud Award for psychotherapy, along with Ngangkari Rupert Peters and Ginger Toby and Professor Helen Milroy.

Marumali is a Kamilaroi word meaning to put back together. Aunty Lorraine developed the program through observing, studying and seeking to understand her own healing journey. She says she was fortunate to have a therapist who told her that the things she was dealing with – the grief and sense of loss – were normal given her experiences, and this gave her the confidence to carry on. Aunty Lorraine presented her work at the New South Wales Mental Health Conference in 1999. The support for her work was such that the conference called for her model of healing and her body of work to be published and circulated to Aboriginal communities and organisations. Lorraine responded to this by developing a five-day training workshop for Aboriginal counsellors.

Training provided under the Marumali healing model is designed to empower Aboriginal counsellors to take the lead in this area of work. All participants in the counsellor training are required to have had previous formal training or work experience as counsellors (SEWBMH 2001). The workshop teaches counsellors the skills they need to work with Aboriginal people who are suffering from grief and trauma as a result of separation. The training program advocates respect for the person who is suffering from the trauma, and a key principle of the model is that each individual be allowed to follow their healing path at their own pace. Clear guidelines are given about what type of support is required at each stage of the healing process. The risks associated with people who are addressing grief and loss issues resulting from separation, including misdiagnosis, are covered and ways of reducing these risks are discussed. Since the development of this training workshop Aunty Lorraine has developed a two-day training workshop for non-Indigenous people, a two-day risk management workshop and a five-day healing workshop.

The important characteristics of the Marumali program are its empowering nature, its cultural base, the fact that it comes from the experience of a person who has herself been through the healing process, and the fact that it allows the person undertaking the healing to do so at their own pace. Also of great importance is the specific way in which the program addresses risks and provides ways of managing those risks. The fact that Aunty Lorraine devotes an entire two-day workshop to risk management acknowledges the importance of dealing with risk. There are programs being offered that do not do so, and this places the counsellor and the client at risk of harm (see Appendix 2).

Men's groups

Men's support groups are seen as important strategies within Indigenous communities for improving health and wellbeing. It is estimated there are over 100 Aboriginal men's support groups operating throughout Australia; however, very few are well documented (McCalman, Tsey et al. 2010b). Two Aboriginal men's groups that are well documented and evaluated are the Yaba Bimbi Indigenous Men's Support Group and the Ma'ddaimba Balas Men's Group, both operating in Aboriginal communities in North Queensland. The groups were evaluated through a partnership with the University of Queensland funded by the National Health and Medical Research Council.

Yaba Bimbi Indigenous Men's Support Group

Yaba Bimbi was established in response to a series of violent suicides among young men from the Yarrabah community, some while in custody. The development of the group has been well documented (Tsey, Patterson et al. 2002; Tsey, Patterson et al. 2004a; Tsey, Wenitong et al. 2004b). The Yarrabah men's group was initially run on a voluntary basis as a support group to provide a safe place for men to talk about their problems and look at possible solutions. The main activities of the group were weekly health education sessions, counselling, men's health clinics provided by an Aboriginal doctor, and activities to promote social skills and bonding (hunting, fishing, camping, visits to the cinema) – all of which the men paid for themselves. The Yarrabah community health service provided a place for meetings, coordination of activities and resources to produce brochures, a video and posters promoting the activities of the group.

A relationship was formed with researchers from the University of Queensland and funding was obtained to appoint two workers. The researchers from the University of Queensland were contracted to evaluate the project. The researchers facilitated planning and evaluation training sessions for the men's group employees and other leaders of the group. Once trained, these men facilitated planning and evaluation sessions for the wider membership of the group. The men developed a set of principles and values to underpin the group (Tsey, Patterson et al. 2002).

Values were identified as 'do's and don'ts' by which a man who takes his 'rightful role' in the community should live. In the planning process the men identified five sets of major initiatives that they wanted to address and believed would enhance their capacity to take their rightful place in society: personal development, leadership and parenting; employment; education and training; tradition, culture and Yaba Bimbi Men's Place; and improving access to men's services. Detailed strategies were developed to address each of these areas.

The men's group progressed over the period 2000 to 2005 to the point where the group was issuing discussion papers jointly with the local community health service to raise issues and suggest options for further development, and as tools for interagency advocacy. The men's group workers were trained in the FWB leadership and personal development program and delivered this program at weekly meetings. Men were referred from the local magistrates court to these meetings. Funding was obtained for a program for young men at risk of becoming involved with the adult criminal justice system and their families. The group identified a need for men to have real jobs, not just participate in Community Development Employment Projects (CDEP), and the focus of the group on education, training and employment gave hope that this was possible. Men are referred to a range of organisations to undertake education and training. The men's group formed a cultural dance group, Yaba Bimbi, which performs at concerts, schools, parties, conferences and openings and has developed a DVD show reel. A business plan was developed and the Yaba Bimbi dance group has a vision to become a professional dance group.

Ma'ddaimba Balas Men's Group

Ma'ddaimba Balas is situated in Innisfail, a rural town adjacent to Yarrabah. This group commenced its activities in 2001 in response to men's concerns about family violence, and the lack of local advocacy, support or diversionary services for men. The group has close links with the local community-controlled Aboriginal health service and the local justice group. Ma'ddaimba Balas itself became an incorporated community organisation. It formed a three-way partnership with the Yarrabah men's group and the University of Queensland in 2004. This allowed the group to employ two men's group workers.

The group offers regular men's support meetings, court support and advocacy, advocacy on issues such as employment and improved access to health services for men, the FWB program, traditional cultural events, and sports and social activities – the latter particularly targeting young men (McCalman, Tsey et al. 2006). Ma'ddaimba Balas has seven broad strategy areas: men's group meetings, networking and advocacy, support for Indigenous men in the courts, providing educational programs and counselling, improving health services for Indigenous men, organising sporting and social groups, and working with Indigenous youth.

Evaluation

Yaba Bimbi Indigenous Men's Support Group

Due to the complexities associated with evaluating such complex interventions without easily measurable outcomes, a series of evaluative papers and reports was published describing in detail the elements of the programs, the interventions, and the social context from which they developed.

The sources of data for the evaluations were participants' observations, the reflections of the men's group project workers (who kept diaries), routinely collected data pertaining to the activities of the men's group, community-level statistical data, and in-depth interviews with knowledgeable community people (13 people were interviewed, eight men and five women. Only two of those interviewed (the two project workers) attended the men's group.

Analysis of the data revealed the men's groups to be effective. In the case of Yaba Bimbi (McCalman, Tsey et al. 2006) the following themes emerged over the period of the evaluations:

- ◆ Continuing personal development and growth for men – this included increased self-esteem and confidence, men spending more time with their children, and a reduction in alcohol use.
- ◆ Identification of the root problem – 'no more bandaid'. The men identified lack of cultural identity, spirituality and values as a root cause of Yarrabah men's problems. They also realised that these underlying factors needed to be addressed if issues such as suicidal ideation, domestic violence, alcoholism, relationship problems and other traumas were to be eliminated from their lives.
- ◆ Reclaiming and redefining Indigenous culture and integration of this with Christian spirituality through dance in the church and elsewhere.
- ◆ A perception that the men's group may be playing a role in suicide prevention and was helping to combat family violence. Furthermore the entire community felt that the men's group was 'the right way to go', and there was a willingness on the part of other community organisations to share resources. The Yaba Bimbi group also faced some challenges, however, including fluctuating attendance at meetings, issues with leadership, a need for men to have their own place, a perception that the men's group was only for men with problems, the effect of Yarrabah's history on the men, and a lack of routinely collected data. These were being addressed at the time of the writing of the paper.

Ma'ddaimba Balas Men's Group

The evaluation of Ma'ddaimba Balas (McCalman, Tsey et al. 2006) was informed by:

- ◆ process information from the monthly reflective meetings between the men's group workers and the researchers
- ◆ regular debriefing meetings with the men's group leaders (conducted due to their heavy workload of advocacy in the courts, support of other men, involvement in counselling and education programs)
- ◆ statistics pertaining to men's group activities kept by the men's group workers
- ◆ in-depth interviews with 23 key local informants
- ◆ a questionnaire administered to community members by the men's group leaders.

The evaluation found that the men's group leaders were very committed and compassionate; the group was very resilient, surviving and continuing to provide advocacy and support and arrange events despite minimal funding; the group had forged close relationships and partnerships with local service organisations to ensure that the range of services are available to men; and there was evidence that the men's group had been effective in reducing the number of breaches of men's domestic violence orders and the number of men incarcerated. However, the men's group also faced a number of key challenges, including low attendance at meetings, lack of management and infrastructure support, lack of leadership and conflict resolution skills, and lack of consistency of educational/therapeutic programs. These challenges were largely due to lack of a place to meet, lack of infrastructure support and lack of human resources.

Meta-ethnography of the men's programs

In 2010 the findings of the five individual evaluation papers and reports for Yaba Bimbi and Ma'ddaimba Balas (Tsey, Patterson et al. 2002; Daly, Tsey et al. 2004; Tsey, Patterson et al. 2004a; Tsey, Wenitong et al. 2004b; McCalman, Tsey et al. 2006) and a sixth paper reporting on the evaluation of a men's group in Sydney (Nakata, Day et al. 2008) – all conducted using a phased approach based on empowerment and participatory action research – were subject to analysis using techniques of meta-ethnography (McCalman, Tsey et al. 2010b). This produced a meta-synthesis of the results of the original evaluations whereby the individual studies were compared, translated and analysed to generate higher order hypotheses about the data that may not have been identified in the original studies (see also the evaluation of the FWB programs). The aim of the meta-analysis was to define the opportunities, challenges and outcomes of the men's groups across time and across the different sites. Reports from the grey literature were included because of the rich material they often contain. The method involved one researcher reading and rereading the individual studies to identify the main themes, concepts and metaphors. Again these were workshopped with the team of authors until there was confidence in the trustworthiness of the identified themes. Common and recurring themes were then clustered by the co-authors.

The analysis identified a range of social and emotional wellbeing outcomes for the men in the group, their families and their communities relating to opportunities and challenges; taking control and responsibility; influencing change through direct program delivery, partnerships and advocacy; and addressing and challenging group and community activities (McCalman, Tsey et al. 2006). The local men's groups were found, despite the challenges each faced, to promote social cohesion, a move towards social norms of respect, responsibility, and improved wellbeing for the men and their families.

Traditional healers

There have been, to our knowledge, no formal evaluations of the traditional healing practices either when practised individually or when practised in conjunction with Western health services. Given the importance of Ngangkari (traditional healers) to Aboriginal and Torres Strait Islander people, it was decided to include a brief description.

We are aware of at least two programs that provide Ngangkari services:

- ◆ the Ngaanyatjarra Pitjanjatjara Yankunytjara (NPY) Women's Council in Central Australia
- ◆ the mainstream Ceduna health services.

Ngaanyatjarra Pitjanjatjara Yankunytjara Women's Council Ngangkari service

The NPY Women's Council employs several Ngangkari and a project officer. The Ngangkari service liaises with remote clinics and hospitals. The Ngangkari provide a range of treatments and interventions. They also provide education on traditional healing and are part of the SEWB program. They provide counselling services and raise awareness of mental health issues. They have produced a book, *Ngangkari Work – Anangu Way: Traditional Healers of Central Australia* (2003), which describes their work. The book describes the aims of the Ngangkari service as:

- To provide information about the role and practices of Ngangkari in order to encourage greater collaboration and understanding between non-Anangu health workers and Ngangkari,
- To promote understanding of the great value and importance that traditional Ngangkari practices have in contemporary Anangu life.
- To promote discussion among funding bodies and local organisations about ways of supporting Ngangkari including issues of payment and transport (2003).

The Ngangkari of the NPY Women's Council were joint winners of the international Sigmund Freud Award for psychotherapy. The service has been identified as a promising practice model because of its role in educating mainstream services about what Ngangkari can do and how the mainstream can work together with Ngangkari for the benefit of the patient (SEWBMH 2001).

Ceduna District Health Services Ngangkari service

This service was instituted by Ceduna District Health Services (CDHS) following consultation with Aboriginal people, who make up 50 per cent of the client population, on how comfortable they were about accessing CDHS. They were not comfortable for a number of reasons, most of which were related to Aboriginal cultural and spiritual beliefs and practices. The Aboriginal community controlled services suggested that these issues would be resolved or at least eased by having a Ngangkari to consult to CDHS and provide services to inpatients.

CDHS obtained funding to establish a Ngangkari service and are now able to call on Ngangkari to work with patients. The Ngangkari see inpatients and also see people on a private basis as outpatients. The collaboration between the mainstream service, the Ngangkari and the Aboriginal community controlled health services and organisations has resulted in many initiatives that are keys to the health and wellbeing of the Aboriginal people of the area. These include:

- ◆ implementation of a renal dialysis service
- ◆ consultation with local Aboriginal people for the purchase of artwork and posters
- ◆ staff undertaking cultural awareness training annually
- ◆ introduction of traditional foods cooked outside in a fire pit, with resident Aboriginal clients providing advice to catering staff
- ◆ regular visits by Ngangkari to mainstream health centres and the Aboriginal communities
- ◆ development of an Aboriginal Services Improvement Plan with involvement from all the communities, including the Aboriginal Services Division. The plan is currently being evaluated.
- ◆ increased employment of Aboriginal staff in nursing positions
- ◆ increased access to scholarship support for Aboriginal staff wishing to undertake nursing training
- ◆ understanding and involvement of visiting specialists with Ngangkari (Tesoriero and Hart 2004).

Social and emotional wellbeing programs

Office for Aboriginal and Torres Strait Islander Health SEWB programs

The Office for Aboriginal and Torres Strait Islander Health (OATSIH) funds a number of Indigenous mental health programs:

- ◆ Link Up, which provides a national network of services supporting and assisting Aboriginal people affected by removal policies in tracing their family history and potentially reuniting them with their families
- ◆ Bringing Them Home (BTH), which provides counselling to individuals, families and communities affected by the forced removal of children from Aboriginal families
- ◆ the Social and Emotional Wellbeing Regional Centre Program, which funds SEWB regional centres around Australia to:
 - provide professional support to Link Up and BTH staff and to other workers, especially mental health workers
 - develop, deliver and purchase training
 - conduct activities to support this, including developing cross-sector linkages and maintaining information systems
- ◆ the Mental Health Program, which funds mental health service delivery projects in Aboriginal community controlled health services nationally to develop and evaluate culturally appropriate approaches to mental health service delivery (Wilczynski, Reed-Gilbert et al. 2007).

Evaluation

Urbis Keys Young was contracted in 2007 by OATSIH to conduct a comprehensive evaluation of these four programs. A team of six consultants, including two Aboriginal consultants, carried out the evaluation. The methods used for the collection of data for the evaluation were:

- ◆ fieldwork in 15 locations around Australia during which the staff of services and other stakeholders were consulted in all locations; consultations also occurred with a total of 49 clients from six locations and 40 members of the Stolen Generations in five locations
- ◆ telephone interviews with 33 key informants suggested by OATSIH, the reference group for the evaluation, the National Sorry Day Committee, other key informants, and people who were not available during the fieldwork
- ◆ 16 written submissions
- ◆ a survey of the mental health delivery projects, to which 11 (58 per cent) of the 19 projects responded
- ◆ a literature review, which aimed to identify best practice and alternative models for service delivery for consideration
- ◆ program data collected by the Link Up and BTH programs
- ◆ a communications strategy to inform the key stakeholders and community members about the evaluation and how they could contribute to it, and also to publicise the findings of the evaluation following the release of the report. This was done through development of a website and other media activities.

The fieldwork was limited by the fact that the evaluators found the key people they wanted to consult with difficult to contact. Many of the programs and services were not expecting the evaluators, and many of the people the evaluators had arranged to interview did not arrive for the interview. The consultations with the clients of services were added in the middle of the evaluation – not an ideal circumstance given the ethical and logistical issues involved. There are many issues pertaining to the reliability of the Link-Up and BTH data. There was little time allowed for the fieldwork, and the clients who were interviewed were not given an allowance for their attendance at the consultation/interview.

The key positive findings of the evaluation were:

- ◆ Link Up and BTH had provided services to a large number of Aboriginal clients across Australia.
- ◆ Link Up, BTH and the mental health services provided services to many people who would not have been likely to receive them otherwise.
- ◆ the programs generally provided services in a culturally appropriate manner as prescribed in the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013 and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Social and Emotional Well Being 2004–2009.
- ◆ There are generally high levels of client satisfaction and positive outcomes for clients of Link Up and BTH and the mental health service delivery projects. This is not the case for a number of the SEWB regional centres.

The key limitations of the programs were:

- ◆ lack of focus on first-generation Stolen Generations members
- ◆ a significant and undesirable level of variation in the skills and qualifications of staff in Link Up and especially in BTH. Furthermore staff of both programs had variable, often insufficient access to training and professional support opportunities, even though support is a key role of the SEWB regional centres. As a result of this and other factors (including the BTH counsellor being a lone practitioner within a large service provider) there was a high rate of burnout in these positions and a high turnover of staff.
- ◆ lack of consistency in service delivery in all four programs across Australia
- ◆ limited geographical coverage, with programs tending to focus on clients in their immediate vicinity. This was found to be especially marked for Link Up and BTH and felt to be responsible for a lack of first-generation Stolen Generations members in rural and remote areas accessing these programs.

In terms of program management it was found that the services to which the programs are attached do little to promote the programs, which tend to see clients who approach them directly. There was little coordination with other services and programs – and close coordination is very important for the clients of these programs, who usually have multiple social and health needs. The data management system is cumbersome and difficult to use. Most of the services have done little in the way of evaluation and monitoring, even though this is part of their contracts. They tend to only meet the formal reporting requirements of OATSIH.

The literature review found very little best practice literature pertaining to these types of services. The consultants identified best practice principles pertaining to the location of services; service delivery issues; the support and training of workers; interagency relationships and activities to raise awareness of the program's existence; and regular action-oriented evaluation and monitoring to inform service delivery.

The findings reported in this evaluation are of serious concern. Despite the methodological problems – a top-down approach such as this is unlikely to engage many people working in community controlled and operated Aboriginal services; only 11 of the 19 clinical services responded to the survey; very few clients were consulted; the consultations that occurred during the fieldwork seem haphazard, with no-one from the supra-regional clinical mental health service run through the Victorian Aboriginal Health Service consulted during the visit to Melbourne – it seems clear that the services are not reaching many of the people who need them, and that the service workers, and thus by extension the clients, are at risk when counsellors are inadequately trained and inadequately supervised and have inadequate support. It is not possible from this evaluation to determine the reasons for this. The same goes for the thin evidence on which the evaluators based their conclusions that the services are culturally appropriate and that there is a high level of client satisfaction.

It is essential that these programs are enabled to conduct their own evaluations, with OATSIH providing funds for the programs to employ qualified people to facilitate the research.

Sexual abuse – healing and justice

Many of the healing programs documented in this chapter offer healing to victims of sexual abuse. However, local and international experience with the responses of mainstream social, legal and health agencies and their impact on Aboriginal victims has led to Indigenous communities moving towards developing their own models for dealing with the victims and perpetrators of sexual abuse. The literature is awash with accounts of the trauma associated with reporting sexual abuse, having to deal with police questioning, negative family responses, and – where police decide to prosecute – the court case and coming face to face with the perpetrator.

Young people have died soon after reporting sexual abuse to the police, some have been excluded from their communities and/or been threatened with physical injury; others have turned to drugs and alcohol (McGlade 2013, etc). The report of the Children on Anangu Pitjantjatjara Yankunytjatjara Lands Commission of Inquiry (2007) found that the mental, physical and emotional wellbeing of children who had been sexually abused declined dramatically, and that this decline was exacerbated by the lack of appropriate responses. The Ampe Akelyernemane Meke Mekarle 'Little Children are Sacred' Inquiry (2007) found that people from Aboriginal communities felt disempowered, confused, overwhelmed and disillusioned (McGalde 2013). The Inquiry Report and Recommendations stressed the imperative that communities be empowered:

'through a determined and co-ordinated effort to break the cycle and provide the strength, power and appropriate support and services to local communities' (NT Government 2007 cited in McGlade, 2013 p. 106).

The terrible impact of sexual abuse on individuals, families and communities across the generations was the catalyst for Aboriginal communities and tribal groups in Canada and the USA to develop healing programs for the victims of sexual abuse based on their traditional cultural practices, whilst at the same time working closely with the local justice systems (Couture et al 2001; McGlade 2007a; EchoHawke 2001; The Harvard Project on American Indian Economic Development 2001).

Hollow Water Community Healing Project (Canada) – Justice as healing

Healing is an Aboriginal justice principle encompassing sentencing circles and community-based diversion programs.

Healing is about taking responsibility. It is about relearning how we are supposed to be. Without knowing what traditional responsibilities are, then the right to self-determination means nothing. Healing is about learning to act in a good way (Patricia Angus – Monture Mohawk law Professor cited in McGlade, 2013, p. 184).

The key principles of the healing program are: to bring the abuse into the open; to protect the victim so as to minimally disrupt family and community functioning; to hold the perpetrator responsible for his/her behaviour; to offer the opportunity for balance to be restored to all parties.

Essential to the program are: participation and empowerment of the victims; potential healing and rehabilitation of perpetrators; involvement of the community; positive benefits to the community; re-establishment of traditional culture and spiritual values.

The Hollow Water Community Healing Program for victims and perpetrators of sexual abuse is described in more detail in Chapter three. The program works closely with the justice system and is funded by the Federal Government. Perpetrators who admit to abusing others do not go to jail but proceed through the healing program. Victims of abuse also go through a program; however, the program has been criticised by some for placing too much emphasis on healing the perpetrator and not enough on healing the victims. Nevertheless, evaluation of the Hollow Water program has shown the recidivism rate amongst abusers who complete the program to be very low (McGlade, 2013).

The Navajo Tribal Program to address sexual abuse in communities

In contrast to the Canadian system of healing circles and diversion programs for perpetrators, the United States of America has enacted federal legislation that enables grants to be made directly to tribes to establish 'victim assistance programs', and to improve tribal investigations, prosecution and general management of cases in ways that limit the trauma to the victim. The Navajo Child Special Advocacy Program provides for both Western medical treatment and counselling and Navajo-based treatment, including diagnosis and referral to traditional healers (EchoHawke, 2001).

Key to the success of the Navajo program are (The Harvard Project on American Indian Economic Development 2001):

1. meticulous collection of information regarding the scope and patterns of child abuse, which allows progress to be measured and services to be structured to meet objectives (this is the type of evaluation that we have recommended for healing programs in Chapter three)
2. a program tailored to meet the specific needs if the Navajo people demonstrated that culture is an important part of service provision
3. development of an effective interview process for the victims, conducted by the program that has resulted in better and more care for victims, and higher conviction rates
4. coordination by the program of the efforts of the various agencies and a multi-disciplinary team made up of physicians, social workers, therapists, mental health staff and educational authorities as well as criminal investigators and prosecutors
5. regular team meetings.

Thus, through this program, the Navajo Nation has been empowered and provided with the resources required to take responsibility for addressing the issue of sexual abuse in their communities.

The Australian context

Dr Hannah McGlade, an Aboriginal human rights lawyer and academic, believes that the starting point for healing in Aboriginal sexual abuse must be the recognition of i) the human rights of Aboriginal women and children, and ii) sexual abuse as a violation of the human rights of women and children. Healing is thus a matter of justice:

'In talking about a different way of addressing child sexual abuse and the development of our own Aboriginal models we must always make sure that we are committed to walking with the victim survivors, and remembering that there is no healing without justice for them' (McGlade, 2007 p. 12–13).

In West Australia, 'Sister Kate's Home Kids', a healing centre, is in the early stages of its development, with key themes being redress, reparation and healing for those who suffered abuse and trauma as children. Intergenerational trauma will also be addressed, including the strengthening of individuals, families and communities (McGlade, 2008).

The experiences of the Canadian and United States of America program show that, to be successful, programs that address sexual abuse, aiming to overcome the cycle of sexual abuse and prevent sexual abuse, must incorporate:

1. being fully informed and developed from grassroots by communities, in close co-operation with the criminal justice system:

'As a matter of human rights, Aboriginal responses to child sexual assault arguably must incorporate the criminal justice system' (McGalde, 2013, p. 190)

2. responses based on the empowerment of women and children and addressing re victimization
3. making Aboriginal communities part of the solution—in the present situation they are not, they are not part of the processes of the criminal justice system and they are not empowered, nor do they have the resources to act
4. empowering Aboriginal communities before they can address issues of sexual abuse; the process of Aboriginal communities empowering themselves requires committed, long-term support from government agencies
5. governments providing the support required to allow Aboriginal communities to develop programs to address sexual abuse; to assess the efficacy of the program (evaluate the efficacy) and use the findings of the evaluations to make changes as required in the program and program objectives
6. developing relationships with the range of agencies, including health services, mental health services, educators, social agencies, the police, and prosecutors (both government and non-government agencies).

McGlade (2013; 2010; 2007b; Cripps and McGlade) suggests that community-based programs to address issues of sexual abuse should:

1. be victim centred
2. focus on supporting participants' identities and healing
3. include a culturally appropriate police investigatory process
4. include Aboriginal counsellors
5. ensure victims have appropriate support throughout (including through the court process)
6. provide culturally appropriate court preparation materials
7. provide Aboriginal witness support staff (McGlade, 2013).

We Al-Li

The We Al-Li healing program was developed by Professor Judy Atkinson. It has not been formally evaluated; however, Professor Atkinson has written extensively (in papers in peer-reviewed journals, her PhD thesis and her book) and spoken at a range of academic and clinical meetings about the development of the program, its underpinnings in Aboriginal culture and spirituality, and the way the program is delivered (Atkinson 1994; Atkinson 2002).

We Al-Li was initiated when Professor Atkinson was asked to help a group of Aboriginal community members in Rockhampton develop a program to address violence within Aboriginal families. A group consisting of community members and academics from QUT met for a year to plan a program that would meet the needs of the community. Professor Atkinson defines We Al-Li as 'a self help community group' (Atkinson 1994, p. 9).

In the We Al-Li model, Aboriginal family violence is seen in the context of colonial history and the current sociopolitical situation, and the trauma associated with family violence to have been transmitted through the generations. We Al-Li is delivered through a group workshop process whereby people are enabled to understand their own violence and the source of that violence, as well as the connections between physical, mental emotional and spiritual injury across the generations. We Al-Li creates 'safe places, healing circles where people could start to break the denial (of violence), talk together and share stories' (Atkinson 1994, p. 10). It emphasises personal and group responsibility:

... through sharing and healing in holistic learning situations, as individuals ... explore behaviours and define strategies for individual, family and community transformation. (Atkinson 1994, p. 10)

All workshops begin with dadirri, which can be defined as deep listening:

Dadirri, a special quality, a unique gift of Aboriginal people is inner deep listening It renews us and brings us peace. It makes us feel whole again. (Atkinson 1994, p. 10, quoting Ungenmerr, 1993)

The safety of all participants in the workshops is of paramount importance. The ways in which safety is maintained while addressing issues that could potentially re-traumatise are discussed in detail in Professor Atkinson's book *Trauma Trails: Recreating Songlines* (2002).

The main workshop series for We Al-Li is called *Lifting the Blankets*. It consists of nine residential weekend workshops. The workshops use visual arts, storytelling and keeping a diary of one's thoughts to support the healing. All workshops have two facilitators who work together. In the first workshop, participants name the violence they have experienced and begin to examine ways they can change the impact of these types of violence on their lives. The second workshop uses an Aboriginal dispute resolution technique to allow people to safely express anger, and the third addresses issues of grief and loss. Other workshops address child abuse and neglect, violence perpetrated by children who are themselves victims of violence, adult violence, substance abuse, and the family/social system. The final workshop in the series is *Ceremony is Healing – Let's Celebrate*.

Professor Atkinson tells the stories of some of the people who have participated in her programs in her book, her talks and her papers. These serve to show how people change for the better through participation in We Al-Li.

The We Al-Li program and workshop series have been running now for almost two decades. Students can undertake a Diploma in Counselling through We Al-Li. Over the years these students have written theses about their participation, their learning and their facilitation of the workshops. This body of work, together with that of Professor Atkinson, provides a powerful argument for both the efficacy of We Al-Li and the fact that it does no harm. It is also pertinent that Professor Atkinson is called upon throughout Aboriginal Australia when there are crises in communities (Atkinson 2012). We Al-Li has been identified as a promising practice model by the SEWB program of OATSIH, which notes that a key feature of We Al-Li is the provision of a safe environment in which people can undertake healing.

Discussion

The programs discussed here are examples of good practice as evidenced by the positive outcomes they have had for participants, their families and their communities over time. The important aspects of successful healing programs are that they are safe for both participants and those providing the services; are developed within the local context; respond to needs identified by local communities; incorporate local cultural practices, values and spirituality; are supported by the members of the local community; and work beyond the individual to family and community. Those providing the program need to ensure the safety of participants at all times, and this often requires the workers being available outside usual working hours. The workers in turn need to be cared for with peer support, mentoring and training built in as an integral part of their job description.

A successful healing program will show positive impacts on individuals, families and communities in terms of empowerment, self-esteem and sense of identity. These in turn have been shown to have a positive impact on health status and health disparities (Wallerstein 2006). There will also be positive impacts in terms of knowledge and skills acquisition by community members and the development of individual, family and community capacity. Healing programs must be sustainable, and sustainability must be developed from the beginning through ensuring that there is intra- and extra-community capacity, that intra- and extra-community networks are in place, and that there are adequate resources and funding in the long term.

It is of concern that the SEWB programs funded through OATSIH have not been well evaluated. These account for the majority of healing programs for Aboriginal and Torres Strait Islander people, and it is imperative that their efficacy be assessed using the methods available at the moment – that is, various forms of participatory action research.

If Aboriginal and Torres Strait Islander people are to have access to best practice healing programs, further research is imperative – especially in the areas of the sustainability of the programs, the transferability of knowledge, and the adaptation of programs successful in one locality to other regions. Methodological development is also urgently required using both Indigenous and Western knowledge. To aid in the development of more rigorous and in-depth methods of evaluation, it will be important to develop appropriate objective measures of the range of outcomes.

Appendix 1: Methods

Overall aims and objectives

The overall aim of this project is to identify and assess all the Aboriginal and Torres Strait Islander healing programs addressing psychosocial issues among Australia's Indigenous peoples; critically analyse the concepts of healing and wellbeing as they pertain to Indigenous Australians; identify future trends in healing and research into healing; and identify gaps where further work is required.

Theoretical approach

We have adopted an approach to this project that places Aboriginal and Torres Strait Islander peoples firmly at the centre, as the original owners of Australia. Thus our method incorporates Aboriginal ways of doing things and is informed by Aboriginal epistemologies (Smith 1999; Kirmayer, MacDonald et al. 2000a). At the same time the work is informed by the principles of mental health research, social sciences research, and the conduct of such research across cultures (Kirmayer, MacDonald et al. 2000a; McKendrick and Bennett 2003; McKendrick and Bennett 2006). Aboriginal experiences of colonisation and institutionalised racism also inform the work (Mellor 2003; Austin-Broos 2011).

Method

We have critically searched and critically analysed the black and grey literature. The black literature is that published in peer-reviewed academic and scientific journals and other peer-reviewed publications and controlled by commercial publishers. The grey literature can be defined as:

... that which is produced on all levels of government, academic, business and industry in print and electronic formats, but which is not controlled by commercial publishers'. (Christensen, Griffiths et al. 2008, p. 103).

The grey literature includes conference abstracts, and reports, research reports, unpublished data, dissertations, policy documents, material found on the internet and personal correspondence. The black literature contains material that has been peer reviewed and thus is likely to be more methodologically and academically rigorous. However, it has been found that a large amount of research activity and descriptions of programs in the area of mental health and wellbeing are not reported in the black literature (Christensen, Griffiths et al. 2008). To ensure we locate as many healing programs as possible we have included the grey literature in this review.

The literature

We searched the black and grey literature pertaining to:

- ◆ the development of the concept of healing in Australian Indigenous perspectives, including holistic definitions of health, social and emotional wellbeing, spiritual wellbeing, Stolen Generations issues, and relevant international Indigenous contexts
- ◆ Aboriginal and Torres Strait Islander healing programs and Indigenous healing programs internationally (identified and critically reviewed)
- ◆ healing programs in Australia and internationally (assessed)
- ◆ the training of healing program workers in Australia and internationally (reviewed).

The search

Electronic databases

- ◆ Medline
- ◆ PsycINFO
- ◆ Google Scholar
- ◆ Web of Knowledge
- ◆ Informit database collection (includes the Aboriginal and Torres Strait Islander Health Bibliography and Indigenous Australia)
- ◆ Aboriginal and Torres Strait Islander Health: Aboriginal and Torres Strait Islander Health Bibliography

Web search engines

- ◆ Google
- ◆ University of Auckland

Websites

- ◆ Aboriginal community health organisations and state and national bodies
- ◆ Aboriginal organisations including the Aboriginal Child Care Agencies (ACCA), legal services, cooperatives
- ◆ state and federal government websites pertaining to Aboriginal people

Key search words

Indigenous healing, Aboriginal healing, Australian Aboriginal healing, Australian Aboriginal healing programs, Aboriginal healing programs, Indigenous healing programs, Torres Strait Islander healing, Torres Strait Islander healing programs, healing, healing programs, wellbeing, Indigenous wellbeing, Aboriginal wellbeing.

Unpublished material

Key informants were asked about unpublished written material pertaining to healing programs. The search included unpublished theses.

Management of data

- ◆ All materials located via the web were loaded into the Papers software (Papers Version 2.1.17, Mекentosj, 2010–2011), which keeps copies of the papers or books in pdf format and sorts them according to specification (author, date of publication, title). In this way the materials were easily accessible and duplications were deleted and not included in the final count.
- ◆ Books, reports, papers and websites that were only available in hard copy or could not be loaded into the Papers application were placed on a reference list.
- ◆ The Papers list and the reference list were merged.

Data sources

A total of 11,456 articles were identified via searches of Google Scholar, Medline, PsycINFO, Web of Knowledge, Google, Informit databases, websites, the Aboriginal health bibliography database and the University of Auckland. A total of 380 sources of data relevant to the review were identified on the basis of the abstract (exclusions included 3,502 duplicates and 7,954 on reading of the abstract). On reading of the full papers (380) a further 75 were excluded due to not including the impact of colonisation on Indigenous people or not providing sufficient information pertaining to context.

Sources pertaining to Indigenous Australians, Canadians, New Zealanders, North Americans and Europeans were included in the analysis. The section on healing and spirituality also included sources from the literature on Western and Eastern concepts, as many of the healing programs drew on multiple systems of knowledge about healing in addition to Indigenous systems. The search was deemed to be complete when no new data sources were being identified.

The data provided information on the following areas of the review, with some papers covering more than one topic:

- ◆ impacts of colonisation and subsequent trauma on Indigenous peoples
- ◆ concepts of healing and spirituality
- ◆ descriptions and reviews of Indigenous healing programs
- ◆ evaluation of healing programs
- ◆ reviews of healing programs

Criteria for inclusion and exclusion of data sources

In each case the identified data sources were scanned manually for relevance to the subject areas under consideration (checking, for example, the abstracts of papers, the introductions to books, the executive summaries of reports, and the homepages of websites). Those not relevant were excluded.

Impacts of colonisation and subsequent trauma on Indigenous peoples

The search period was 1980–2012 (research and academic writing pertaining to the traumatic impact of colonisation on Indigenous peoples began in the 1980s).

Sources were included if they addressed the impacts of events from the time of colonisation to the current day on Indigenous peoples in terms of wellbeing.

Sources that contained only a description of events without consideration of their impact were excluded.

Concepts of healing and spirituality

The search period was 1970–2012 (the modern literature pertaining to healing practices in relation to social and emotional wellbeing began in the 1970s).

Sources were included if they contained a definition(s) of healing, discussion of the process(es) of healing and discussion of the social and epistemological context of healing.

Sources were excluded if there was insufficient information pertaining to context.

Descriptions and reviews of Indigenous healing programs

The search period was 1990 – 2012 (most Indigenous healing programs began in the early 1990s).

It had been hoped that the description of healing programs would include the theoretical or epistemological basis of the program, the processes of healing, the staff delivering the programs, the qualifications required of staff and the types of problems the programs addressed. Very few papers met these criteria. Thus in this section all sources that contained even a rudimentary description of a healing program were included.

Evaluation of healing programs

The search period was 1990–2012 (as above).

Materials were included if they contained a detailed discussion of the method of evaluation, including the evaluation criteria, and a discussion of the findings of the evaluation in the social and epistemological context of the healing program. All evaluations identified met these criteria.

Reviews of healing programs

The search period was 1990–2012 (as above).

All reviews of healing programs were included.

Data source types

- ◆ Papers in peer-reviewed journals
- ◆ Reports published by academic institutions
- ◆ Reports to government and government publications
- ◆ Reports of Indigenous organisations – these were usually included under academic and government reports through partnerships with academic institutions and/or government departments
- ◆ Books and book chapters
- ◆ Websites of:
 - Indigenous healing programs
 - state, territory and federal government agencies
 - Aboriginal organisations
- ◆ Other – including PowerPoint presentations, calendars, pamphlets, annual reports and the like from Aboriginal organisations and healing programs, government agencies and academic institutions.

Sources of data and subject areas

Table A1 summarises the sources for the articles retained in the review process. Thirty-nine per cent (118 out of 305) of data sources overall were papers in peer-reviewed journals, 12 per cent reports for academic institutions, 12 per cent government reports, 16 per cent books and book chapters, and 14 per cent websites and other.

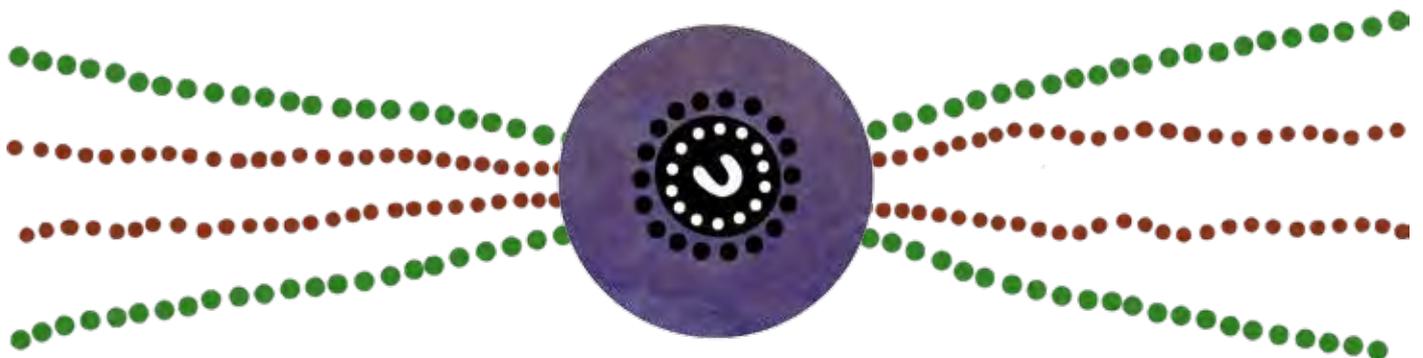
However, the types of data sources differ for subject areas, with over 50 per cent of sources for the background and healing/spirituality areas being from peer-reviewed journals compared with 23 per cent for descriptions of healing programs and 25 per cent for evaluations of healing programs. The most common sources of data for descriptions of healing programs were websites and other (35 per cent), while for evaluation of healing programs reports from academic institutions accounted for 35 per cent of the data.

The implications of the differences in types of data sources for the main subject areas of this review are discussed in the appropriate chapters.

Table A1: Sources of data for subject areas

Data source	Subject area				Total (no.)
	Background (no.)	Healing/ spirituality (no.)	Description of healing program (no.)	Evaluation of healing program (no.)	
Peer-reviewed journal	34	50	23	11	118
Academic report	6	13	5	15	39
Government report	2	9	17	10	38
Book / book chapter	15	11	18	7	49
Other*	3	5	36	0	42
Total no.	60	86	72	43	305

*Other includes websites. All websites used described healing programs.



Appendix 2: Aboriginal and Torres Strait Islander healing programs

Healing program	Overview	Programs	Evaluation	Other
A&TSIHS Brisbane www.atsichsbrisbane.org.au/mental-health	Improve access to culturally appropriate and high-quality mental health services; empower Indigenous people to become increasingly involved in own services delivery	General counselling; Bringing Them Home; spiritual and cultural counselling; advocacy and referral; cultural healing camps; programs for homeless; liaison; increase community awareness of mental health problems	No evaluation of this program – see also evaluation of OATSIH services	Not enough information to adequately assess
Aboriginal Women Against Violence	Train Aboriginal women to become trainer mentors and advocates in own communities; establish a committee Aboriginal Women Against Violence	Group activities; cultural activities	Yes – found that the program provided a safe space for women to explore the impact of violence on their own lives and the lives of their families	Program was a pilot – time frame too short to assess value. No assessment of impact on families and communities.
ADAC Makin Tracks www.adac.org.au	Assist communities to develop strategies for prevention and management of petrol sniffing, alcohol and other drug misuse	Mobile team of two professional educators around drug and alcohol issues	No	Insufficient information to adequately assess
ADAC Police Diversion Liaison www.adac.org.au	Assist young Aboriginal people (under 18 years) charged with simple possession of illicit drugs	Project officer can assess young people diverted under this scheme; referral of young person for counselling; support	No	Insufficient information to adequately assess
Balanu Foundation www.balanu.com.au	Healing programs for Indigenous youth in the Darwin region	Personal development program addressing negative behaviours and consequences; camps; support; other activities	No	Insufficient information to adequately assess
Black on Track www.blacontrack.com.au	Mobile program run by an individual	Many workshops advertised	No	Insufficient information to adequately assess; however, concerns about adequacy of support
Boomerang Parenting Program	Aboriginal parents and their children	A mix of traditional Aboriginal and Western healing methods	Yes – but by Western therapists using Western methods who acknowledge the inadequacy of the evaluation	Evaluation notes that more Aboriginal therapists and workers required for the program

Bush Mob www.bushmob.com.au	Young Aboriginal people at risk who live in urban areas and town camps in Alice Springs. Work is with the young people and their families.	Bush adventure therapy; residential program for young people aged 12–24 who want to live free of sniffing, alcohol and drugs – 24-hour care, counselling, education and training; life skills; medical check-up	No	Insufficient information to adequately assess
Central Australia Aboriginal Alcohol Program www.caaapu.org.au	Provide a safe, nondiscriminatory healing place that equips clients with the tools to live a healthy, sober, active and productive life; reduce harm from alcohol and other drugs; recognition of the unique spiritual and cultural strengths of Aboriginal people	Located in Alice Springs; outreach to remote communities; residential treatment program; women’s residential facility; Safe Healing Program	No	Insufficient information to adequately assess
Congress Social and Emotional Wellbeing Program	Address issues of depression, anger management, suicidal thoughts, loneliness, assistance to youth, financial and budgeting services, access to psychiatrist	Range of services	No See also OATSIH SEWB evaluation, Chapter 4	Insufficient information to adequately assess
Central Desert Night Patrol www.centraldesert.nt.gov.au/night-patrol	Operates in 11 Central Desert communities	Safe transport; diversion from criminal justice system; intervention to prevent disorder	No	Insufficient information to adequately assess
Central North Adelaide HS Family and Community Healing Program	See Chapter 4			
Cross Border Justice Project	Improve the safety and security of the Aboriginal people in the area	Justice services project in Central Australia that crosses NT, WA and SA borders	No	Insufficient information to adequately assess
Cummeragunja community development drug action team	Reduce the impact of substance abuse on the community of Cummeragunja	Identify problems in the community; address needs not already catered for; develop a local drug action plan	No	Insufficient information to adequately assess
Danila Dilba Social and Emotional Wellbeing and Youth Centre, Darwin	Funded through the OATSIH SEWB programs (BTH and Link Up)		No See Chapter 4 OATSIH SEWB evaluation	Insufficient information to adequately assess
Deadly Vibe	See Chapter 4			

Derbal Yerrigan Stolen Generation/ Bringing Them Home www.derbalyerrigan.com.au/programs/stolen-generation-bringing-them-home	Funded through the OATSIH SEWB programs (BTH and Link Up)		See Chapter 4 OATSIH SEWB evaluation	Insufficient information to adequately assess
Drumbeat	Program for Indigenous and non-Indigenous at-risk school children; has been run in WA and NT	Children randomly assigned to the program or normal school activities	Yes in WA. Program children had improved school attendance and self-esteem; however, more at-risk children assigned to the program	Insufficient information to assess
Family Wellbeing Empowerment Program, Yarrabah	See Chapter 4			
Galganyem Youth and Community Wellbeing Program	Bring Indigenous and non-Indigenous youth together for positive experiences. Partnership between community and university.	Camps held in community with visiting university students living everyday life with the Indigenous youth	No	Insufficient information to assess
Gamarada www.gamarada.org.au	Based in Sydney and run by the men who attend	Incorporates traditional Aboriginal healing, Western and Eastern methods. Ten-week healing program; two-day healing and life skills program; anger management and self-healing; parenting	Supported by influential Aboriginal and non-Aboriginal sponsors; however, not evaluated	Insufficient information to assess
H.E.A.L. Program, Larrakia	Improve the health and wellbeing of homeless people in Darwin by combating stigmatisation and its adverse impacts	Provides practical support to homeless people and challenges attitudes of mainstream. Key programs – Arts in the Grass; Darwin Vision; Grass Buddies	No	Insufficient information to assess
Inala Indigenous Early Year Intervention	Began with the premise that all parents want the best for their children	Established a steering group; developed an Indigenous child health promotion resource; Indigenous playgroup; liaising with local agencies; supported 50 people to undertake early years training within the community	No	Insufficient information to assess
Jalaris Aboriginal Corporation – Kinship www.pha.net.au	Works with marginalised families in the Kimberly and is based on the kinship system	Uses early intervention, child-centred approach to family healing. Kids future club; family support outreach; short course accredited training for families and carers.	Evaluation in progress	Sounds promising but insufficient information to assess

Koori Cognitive Skills Program	Develop the cognitive skills of Koori prisoners and reduce their risk of reoffending		Yes – a promising program but with problem areas. Evaluation has been removed from the Corrections Victoria website	All those who participated in the evaluation were prisoners and none criticised the program
Koori Fathering Program	North Coast NSW		No	Insufficient information to assess
Let's Start www.cdu.edu.au/letsstart	Test project aiming to build strong family relationships	Sharing of stories between parents; problem solving for parents and children; assist in transition to school; help children listen	Yes – however, the program was not modified in any way to cater for the needs of Aboriginal children and their parents, and participation dropped off markedly over the 10 weeks of the program	Showed a decrease in problem behaviours of school-age children; thus although only in the early stages, is worth further development (especially in catering to the needs of Aboriginal children and parents) and evaluation
Ma'ddaimba Balas Men's Group	See Chapter 4			
Marumali Circle of Healing www.marumali.com.au	See Chapter 4			
Maya	Strengthen the connections of Aboriginal families, communities, land and culture, to lead to inner peace and the resilience to live healthy and productive lives	Healing Family and Community; Healing Aboriginal Men; Healing Aboriginal Women; Healing Addiction; Heal the Healers. Activities; workshops on trauma and grief; cultural awareness programs; smoking ceremonies; warriors ceremonies	No	Insufficient information to adequately assess
Ngangkari Service (NYP Women's Council)	See Chapter 4			
Ngangkari Service, Ceduna Health Service	See Chapter 4			
Ngarlu	Traditional Aboriginal healing technique		No	Insufficient information to adequately assess
Northern Bundji Bundji Program	Justice program		No	Insufficient information to adequately assess
Nunkuwarriin Yunti SEWB www.nunku.org.au			No; see also evaluation of OATSIH SEWB, Chapter 4	Insufficient information to assess

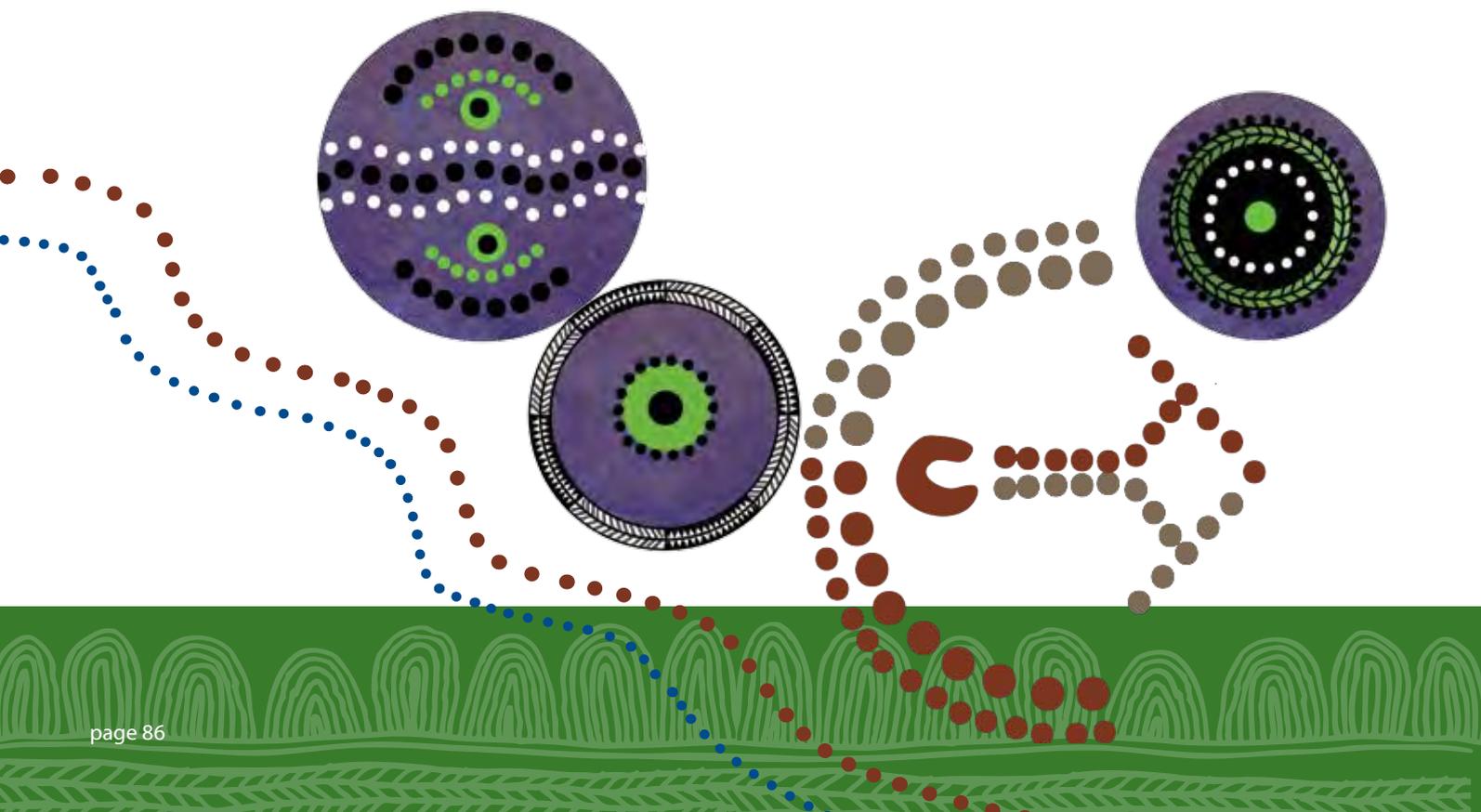
Red Dust Healing www.thereddust.com	Individually run program with no academic or community links	Wide range of workshops	No	Concerns about safety, adequacy of support
Rekindling the Spirit Family Centre, Lismore www.rekindlingthespirit.org.au				
Seven Phases to Healing www.lossandgrief.com.au	Healing from loss and grief		No	Insufficient information to adequately assess
Spirit Dreaming www.magickalrealm.com.au/healing-a-wellbeing-programs	Health and wellbeing programs for Aboriginal and non-Aboriginal men and women; Aboriginal owned and run	Programs for prisoners; women's healing circles; narrative therapy; meditation	No	Insufficient information to adequately assess
Tirkandi Inabirra Cultural and Development Centre www.tirkandi.org.au	Strengthen personal identity and resilience; targets young men who have potential but are judged by their family and/or community as just about to get into trouble	Residential centre for young Aboriginal men aged 12–15 years from the Riverina; caters for 14 young men for six-month periods	No	Insufficient information to adequately assess
Victorian Aboriginal Health Service Family Counselling Service	Funded through the OATSIH SEWB programs (BTH and Link Up)		See evaluation of OATSIH SEWB, Chapter 4	Insufficient information to assess
We Al-Li	See Chapter 4			
Working with Adolescents to Prevent Domestic Violence	Innovative project to reduce domestic violence by working with adolescents	Range of programs based in the community	Yes. A positive program with positive impact on the adolescents involved, especially in relation to their views of violence.	A worthwhile program; however, has not been running long enough to provide information about impact on family and community
Wuchopperen Social Health Team, Cairns www.wuchopperen.com	An OATSIH SEWB program	Counselling for individuals, couples and families; BTH counselling; Link Up; support services; substance use programs; domestic violence programs	No; see also Chapter 4 OATSIH evaluation	Insufficient information to adequately assess
Yalmambiladhaany	Aboriginal women's peer education group in mid-western NSW	Ten-week program covering traditional knowledge; changes through life; pregnancy and care of mother and baby; preventing illness in women; healthy relationships. Includes field trip.	Yes – program evaluated in week 10 by the women themselves. Generally well received by the women.	Insufficient information to adequately assess

Yaba Bimbi Indigenous Men's Support Group	See Chapter 4			
Yorgum Aboriginal Family Counselling Service (SEWB, Link Up) www.yorgum.com.au	Offers a range of traditional and Western healing techniques	Variety of healing services to Aboriginal people in Perth. Grandmothers Group; counselling (one on one, BTH, family, couples, sexual abuse; family violence, grief and loss); Child Sexual Abuse Program; Workforce Support Unit	No; see also Chapter 4 evaluation of OATSIH SEWB	These programs have been operating since 1991; however, there is not enough information to adequately assess

Discussion: Healing Programs

The range of healing programs operating throughout Australia for Aboriginal people is testament to the need for such programs – for women, men, children, families and communities. Most of the programs are operated through Aboriginal communities, Aboriginal community organisations and, in particular, Aboriginal community controlled health services. Unlike the programs discussed in detail in Chapter 4, the programs documented here have insufficient information recorded in the black or grey literature to determine their usefulness.

Our discussions with Aboriginal people around Australia, and our own experience, lead us to conclude that there are many healing programs being run through Aboriginal communities and organisations that have not been documented at all. Lack of documentation – again from our consultations and our own experience – is usually due to the fact that most of the time and resources of those working in healing centres is taken up with the day-to-day work of delivering the services. However, lack of documentation has ramifications in terms of the program being less likely to attract funding, and this review has found that programs that do not have long-term adequate funding and resources are not likely to succeed. Indeed the programs we were able to discuss in detail in Chapter 4 are all well funded and have been funded for several years, and all have formed partnerships with an academic institution, thus facilitating evaluation, knowledge and skills transfer and the ability to attract further funding. Documentation of programs is also important because the lessons learned in one community are often useful to communities wanting to establish their own healing programs.



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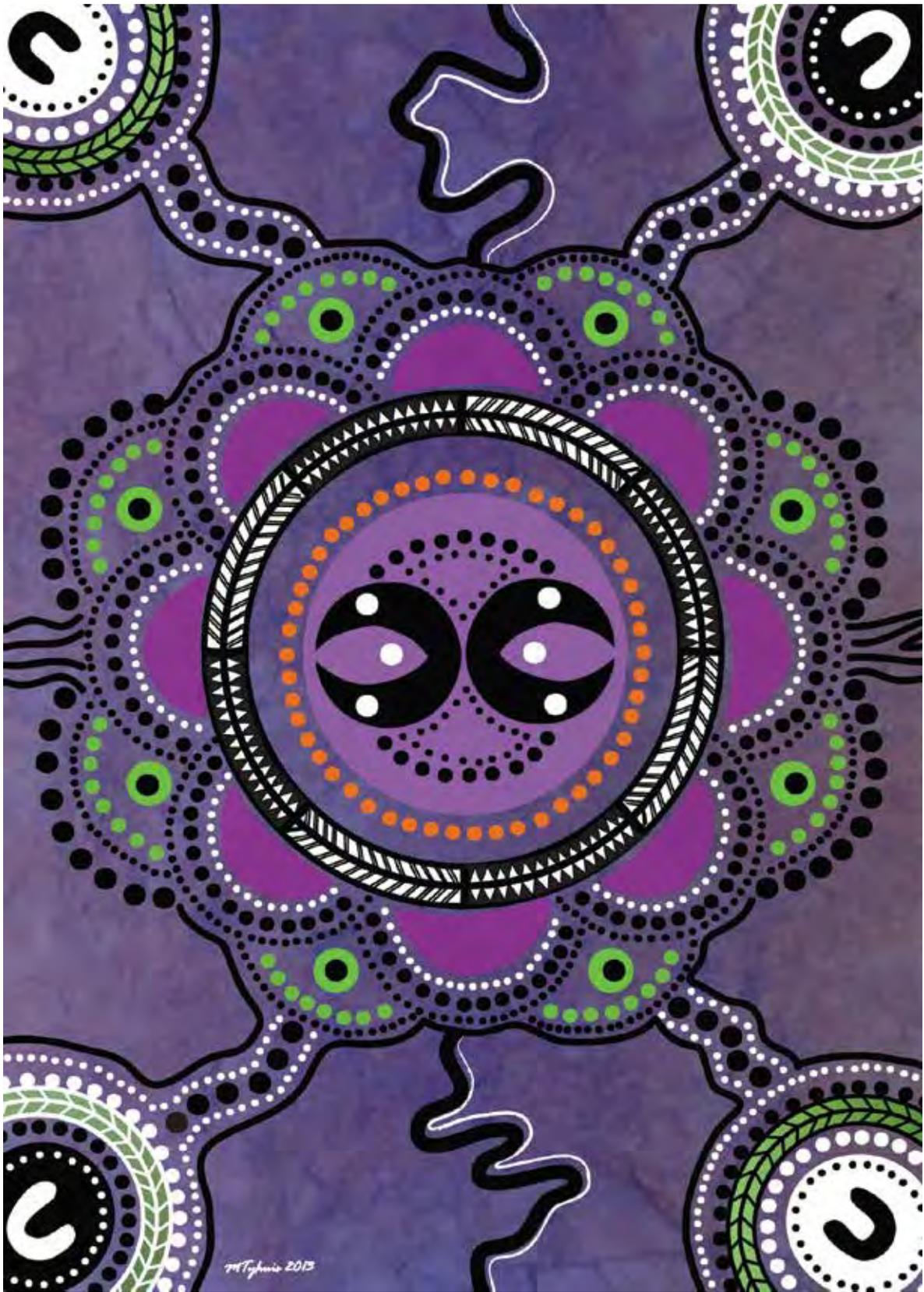
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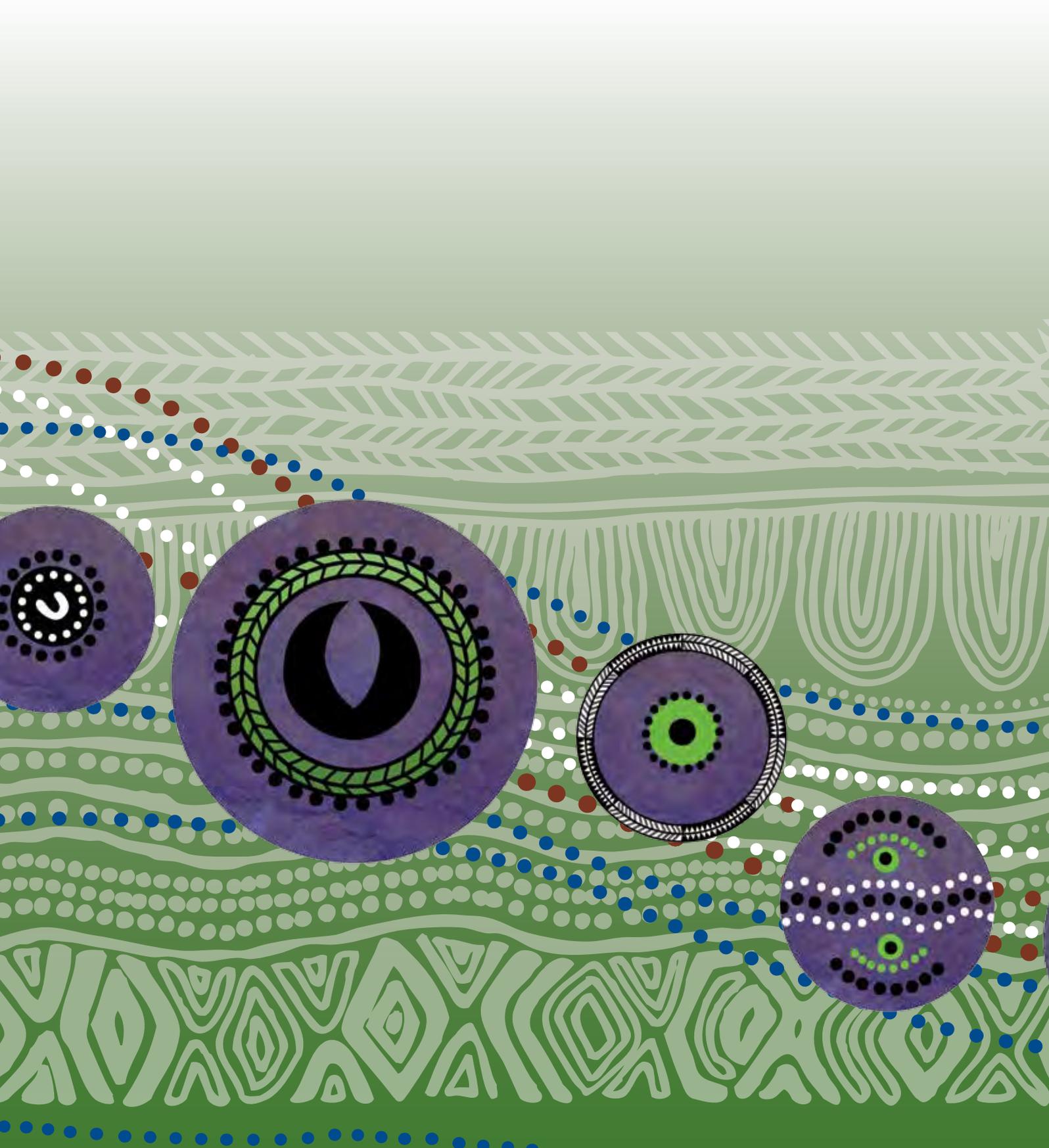
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