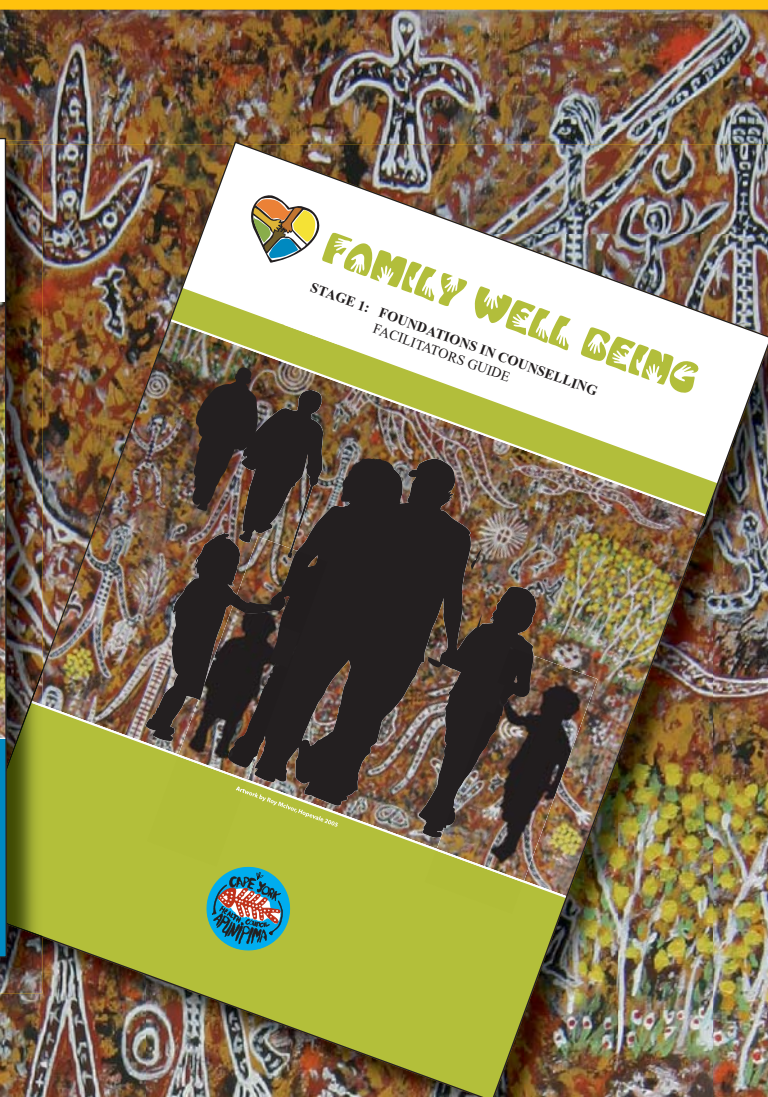
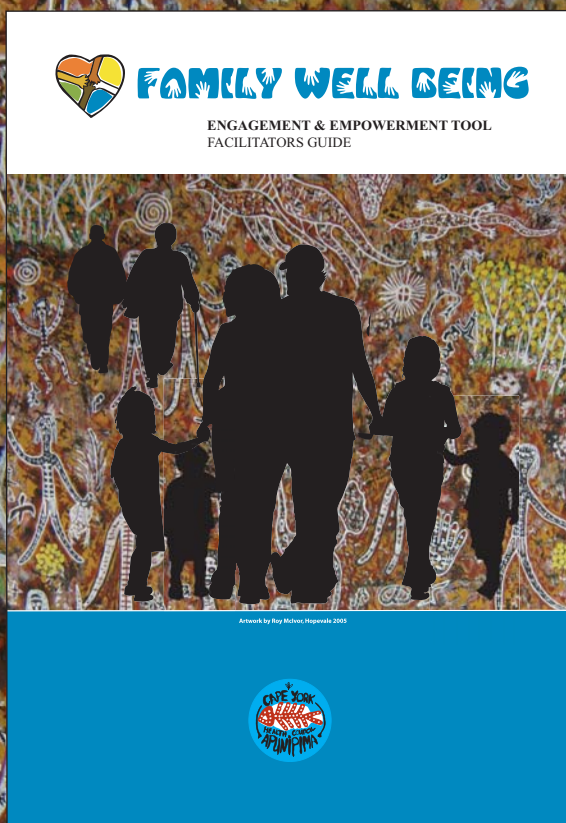




FAMILY WELL BEING

Final Evaluation Report 2006



Authors

• *Komla Tsey* • *Teresa Gibson* • *Liz Pearson*



‘Wallan and Mutharr’

Roy Mclvor

Hopevale artist Roy Mclvor's acrylic on canvas work 'Wallan and Mutharr' represents the Family Wellbeing program, its aim and objectives.

It tells a story of two ancestral beings, Wallan and Mutharr. Wallan is a hunter, sharer and giver, a person who does the right thing for his extended family and community and helps them.

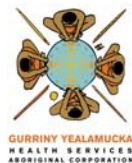
Mutharr is Wallan's opposite, he expects everything to be given to him, doesn't go hunting and therefore cannot share with his family and community. Mutharr does not care to be a provider (hunter) he sits back.

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The Family Well Being program was originally developed by the Aboriginal Education Development Branch, a division of the Office of Vocational and Education and Training, South Australia.

For further information contact

James Cook University

School of Indigenous Australian Studies

PO Box 6811, Cairns Q 4870

Ph. (07) 4042 1710

email. komla.tsey@jcu.edu.au

elizabeth.pearson@jcu.edu.au

teresa.gibson@jcu.edu.au

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EXECUTIVE SUMMARY

This is the third and final in a series of Family Wellbeing participatory action research (PAR) evaluation reports prepared by Apunipima Cape York Health Council over the past 5 years. The present evaluation confirms previous FWB evaluation findings across a range of settings and other evidence that the process of empowerment is lengthy, taking years to achieve change beyond the individual level. It also highlights the process of initial engagement and personal capacity development which enhances individual social and emotional wellbeing.

This provides a critical foundation for achieving a healthier life. Many health promotion programs overlook this phase, assuming a level of personal strength and capacity which may not exist in communities such as Cape York experiencing relative powerlessness and social and economic marginalisation due to many things including government policy but specifically those social determinants that impact on health and the destructive effects of alcohol.

The FWB program is being increasingly incorporated into a range of health interventions across northern Australia. These include: mental health, schools health promotion, alcohol and prevention and rehabilitation, workforce empowerment, diversionary and rehabilitation for men entering the criminal justice system as alternative to imprisonment, rehabilitation within prison, reducing family violence, leadership and governance, Job Preparedness and Welfare Reform, and Self-care in Chronic Disease management. Although these are diverse areas of interest, they all share common core components in the need for people to gain greater control over their lives and situations and skills to make and sustain healthier lives.

Apunipima has embarked on a long term transition process to allow greater community control and ownership for the delivery of primary health care services in Cape York Peninsula. A set of health performance indicators to be measured before, during and after the five year transition period are being developed. Key priority measures will include: increased birth weights; decrease in alcohol and substance misuse; decrease in disease burden, especially chronic disease; happy, healthy families with renewed culture; clean and safe environments; and Cape York people taking responsibility and control of their own health. Empowerment and control are clearly common elements that must be effectively promoted across a range of health, education and employment services and programs if success in these areas is possible.

Given the critical importance of empowerment in achieving social and emotional wellbeing, Apunipima developed a strategy identifying medium to long term sub strategies called "Strengthening and Supporting Families and Carers". It takes a community development approach to health and the social determinants impacting on health across the continuum of care, and is a framework for social emotional wellbeing for Cape York. The aim is to work closely with a range of relevant government and non-government departments and organisations to implement the identified sub strategies and programs that will improve the social and emotional wellbeing of community people.





The relevant agencies include Queensland Mental Health, Alcohol and Other Drugs (ATODS), Education Queensland, Child Safety, Department of Communities, Royal Flying Doctor Service (RFDS), Cape York Partnerships and the Cape York Institute, the FNQ Regional Division of General Practitioners and the Centre for Rural and Remote Mental Health Queensland and including Gurriny Yealamucka Health Service (Yarrabah) in order to appropriately integrate or embed the FWB or other proven empowerment approaches into their services focusing on children, young people, adults and the elderly. Informed by the Cape wide whole-of-community approach, embedding FWB and other empowerment strategies in these services and programs will be supported and coordinated regionally through the Regional Health Forum processes.

Overall, however, the Cape York health reform process needs to be grounded more explicitly in the context of the Substance Misuse Strategy. As the Strategy argues, the epidemic of substance abuse is not just one of many factors contributing to the poor health and early deaths for Indigenous people in the Cape, it is the central factor. From this perspective, any efforts to improve health and life expectancy must first and foremost confront substance abuse.

Clearly it is vital that Apunipima, the lead agency responsible for health reform, ensures that immediate and appropriate steps are taken by the relevant agencies to fully implement simultaneously all elements of the six-point Cape York Substance Misuse Strategy at community levels rather than the current situation whereby only fragments of the strategy are being implemented at any given time in a community. Unless the Substance Misuse Strategy is implemented in a way that respects the spirit and integrity of the document Apunipima would be setting itself and indeed the health reform process up to fail.

RECOMMENDATIONS

That the Cape York Regional Health Forum endorses the following recommendations:

- That further planning is done by Forum members to decide agree upon a set of proven capacity building products including Family Well Being; and a consistent evaluation framework or models inclusive of Participatory Action Research;
- Acknowledges and endorses the Family Wellbeing project as one of the tools for community capacity building;
- That Family Well Being Team delivers to Health Action Teams, community members and service delivery agencies as the platform for developing a community driven empowerment and capacity building framework;
- The Family Well Being Team to negotiate funds to build the infrastructure and resources of the Social Emotional Health and Well Being Team in Pormpuraaw, Cape York Peninsula as the first community pilot site for the empowerment framework;
- The Family Well Being Team to negotiate funds to sustain the enabling structures/resources within the individual communities that support the regional delivery of Family Wellbeing; and the empowerment and capacity building framework for Cape York.

Apunipima Cape York Health Council, as the lead agency responsible for health reform, to ensure that immediate and appropriate steps are taken by the relevant agencies to fully implement simultaneously all elements of the six-point Cape York Substance Misuse Strategy at community levels;

Further:

- National policies are acknowledged as major influences on upstream factors impacting on health outcomes; therefore policy should build up national health capital through investment in physical assets (i.e. health care system infrastructure, schools, transport systems, housing and social services);
- Fast track policy implementation that encompasses social determinants that impact on living and working conditions and behavioural risk factors. Which will drive positive and constructive government-supported initiatives to improve social emotional well being to reduce the risk of suicide;
- Invest and build service capacity, enabling structures and infrastructure for empowerment modelling of social emotional wellbeing in Cape York Peninsula as first pilot site for the Family Well Being empowerment and capacity building frameworks;
- Recognise that capacity building requires financial, human and social infrastructure in addition to strong policy direction. Human investment refers to developing the skills of health workers and community members in a strategic coordinated planning framework and aligned to the principles of community control rather than funding isolated capacity building projects across multiple government agencies.



CHAPTER ONE: INTRODUCTION

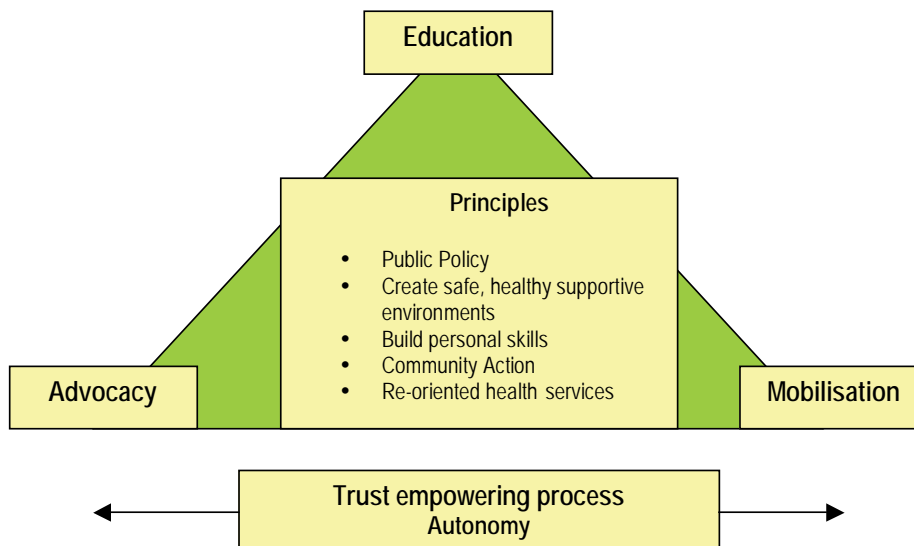
Twenty years after the declaration of the Ottawa Charter for Health Promotion, empowerment has been recognised by the World Health Organization (WHO) as a viable strategy for improving individual and community health outcomes. The recently released WHO Health Evidence Report on the effectiveness of empowerment to improve health (Wallerstein, 2006) found that participatory empowerment interventions with socially excluded populations have produced empowerment across psychological, organisational and community levels, leading to improved health outcomes and quality of life.

The study highlighted that successful empowering interventions were participatory, based on empowerment as a multi-level construct and ensured individual and community involvement in decision making. However, the report also found that effective empowerment strategies could not be standardised and there was a need for the development and evaluation of programs which are locally relevant and address broader social and economic inequalities.

This report presents the findings of the third and final evaluation (January 2005- December 2006) of a 5-year Apunipima Cape York Health Council (Apunipima) Family Wellbeing (FWB) empowerment project. The aim of the project was to adapt the Adelaide based FWB program as a 'family and clan engagement tool' that would enhance the capacity of residents of Cape York to take greater control and responsibility for their lives, in the context of a broader Cape York Partnerships Strategy.

Previous evaluation reports clearly demonstrated the effectiveness of the FWB empowerment approach as a tool for engaging participants on a wide range of issues affecting their health and wellbeing and those of their families. Informed by the principles of participatory action research (PAR), the series of reports were designed to assist the project partners to monitor and improve the quality of the program over time.

World Health Organisation Ottawa Charter Health Promotion Framework





This final evaluation of the project focuses on steps being taken by Apunipima to both sustain as well as embed the FWB or other proven empowerment approaches into a range of services and programs including the implementation of child maternal health, chronic disease, drug and alcohol, social emotional wellbeing and mental health, family violence, education and welfare reform strategies across north Queensland. The report also documents the development of a set of FWB resources under a National Suicide Prevention Strategy funding (June 2005- December 2006).

The present evaluation report therefore needs to be read in conjunction with the following previous reports:

- Tsey, K., Deemal, A., Whiteside, M. & Gibson, T. (2003). 'It's an eye-opener for people to see you can change things': An evaluation of a 'family wellbeing' personal and community development pilot project in two Cape York Communities. Apunipima Cape York Health Council and University of Queensland School of Population Health, Cairns.
- Tsey, K., Deemal, A., Whiteside, M. & Gibson, T. (2003). 'We learnt how to be a good leader, help live a good life': An evaluation of a pilot 'family wellbeing' program in two Cape York primary schools. Apunipima Cape York Health Council and University of Queensland School of Population Health, Cairns.
- Tsey K., Whiteside M., Daly B., Deemal A., Gibson T, Cadet-James, Y., Wilson A., Santhanam R. & Haswell M. (2005). Adapting the family wellbeing empowerment program to the needs of remote Indigenous young people, Australian and New Zealand Journal of Public Health, 29(2):112-116.
- Travers, H., Gibson, T., Tsey, K., Bambie, J. & McIvor, R. (2004). 'Just for Bama'. An evaluation of the Family Wellbeing personal and community engagement tool in a Cape York community. University of Queensland and Apunipima Cape York Health Council, Cairns.

The report is structured into six chapters:

- Chapter 1: Introduction
- Chapter 2: The empowerment Research Program
- Chapter 3: Approaches to health development in Cape York
- Chapter 4: Description of the FWB empowerment program
- Chapter 5: Current evaluation and findings
- Chapter 6: FWB in the context of transition to community control

The next chapter provides an overview of a broader Empowerment Research Program of which the Apunipima FWB initiative forms a part. The aim is to locate the Apunipima FWB program within an emerging public health research highlighting issues of empowerment and control as critical determinants of health and wellbeing.

CHAPTER TWO: THE EMPOWERMENT RESEARCH PROGRAM

2.1 Background

A major challenge facing the public health profession in the 21st century is how to develop appropriate strategies and interventions to reduce growing health inequalities that reflect the increasingly unequal socio-economic status of populations. Internationally and within Australia, there has been extensive academic and policy interest in social determinants of health. However, there remains a chronic lack of understanding about the causal pathways linking social disadvantage and health, and a serious lack of evidence-based public health interventions that aim to address health inequalities (See Oldenburg et al 2000).

Evidence from social gradient research indicates a need for micro level studies that explore issues of control of destiny and empowerment (Syme 2004). A better understanding of strategies that enhance people's capacity to take greater control over their circumstances is imperative in the context of Indigenous health.

As a group, Indigenous Australians experience higher levels of illness and premature death compared with the rest of the population. They are also more likely to be incarcerated, experience family violence, have lower levels of education and employment, and suffer from excessive use of alcohol and other substances. Recently, community leaders using language that resonates with notions of empowerment and control in the emerging public health literature have called for more innovative and creative research that would assist Indigenous people take greater control and responsibility for their situation (Pearson, 2000).

Empowerment is central to the Ottawa Charter for Health Promotion and subsequent WHO health promotion strategies. As a theoretical construct, empowerment involves both processes and outcomes which generate change at multiple levels – individual, organisational and community; strengthening the capacity for collective action to positively influence social situations (Wallerstein 1992). Although there has been clear global acceptance of these concepts as core principles of health improvement, the translation of this rhetoric into action has remained less clear.

In 2006, twenty years after the declaration of the Ottawa Charter for Health Promotion, the World Health Organisation Health Evidence Network published a review of the evidence for the effectiveness of empowerment in improving health (WHO, 2006). The report identifies pathways through which empowerment is generated at psychological, organisational and community levels and links the effect of these outcomes to improvements in health. The report concludes that there is evidence that initiatives based on empowerment as a multi-level construct can reduce health disparities but that successful approaches cannot simply be replicated across populations.




The report also identifies the need for development and evaluation of strategies relevant to the lived experience of populations experiencing socially exclusion (WHO, 2006). Thus the operationalisation of the process of empowerment with marginalised populations and demonstration of its potential in reducing health inequalities remains a major challenge.

Fundamental to any initiative that aims to enhance empowerment and control is that it is relevant to the needs of its participants, that it starts where people are 'at' and that it engages different people who have differing life experiences and opportunities and who may be at different levels of motivation and ability.

Wayne McCashen has developed a framework which views empowerment/disempowerment in terms of a continuum (Figure 1).

Figure 1: Spectrum of Empowerment

				
	Disempowered		Empowered	
Present Experience	Diminished ability Diminished motivation	Ability Insufficient motivation	Unrecognised ability Sufficient motivation	Recognised ability High motivation
Tasks	Deep listening Validation Provide resources Small steps	Deep listening Validation Rewrite the dominant story Add resources Build a Picture of the future Start with small steps	Elicit and build on strengths Work with/enable Strengthen the main story	Facilitate/enable Ensure resources Re-affirm the main story.

Source: McCashen (1998) cited in Tsey, Whiteside, Deemal et al. 2003

This framework provides some ideas in regard to the different actions required for working with people at different stages of empowerment. While those at the more empowered end of the spectrum need to be 'enabled' or given opportunities, people at the disempowered end may well first require support to start to build a sense of hope.

Creating group environments where people feel safe to interact and share experience, and learn from and support one another is critical to empowerment. Group interaction is an important ingredient for change. Processes that enhance discussion between people who bring different experiences and knowledge provide opportunities for broadening understanding, reinforce potential connections, minimise divisions and build confidence to plan and work together.



2.2 Definitions

Empowerment can be defined as a multi-level construct that involves people assuming control and mastery over their lives in the context of their social and political environment (Wallerstein 1992 p 198) or a social action process that promotes participation of people, organisations and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice (Wallerstein 1992 p 198).

Control is the ability of people to deal with the forces that affect their lives, even if they decide not to deal with them (Syme 2003) or the capacity to deal with day to day challenges of life without being overwhelmed by them (Syme 1998).

Health is defined holistically as not just the physical wellbeing of an individual but the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life-after-death (NAHS 1989).

Wellbeing includes health, social well-being, economic well-being, environmental well-being, life satisfaction, spiritual or existential well-being, and other characteristics valued by humans (AIHW 1994: 1); and is defined as a state of health or sufficiency in all aspects of life (ABS 2001:6)

2.3 Aims and Objectives of the Empowerment Research Program

The overall aim of the Empowerment Research Program is to understand and demonstrate the capacity of empowerment interventions focused at the individual, group and community level to contribute to broad improvement in health of Indigenous Australians.

The broad research objectives include:

Short-term objectives (2001-2005)

1. Determine the utility of empowerment interventions (based on fostering analytical and problem-solving skills and expertise) as tools to engage and support individuals and groups in Indigenous settings to take greater control and responsibility for their health and wellbeing
2. Develop appropriate in-depth qualitative tools to monitor and assess the nature of empowerment interventions, their acceptability and effectiveness in a variety of settings, as well as the range of contextual issues that may arise in implementing such interventions

3. Identify the possible pathways through which personal or psychological empowerment might lead to structural empowerment and vice versa
4. Determine the medium-longer term sustainability of empowerment interventions and devise appropriate strategies to promote sustainability
5. Identify the skills, training and support needs for local Indigenous community based empowerment research facilitators, and best practice models of organising and providing such support.

Medium-longer term objectives (2006-2010)

1. Develop appropriate measurement tools to quantify the efficacy of empowerment interventions
2. Assess the role and usefulness of empowerment interventions, more specifically in Indigenous communities experiencing high levels of alcohol misuse, family violence, unemployment and limited opportunities for gainful employment
3. Explore the potential of empowerment interventions as tools to enhance chronic disease (e.g. diabetes, mental illness) management and prevention
4. Develop frameworks to undertake appropriate economic evaluation (such as cost effectiveness analysis) of complex empowerment interventions that aim to foster greater control and responsibility
5. Determine the possibilities and limitations of empowerment interventions as tools addressing health inequalities at population levels
6. Develop best practice approaches to collaborative working relationships between academic researchers and relevant stakeholders that would promote the concept of empowerment at community, organisational and policy levels
7. Develop a critical mass of interdisciplinary empowerment and community development research expertise from grassroots levels through to doctoral and post-doctoral levels
8. Make contributions of local, national and international significance to the knowledge of evidence based approaches that engage and support individuals and groups to take greater control and responsibility for their health and wellbeing.





2.4 Key partners in the Empowerment Research Program

The key partner organisations and people in the empowerment research program are:

- James Cook University, School of Indigenous Australian Studies and School of Public Health and Tropical Medicine (Yvonne Cadet James, Valda Wallace, Komla Tsey, Mark Wenitong, Mary Whiteside and Janya McCalman)
- University of Queensland, School of Population Health (Melissa Haswell, Andrew Wilson, Brenda Hall, Valmae Ypinazar, and Rachael Wargent)
- Apunipima Cape York Health Council (Teresa Gibson, Liz Pearson and Cleveland Fagan)
- Gurriny Yealamucka Health Council Aboriginal Corporation, Yarrabah (David Baird, Ruth Fagan, David Patterson, Bradley Baird, Les Baird, Senimelia Kingsburra, and Kaylene Jackson)
- Tangentyere Council, Alice Springs (Eunice Blackmore and Kathy Abbott)
- Yaba Bimbie Men's Group, Yarrabah (David Patterson, Bradley Baird and Dennis Warta)
- Ma'Ddaimba-Balas Men's Group Innisfail (Darryl Ahkee, Anthony Jia and David Ambrum)
- Queensland Department of Communities (formerly Department of Families), North Queensland Regional Office (Karen Dini-Paul)

2.5 Intervention approaches used to promote empowerment and control

We have utilised two practical programs or tools for studying empowerment and control and their relationships to Indigenous health. These are the Family Wellbeing Empowerment Program and Indigenous Men's Support Groups. Both of these interventions are 'inside-out solutions' that build on Indigenous strengths. The dominant image of Indigenous Australia portrayed by health statistics and the media is a traumatised people plagued by chronic and debilitating disease, incompetent governance systems, alcoholism, violence, unemployment, boredom and appalling education outcomes.

Too often these images overlook crucial facts that Indigenous communities, like all human societies, mainly consist of people trying as best as they can to go about the daily business of living a meaningful life. Equally important is that no matter how desperate the situation might look to the outsider, communities often have pockets of exceptional strength, resiliency, creativity and innovation.

Despite this health professionals and development workers continue to assume that best practice health interventions among Indigenous peoples depend entirely on the ingenuity, expertise and generosity of the outsider. This has led to repeated mistakes in 'fixing up' problems for Indigenous peoples rather than harnessing and supporting those strengths from within.



2.5.1 Indigenous Men's Support Groups

Indigenous Men's Support Groups have been established in many communities throughout Australia. Although there is considerable diversity in the composition and priorities of men's groups, they have a common aim of empowering men, supporting and being a role model for younger Indigenous men, and addressing the factors identified as contributing to social dissatisfaction and poor health and wellbeing in Indigenous communities. Men from the Yarrabah Yaba Bimbie Men's Group developed a list of 'Do's and Don'ts' by which a man who "takes his rightful role in the community" might be recognised. This model was the platform and transferred by Apunipima Men's Health Officers, (who had also undertaken FWB Leadership Training Stage 1), to the men's groups in Wujal Wujal, Lockhart River and the Northern Peninsula Area.

As well as giving the men a clear identity, values and social norms to which they aspired, the Do's and Don'ts also provided a set of criteria which allowed men to reflect and evaluate their own progress over time. Far from fitting the stereotyped view of Aboriginal men as passive welfare recipients, our work has shown men's group leaders to be highly committed and motivated people who provide significant support services through voluntary contribution of their time.

Participants of men's support groups have reported health-related benefits such as improved confidence, reduced alcohol use, spending more time with their children and contributions (as part of other broader community initiatives) to reductions in rates of suicides. (See relevant Men's Group publications under references).

2.5.2 The Family Wellbeing Empowerment Program

Developed by Adelaide-based Indigenous Australians, the aim of the Family Wellbeing program is personal transformation based on principles of psycho synthesis and grounded in Indigenous experiences of family survival (Tsey & Every, 2000). Psycho synthesis is a process of personal growth which involves harmonising the physical, emotional, mental and spiritual aspects of life through learning a range of practical techniques. The goal of psycho synthesis is to foster ongoing growth through the application of these techniques to everyday living.

Survival experiences of course facilitators and participants are the main learning resource of the program. Group processes play an important role in facilitating a safe and supportive learning environment in which participants feel comfortable to reflect and express feelings.

Through a supportive group process participants develop the confidence and skills to address their personal wellbeing, family unity and community harmony. FWB articulates the human qualities necessary for leadership and healthy relationships such as vision, respect, empathy, and compassion. It advocates relationships that are based on wisdom, acceptance, freedom and honesty and provides a safe forum for reflection and learning skills to achieve these personal qualities and relationships.



The safe and supportive learning environment also provides an opportunity for people to reflect on and share stories about important questions for life: Where am I going with my life? Who is benefiting and who is losing out? What can I do to change the situation? With what consequences? The focus on sharing stories/narratives is also the strength of the program.

Bruner (1990) highlights the role of narrative in social cohesion and stability and says that one of the most powerful forms of social stability is the human propensity to share stories of human diversity and to make their interpretations congruent with the divergent moral commitments and institutional obligations that prevail in every culture.

Breakdown in culture is connected with impoverishment of narrative resources; not that there is a total loss of stories but that the 'worst scenario' story comes to dominate daily life and variation no longer seems to be possible.

FWB has five stages. Stages 1 to 4 consist of nine 4-hour sessions and Stage 5 is a 1-week intensive facilitator training course.

Stage 1 introduces participants to the course, the participants learn about basic human needs and the kinds of behaviour that can result when these are not met; dealing with conflict; understanding emotions; understanding crisis; the effect beliefs and attitudes can have on our choices; and practical skills in looking after ourselves and providing counselling and support to others.

Stage 2 deals with the process of change, how it affects people and how to deal with it. Another aspect of this stage is for participants to reflect on their own life as a means to developing their inner qualities and strengths. Loss and grief are also focused on.

In Stage 3 the focus is on family violence, how it affects people, how to recognise signs of abuse, the skills needed to deal with it, the healing process; and creating emotional health.

Stage 4 focuses on relationships; understanding ourselves; balancing the mind, body and emotions. It also looks at the traditions and values of the participants and the FWB course is looked at as a whole.

The final stage is facilitator training which enables participants who have done the previous four stages to be able to facilitate FWB.

It is important to outline the key policies and ideas that have been driving health and social reform agendas on Cape York Peninsula over the last five years. The aim is to locate Apunipima FWB program within its relevant policy contexts. This should help explain Apunipima's current efforts to support relevant agencies to integrate and embed the Family Wellbeing into a wide range of services and programs including: Child Maternal Health, alcohol and drug services, mental health, suicide prevention, chronic disease management, school health program, leadership and governance, family violence and preparation for work.

CHAPTER THREE: APPROACHES TO BETTER HEALTH IN CAPE YORK

3.1 Health-related problems and challenges for Cape York people

Levels of health for Indigenous people in Cape York are significantly worse than those for many other Queensland communities. Figures show that mortality rates in Cape York are 2-3 times higher than in Queensland overall, and that median age at death is at least 20 years younger for Indigenous Queenslanders than for non-Indigenous people.

It is widely recognised that alcohol is one of the main factors influencing these figures. Alcohol related deaths in Cape York are reported to be 21 times the general rate for Queensland.

Chronic disease is another main cause of poor health and early death. Over 90% of the burden of disease in Indigenous communities relates to chronic disease (including diabetes, heart disease, renal disease, respiratory disease, mental health problems and sexually transmitted infections). Average diabetes rates for Australians aged over 15 is 7%, but for Aboriginal people in the Northern Zone the rate is 13% and for Torres Strait Islanders it is 24%.

Recent efforts to improve the health of people in Cape York have focussed on turning around these factors. Four main strategies that outline their own ways of viewing and tackling the challenges are summarised below:

- Cape York Substance Abuse Strategy
- The Enhanced Model of Primary Care
- Apunipima's River of Life and Health Strategy
- Community-Controlled Health Model

3.2 Cape York Substance Abuse Strategy

Cape York Substance Abuse Strategy was developed in 2002 by the Apunipima Alcohol and Drugs Working Group and Cape York Partnerships. The Substance Abuse Strategy describes substance abuse as a psycho-socially contagious epidemic. According to the Strategy the epidemic of substance abuse is not just one of many factors contributing to the poor health and early deaths for Indigenous people in the Cape, it is the central factor. From this perspective, any efforts to improve health and life expectancy must first confront substance abuse.

The Strategy uses and builds on the language and concepts of Alcoholics Anonymous (AA). The AA model sees substance abuse as an addiction, a central part of which is denial. The Substance Abuse Strategy extends the concept of denial beyond the individual level and applies it at a social level.

The Strategy emphasises that, in Aboriginal communities in Cape York, everyone is "part of a social web that is infected by an epidemic" (p. 21). Denial - part of the behaviour of addicts - also explains the behaviour of family, friends, the community and the whole society. The health of Aboriginal people in the Cape will not change until the epidemic, and the behaviours that have developed as a result, are owned, acknowledged as unacceptable, and confronted.





Explanations that postpone the need to confront alcohol abuse are seen as part of the denial: they support the passive approach that has allowed the social epidemic to continue.

The Substance Abuse Strategy is intended to influence community councils, Queensland Health, other government departments, and other Indigenous and non Indigenous regional agencies.

Key underlying points that the Strategy makes are:

- Aboriginal people must face up to the grog and drug problem and not expect other people to solve the problem
- Partnerships between Aboriginal people and government – with Aboriginal people taking primary responsibility - are the best approach
- Where community leaders and organisations are unprepared or unwilling to address the problems, the State Government must act
- Substance abuse must be tackled from multiple angles.

The Strategy identifies 6 main factors that support the growth of alcohol and drug epidemics (and that therefore influence poor health):

- Permissive social standards;
- Drug availability;
- Money to acquire the drug;
- Time to use the drug;
- Examples of drug use by others in the community including Australia's permissive attitude to drug use;
- The environments in which people exist.

Six strategies are proposed that, together, are intended as a holistic approach to increase life expectancy and rebuild Aboriginal society.

(i) Rebuild intolerance of substance abuse

The fundamental basis of the Strategy is the need for Aboriginal people to develop uncompromising intolerance of substance abuse. This means taking a radical approach, rejecting explanations and approaches that support denial.

Denial is supported by tolerance from family and friends. It is also supported by attempts to promote moderate drinking behaviour, by harm minimisation, voluntary rehabilitation, and by "symptom theory" (seeing addiction as a symptom of underlying social and economic problems). All these approaches are permissive and accept abuse, instead abuse must be rejected.

The Strategy claims we must see that addiction is a condition in its own right and can be addressed without first righting social, historical and economic wrongs. The exact ways that intolerance should be rebuilt are specific to each community but the overall aim is to restore Aboriginal Law, giving it legal force to rebuild social and cultural standards that are intolerant of substance abuse and the behaviour associated with it. This should happen through Community Justice Groups.

(ii) Control availability and supply

The Strategy involves zero tolerance policing around supply and use of illicit drugs, and restrictions for alcohol, which may involve temporary prohibition. Although the Strategy says that controlling supply is not a magic bullet, and must be seen only as part of a multi-pronged approach, it does emphasise the need to break the problem in a fundamental way- that may require prohibition even for moderate drinkers. The Strategy recommends community planning, through Community Justice Groups, to develop community-specific Alcohol Management Plans. For development of the plans, processes must be used that allow power to lie with the sober, responsible members of the community, who are often weak and vulnerable physically and politically (the young, elderly, and/or women). If the process used is legalistic or adversarial, those with addiction problems will defend substance abuse.

(iii) Manage money

Lack of banking facilities and lack of services that allow people to purchase goods and services without cash lead to large amounts of cash in communities. This fuels epidemics of substance abuse and gambling. The amount of disposable money should be addressed by implementing assisted Family Income Management (FIM); establishing facilities such as credit unions; and introducing Compulsory Income Management Orders for abusers.

(iv) Manage time

Although some people claim that boredom is a reason for substance misuse the Strategy claims that addictions are at the root of much boredom. It recommends building jobs (real economy), developing volunteerism, and increasing opportunities for cultural activities, sport, recreation and travel.

(v) Treatment and rehabilitation, voluntary and compulsory: health interventions that are family based

As well as providing rehabilitation for those who ask for it, those who do are usually at an advanced stage in their drinking. To tackle the epidemic, it may be necessary to enforce compulsory rehabilitation for some people. Orders should be able to be made by a Magistrates Court on the recommendation of family members or a Community Justice Court. The main reason for compulsory rehabilitation is to reduce the likelihood that current drinkers will provide an example that encourages new people to start drinking. For the same reason, social drinkers should recognise their responsibility to provide moral leadership.

Health interventions should be delivered in a way that sees the health of each individual in the context of their family health history and circumstances. Public health approaches could work with families and extended families to think and plan their collective health as a family. Doctors could build on the knowledge health workers have of patients' histories and families, to give more relevant health consultations and planning.

(vi) Fix up home and community environment

Rebuild pride and order in home and community environments. Community Councils can support this, working towards a physical environment that is well maintained, safe and pleasant.





3.3 Enhance Model of Primary Care

The Enhance Model of Primary (EMPC) is the approach developed by Queensland Health during 2002/3 to address chronic disease among Indigenous people in North Queensland. It builds on the Chronic Disease Strategy (CDS), also developed by Queensland Health.

The EMPC sees chronic disease as:

- (1) a main cause of ill health among Indigenous people in North Queensland, and
- (2) largely preventable.

Given the high proportion of people who already have chronic disease, the EMPC (and the CDS) acknowledges the ongoing need for services to treat health complications associated with chronic diseases, but it sees the need for more attention to be focussed on reducing the causes and the development of chronic disease.

The Chronic Disease Strategy (CDS) recognises that chronic diseases are all largely influenced by the same behavioural factors, including alcohol abuse, tobacco smoking, poor nutrition, obesity, and lack of physical activity and by broader social and environmental factors including income, housing, education and employment.

Once chronic disease has developed, it is made worse by the continuing influence of the same factors, or efforts can be made to prevent its progress by identifying it early, and changing behaviour, conditions, and/or providing treatment.

The Model is part of Queensland Health's policy, and forms part of agreements between Queensland Health and Apunipima. The CDS recognises that until recently most health care has been focussed on very sick people, and that to make a real change, more energy and more services must be focussed on prevention and early detection of chronic disease. To achieve this, the CDS identified three main streams of work: prevention, early detection and management.

Prevention includes programs that aim to address tobacco smoking and alcohol abuse, and that aim to promote physical activity, healthy women and babies, safe sex, immunisation, mental health and environmental health.

Early detection programs include children's checks and annual health checks for women and men so that chronic disease can be identified at its early stages. Brief intervention is also included in this stream, where health staff can provide information, support and/or treatment to help people in early stages of chronic disease to stay healthier.



The third stream is management for people with more advanced chronic disease. This includes using and maintaining recall registers for regular check-ups, and providing treatment and care for people with diabetes, cardio vascular disease, renal disease, chronic respiratory disease, STIs, and mental health issues.

The Enhanced Model of Primary Care offers a way of applying the Chronic Disease Strategy in remote communities in North Queensland. It involves working with communities to identify their main health problems, and to consider which services and programs they need, and how they should be delivered.

3.4 Apunipima's River of Life and Health

In 2000 the Apunipima Governing Committee adopted The River of Life and Health Strategy; and this framework continues to underpin the Organisation's work. It is summarised and referred to in Annual Reports and is updated and explained in more detail in an in-house document that takes into account the development of the EMPC and the goal of community control of service delivery.



The River of Life and Health framework is based on an image of life as a river. Children start life upstream and, with good parenting and education can develop sound foundations for social and emotional well-being and good all-round health. They can develop the ability to swim safely across the river to the banks that offer healthy adult life with a range of opportunities. Without a good start, children get stuck on the wrong side of the river, where rough water and waterfalls (alcohol, drugs,



violence, poor health etc) make life risky. Safety nets can be put across the river to try to stop or help those who get caught in the rough water (prevention and early detection) or to manage the damage for those who go over the waterfall (treatment and services for those with diabetes, depression, STIs, etc). But the most effective way to a healthy adulthood is to ensure a good start.

The framework shares with the EMPC the understanding of health problems as the outcome of the social environment (tobacco, alcohol and other drugs, family dysfunction, lack of exercise, poor health literacy, passive welfare, economic and employment disadvantage, gambling), and the physical environment (inadequate housing, overcrowding, inadequate food storage and cooking facilities, inadequate public health infrastructure, lack of facilities for diversionary activities). These conditions lead to high rates of injury, obesity, poor nutrition, preventable infections, high STI rates, low personal resilience, which in turn lead to chronic diseases and other poor health outcomes.

The River of Life has another theme that underpins the focus on prevention: preventative health care is about self-determination and so must be community based and owned.

The River of Life framework is intended not only to guide and influence the way Apunipima does its work, but it also aims to be a guide for communities, and for other agencies whose work impacts on health, including agencies related to education, employment opportunities, environmental factors etc.

When applied to Apunipima's activities the River of Life strategy indicates that programs and projects must be:

- a) related to upstream work
- b) community based, capable of being community controlled and ultimately community run.

The central point is that chronic disease should be addressed 'upstream' before it has the chance to develop. The main focus should be on the social determinants of health, which include the social environment and the physical environment. To address these effectively requires a coordinated and collaborative approach across sectors, and across organisations.

The two main themes of community control and a prevention focus are combined in an approach that identifies the need for communities to develop and own plans to improve the social and physical determinants of health in their own community.

3.5 Community-controlled health trials

From its inception in 1994 Apunipima Cape York Health Council's long term goal has been to work towards community control and ownership of health service delivery throughout Cape York. During the first half of 2005 the Cape York Institute, in partnership with Apunipima, explored and presented proposals for new ways of delivering health services, and proposed a pilot health social enterprise. The framework underlying the Trials is the Apunipima River of Life Strategy, with its dual emphasis on upstream causes of ill health, and on the need for community control of the development and monitoring of Indigenous health systems. The proposals were developed for presentation at the Regional Health Forum. The proposal would influence the way Queensland Health, Department of Health and Ageing, and communities provide services and organise funding.

The proposed models for health services emphasise the importance of community participation in, and control of, development and monitoring of health services. The proposal offers 5 potential models of health service delivery and funding, allocating control and management in various ways between Queensland Health, Department of Health and Ageing, and the community.

The social enterprise model, which is proposed as part of the community controlled trials, identifies ways to specifically target identified upstream drivers of health. The early proposal identifies 10 upstream drivers of health. The drivers are rated according to the effectiveness of current initiatives, and the likely ability of a health social enterprise to address them. Using these 2 scales as axes on a graph, the individual drivers are plotted to indicate the areas in which social enterprises should first be piloted. Physical recreation, nutrition, and housing conditions (in descending order) are the areas considered best suited for health social enterprises.

The Cape York Regional Health Strategy has been developed and the land mark signing of the Deed of Commitment on the 15 August 2006 by Queensland Health, Department of Health and Ageing, FNQ Regional GPs Division, Royal Flying Doctor Service, Mookai Rosie, Queensland Ambulance Services, and Apunipima Cape York Health Council is the first step towards achieving significant health and social reforms as highlighted in the key policy documents above.

The rest of this report focuses on the role and contribution of Family Well Being and other proven empowerment approaches towards the achievement of aims and objectives of the health and social reform agenda.



CHAPTER FOUR: APUNIPIMA FAMILY WELLBEING EMPOWERMENT PROGRAM

4.1 Background

In the context of Cape York, there has been frustration by Indigenous leaders such as Noel Pearson (2000) about a lack of progress in improving health and wellbeing. As a result, there have been calls for the situation to be re-evaluated, and in particular for Indigenous people to take greater control and responsibility so as to become agents of their own change.

A nationally acclaimed Cape York Partnerships Strategy was developed as the main vehicle for people to become agents of their own change. Apunipima Cape York Health Council, as the lead health agency in the Cape York Partnerships, was given the special responsibility to come up with a 'family and clan engagement tool' that would empower Cape York people to take greater charge of their affairs in the context of the broader Partnerships processes.

At about the same time that Apunipima started exploring options for developing a community engagement tool, Audrey Deemal from Hopevale was asked to undertake a study as part of her Masters Degree of Applied Epidemiology course to find out why there were high levels of stress among young women.

This led to the partnership between Apunipima, James Cook University and UQ who established the FWB Empowerment Team to adapt and pilot the Indigenous developed FWB Empowerment Program as part of the broader Empowerment Research Program. In 2001 Teresa Gibson became the FWB Empowerment Coordinator through to 2007. During this time Teresa completed a Graduate Diploma in Health Promotion at Sydney University (2005); an article was published in the Aboriginal Torres Strait Islander Health Worker Journal, "Teresa Gibson: My Story", and she has coauthored on publications as outlined through this report.



Teresa Gibson with Professor Marilyn Wise at Sydney University

4.2 Previous evaluation

A series of 30-hour workshops were conducted in the two pilot sites between April 2001 and May 2005. A total of 88 adults participated in the workshops in the two pilot communities. Due to concern about teasing, bullying, fighting, low self esteem and what was described as 'truancy', adults in the pilot communities also requested that the program be adapted for school children.

A total of 70 students aged between 9 and 12 years participated in a schools pilot. Previous evaluations established the capacity of the FWB approach to "engage" individuals and communities to take greater control and responsibility for their situation. Program participants first addressed personal and immediate family issues, and this led to a ripple effect of increasing harmony and capacity to address issues within the wider community (Tsey and others 2003; Tsey, Travers et al 2005).



Similar findings were reported in the school setting. Outcomes included increased analytical and reflective skills and positive behaviour changes amongst the Indigenous and non-Indigenous students who participated. A key recommendation of the research was to integrate FWB into standard school curriculum (Tsey et al 2005).

4.3 Key developments since the previous evaluation

Since the last evaluation report in 2004 Apunipima has taken on a major role in the transition towards community-controlled health service delivery across the region. The Council has been restructured to become less involved in direct service delivery in individual communities, including the delivery of the Family Well Being Program in Hopevale and Wujal Wujal.

This section of the report outlines the key steps that Apunipima has taken since 2005 to achieve the key FWB deliverables under the 2005/6 National Suicide Prevention Strategy funding within the Organisation's changing roles and responsibilities.

4.4 Continuing delivery of FWB in Hopevale and Wujal Wujal through a brokerage arrangement with University of Queensland


Apunipima and UQ have been working together on a range of health initiatives over many years. The most recent activities arising from this collaboration are the Australian Integrated Mental Health Initiative (AIMhi) and the Australian Health Ministers Priority Driven Research (PDR) project, which are closely linked with the Family Well Being Program. PDR began in 2005 with consultations and preparations with the communities of Yarrabah and Hopevale. Apunipima was a partner organisation on the original success grant proposal and is an active Steering Committee member.

Because of the consistency of process and outcomes of the Family Wellbeing Program and the Priority Driven Research project, Apunipima transferred a contribution of the National Suicide Prevention Strategy funding to University of Queensland to support the employed FWB community-based position in Hopevale, which still allowed Apunipima to meet its objectives of the funding agreement between Apunipima and the National Suicide Prevention Strategy.

A local resident who had completed the FWB leadership Training Stage 1 with Teresa Gibson was recruited in August 2006 and is based at the Hopevale Primary Health Centre.

Under a formal memorandum of understanding between UQ, Hopevale Council and Apunipima the latter has:

- Made its existing equipment and materials in Hopevale available to the researcher

- 
- Provided a financial contribution of \$18,000 (including GST) to the Cairns office of the UQ to be used for the salary of the researcher; and
 - Continued to be an active Steering Committee member for the AIMhi, PDR projects and the Empowerment Research Program.

4.5 FWB facilitator Manuals

Apunipima also contracted JCU to undertake the revision and development of a set of FWB facilitator manuals as a key component of its strategy to make the program as readily available as possible to a wide range of relevant agencies and organisations.

A part-time Senior Research Officer with expertise in education and training was employed. With support of a Steering Committee drawn from Apunipima, UQ, JCU, and Education Queensland a set of facilitator manuals were either developed or revised as follows:

1. FWB Engagement and Empowerment Tool (fully revised from the original FWB personal development and leadership program to be used as a generic “engagement” tool across all age groups. It will address the broad spectrum of health and social reform areas including drug and alcohol, suicide prevention, chronic disease management, school health promotion, leadership and governance, family violence and preparation for work, etc.). Stages 1-4 are available to any participants of the Engagement and Empowerment Tool if they wish to proceed to advanced stages through a registered training organisation. Stages 1-4 can be used for workforce training in the areas of social emotional wellbeing e.g. mental health, drug and alcohol counselling, family violence etc.
2. FWB Stage 1: Foundation in Counselling
3. FWB Stage 2: The Process of Change
4. FWB Stage 3: Changing the Patterns
5. FWB Stage 4: Opening the Heart
6. FWB Children’s Leadership Facilitators’ Guide



4.6 Bound for Success FWB Schools' Curriculum

In 2003 Apunipima published *We Learn How to Be a Good Leader, Help Live a Good Life: An Evaluation of a pilot 'family wellbeing' program in Two Cape York Primary Schools*. It highlighted that to be sustainable the 'family wellbeing' school program should be integrated into the school curriculum; and for this to occur ongoing dialogue between key stakeholders to examine the evaluation findings, and make a decision to continue the program in schools was required.

Liz Pearson, representing Apunipima at a First Years Teacher Orientation Forum in January 2006 recognised that the principles and framework of FWB could work succinctly with the 'Bound For Success' and 'Rich Task New Basics Curriculum' and established a steering committee with Apunipima, James Cook University, Queensland Department of Education and the Arts Queensland to develop a 10 week unit of curriculum, Making My Way Through (MMWT), based on the Family Wellbeing empowerment program.

On the basis of the findings of previous FWB pilot in the schools, Apunipima approached Queensland Education Bound for Success Curriculum Team to incorporate FWB Units into the school curriculum. The Queensland Department of Education and the Arts not only accepted the recommendation to integrate FWB into school curriculum but went a step further to build an entire term of the Year 7 curriculum around the FWB empowerment principles. The result is the innovative MMWT unit which is to be piloted within the Cape York Bound for Success Education Strategy in Hopevale, Bloomfield River (Wujal Wujal) and Pormpuraaw schools in 2007.

The Cape York Bound for Success Education strategy is a new approach to Indigenous education in Cape York aiming to increase student attendance, achievement and school completion, through providing a comprehensive approach to the barriers children across the region face in attending school and remaining in education (Queensland Department of Education and the Arts 2006).

The strategy has three major components: greater community input into schooling, improved education services at all stages of schooling and ongoing research. Aligned with the Queensland Department of Education and the Arts Curriculum Assessment and Reporting framework (QCARF), Bound for Success focuses on:

- Literacy and numeracy skills
- Consistent curriculum framework
- Integration of curriculum, pedagogy, assessment and reporting
- Improved preparation and support for transitions and students studying away from home
- Pathways for career and/or further education.



MMWT is a ten week unit of curriculum designed to align with the Bound for Success Curriculum strategy and current Department of Education and the Arts' Queensland initiatives. It is underpinned by recognition that students in the 21st century face particular challenges and need to be prepared as citizens, not only for their local community, but for a regional, national and global context.

Such preparation involves building personal resiliency, a strong sense of identity, a set of values that incorporate respect and valuing of diversity and the skills needed to participate and respond to a wide range of needs of different groups and individuals.

MMWT is targeted specifically at Year 7 students in recognition of their need to prepare themselves for adulthood and transitioning to either boarding school or the local High School that also services nearby communities. Ongoing student retention is largely dependent on a successful transition program over which students have influence.

The learning objectives of the unit encapsulate the intent of Family Wellbeing; in particular:

- increased analytical and reflective skills
- positive behaviour changes
- better understanding of self and the needs of others
- discovery and building of a sense of hope
- building self esteem and confidence
- development of skills in problem solving and making decisions
- starting to plan for their future
- knowing their potential as leaders.

A number of considerations influenced the design of the Making My Way Through curriculum unit. These included:

- The increasing role of digital technology in daily life and the need for students to be not only literate but creative in this area
- The premise that local issues shape identity
- The need for students to develop critical and analytical skills necessary not only for consuming information but also for understanding their experiences and exploring life choices
- The knowledge that students have the potential to obtain support and direction through family, local, regional or global systems of which they may not even be aware.

The unit was therefore designed to be intellectually rigorous, embedded within a supportive classroom environment that recognises differences in individual interpretations of the world and to support connections between the student and their wider world.



Under girding this curriculum is the development of interactive graphics, scenes and ‘avatars’ (indigenous characters) that will be used as tools by school children and integrated as part of the social emotional wellbeing model for Cape York as narrative therapy in Child Mental Health.

Apunipima will further strengthen its partnership with Education Queensland and Queensland Health by establishing a steering committee to develop interactive scenes and scenarios, and software for learning relating to the “Bound for Success: Map of Development Health Awareness Curriculum”. This captures Hygiene, Self Care and Safety, Nutrition, Emotions, Relationships, Identity, Spirit and Senses. Children using avatars and scenes will be empowered to take responsibility to manage changes impacting on their health and wellbeing.

4.7 Participatory Planning and Evaluation for Apunipima staff

On the basis of the documented positive outcomes being achieved through the FWB program, Liz Pearson invited JCU/UQ empowerment research team to train and support Apunipima staff in applying the same empowerment and participatory action research principles to program planning and evaluation. This was adopted across the entire organisation and has continued. The process started in January 2005, the Participatory Planning and Evaluation (PP&E) project objectives were to assist staff:

- Develop greater understanding and appreciation of the policies and ideas driving health and social reform in Cape York
- Ground key Apunipima programs and services within the wider policy and theoretical contexts
- Develop practical skills and expertise to plan, monitor, evaluate and report their program/service outcomes
- Develop a sustainable planning and evaluation mechanisms for Apunipima to pro-actively plan and manage rapid organisation change.



Apunipima Cape York Health Council staff at a PAR Workshop in December 2006



The PP&E Team drew on a set of knowledge systems to inform monthly reflective planning and evaluation learning workshops for staff. These bodies of knowledge include:

- Synthesis of current thinking and approaches to developing better health in Cape York (including the Cape York Substance Misuse Strategy, Enhance Model of Primary Care, Apunipima River of Life strategy and Community-controlled health trials) as presented in Chapter 3 of this report
- A body of change management literature highlighting the role and critical importance of emotional intelligence (i.e. understanding our emotions and how to deal with them) in creating healthy and productive working environments
- Literature addressing the role of workplace stress in creating health inequalities and the role that worker empowerment and control of job latitude can play in reducing stress thereby improving health and productivity at the workplace
- A strengths-base approach literature emphasising simple yet powerful strategies for working with people to bring about change including focusing on people's strengths, knowledge and resilience rather than on problems or needs, separating the person from the problem, creating a vision for the future, celebrating small steps for change and using these small steps to build the belief that change is possible, no matter how difficult a situation first appears. (De Shazer 1986, McCashen 2005).

An Office of Aboriginal and Torres Strait Islander Health (OATSIH) Planning and Reporting template was used by all staff to plan and report their work monthly. "Pre" and "post" questionnaires measuring staff morale and confidence was administered to all staff. The questionnaire was based on Boston Consultants pictorial diagram, entitled 'A roadmap for change', charting the path an organisation may or may not follow, moving through phases from stagnation to preparation, implementation, determination and finally to fruition.

The PP&E project was formally completed in September 2006. The final follow-up questionnaire was administered to staff in December 2006 and a final report produced adding weight to the broader documentation and research by Apunipima mapping the move to community control. Meanwhile, Apunipima management and staff valued the PP&E process and have committed themselves to continuing the monthly PP&E workshops as a key strategy in the move towards a fully community controlled health service. Unit Managers and their teams will take turns to facilitate the monthly PP&E workshops with the empowerment research team available to provide backup support if needed.

This process undertaken in the Family Wellbeing framework can be applied to multiple workplace settings, including Queensland Health workforce involved in reforming disempowering workplace practices, empowering Indigenous health worker workforce, and understanding and participating in change management processes in the move to community control.



4.8 Other key developments

Other important developments since January 2005 include:

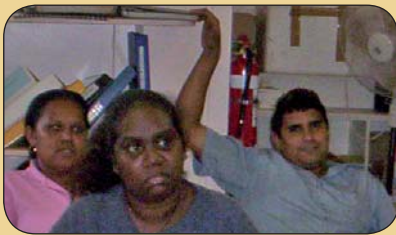
- FWB has been supported by the Executive Director of Community Health, District Manager of CYDHS, and DONS.
- Ongoing community delivery of Stage 1 FWB to Hopevale Primary Health Care Centre staff; Wujal Wujal Aged Care staff; PCYC for School after Care program for young people
- Development of FWB promotional DVD
- Basic Stage 1 FWB delivered in-house to over 90% of Apunipima staff including all the core program staff - Women's Health; Men's Health; Foetal Alcohol Syndrome FAS, STD, Policy/Advocacy
- Full 5-stage including Facilitator Training delivered to 5 core Apunipima program staff as part of a regional north Queensland initiative to build facilitation capacity –18 facilitators trained across the region
- Community 'refresher' workshops in Hopevale
- FWB university research partners invited by Apunipima management to train entire staff in the principles of PAR and to mentor and support staff to use the PAR approach as tools for supporting the organisation in its efforts to become the peak community controlled comprehensive primary health care service - note PAR is the overall FWB research paradigm and the usefulness and relevance of the approach motivated its adoption at organisational level as tool for organisational change
- Presented at Northern Indigenous Mental Health Workforce
- Coordinated Regional FWB Workshop with James Cook & University of Queensland
- Presented at the National Empowerment Conference for Social Policy Melbourne
- Presented at the International Society for Equity in Health
- Advocacy through the Cape York Regional Health Forum and other relevant channels for the FWB approach to become the foundation for all social and emotional wellbeing including mental health services for Cape York
- Embedded FWB principles of empowerment and evaluation in professional develop of Queensland Health workforce in the Healthy for Life Initiative
- The use of FWB as a tool for delivery of education awareness workshops about Foetal Alcohol Spectrum Disorder/Foetal Alcohol Syndrome as identified in Apunipima's final FASD Report It's In Your Hands: Creation Of Life 2000-2006
- Steering Committee established with Apunipima and the JCU School of Indigenous Studies to design the Graduate Certificate, Graduate Diploma and Masters in Social Emotional Well Being.



Cairns Workshop



Hopevale Workshop



CHAPTER FIVE: CURRENT EVALUATION

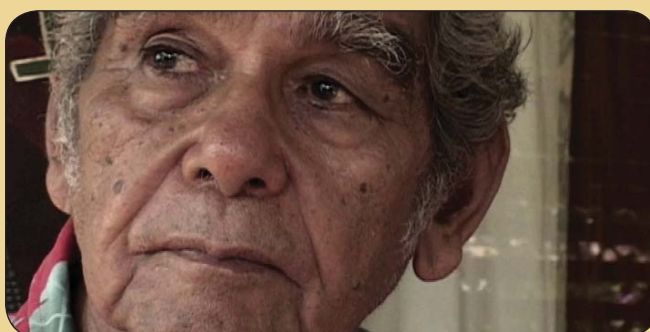
5.1 Approach to the evaluation

The pathways to empowerment and improved health described in the World Health Organisation Health Evidence Network report (2006) recognise that change occurs slowly, with documented examples of successful empowerment initiatives taking up to six years to realise broader social change (Wallerstein 2002). Documenting and analysing empowering strategies over time helps us to better understand the process of empowerment and ways in which change is generated at multiple levels.

The main source of data for the current evaluation is analysis of unedited video footage of a one-day reflective workshop for FWB participants (Wujal Wujal and Hopevale, including Queensland Health staff that had done FWB) in December 2005, plus in-depth interviews with ten information rich participants immediately following the workshop.

The purpose of the workshop held in Cooktown in December 2005 was to enable people in Hopevale and Wujal Wujal who had participated in the program over the previous 5 years to critically reflect as a group on the role of FWB within their communities, the highlights and challenges associated with using the concepts skills and their ideas for the future.

Cooktown & Wujal Wujal Workshops





Recording the reflective workshop and interviews visually on a DVD had a number of advantages in terms of data analysis. It enabled verbal and non-verbal cues, interactions between participants and changes in the physical layout of the workshop setting to be accurately observed rather than relying on handwritten notes or audio- tapes. This added to the richness of the data and enabled scenes to be replayed for clarification and verification during analysis. Narrative analysis recognises that the stories we tell about our lives provide insight into our experiences and how we make sense of our lives.

The DVD's were viewed a number of times. Detailed notes of the stories and reflections by participants were recorded initially. These were then analysed for recurring themes. A further viewing was undertaken specifically to identify and record non-verbal cues, interactions between participants and changes in the physical setting and this analysis has been integrated with themes emerging from participants' reflections and stories including the in-depth interviews. A key data limitation is that concern for young peoples' health and wellbeing dominated participants' narratives but the views of young people have not been directly canvassed in the study.

5.2 Findings

Of the 88 people exposed to the FWB program in the two communities 26 (30%) participated in the one-day reflective workshop (10am – 4pm). This represented a high participation rate given the logistic challenges of bringing participants from these two remote settings to a central meeting point in Cooktown. Participants' ages ranged from 20-70+ with a median age of 35-45. More women than men (16 versus 10) participated in the reflective day, reflecting the fact that overall more women were involved in the FWB program.

Disillusioned with programs that had been irrelevant, inappropriate or too complex, participants were initially skeptical of a new program and this is reflected in the relatively small number of people recruited to the FWB program in each community.

The program continues to focus on involving small groups of local people who can support and develop community capacity for change. While numbers were small, table 1 indicates that the level of individual exposure to the program was relatively high with over half of participants completing the full ten 3-hour sessions or 30 hours of learning.

Table 1 Participation in Family Wellbeing Pilot Study 2001- 2005

Community	10 topics (30 hours)	5 topics (15 hours)	Total
Community 1 (pop. 800)	39	18	57
Community 2 (pop. 300)	11	20	31
Total	50	38	88



It is the experience of the program facilitators that it takes this level of intensity in exposure to the program for meaningful engagement and personal capacity development to occur.

Common narratives which emerged from the analysis are: life before FWB; new perspectives and skills; acknowledging and celebrating change; integration with existing programs; and living the new perspective-modelling FWB. As much as possible, participants own words or phrases have been selected from the data to illustrate the narratives.

5.2.1 Life before FWB

Reflecting on their life prior to involvement with FWB, participants described a period of despair, frustration or hopelessness often related to a personal crisis such as the suicide of a family member. One participant described her life following a family suicide as *“a big emptiness”* while another recounted that *“when I lost my son, there was no tomorrow for me”*. This was compounded by an inability to express feelings or manage strong emotions such as anger and relate to others in a positive way. One participant related that in the past she was *“holding my anger within myself”* and often felt lonely. This contrasted with her more positive experiences early in life *“growing up I learnt more about culture. I learnt more with mum and dad and grandparents – going out hunting and gathering, sharing food together, playing together with families. We used to follow old people a lot.”* Reflecting on his own experience of isolation, another participant related that in the past he had often judged other people harshly.

In reflecting on her life prior to FWB, one participant focused on her frustration in the workplace, saying *“Before FWB I was sort of stuck as a young person, I was very stuck and just not being heard, not being heard as a young person was one of the things because being the only young person in the workforce and you’ve got all these ideas and you want to talk to the elders and let them know how you feel, then sometimes they’re not listening and I feel frustrated as a young person”*.

In contrast, another participant described a sense of community wide malaise about the future as *“at the moment no-one understands themselves. This is why we are just sitting and wanting handouts. Because we don’t know ourself. We don’t know what we want”*.

5.2.2 New perspective, new skills

FWB provided an opportunity for participants to critically reflect on their lives and re-evaluate the manner in which they understood and acted on their experiences. For most participants, this involved recognising that problems and conflict were part of everyday life and that no matter how difficult the circumstances, it was possible to manage change, support others and remain focused on the future. Confidence and optimism about the future was expressed by most participants.



Following FWB, participants related being able to analyse and manage conflict, express feelings, manage strong emotions and build better relationships in the family and the community, resulting in a sense of optimism about the future. As one participant related *“we can help them now, we’ve got the strength back – some of it”*.

Being able to share their feelings with a trusted group of people was important in validating those experiences and reducing self blame. Sharing meant *“I am not the only one who has problems”* while another participant related *“It makes you feel better about yourself if you share with others”*. These skills developed in FWB were able to be applied in the family and the workplace. One participant described the importance of building nurturing relationships in the family, describing this as *“setting our foundation”* and saying that FWB had *“taught me about sitting down in a bigger group”*. FWB had also resulted in improved workplace relationships in one instance with one participant saying *“it opened our eyes up to see each others problems”*.

Most participants identified the tragedy of youth suicide and the needs of young people as a priority for the future. The skills and confidence acquired through FWB were considered by some to be important in enabling them to be a role model and leader in the community. Demonstrating problem solving skills, being respectful towards young people and elders, and providing informal opportunities for these two groups to come together to tell stories were suggested as strategies to address the needs of young people. While one participant viewed the undermining of cultural practices, high alcohol consumption and peer pressure as precursors to suicide, another participant focused on mediating factors such as lack of family and community support, as evidenced by the following story:

“We went up to the Laura Dance Festival. We were having a yarn and telling them all we’ll learn the languages and you young fellas can sing the songs. What broke my heart was then he said to me “I don’t want to dance because no-one claps for us. Our people don’t support us.” And this is a young boy. Tears came to my eyes and I felt so sad and that’s true. Our young people need support and if they are going to go out and perform – there was a few people from our community and no-one clapped for them. Our children need more support when they’re performing or down the street doing something – give them encouragement. It’s no good telling them they’re useless. That’ll go through their head and they take their life”.

Reiterating the relevance of FWB to everyday life, one participant related its usefulness in a range of contexts as *“it’s for anybody, It helps you understand yourself you know to take one thing at a time – you can’t just take a big sledge hammer and smash the rock. You’ve got to chip away be chipping away at it. It’s the same in life. FWB will help you to understand that”*.



5.2.3 Acknowledging and celebrating change

A key theme emerging from the data was that of acknowledging and celebrating change following introduction of the FWB program. This related not only to personal change, but also the way in which FWB is delivered and developments with accreditation and application of the program in a number of contexts.

Participants reflected on the previous years with a sense of pride and optimism about the future. The fact that Wujal Wujal and Hopevale people associated with the program were able to meet as a group for the first time at the workshop was regarded as a significant milestone. One participant commented that *“it’s exciting to see a program that started off really small and how it’s developed and grown. It’s having commitment”*. Another participant reflected that when the program commenced 4 years ago, it was supported by fortnightly visits by university program partners based in Cairns. Involvement of university partners have gradually become less frequent until from 2004 when Apunipima staff have delivered and supported the program in the communities.

Overall, participants reflected positively on the past year, with one person noting that they were *“starting to see the light at the end of the tunnel”* and another that *“something good is happening”*. Some participants described the year as rewarding while others focused on meeting challenges. One participant reflected on her achievements during the year as *“I never thought I’d be at uni and finally achieving something that I’ve never dreamt of before but anything is achievable if you set your mind to it. I encourage people to keep learning”*.

For this person, university studies had *“given me a greater vision of where Family Wellbeing is going to move in the future”*. Recognising that the content of FWB fitted with the World Health Organisation Ottawa Charter for Health Promotion, this participant viewed FWB as a key tool in health promotion.

Other participants recounted instances of how the skills learnt at FWB had been applied in their family and work life. One participant described the application of the program in this way: *“It helps me in my workplace and in the community and even with family at home. I feel I am able to support my own children – how to speak to them in a way that they understand”*. For another participant FWB skills had encouraged him to *“embrace change and find strategies to deal with it. It has been very useful to me”*.

Beyond self and family, participants highlighted the applicability of FWB skills in the community and the workplace. The experience of FWB presented one participant with a life changing challenge as *“FWB gave me a challenge to go out there and build better relationships with community and share my insights just to give my community what I went through and that changed my life and now to come this far with the help of other health workers”*.



For another, the experience of FWB had been the catalyst for a deeper understanding of work colleagues *“as a work group we did FWB – even though we worked together, we didn’t know each others problems – before we just did our work and went home. It’s very good for a work group. Now we understand each other, especially working with elders”*.

Of particular significance to participants was the accreditation of FWB by the TAFE College. The participation of 18 members from regional north Queensland in five blocks of one week was described as *“an extraordinary commitment”* given past experiences recounted by participants of how difficult it can be to engage and motivate people to be involved in community groups.

The fact that a range of regional organisations saw the relevance of the FWB empowerment tool and are incorporating the principles and framework into their core businesses such as parenting education, alcohol rehabilitation, diversionary program for men in the criminal justice system, and family violence prevention was seen as a key factor in the success of the program vis-à-vis other stand-alone programs.

Reflecting on the year, one participant recounted that *“the highlight was doing the TAFE course”*. The awarding of a certificate following the TAFE training was valued highly by participants as evidenced by the following exchange initiated by participants during the workshop:

Speaker 1 *“From attending the sessions with the certificate on the end is actually really useful for me – for job prospects and adding in a resume sort of thing so I found a lot of good things came out of it just by being involved as a researcher.”*

Speaker 2 *“So that certificate that’s recognition for prior learning – the certificates that we’ve received”*

Speaker 3 *“People who did the full 10 topics were able to get that accredited through TAFE”*

Speaker 4 *“So you got yours – did you get yours?”*

Speaker 1 *“I’ve been using it”*

This was followed by further discussion and a group agreement to follow-up with those who had not yet received certificates. For one participant, enhanced employment prospects following FWB provided tangible evidence of the value of the program as *“that’s true empowerment when you can work in your own community and be paid proper wages not CDEP – that’s empowering”*.



5.2.4 Integration with existing programs

Beyond the application of FWB skills in the family, community and workplace, participants identified ways in which FWB had been integrated with existing programs either through referrals, workforce development or filling gaps in services. On the basis that the evaluation of the pilot program found that FWB was an appropriate way of engaging Indigenous people, one participant recounted that Apunipima now require every staff member to complete FWB so that it becomes integrated with all programs areas.

Another participant described the appropriateness of FWB in the area of suicide prevention saying that after considering other training available, *“I looked at FWB; the 3 of us did the stage 1 and saw that as being more useful in the kind of work that life promotion does”*. For this person, the fact that FWB had been found to work was critical to the decision to complete the program *“because I think that anything that works, anything that develops the aspects of this particular program in the community is worthwhile to help turn around what identified as needs in the community. Anything that works I'm quite happy to be part of”*.

Integration with existing mental health services was also identified as a way in which FWB might be used to address the needs of consumers. One participant described its application as *“one of the things that consumers said was that they had no-one to talk to and I see FWB as instrumental.... It can give confidence to take charge and shows there are more than one pathway to recovery”*.

In contrast, one participant who had been associated with the program but not completed the course recounted her experience of FWB and its potential as an alternative to service delivery, saying *“it gives you a focus to get together and talk about real issues not gossiping, not saying anything negative but how can we do this? What's a better way for us as individuals and members of the society we are in....when you know who has done FWB and know that everyone is going to respect the trust and that when we've got problems we know who you can go to so there's a support group that's growing...hopefully one day it can bring in the whole community and we won't rely so much on professionals, we'll all be supporters not detractors not cutting down, not creating conflict but creating wellbeing”*.

Implicit in this view is that the integration of FWB into the way of life of people in these communities will take time. For one participant, plans to develop a men's group where the FWB approach could be introduced to more men were tempered by concern with uncertainty about future funding for the program.

“I do hope that the government won't say we won't give money and more. Sometimes it can take a few years for things to happen. It's time now for more people to be involved and through that we can get the message across. As an elder, I want to see good results come out of this, people to be happy, people to be talking to each other, and young people to be doing some good in life rather than something that is not good, something that will destroy their lives.”





5.2.5 Living the new perspective – modelling FWB

A distinct feature of the reflective workshop was the opportunity to analyse the group dynamics and interaction between participants during the course of the day. Having a video recording of the workshop aided a more detailed analysis unrestricted by the time constraints and distractions associated with direct observation.

Simultaneous with the discussion and story telling in relation to FWB, participants were modelling the skills they had learnt, suggesting that they were indeed living the new perspective. This was evident through demeanour, language, perspective, and the demonstration of particular skills.

Participants expressed pride in their own and others' achievements and responded with applause, congratulations, nods, smiles or words of encouragement to each others' stories. Participants contributed freely, taking turns to speak, listening attentively, asking questions, seeking clarification and requesting information. This added to an atmosphere of warmth and collegiality amongst participants which contrasted with their experience of day to day life described by one participant as *"There is a lot of conflict, a lot of problems in the community. I enjoyed attending the FWB program because all that got switched off. With the group agreement, people were able to talk to each other person to person and not worry about what's happening in the background. There's a lot of meetings going on and FWB is one of the first that I have actually enjoyed attending"*.

At the outset, participants demonstrated confidence by offering suggestions on how the workshop should proceed. Following the suggestion that *"we want to try and make this informal – have a yarn – sharing our thoughts and ideas"*, one participant, with agreement from others suggested that the group move to sitting in a circle for sharing stories. Participants contributed freely to the development of a group agreement for the conduct of the workshop, commenting that this was a technique used in FWB and clarifying the meaning of the agreement in this context.

Participants consistently framed issues in terms of challenges and opportunities in line with the FWB approach. When challenges were identified, participants on a number of occasions, referred to strategies they had adopted to address them such as brainstorming and networking.

Whilst acknowledging that some initiatives such as men's groups take time to develop, participants were generally optimistic, focusing on ideas to educate, engage young people and build better relationships.

CHAPTER SIX: FAMILY WELLBEING IN THE CONTEXT OF HEALTH AND SOCIAL REFORM IN CAPE YORK

The 'Just for Bama. An evaluation of the Family Wellbeing personal and community engagement tool in a Cape York community' report published in 2004 identified for Apunipima to take this program forward as its main engagement tool within the broader Cape York Partnerships strategy it needed to integrate FWB into its core business as the foundation stone for holistic health development in Cape York.

Apunipima has now embarked on a long term process in the move to community control of health service delivery in Cape York Peninsula. This process is part of a highly complex planning and implementation process that is embedded in a broad framework of improved governance and strategic action that aim to assist the Cape communities to recover from a disempowering past and reclaim a brighter future. Four main strategies informing the process are: Cape York Substance Abuse Strategy; The Enhanced Model of Primary Care; Apunipima's River of Life and Health; and Community-Controlled Health Model Trials.

The overall aim of the health services transition is to establish a better model of health care that will lead to better health status among Cape York residents. A set of health performance indicators to be measured before, during and after the 5 year transition period are being developed.

Key priority measures will include:

- decrease in alcohol and substance misuse
- decrease in disease burden, especially chronic disease
- happy, healthy families with renewed culture
- clean and safe environments
- Cape York people taking responsibility and control of their own health.

Empowerment and control are clearly common elements that must be effectively promoted across a range of health, education and employment services and programs if success in these areas is possible.

The current evaluation confirms previous FWB evaluation findings across a range of settings and other evidence that the process of empowerment is lengthy, taking years to achieve change beyond the individual level but also highlights the process of initial engagement and personal capacity development which enhances individual social and emotional wellbeing. This provides a critical foundation for achieving a healthier life.

Many health promotion programs overlook this phase, assuming a level of personal strength and capacity which may not exist in communities such as Cape York experiencing relative powerlessness and social and economic marginalisation due, among other things, to destructive effects of alcohol and drug misuse albeit by minority sections of the population.





FWB program is being increasingly incorporated into a range of health interventions across northern Australia. Listed below are areas in which significant progress has been made. While some are in discussion phases, others have commenced through informal activity. These include (see relevant FWB publications under References):

- Promoting Mental Health, achieving better outcomes for mental health consumers
- Alcohol Prevention and Rehabilitation
- Empowering workforce: re-focussing of staff towards organisational change and greater harmony
- Diversionary and rehabilitation programs for the criminal justice system, alternative to incarceration
- Working with people in prison and rehabilitation for offenders upon release
- Life promotion and suicide prevention
- Reducing family violence
- Enhancing parenting skills and approaches
- Schools Based Program to enhance children's understandings of themselves and their peers
- Leadership and Governance training
- Job Preparedness as a component of the Welfare Reform Agenda
- Self-care in Chronic Disease among Men and Women

Although these are diverse areas of interest, they all share common core components in the need for people to gain greater control over their lives and situations and skills to make and sustain healthier lives.

Given the critical importance of empowerment in achieving social and emotional health, Apunipima created a Social and Emotional Wellbeing Coordinator position in 2006 with regional responsibilities.



The aim is for the Coordinator (Teresa Gibson) and line manager (Liz Pearson, Manager Health Policy and Planning) to work closely with a range of relevant agencies including Queensland Mental Health, Alcohol and Other Drugs (ATODS), Education Queensland, Child Safety, Department of Communities, Royal Flying Doctor Service (RFDS), Cape York Partnerships, FNQ Regional Division of General Practitioners and the Centre for Rural and Remote Mental Health Queensland and including Gurriny Yealamucka Health Service (Yarrabah) and other relevant stakeholders in order to appropriately integrate or embed the FWB or other proven empowerment approaches into their services focusing on children, young people, adults and the elderly.

Informed by the Cape wide whole-of-community approach, embedding FWB and other empowerment strategies in these services and programs will be supported and coordinated regionally through the Regional Health Forum processes. In this regard, Apunipima is concerned that Government Departments continue to fund multiple capacity building and empowerment related projects without strategic planning and coordination of such projects. This once again highlights the perennial need to plan and coordinate existing and new services more efficiently across the continuum of care to ensure value for money.





6.1 Recommendations

That the Cape York Regional Health Forum endorses the following recommendations:

- That further planning is done by Forum members to decide agree upon a set of proven capacity building products including Family Well Being; and a consistent evaluation framework or models inclusive of Participatory Action Research;
- Acknowledges and endorses the Family Wellbeing project as one of the tools for community capacity building;
- That Family Well Being Team delivers to Health Action Teams, community members and service delivery agencies as the platform for developing a community driven empowerment and capacity building framework;
- The Family Well Being Team to negotiate funds to build the infrastructure and resources of the Social Emotional Health and Well Being Team in Pormpuraaw, Cape York Peninsula as the first community pilot site for the empowerment framework;
- The Family Well Being Team to negotiate funds to sustain the enabling structures/resources within the individual communities that support the regional delivery of Family Wellbeing; and the empowerment and capacity building framework for Cape York.

Apunipima Cape York Health Council, as the lead agency responsible for health reform, to ensure that immediate and appropriate steps are taken by the relevant agencies to fully implement simultaneously all elements of the six-point Cape York Substance Misuse Strategy at community levels;

Further:

- National policies are acknowledged as major influences on upstream factors impacting on health outcomes; therefore policy should build up national health capital through investment in physical assets (i.e. health care system infrastructure, schools, transport systems, housing and

social services);

- Fast track policy implementation that encompasses social determinants that impact on living and working conditions and behavioural risk factors. Which will drive positive and constructive government-supported initiatives to improve social emotional well being to reduce the risk of suicide;
- Invest and build service capacity, enabling structures and infrastructure for empowerment modelling of social emotional wellbeing in Cape York Peninsula as first pilot site for the Family Well Being empowerment and capacity building frameworks;
- Recognise that capacity building requires financial, human and social infrastructure in addition to strong policy direction. Human investment refers to developing the skills of health workers and community members in a strategic coordinated planning framework and aligned to the principles of community control rather than funding isolated capacity building projects across multiple government agencies.





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Your Notes



Apunipima Cape York Health Council
343 Fearnley Street, Manunda, Q 4870
PO Box 2797 Cairns, Q 4870

Ph. (07) 4051 7450 Fax. (07) 4051 7940

www.apunipima.org.au