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A health service and community partnership utilising action research for the development of Aboriginal and Torres Strait Islander mental health services

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A Health Service & Community Partnership utilising action research for the development of Aboriginal & Torres Strait Islander Mental Health Services.

A thesis submitted in partial fulfilment of the requirement for the award of the degree of



**Doctor of Public Health
University of Wollongong**

by

Christine Salisbury

**Department of Public Health & Nutrition
University of Wollongong**

1997

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ABSTRACT

Legge (1992:97) argues for a recognition that “health is created beyond the health system and there is a need to ensure that health problems are seen from the perspective of the local community rather than as technical problems for health professionals to define or treat”.

The improvements in Aboriginal & Torres Strait Islander health that are badly needed in Australia create an imperative to develop Indigenous participatory planning processes in health services. It is necessary to identify processes which facilitate involvement and ownership of a participatory process thereby ensuring an Indigenous perspective is brought to bear on health problems.

The aim of this study was to examine the effects of an action research partnership between the Tweed Valley Health Service (TVHS) and the Aboriginal & Torres Strait Islander community for the development and delivery of Aboriginal & Torres Strait Islander Mental Health Services. It was proposed adoption of Labonte’s (1989) view that empowerment means to have increased capacity to define, analyse and act upon one’s problems, in an action research partnership between the local Aboriginal & Torres Strait Islander community and TVHS, would assist in operationalising Indigenous community participation in TVHS planning. To achieve this type of ‘partnership’ the health service had to be willing to enter the partnership and to give the authority to the Aboriginal & Torres Strait Islander Health Outcome Council to seek and trial solutions on Aboriginal & Torres Strait Islander Mental Health matters. This represents a structural change and a sharing of power. Key outcomes were defined as the extent to which the re-organised services proved to be acceptable and utilised by the local Aboriginal & Torres Strait Islander population. Outcomes were

operationalised through measures of service utilisation and consumer satisfaction with accessibility, process and outcomes.

The study trialed participatory action research as a method for Indigenous participation in Mental Health Service planning and development and concludes that it is a valid model for cross cultural research and health service development in a complex medical setting. The method facilitated the accommodation of different cultural perspectives on health and research and the operationalisation of Indigenous participation in health service planning and development.

The TVHS and Aboriginal & Torres Strait Islander partnership in service development and delivery resulted in a set of components that were considered essential for the provision of an effective Aboriginal & Torres Strait Islander Mental Health Service:

1. Acknowledgement by the TVHS that life is experienced as stressful for Aboriginal & Torres Strait Islander's with grief and loss being experienced more frequently by members of the Aboriginal & Torres Strait Islander community.
2. Acknowledgement by the TVHS that Aboriginal & Torres Strait Islander persons experience public health facilities as discriminatory and not culturally accepting.
3. The first point of contact with TVHS for an Aboriginal & Torres Strait Islander person in distress should where possible be with an Aboriginal & Torres Strait

Islander person available 24 hours per day and able to provide an outreach service.

4. The service must represent an Aboriginal & Torres Strait Islander solution with Aboriginal & Torres Strait Islander control.
5. The TVHS should provide a context that is accepting of Aboriginal & Torres Strait Islander people.

1. INTRODUCTION

"It's all about trust, and building that trust up so that our people will seek out help when it is needed." (Bugalwena Team member, 1996)

Any discussion of Aboriginal & Torres Strait Islander mental health belongs in an historical context of Aboriginal & Torres Strait Islander health in general, including a recognition of the differences in circumstances that exist between Aboriginal and non-Aboriginal groups (Hunter, 1993). The ill health of Aboriginal & Torres Strait Islander people is in part, the result of a history of colonisation and dispossession. Swan, (1988:1) states, "The theft of Aboriginal children by non-Aboriginals in authority was a systematic attempt at cultural genocide, and to this day has produced the background for many years of horrific memories, distress, and Mental Health problems that still need to be addressed". In Australia today, Aboriginal & Torres Strait Islander persons suffer higher rates of mortality and morbidity than any other group. Mental health problems among Aboriginal & Torres Strait Islander people are increasing, including suicide, interpersonal violence, parasuicide and self mutilation (Hunter, 1991).

Thomson (1984:939) states: "The health status of Australian Aborigines is far inferior to that of non-Aboriginal Australians. The factors underlying this low standard of health are complex but relate to the gross, social inequality experienced by Aborigines, even today. The social inequality, characterised by extreme socioeconomic deprivation and relative powerlessness, is the end result of the European occupation of Australia, which caused Aboriginal depopulation and

depossession". The poverty and social inequality in which most Aboriginal & Torres Strait Islanders exist must be taken into account in the development of any health policy because the provision of health services can only marginally affect the health status of populations (Saggers and Gray, 1991). On almost all health indices Aboriginal & Torres Strait Islander people experience worse health than non-Aboriginal people. For example, Aboriginal & Torres Strait Islander persons on average have shorter life span than non-Aboriginal people, for men between 12 and 20 years less and for women between 4 and 21 years less. Aboriginal & Torres Strait Islander babies die at a rate three times higher than non-Aboriginal babies. The maternal Aboriginal & Torres Strait Islander mortality rate is three to five times greater than that of other Australians (Thomson, 1991). Furthermore, the prevalence rates of almost all diseases are higher in the Aboriginal & Torres Strait Islander population. Diabetes shows the typical disturbing comparison with an Aboriginal & Torres Strait Islander prevalence rate of between 7.5% and 16% while the non-Aboriginal rate is 3.4% (Glatthaar et al., 1985).

Aboriginal & Torres Strait Islander View of Health

The National Aboriginal & Torres Strait Islander Health Organisation (NAIHO 1982:2) states that health is: "Not just the physical well-being of the individual but the social, emotional and cultural well being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life. Health care services should strive to achieve the state where every individual is able to achieve their full potential as human beings, and thus bring about the total well-being of their community". This means health cannot be artificially separated from the emotional and social well being

of the individual.

Eckermann et al., (1992:174) say, when discussing Aboriginal & Torres Strait Islander health, "that a sense of community is essential to a sense of self and that this, in turn, is essential to health". They maintain that traditional health services fail to take account of this wider context. Houston (1991) maintains that the key elements identified by the National Aboriginal Health Strategy Working Party, (1989), which should characterise primary health care services are appropriateness, acceptability, access, contribution to social development, co-ordination with other sectors and community participation and control. Houston (Eckermann et al., 1992), also proposes that health services "do not provide scope for activities which are intended to directly strengthen the communities' social and cultural identity and advance community empowerment" (Eckermann et al., 1992 : 177). Many health services in Australia have only recently begun to address some of these important cultural issues. Furthermore, unless health services are prepared to change, they are likely to remain unpleasant places to visit for those people not of the dominant white culture. Towler (1994) found that many Aboriginal people fail to consult doctors because of medical jargon, cost, unfriendly environments, difficulty getting appointments and racism. Furthermore, traditionally health services have not been designed to consult with Aboriginal communities and they have had little interest in community consultation and development (Eagar & Garrett, 1995).

The Right to Participate

The World Health Organisation in the "Health for All" strategy emphasises the importance of community in the support and operation of health services.

The Alma-Ata Declaration states: "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care" (WHO 1978:2). Similarly, the Ottawa Charter for Health Promotion (WHO 1986) maintains that empowerment of the community to control their own destiny and manage their own health is central to community development and health promotion. There are a number of definitions of the term "community" ranging from "a group of people living in the same geographical area sharing defined basic values and organisations and/or a group of people sharing the same basic interests", (Bjaras et al., 1991:200), through to a psychological definition such as "groups with common bonds so that frequent and significant interaction occurs between group members" (Jones, 1977:27). The idea that a community is confined to a geographical area is now outdated and the key concepts are that people share a sense of identity and that there is social interaction.

Legge (1992:97) argues for a recognition that "health is created beyond the health system and there is a need to ensure that health problems are seen from the perspective of the local community rather than as technical problems for health professionals to define or treat". The concept of community participation has been widely promoted by the NSW Department of Health, however most health planning has been from a bureaucratic/technical stance based not on needs analysis but on traditional resource allocation. Eagar & Garrett (1995:45) comment, "The health

sector, however, is very unsophisticated about the notion and definitions of community development and the uses of the term tend to refer to any local planning or development activity which happens outside of a hospital or a therapeutic setting".

Community consultation in mainstream health services has taken many forms, ranging from ad hoc advisory structures, community representation/advocacy, volunteer networks, self-help, to receiving information as individual consumers or carers, (Commonwealth Department Of Human Services & Health, 1993).

Participative Planning

The National Health Strategy Issues Paper, No. 12, (1993) identifies the benefits of consumer participation as improving health outcomes through the empowerment of consumers. Furthermore, it acknowledges "that current structures, processes and attitudes do not actively encourage community participation or strengthen accountability"(1993:9). The difficulties of community consultation are highlighted by O'Neill (1992) advising caution in that, the community as a whole does not participate and that the representativeness of subgroups can always be questioned. Rifkin (1986) describes the impossibility of having a universally acceptable definition of community participation. The author also maintains that the process cannot be considered outside a political context. She suggests three models of community participation, namely, the medical model (removal of disease), the health planning model (access to health services) and the community development approach (better living conditions). Community development is an intersectoral approach that involves people gaining greater control over their own health. The model seeks to de-medicalise health and to empower citizens.

Participative planning is a means “of identifying the need for significant change through the direct input of members of the community” (Broadhead et al., 1989:256). In Broadhead’s (1989) model of health planning the community development concept fits within the participatory approach. This approach relies on the views of the community flowing into health planning to create social change and democratise decision-making. The model is based upon information flowing between the community and the planners within a process seen as legitimate by the community.

Eagar & Garrett (1995) nominate principles to overcome some of the dilemmas associated with community participation in planning. Firstly it is proposed that the bureaucracy act as advocate to ensure equity for those groups most disadvantaged in their access to health resources. Secondly, that the public health sector expose its planning processes to the community, so that policies and plans can be debated in the community. Thirdly, they propose that public accountability and participation in health planning be incorporated into health legislation. Fourthly, community consultation protocols be developed in collaboration with community groups. Finally, Eagar & Garrett recommend that structures be developed that facilitate education and information flow between consumers and health planners. Similarly, Broadhead et al., (1989) maintain that community members need opportunities to participate at all levels in bureaucratic structures that entrench ongoing community participation, thereby demonstrating political commitment. As stated by Broadhead et al., (1989:256), “A real devolution of power to the community to influence the decisions which affect their lives cannot be dependent on the grace or whimsy of public officials”.

Godbout & Leduc (1987) as reported in O'Neill (1992:297) claim that "citizen participation usually ends up consolidating the power of professionals or bureaucrats and not as a way to empower the community". They maintain that five factors must be present for community participation to become empowering. Firstly, there must be adequate information available about the system and operation of the agency. Secondly, the representatives must have a strong mandate from the community or users. Thirdly, that the community be represented by a strong personality able to argue the issues. Fourthly, that the community representatives must be able to access their constituencies and finally that the community have representation at Board of Management level.

Towards Aboriginal & Torres Strait Islander/Health Service

Partnerships

In 1995, the NSW Health Department and the Aboriginal Health Resources Co-operative Ltd., developed a document titled, The NSW Health Summit Partnership Agreement. This Agreement contained a number of guiding principles for the provision of Aboriginal & Torres Strait Islander Health Services. The principles are espoused in the National Aboriginal Health Strategy and are based upon Aboriginal & Torres Strait Islander self determination, a partnership approach and the importance of intersectoral collaboration. "The aim of the Partnership is to ensure that the expertise of Aboriginal Communities is brought to health care processes" (Guiding Principle No. 2). The Aboriginal Health Resources Co-operative Ltd in the New South Wales Health Department is an equal member of the Partnership. The role of the Co-operative is to:

1. advise the Minister of Health on agreed positions relating to Aboriginal Health at a national level;
2. enhance both local Aboriginal & Torres Strait Islander community control and;
3. influence policy designed to improve the provision of health services.

At a community level the Partnership Agreement recommends Aboriginal & Torres Strait Islander community involvement in the development of local health plans with an emphasis on improving environmental conditions, such as housing, sanitation and water.

Cross Cultural Research and Health Service Delivery

There has been considerable concern expressed by Aboriginal & Torres Strait Islander groups that research has been harmful to the Indigenous population. The National Aboriginal Health Strategy (1989) stated that, "Research is frequently imposed on Aboriginal communities, with the Aboriginal communities usually having no control or redress. It rarely provides any benefit to the Aboriginal participants and is often used in a detrimental manner by the media and governments". Furthermore, the National Aboriginal Health Strategy questions the dominant research paradigm and the cultural and philosophical value systems from which it arises. It claims that the model reflects the values of the dominant culture in terms of the problem definition and method of inquiry. The Strategy identifies assumptions that are implicit in this process and state, "in Aboriginal research, very few take the trouble to define the problem from the Aboriginal community perspective" (National Aboriginal Health Strategy 1989:208).

The National Aboriginal Health Strategy (1989) recommended a number of guidelines for Aboriginal health research. In particular, the guidelines outline a process for gaining ethical approval through consultation with the participating Aboriginal communities. In addition, the guidelines indicate that research be culturally sensitive to issues of gender, family, body and Aboriginal law. Consent must also be gained by the researchers from the participating community and where possible local Aboriginal & Torres Strait Islander people should be employed in the research process. Similarly, publication of the findings of any research should be with the consent and acknowledgement of the participating community. In general, the guidelines maintain that any research involving Aboriginal & Torres Strait Islander communities should employ appropriate methods likely to contribute significantly to new knowledge. In summary, the National Aboriginal Health Strategy proposes that Aboriginal & Torres Strait Islander people participate in all aspects of health research from problem definition through to report publication and communication of findings.

The National Consultancy Report on Aboriginal & Torres Strait Islander Mental Health (Swan & Raphael 1995:1) states that "Aboriginal people perceived mainstream Mental Health Services as failing them, both in terms of cultural understanding and response and repeatedly identified the need for Aboriginal Mental Health Services, which took into account their concepts of the holistic value of health and their spiritual and cultural belief, as well as the context of their lives". The report recommends that policy be guided by the principles of Aboriginal & Torres Strait Islander self determination and where health is viewed as holistic. The report describes and recommends culturally valid services that acknowledge the ongoing impact of family and kinship ties, grief and

loss, racism and social disadvantage. Furthermore, the report states there is no single Aboriginal & Torres Strait Islander group or culture and that services must be acceptable to local Aboriginal & Torres Strait Islander communities. The report recommends the development and funding of a range of appropriate services, including Aboriginal & Torres Strait Islander psychiatrists and mental health workers.

Within New South Wales the number of funded Aboriginal Mental Health Services are limited. Frequently Aboriginal health educators exist as sole positions attached to community teams, with little training in mental health specifically. Aboriginal & Torres Strait Islander people are reluctant to utilise conventional Mental Health Services (McKendrich, 1994; NSW Aboriginal Mental Health Report, 1991; Dunlop, 1988). Such services are culturally inappropriate for Aboriginal & Torres Strait Islander people and do not meet their needs. Nathan (1979:2) states, "I just don't think that the hospitals or clinics care enough about Aborigines..... I don't like going to white places.... going into one of those waiting rooms and being stared at I'm not cared for at hospitals". If health services are to meet the needs of the Aboriginal & Torres Strait Islander community, they must be judged to be relevant and trustworthy by the consumers of the service.

Bachrach (1983:178) states, "All the service structures in the world will be ineffective if patients have no access to them or if they are not relevant to patient's needs". These comments are especially relevant to Aboriginal & Torres Strait Islander people. Further Aboriginal & Torres Strait Islander Health Service development requires the participation of Aboriginal & Torres Strait Islander consumers. Eckermann et al.,

(1992: 188) describe community participation in the following way, "Solutions can be found from within Aboriginal strategies: those that are imposed by outsiders frequently fail. This is what community participation in health is all about".

To develop effective methods of Indigenous community participation in health research requires the identification of processes that accommodate different cultural perspectives. Exploratory trials are required to identify optimal processes for ensuring adequate Indigenous involvement and ownership in health service planning and delivery. For example culturally appropriate measures are required for assessing the effectiveness of health services at all levels of delivery. The community development model is favoured because it facilitates empowerment of the Indigenous community through participation in problem definition, strategy development and service implementation and evaluation.

Background

The impetus for this study arose from the findings of a study undertaken by the Tweed Valley Health Service (TVHS) in 1994. This study identified an alarming difference in the levels of stress experienced by members of the local Aboriginal & Torres Strait Islander community compared to a matched group of non-Aboriginal residents. The study reported significant differences in the number of stressful events experienced in the last 12 months between the two groups. Table 1.1 on page 12 displays the relevant data.

Table 1.1
Stressful Events in the last 12 months

	ATSI	Non-Aboriginal
1. Death of a family member	51%	16% *
2. More than one death	69%	5% *
3. Separation	15%	18%
4. Divorce	11%	5% *
5. Child in trouble with Police	3%	8%
6. Criminal charges	13%	8%
7. Suicide attempt	5%	6%
8. Miscarriage	3%	3%
9. Nervous breakdown	5%	6%
10. Loss of Job	21%	10% *
11. Unemployment more than 6 mths	26%	15% *
12. Severe money worries	51%	25% *
13. Loss of home	3%	1%
14. More than 4 shifts of house	5%	5%
15. Car crash, self, family member	5%	1%
16. Sexual Assault	0%	3%
17. Victim of violent assault	15%	1% *
18. Other	6%	3%

Table 1.2
Barriers to Mental Health Service

The groups were asked if they had wanted Mental Health treatment but had not been in touch with the service.

	ATSI	Non-Aboriginal
1. Don't know how to contact them	18%	1% *
2. Didn't know they were there	1%	0%
3. They are not Aboriginal	26%	0% *
4. They wouldn't understand	18%	5% *
5. They might get me in trouble	11%	0% *
6. I might get locked up	11%	0% *
7. It would be shameful/embarrassing	55%	1% *
8. I'm not mad	60%	8%

*P<0.001 Analysis of variance.

Source: Salisbury, C and Follent, S. (1996) Bicultural Stress : An Aboriginal Community Perspective. Australian Journal of Primary Health-Interchange Vol 2, No 2; 78-85.

Aboriginal & Torres Strait Islander Health Outcome Council members commented:

“I did not realise the gap between the two communities would be so overwhelmingly wide....when we presented the local community with our findings it was a surprise to see them so accepting of the results...they only confirmed what they already knew.”

“....there's not much chance of reaching 60 years of age...”

“.....the results of the survey did not come as a surprise..the areas of grief, financial problems and assault are all common issues that our people must face..”
(Aboriginal & Torres Strait Islander Health Outcome Council members, 1994)

The TVHS study also identified that the provision of Mental Health Services to local Aboriginal & Torres Strait Islander people was poor. Barriers to Mental Health Service utilisation shown in Table 1.2 on page 12, were identified by Aboriginal & Torres Strait Islander respondents and included:

“When you go to these places (Mental Health Services) you are labelled, when you talk to someone from there you are labelled, so rather than go and get fixed up, you suffer because you don't want to be labelled and put yourself under more stress.”

“Almost every family has a story to tell about the treatment received or that they

did not receive..we don't trust the system with the safety of our people.

(Bugalwena Team Members, 1996)

As a result of these important and disturbing findings the TVHS and leaders of the Aboriginal & Torres Strait Islander community agreed to work together to improve access to the Mental Health Services for the Aboriginal & Torres Strait Islander community.

Aims and Objectives

The aim of this thesis was to identify processes which facilitate Aboriginal & Torres Strait Islander community involvement and ownership in Mental Health Service planning and delivery. In particular the thesis sought to examine the utility of 'participatory action research', as defined by Elden & Levin (1991) as a method for facilitating the development of a partnership between the TVHS and the local Aboriginal & Torres Strait Islander community. The Elden & Levin (1991), model is described in more detail on page 36. Participatory action research is a method of research that seeks to involve local people in the research process. The process is completed through a series of plan, action and review cycles. The action research partnership between TVHS and representatives of the local Aboriginal & Torres Strait Islander community was based upon Labonte's (1989) view where empowerment involves the capacity to define, analyse and act upon one's problems. The process was guided by Gustavesen's (1985) principles of democratic dialogue which encourage participation and active involvement of the group. Further details are provided on page 34.

The study was based on the proposition that an action research partnership between the TVHS and the Aboriginal & Torres Strait Islander community would provide a forum for the development of culturally appropriate and acceptable methods of service delivery. As a result access to health services for Aboriginal & Torres Strait Islander people would improve and utilisation would increase perhaps, achieving in the long term, improvement in Aboriginal & Torres Strait Islander health status.

To achieve this type of 'partnership' the TVHS had to be willing to enter the partnership and to delegate the authority to the Aboriginal & Torres Strait Islander Health Outcome Council to seek and trial solutions on Aboriginal & Torres Strait Islander Mental Health matters. The Aboriginal & Torres Strait Islander community representatives had to be willing to examine the barriers to public health services from the Aboriginal & Torres Strait Islander perspective. They then had the opportunity to trial solutions and improve health service delivery. A case study research design was used to trial participatory action research as a method for facilitating Indigenous involvement in health care planning and service delivery. The research method had to accommodate the different paradigms of health held by the Aboriginal & Torres Strait community and staff of the TVHS. It also had to conform to the research guidelines outlined in the NSW Health Summit Partnership Agreement (1995). The selection of action research as the methodology was based on the Lewinian proposition reported in Argyris and Schon (1991:86) "that causal inferences are more likely to be valid and enactable when the people in question participate in building and testing them. Hence, the aim is to create an environment in which participants give and get valid information, make free and informed choices and generate internal

commitment to the results of their inquiry”.

The objectives of the study were:

- a. To contribute knowledge as to the utility of participatory action research as a method for facilitating Aboriginal & Torres Strait Islander community participation in health service planning and delivery.
- b. To contribute to public health practice by assessing the extent to which an action-research partnership resulted in changes in the delivery of mainstream health services, increased acceptance and utilisation of services by members of the Aboriginal & Torres Strait Islander community and improvements in consumer satisfaction with service delivery.

The research questions were:

1. How was the action research method useful for facilitating partnership in terms of:
 - a. Achieving participation.
 - b. Maintaining participation and partnership.
2. What are the effects of an Aboriginal & Torres Strait Islander and TVHS partnership on:
 - a. Methods of service delivery.
 - b. Utilization of services by members of the Aboriginal & Torres Strait Islander community.

- c. Consumer satisfaction with service accessibility and delivery.
- d. Outcomes of care.

This study sought to extend theory in two areas. Firstly, in the examination of the utility of action research for facilitating Aboriginal & Torres Strait Islander community participation in health service planning and delivery and secondly, to assess the extent to which the action research partnership resulted in changes to mainstream health services, that increased satisfaction and utilisation by the Aboriginal & Torres Strait Islander community.

The Role of the Researcher

Participatory action research involves the researcher as a participant, who impacts on the process and is impacted upon (Elden & Levin, 1991). Hence, I have chosen to introduce myself. I am a clinical psychologist with 10 years experience as a Community Health Service manager. My interest and experience in Indigenous health began 20 years ago in New Zealand when the Maori people began to challenge the dominant professional and medical ideologies and question whether they were applicable to their world view. I am currently responsible for the provision of an Aboriginal & Torres Strait Islander Community Health Service. This work began when it became evident that the needs of the Aboriginal & Torres Strait Islander local community were not being met by the TVHS. For the remainder of my thesis I have chosen to adhere to academic custom and use the third person.

Structure of the Report

Chapter 1, provides an introduction to the area of study and cites the work in context.

The methodology is introduced and the study is outlined.

Chapter 2, provides a review of the literature surrounding Aboriginal & Torres Strait Islander mental distress. The Chapter outlines a model of empowerment through partnership and then introduces the case study and the participatory action research model. Finally the limitations of qualitative research are examined.

Chapter 3, describes the methodology, and the input of the researcher. A diagrammatic summary of the cycles involved in the research is included.

Chapter 4, provides a description of the action research cycles, the key findings and a summary of the service acceptability and utilisation changes.

Chapter 5, provides a discussion of the findings .

Chapter 6, contains the conclusion, recommendations and areas for further research.

2. LITERATURE REVIEW

2.1 Aboriginal & Torres Strait Islander Mental Distress

This Chapter is in three sections. Section 1 describes Aboriginal & Torres Strait Islander mental distress including problems in service provision. Institutional racism and the inappropriateness of using a western medical model to estimate levels of psychiatric disorder in Aboriginal & Torres Strait Islander populations are described. High levels of Aboriginal & Torres Strait Islander mental distress are linked to European occupation and oppression. Cultural difference relating to different perceptions of health and the need for culturally appropriate Mental Health Services are outlined. Section 2 describes the concept of empowerment based upon Labontes (1989) view where empowerment means to have increased capacity to define, analyse and act upon one's problems. The action research model and the partnership approach are outlined. Section 3 examines case study research and participatory action research models.

The National Aboriginal Health Service Working Party (1989:9) stated:

“Mental distress is a common and crippling problem for many Aboriginal people and appropriate services are a pressing need. Advances in the understanding and progress has yet to benefit Aboriginal people. Culturally appropriate services for Aboriginal people are virtually non-existent. Mental Health Services are designed and controlled by the dominant society for the dominant society. The health system does not recognise or adapt programs to Aboriginal beliefs and law, causing a huge gap between service provider and user. As a result, mental distress in the Aboriginal community goes unnoticed, undiagnosed and untreated”. Slattery (1987), in a discussion of

transcultural therapy with Aboriginal & Torres Strait Islander families, argues that there is a crisis in Aboriginal health, but that a comparable prevalence of serious mental disorders in Aboriginal & Torres Strait Islander communities belies a much deeper psychological malaise, evidenced by substance abuse, anxiety and depression.

Radford et al., (1990:20) conducted a study on stress and destructive behaviour among Aboriginal & Torres Strait Islander domestic caregivers. The report titled, 'Taking Control', provided both a psychological and an anthropological perspective on Aboriginal & Torres Strait Islander mental health. The major findings indicated: "15% had suffered sexual abuse, 51% had experienced physical violence, 24% had deliberately hurt themselves, 31% had seriously thought about taking their own lives, and 19% had made at least one serious suicide attempt". This survey provides evidence of the level of intense psychosocial distress that exists in Aboriginal & Torres Strait Islander communities. Eastwell (1985) similarly argues that the extent of psychiatric disorders in urban Aboriginal & Torres Strait Islander populations is hidden because of under-use of Mental Health Services and under-diagnosis.

There has been thirty years of published research on Aboriginal & Torres Strait Islander mental health. Recent researchers have attempted to measure the incidence of psychiatric diagnoses through the overlaying of a western psychiatric medical scientific model onto 'observed' or 'reported' symptoms in a variety of Aboriginal & Torres Strait Islander communities (Nurcombe & Cawte, 1967; Cawte et al., 1968; Bianchi et al., 1970; Kidson & Jones, 1968). The majority of the work has examined an Indigenous minority culture from a western cultural perspective, whose assumptions, definitions and understandings of health and well-being are in many ways, very

different from those of most Aboriginal & Torres Strait Islander's .

Reser (1991) describes a number of problems in the identification of the incidence of psychiatric diagnoses in non-western cultures. He reports that the problems include the lack of any specifics with respect to method and procedure, a reliance on another culture's classification and diagnostic scheme, a discounting of discrepancies between Indigenous and western labels and criteria, and a cataloguing of culture-specific diagnostic categories; fear of sorcery syndrome, mimetic illness, and shared depressive illness which are then made to fit into conventional categories, usually the International Classification of Diseases (ICD). A debate exists as to the universal applicability of these psychiatric terms and categorisations and the way that "culture" affects symptomology, but these issues are rarely addressed effectively because of the authors' assumptions "about the primacy of their own conceptual framework" (Dunlop, 1988).

Given this problematic framework, psychiatric surveys taken at face value appear to support the view that "prevalence of mental illness" in remote Aboriginal & Torres Strait Islander communities at the time of survey was not particularly high (Reser, 1991). Eron & Peterson (1982) argue that the estimation of prevalence of mental illness in other cultures is extremely difficult. They suggest 'culture' mitigates the ways in which behavioural aberrations are manifested and distributed. Culture dictates what is perceived as acceptable behaviour and abnormal behaviour is largely a matter of deviation from a given culture's socially accepted norms of morality or actions. Kahn (1986:47) states "there exists no adequate study of the forms of mental disorder among Aboriginal people, although there have been a few notable attempts". Janes et al., (1986) suggest that conventional epidemiological data alone, whether of physical or

psychological morbidity, provides a weak basis for designing sound intervention strategies. Without anthropological and psychological contextual data any description misses crucial variables, interactions and cultural meanings. Reser (1991) proposes that psychiatric surveys employing a western perspective when studying Aboriginal & Torres Strait Islander populations have not appreciably advanced cross-cultural understanding of Aboriginal & Torres Strait Islander mental health. The relationship of cultural identity to incidence of psychiatric symptoms was examined by Bianchi et al., (1970:318). These researchers say emulation of western patterns was found not to be in relationship to psychiatric symptomology: “The most striking finding in this study is that none of the parameters of cultural identity used by us are importantly associated with symptom levels”.

There are occasional references to ethnopsychiatry, transcultural psychiatry and cross-cultural psychopathology. Cawte (1972) identified more than 20 years ago in a substantial body of work, that cultural differences must be acknowledged and that there was little co-operative interaction between psychological anthropology and transcultural psychiatry. He suggested there were three concerns contributing to the high level of mental illness among Aboriginals, namely:

1. the difficulty faced by Aboriginal persons in adapting to the needs of modern technological society;
2. oppression and exclusion resulting from European conquest; and
3. exclusion from the country’s main opportunity structures’.

He recommended “to effectively relieve suffering, greater Aboriginal involvement was needed in cross cultural psychiatry, cultural training for non-Aboriginal workers, and

the inclusion of the traditional Aboriginal healers in a treatment context” (p 2a).

Institutional Racism

Coombs et al., (1983) provide a theoretical context suggesting maladaptation occurs when people are placed in situations that are imposed upon them by external forces. The study describes health as an holistic state and outlines the effects of poverty and dependence on health. Coombs suggests that health is the response to the total life style of the person or community concerned and services must be designed with Aboriginal & Torres Strait Islander involvement and participation. Oppression and institutional racism contribute to the difficulties in Aboriginal & Torres Strait Islander Mental Health, such that in a Northern Territory report, Spragg (1984:21) can state that, “the employment of Aboriginals as health workers has achieved only limited success as there does not seem to be a genuine conviction among their workers that western methods are superior to their own.....reluctance of a people to abandon their own heritage”. The report continues to describe the difficulty in being criticised for not providing European standards of health care and having to destroy Aboriginal cultural practises in the process.

Prejudices are revealed when the association between modern changed circumstances of Aboriginal & Torres Strait Islander people and certain mental disorders are discussed in terms of assimilation which imply that this is a result of the failure of Aboriginal & Torres Strait Islander people to adequately “adapt” and “adjust”. Brady & Morice (1982b) suggest institutional racism exists where the victim is blamed for failing to adapt to the demands of the dominant culture. They say Western psychiatric examination of Aboriginal & Torres Strait Islander mental health has attempted to fit

cases into a pre-existing conceptual framework without questioning the validity of such a position. Such a position is questioned when considering that many central Australian languages have a dual meaning for the term “madness” which also refers to deafness. Further more, they report, this has obvious implications for how a community may perceive and react to individual behaviours and that the context of behaviour and the external constraints placed upon it will inform problem identification, descriptions, understanding and action.

During the 1980's there were several government inquiries into the health of Australians, to inform a National Health Strategy, namely the Better Health Commission (1986) and the Health Targets and Implementations (Health for All) Committee (1988). It is notable that Aboriginal & Torres Strait Islander health was the worst of all and yet it was not targeted as a major goal. However, by 1989 the Hawke government was promoting the principles of Aboriginal self determination and self management. The Mabo decision, the Native Title Act (1993), the National Land Fund and the Social Justice Package have focussed attention on the rights (as distinct from welfare) of Aboriginal & Torres Strait Islander people, including the right to accessible, equitable medical services. Inappropriate and inadequate Mental Health care was cited by the Royal Commission into Aboriginal Deaths in Custody commissioners as a major contributing factor in the imprisonment and deaths of a high proportion of the cases investigated. The Royal Commission into Aboriginal Deaths in Custody noted the importance of Aboriginal & Torres Strait Islander communities having control over their own health and Mental Health Services. The National Mental Health Strategy (1992) identified the special needs of Aboriginal & Torres Strait Islanders and recommended culturally appropriate services, within the context of consumer rights, prevention and health promotion, equity

of access to services and responsibility.

Cultural Difference

Indigenous psychology reflects a paradigm shift derived from very different understandings of the person (Carrithers et al., 1985) and an acknowledgement of the nature and importance of social constructions and social meanings. Miller (1984:975) suggests that “what constitutes objective knowledge of the world is framed in terms of culturally variable concepts acquired gradually over development”. Kleinman (1986) has contributed the understanding that cultural beliefs of health and illness are related to recovery rates. The patient’s view of the “illness” is as important as the clinician’s view. If the two views do not relate to each other, treatment success is impeded. Kleinman’s (1987) comments on the WHO International Pilot Study of Schizophrenia describe the application of a template of symptoms to psychotic patients in a number of societies to identify groups of patients who seemed similar. The study identified similarities but left out those patients who failed to fit the template, the very patients of greatest interest from a cultural perspective. Kleinman suggests both views are necessary. That is, a viewpoint where similarities are identified and a viewpoint where differences are identified.

Mental health has been described as a “social construction” with sociocultural factors influencing aspects of psychiatric disorder (Berger & Luckman, 1966; Millon, 1988; Comas-Diaz and Griffith, 1988). Berger & Luckman (1966:44) suggest that information about “what I am” is not continuously available to people and that such reflections about self is “typically occasioned by the attitude towards self that ‘the other’ exhibits”. This suggests there is a continual definition and redefinition in order to

know one's self. The construction of self relates directly to one's world view and informs the labelling of actions as acceptable or unacceptable. Coombs et al., (1983:4) propose that 'who' a person is in an Aboriginal & Torres Strait Islander cultural context is a nexus of relationships, a set of bounded expectations, obligations and human connections: "It is evidenced not only in kinship terminology, self-reference and address forms but in the complex and rule-prescribed modes of interactions, in the way the world is divided, in the most fundamental cultural assumptions about relationships to the world, to others, to self". Self is defined in a different manner from western, more individualistic orientation.

The Indigenous psychology of Australia contains cultural views, theories, social institutions, ways of knowing and interpreting the world and advice on how persons should act, feel and find happiness (Heelas, 1981). Knowledge of the Indigenous perspective is essential to provide appropriate intervention strategies and methods of Aboriginal & Torres Strait Islander Health Service provision. Perspectives on causality inform how a condition is viewed and whether an intervention makes sense and is therefore valid (Reser, 1991).

Geertz (1975) suggests the understanding of the nature and meaning of self in another culture is a "prerequisite starting point:" for understanding anything else about a culture. The view of self impacts onto the degree of 'relatedness' and how this functions in terms of social support, correctness and identity. A state of non-relatedness is particularly difficult when one's network is self defining, self supporting and self validating. For Aboriginal & Torres Strait Islander persons, whom one assumes do not gain validation from mainstream society, to be 'lost' or non-related "appears to

engender a particular stressful and painful relational vertigo” (Reser, 1991:259).

Culturally Appropriate Services

The Royal Commission into Aboriginal Deaths in Custody (1989) recommended that counselling was urgently needed by Aboriginal & Torres Strait Islander families who had experienced losses. The Reclaiming Our Stories, Reclaiming Our Lives Project (Aboriginal Health Council of South Australia 1995) identifies the importance of naming the injustices that have occurred to Aboriginal people in Australia as part of the counselling process. The injustices that were named included the history of genocide, removal of children from their parents and families, government policies on distinguishing between people on the basis of how much Aboriginal “blood” they had, high levels of unemployment, poverty, homelessness and imprisonment, racism and inadequate funding for Aboriginal Services.

“Injustices experienced by past generations are carried actively in the form of shame and sadness by the present generation, and have real effects on their lives” (Aboriginal Health Council of South Australia, 1995:6). This project offered counselling to Aboriginal & Torres Strait Islander families and persons and was based on a guiding philosophy that suggested “it was not the place of people from outside of the Aboriginal Community to provide answers” and it was “to work with Aboriginal & Torres Strait Islander people so that :

- a. They could more fully honour and embrace the special knowledge and skills, relevant to healing, that they already possess;
- b. Their special knowledge and skills might be more fully developed and made more

widely available to the whole Aboriginal community; and

- c. Ways could be explored in which these knowledges and skills might be taken up in the development and provision of appropriate counselling services.” (Aboriginal Health Council of South Australia, 1995:2).

Accountability was to the Aboriginal community as was ownership of data and materials. This project recognised the continuing failure of health services to provide appropriate counselling services to those Aboriginal & Torres Strait Islander persons affected by deaths in custody, as a social justice issue that continues to subjugate Aboriginal & Torres Strait Islander persons. The project demonstrated a method of delivering counselling services that acknowledged Aboriginal & Torres Strait Islander strengths and cultural differences.

The Health Service Association of NSW in their position paper on Mental Health (1994:10) in noting Aboriginal & Torres Strait Islander mental health concerns have concluded that “existing mainstream Mental Health Services are not equipped to deal with the complex problems of Aboriginal & Torres Strait Islander people”. The position paper recommended the training and support of Aboriginal & Torres Strait Islander Mental Health staff in order to provide a culturally appropriate service, presently within mainstream Mental Health Services and, ultimately, separately. It recommended that non-Aboriginal staff receive training which will enable them to deliver Mental Health Services which are more culturally sensitive and appropriate to the needs of Indigenous people. The paper noted that services must be required to record data which enables the effectiveness of Mental Health Services for Aboriginal & Torres Strait Islander people to be monitored and evaluated.

Summary

There is a clear clinical imperative to develop Mental Health Services that are able to close the gap between service provider and Aboriginal & Torres Strait Islander user.

The development of Mental Health Services that are judged to be culturally acceptable by Aboriginal & Torres Strait Islander communities must occur before there can be any improvement in Aboriginal & Torres Strait Islander health status. Solutions need to be found through engaging the Aboriginal & Torres Strait Islander community in meaningful participation in health service development.

2.2 Empowerment Through Partnership

This section describes the theoretical assumptions underlying a model where empowerment occurs through partnership. This partnership between the TVHS and members of the local Aboriginal & Torres Strait Islander community was based upon Labonte's (1989) view where empowerment means to have increased capacity to define, analyse and act upon one's problems. The processes adopted to facilitate the partnership developed in this study are described, particularly the principles of 'Democratic Dialogue'. It is proposed that the action research method increased the capacity to define, analyse and act upon health problems for the Aboriginal & Torres Strait Islander participants. The provision of this opportunity in partnership with the TVHS has the potential to be empowering.

Empowerment

The benefits of consumer participation and accountability according to the National Health Strategy Paper No 12 (Commonwealth Department of Human Services and Health 1993) include the following: allowing a health service to know what needs to be changed; improving health outcomes through the empowerment of consumers; increased service responsiveness to consumer needs and more appropriate allocation of resources. Improving health outcomes through the empowerment of consumers, is based on the assumption that individuals can, and are able to, take responsibility for their own health. Community development has been identified as a process through which inequities in health care can be addressed. For community development to function persons engaged in the process need to be "empowered". To be empowered means to increase one's capacity to define, analyse and act upon one's problems

(Labonte, 1989).

In order that 'participation' can occur, Pearse & Stiefel (1979) suggest there needs to be profound social structural change and a 'massive redistribution of power'. Within the existing societal and professional health structures, those who already have access to power are in a position to retain their power. Aboriginal & Torres Strait Islander community control for the current health system, based on the medical model is threatening to the existing social order. Therefore attempts at community participation result, through inequities in knowledge and power, in the continuation of the status quo. Health resources continue to be directed to acute services, rather than to primary health services, essentially excluding those most in need and least serviced by existing government services. "The process of consultation can be a particularly destructive experience for Aboriginal & Torres Strait Islander communities if it does not adequately reflect and respect their way of doing things and the kinds of outcomes which they would wish for their people" (Commonwealth Department of Human Services & Health, 1995:49).

Legge (1995) in describing the new public health model interfacing with social development, outlined the importance of acknowledging the various positions that exist in society. He suggests that the relation of power and knowledge and the construction of reality in the Aboriginal & Torres Strait Islander culture must be recognised by those providing health services. To simply apply reductionist, epidemiological principles and intervene as the 'expert' who knows best, is unlikely to produce a satisfactory outcome in Aboriginal & Torres Strait Islander health. On the

other hand he maintains that seeking symmetrical relationships can result in the reshaping of a shared situation. (Legge, 1995:8).

Eckermann & Dowd (1990 : 8:18) identify the operant processes in primary health care and community development as; participation, responsibility, co-operation and the development of health goals at the local community level and suggest..... “in Western industrial societies, such as Australia, we find it extremely difficult to operationalise such empowerment”. The bureaucratic goal of consumer consultation is based on a model of seeking advice on our health system from community representatives. To move towards shared or community ownership of the health system requires a fundamental shift of power. “Community participation which reaffirms existing structures and patterns of decision making, then is unlikely to challenge established, socially and legally sanctioned professional and administrative hierarchies” (Eckermann et al., 1990 : 189). Labonte (1989) advocates a political analysis of community empowerment. He suggests community empowerment may result in status quo practice through lack of linkage to political theory and social organisation.

Partnership

The literature on community participation in health service planning suggests that health problems should be seen from a local rather than a technical perspective (Legge, 1992), and that it is not helpful to intervene as experts on an asymmetrical basis (Legge, 1995). Organisations such as the World Health Organisation - UNICF (1978) describe individuals having the right to participate in their own health

planning. Broadhead (1989) outlines a participative planning model which contains the following characteristics:

- a flow of information from the community to the planners
- a flow of information from the planners to the community
- a process which is seen as legitimate by the community
- a process such that the directions set as consequences of the participation are seen as legitimate by those who must implement them.

The factors relating to the poor health status of Aboriginal & Torres Strait Islanders are complex (Thompson, 1984). According to Eckermann et al., (1992) attempts at Indigenous community participation in health planning must involve the ‘sense of community’ and encompass a holistic wider view of health (National Aboriginal & Torres Strait Islander Health Organisation, 1982). Furthermore, Eckermann et al., (1992) describe the difficulty in operationalising Indigenous empowerment in Australian health service planning. The literature suggests that studies are necessary to document and validate the process of Indigenous community participation and provide guidelines of “how to consult” and, more particularly, how to share power.

According to Elden & Levin (1991:134) “Empowering participation occurs between insiders and outsiders in what is known as cogenerative dialogue. Both insiders and outsiders operate out of their initial frames of reference but communicate at a level where frames can be changed and new frames generated”. Cogenerative dialogue (Levin et al., 1980; Greenwood, 1989) is regarded as conducive for the development of new ideas. Cogenerative dialogue facilitates the development of interaction

through dialogue and the production of new knowledge. This knowledge is a shared product of the participatory action research process, it is then tested out by the group, by acting upon it and reviewing it over time and in different settings.

Democratic Dialogue

The principles guiding the process adopted by the researcher during the participatory action research were taken from Gustavsen's nine, 'criteria for democratic dialogue' (Gustavsen, 1985 : 474 - 475). Gustavsen describes dialogue as an exchange where points and arguments move to and fro, between the participants with all participants being able to participate. Persons should be encouraged to be active in the discourse with equal status awarded to all. Personal experience was the foundation for participation and at least some of the experience of each participant must be considered legitimate. A full understanding of the issue must be made possible for everybody with all points of view accepted as legitimate and finally the dialogue must continuously produce agreements which can provide a platform for investigation and practical action.

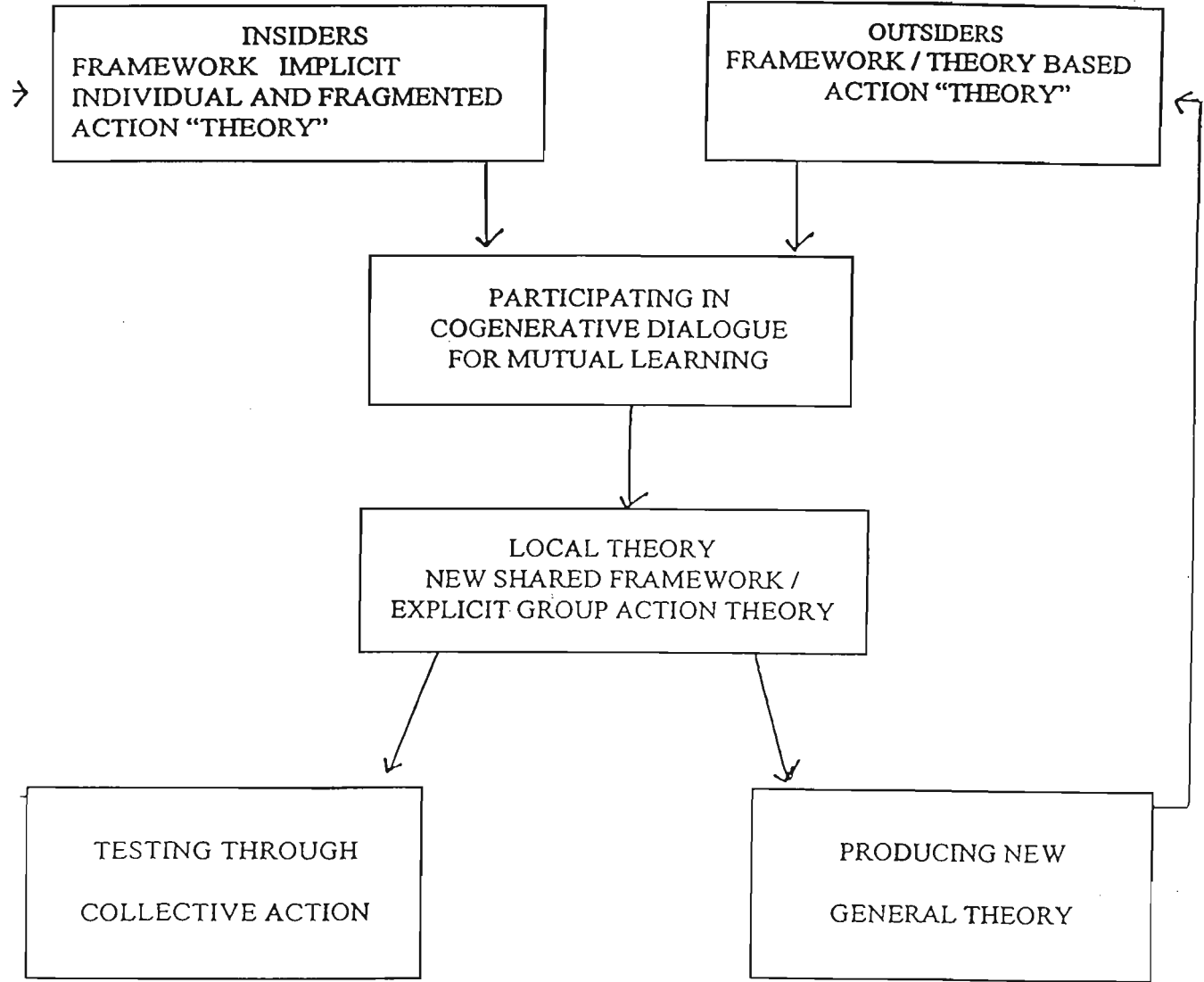
The Cogenerative Model

The participatory action research model developed by Elden & Levin (1991) arises from political concepts of democracy, political equality and social justice. Elden & Levin (1991) do not work from a 'detached' and 'value-neutral' position rather a collaborative involvement between the researchers and the group under study is sought. Elden & Levin (1991:128) describe the values and context of their work in the following terms. They suggest that they have a commitment to the democratic

process and that people have the right to quality jobs. A ‘good’ organisation is one that is based upon self-management, develops human potential and equalises power in the organisation. They rely on sociotechnical systems thinking as a way to re-design organisations and are supported through a network of well financed public or nonprofit research institutes. Their work exists in a context of specific labour legislation and industrial relations in Norway which supports participation in work practices. Finally, Elden & Levin aim for the researcher’s role to be one of ‘co-learner’ rather than that of expert in charge. The researcher’s expertise includes the ability to ‘fade out’ as participants take charge of their own learning. The model is shown in Figure 2.1, A Model of Participative Action Research Scandinavian style : The Cogenerative Way (p 36).

Elden & Levin (1991) indicate that their model of participatory action research needs to be understood in this context. They do not seek to generate data that can be used by independent reviewers to validate conclusions. Rather they seek to create concepts that clarify participatory action research and its praxis. The cogenerative model describes insiders (local participants) and outsiders (the professional researchers) collaborating in creating theory that participants test out by acting on it. “The results are then fed back to improve the participants’ own ‘theory’ and to further generate more general (scientific) theory” (Elden & Levin, 1991:130).

Figure 2.1
A Model of Participative Action Research Scandinavia Style: The Cogenerative Way



Source: Elden, M. & Levin, M. (1991), Cogenerative Learning : Bringing Participation into Action Research in Whyte (ed) 1991. Participatory Action Research. California. Sage, 130.

Elden & Levin (1991:131) take the position that “a researcher has no legitimate monopoly on explaining social worlds as making sense or reality interpretations” and “theory is influenced by the local situation in which it is created”. Participatory action research provides a method and a way of learning how to explain a social world through the construction, testing and improving of theories. The aim is for participants to learn from the research, as learning is a good strategy to empower people. Participants in the process discover new knowledge, and in “deutero-learning”; a term used by Argyris & Schon (1978) which means they learn how to learn.

Participatory action research provides a context for the creation of new possibilities for action. Frameworks or ways of understanding come from an insider versus an outsider perspective, such as “the richness and quality of the research depends on the ability of the insiders and the outsiders to play their different frameworks and expertise against each other to create a new, third explanatory framework”(Elden & Levin 1991:132). This creates the new knowledge not previously available to either, a creation of a shared framework or local theory. Insiders have knowledge about their own social world that has not been systematically tested. Conversely outsiders (researchers and the external ‘experts’) have training in systematic inquiry, analysis, and in the creation of new knowledge and theory. The outsiders will have a formal research framework including abstract concepts, a commitment to scientific methods and publication of theory. The ‘outsider’, a ‘researcher’, ensures that what is learned in a participatory action research contributes to the accumulation of knowledge.

In studying other cultures McTaggart (1993) suggests that action research can be viewed as a methodological effort to reduce concerns about exploitation in cross cultural work. He proposes action research tends to occur in areas such as medicine, agriculture, health education and education which have a western orientation. To address the possibility of exploitation and western cultural imperialism, participatory action research relationships between participants must be “openly and explicitly dialogical with commitments to symmetry and reciprocity in discourse, practise and social organisation” (McTaggart, 1993:65).

McTaggart (1993) suggests that commitments to symmetrical dialogue will reduce the possibility of exploitation and cultural imperialism, however, when a researcher is a full participant in the group process there is a risk that the genuine blending of ideas will unintentionally result in loss of the Indigenous perspective. This insidious cultural imperialism must be guarded against as it may result in threats to the validity of the research process. This poses risks for the participants and the researcher and the validity of the findings. The continuous cycle of consensual validation in participatory action research provides some protection.

McTaggart (1993:66) describes action research, “not as a method or procedure but a series of commitments to observe and problematise” through practice of the general principles of action research. Within cross cultural research he identifies the necessity of acknowledging the culture of the group, which is described by the forms of language, discourses, activities, practices, social relationships and organisation. He describes action research producing the engagement of local knowledge, the

relationship between research and social movement and the practise of 'emancipation'. This development of culturally appropriate practices articulates a richer understanding of the "ways in which indigenous peoples' views, culture and specific practices might be taken into account" McTaggart (1993:73).

Summary

The development of culturally appropriate health services for Aboriginal & Torres Strait Islander communities can only occur in partnership with the local communities. The model proposed in this section suggests that empowerment can be operationalised through a partnership between the TVHS and the local Aboriginal & Torres Strait Islander community. Furthermore, the literature suggests that the cogenerative participatory action research method provides a vehicle for operationalising a partnership in which the participants have opportunity to define, analyse and act upon the health problems of their community.

2.3 Case Study and Participatory Action Research

Participatory action research is a qualitative approach to research which seeks to gain in-depth information about complex, real life phenomena. As such it represents a case study research design in which the focus is on quality of information rather than quantity. This study represents a case study involving a single case, namely a partnership between the local Aboriginal & Torres Strait Islander community and the public sector TVHS for improved Mental Health Service delivery with data collected from multiple sources throughout three cycles of action research.

This section explores the complexities of completing this type of research and introduces case study research based on Yin's (1989) model and examines participatory action research in greater detail. One of the challenges of undertaking qualitative research is the amount and complexity of data confronting the researcher. It is therefore critical that careful consideration is given in the early stages of the study to choice of variables to be observed and to data management. Limitations of qualitative research and the challenge of ensuring rigour are outlined.

Case Study Research

Yin (1981a) provides a definition of a case study that states; "A case study is an empirical inquiry that:

- investigates a contemporary phenomenon within its real-life context; when
- the boundaries between phenomenon and context are not clearly evident; and in which

- multiple sources of evidence are used.

He identifies five components of a case study research design that are especially important. The study's questions and propositions, the units of analysis, the logic linking the data to the propositions and the criteria for interpreting the findings (Yin, 1989). Data is gathered from multiple sources to generate a chain of evidence related to the study's questions and propositions. Yin (1989) argues that case studies should be evaluated in terms of the adequacy of the theoretical inferences that are generated. For example, he states, the single case study is an appropriate design to confirm, challenge or extend a theory. The model is appropriate for unique situations or exploratory study. The potential vulnerability to the single case design is that the findings are not able to be generalised to broader populations (Bryman, 1989; Yin, 1989). Yin (1989) argues that scientific facts are rarely based on a single experiment but usually based on multiple sets of experiments, which have replicated the same phenomenon under different conditions. "The case study, like the experiment, does not represent a sample and the investigator's goal is to expand and generalise theories (analytic generalization) and not to enumerate frequencies (statistical generalization)" (Yin 1989:21).

The strength of the design is the ability to focus systematically on complex phenomenon in real life situations. Yin (1989) says the approach should be guided by:

- the development of a theoretical proposition against which patterns of empirical data can be examined;
- the establishment of a research data base for the organisation of qualitative and quantitative information;
- recording of interviews and research meetings in a data base to facilitate the examination of themes;
- recording of changes over time and outcomes of each research cycle.

Yin (1989) proposes that data collection be based on three principles in order to strengthen construct validity and reliability. The first principle involves the collection of various types of evidence from multiple sources, gathered systematically, to create a converging chain of evidence. Yin maintains that this will reduce the threat to construct validity. The aim is to provide evidence from various sources about the same phenomenon. In this way confidence in the validity of the findings is enhanced. The second principle suggests a method of organising and documenting the data collected for case study. Essentially, the development of a research plan which facilitates data collection, management and validation by key participants. The final case study report draws on this data base to explore the extent to which the findings match the theoretical framework. The final principle increases reliability of the inferences drawn in a case study and is the provision of a chain of evidence. There should be a coherent sequence from initial research questions through to subsequent questions and ultimately to the conclusions drawn.

Qualitative research as defined by Bryman (1989) has a number of qualities that are useful pre-requisites for the study of social reality. The researcher adopts an insider approach, developing a strong sense of context with an emphasis on process. The approach is unstructured and does not begin with a prior hypothesis, rather multiple sources of data are produced and then checked for validity against other sources, within a social context. The researcher maintains a close proximity to the interactions being studied. Quantitative studies have different assumptions; usually they begin with a hypothesis to be tested with little emphasis on interpretation and attention to the context in which the events occur. Of particular importance in quantitative studies is the controlling of extraneous variables. Measures of data are usually single source from an external position to the organisation being studied. The use of a qualitative approach is particularly appropriate in a situation where the views of the Indigenous people are unknown. The emphasis on process provides an opportunity to develop a sequence of events rather than a single measure.

Bryman (1989) describes some of the problems in qualitative organisational research beginning with difficulties in gaining access to organisations and the debate regarding whether access should be sought from the top of an organisation. Crompton & Jones (1988) recommended this strategy. Others recommend access through lower levels of the hierarchy (Buchanan et al., 1988). Provision of clear explanations about the researcher's intentions (Buchanan et al., 1988) and the offer of a report (Brown et al., 1976) are methods proposed to improve access.

Difficulties in gaining access to organisations, including communities, relates to most types of social research.

To avoid problems of bias associated with qualitative research, Bryman (1989) maintains that it is necessary to bring the researcher's and the subjects' perspectives into closer alignment. One approach is through a process of respondent validation in which the researcher constantly checks their information and their interpretations with the subject. This process is further complicated when as in participatory action research, the researcher is also a participant in the process. Participant observation is discussed more fully on page 51 .

Abraham (1994), in an exploratory action research study with Indigenous Management Training, considered rigour from the case study model proposed by Yin (1989). Abraham examined his data from the perspectives of reliability (the ability for the study to be replicated elsewhere), external validity (generalising findings), internal validity, (determining causality) and construct validity (objective data collection). Reliability was established through adherence to Yin's (1989) case study protocol ensuring the procedures followed were explicit and detailed. Abraham (1994) commented that his findings were limited to one particular locality and could not be generalised to other settings. Further replications would contribute to the generalisability particularly if the study was undertaken on multiple sites.

Case studies deal with operational links needing to be traced over time and require careful attention to the selection of the correct operational measures.

Yin (1989) makes a strong case for the use of multiple sources of evidence developed over time and from different sources to contribute to a chain of evidence. Pattern matching (a comparison on an empirically based pattern with a predicted one), explanation building (stipulation about the causal links explaining a phenomenon) and time series analysis (the sampling of data over time) are described as contributing to internal validity. Time series analysis is the collection of samples of data over time where there may only be a single variable. Statistical tests can be used to test differences between measures. Observing change over time can strengthen the conclusions that can be drawn from a study. Yin (1989) suggests the comparison of an empirically based pattern with a predicted pattern can strengthen internal validity if the patterns coincide. Pattern matching allows for the testing of alternative propositions or other plausible explanations. Questioning new empirical observations against general scientific principles can lead to theory development.

Bryman (1989) comments on a weakness of the case study model as the inability to generalise from a single case study. He makes a case for the use of multiple cases. Like Yin (1989) he maintains that case studies should be evaluated in terms of the adequacy of the theoretical inferences that are generated. Furthermore, he also emphasises that a single case study should not be treated as a sample of one.

Burgelman (1985) comments that the purpose of the case study is primarily to generate new insights that are useful for building theory. Where a study is based on one research method to generate theory, the interpretations are potentially vulnerable to bias. This problem can be overcome to some extent through the collection of multiple sources of data over time and through triangulation. Babbie (1995) suggests, triangulation can be considered as the use of several different research methods to test the same finding. Triangulation also refers to the use of different observers, methods, and theoretical perspectives to examine the same phenomena.

Case study research frequently generates large amounts of diverse data. The complexity and enormity of the task can be overwhelming for the researcher attempting analysis (Whyte, 1984). Bryman (1989) suggests that unlike the analysis of quantitative data there are few 'rules of thumb' for the analysis of qualitative material. The subjective interpretation may place a restriction of the types of data analysis that can occur (Yin, 1989). Qualitative researchers can restrict their interpretation to the major themes emerging. "A common approach to the analysis of qualitative data, whereby patterns and theories are elaborated and afforded a conceptual coherence, and then further extended to a wider theoretical domain" (Bryman, 1989:167).

Locke (1989) described difficulties in implementing qualitative research, such as, the time and energy required, the intrusion into the lives of participants,

the need for flexibility and the maintaining a holistic view and Siedentop (1989) describes the variation in findings when studies are replicated.

Participatory Action Research

Whyte (1991:7) suggests that participatory action research evolved out of three streams of intellectual development and action, namely, social research methodology, participation in decision making by low-ranking people in organisations and communities, and sociotechnical systems thinking regarding organisational behaviour.

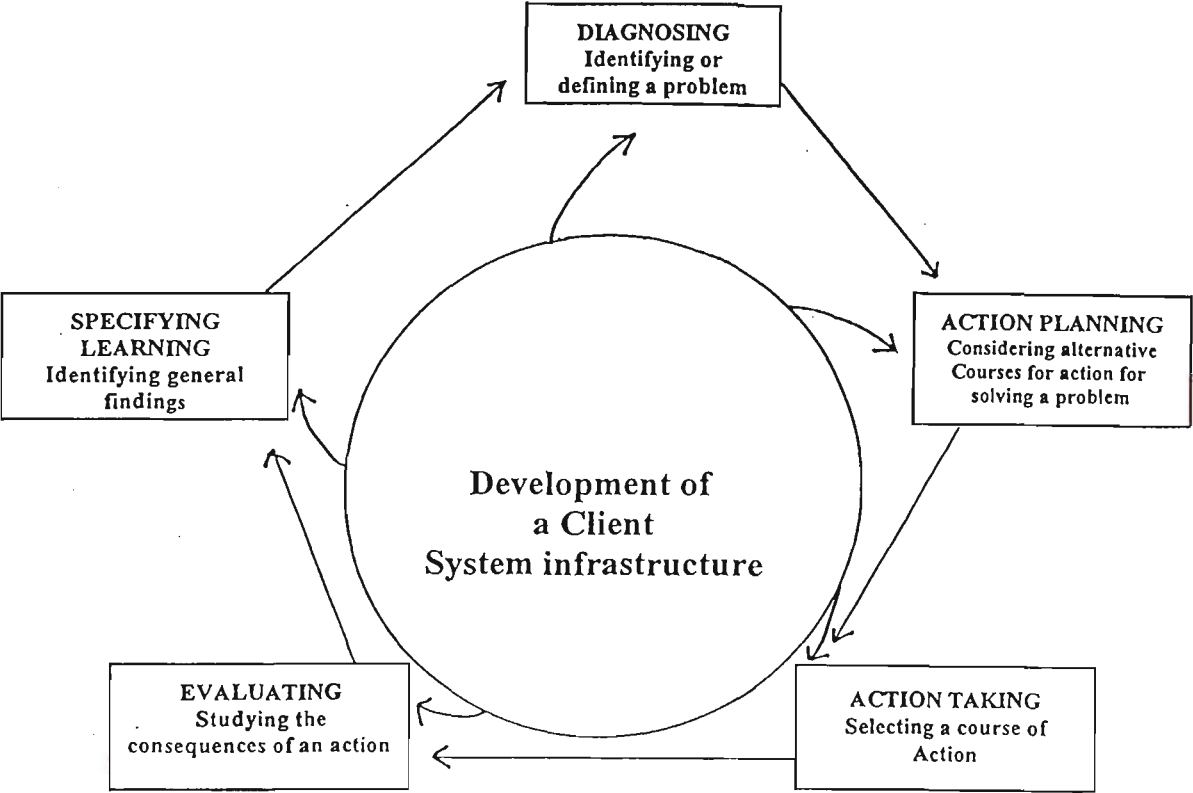
Whyte (1991:8) maintains that behavioural social research methodologies typically discover basic facts and relationships about events and it is up to others “to somehow make use of what social researchers discover”. He suggests an alternative view where research and action may be linked for both the advancement of science and the improvement of human welfare. According to Whyte (1991), participatory action research is a model of research where people from an organisation or group under study participate actively with the researcher throughout the process from initial design to the final presentation of results and importantly discussion of implications for action.

Participatory action research is reported to have the potential to stimulate and guide major organisational change leading to rethinking and restructuring relations (Elden & Levin, 1991). The process begins with the identification of a problem, bound by all the social constraints and context of the time.

Then, a collaborative process between the researchers and the participants that endeavours to “see as much of the relevant expertise as possible from all over the organisation is mobilised” (Whyte et al., 1991:2). Participatory action research aims to ensure that solutions are found within what people know to be true from their own perspective. Furthermore, Whyte et al., (1991:21) claim that “science is not achieved by distancing oneself from the world, as generations of scientists know, the greatest conceptual and methodological challenges come from engagement with the world”.

Lewin (1952) described action research as a “spiral of steps, each of which is composed of a circle of planning, action and fact finding about the result of the action” (Susman & Evered 1978:578). Common elements of action research have been identified by a number of researchers, including Argyris et al., (1985) ; Elden & Chisholm, (1993); Greenwood, et al., (1993); Susman & Evered, (1978). Consistent characteristics of action research are that it is cyclical, collaborative and action oriented. A typical action research model is described by Susman & Evered (1978) shown in Figure 2.2 on page 49.

Figure 2.2
An Action Research Model



Source: Susman G. & Evered R.P., (1978). An Assessment of the scientific merit of action research. Administrative Science Quarterly. 23 (4): 584

Researchers (Ketterer et al., 1980; Peters & Robinson, 1984; Hult & Lennung, 1980) agree that action research is an approach to applied social research where the researcher and the participants collaborate in the solution to a problem, providing findings that contribute to scientific theory. Many research designs can exist within action research (Bryman, 1989). Abraham (1994) examined the characteristics of the action research method identified by Peters & Robinson (1984) including the authors who supported the inclusion of each characteristic. A summary of the characteristics suggests action research focuses on solving problems through being action oriented and cyclical. The process moves from planning, action, observation and reflections to the next cycle and is useful in applied settings. The process is collaborative where the participants are simultaneously the people being studied and are involved in the research.

In summary, participatory action research acknowledges alternative and local knowledge while contributing to general scientific theory. Participants discover knowledge, and find new ways of action. The focus on problem solving and action creates a framework for findings, with a whole system perspective. The type of methodology within participatory action research can be quantitative or qualitative, and participation has the potential to be empowering. According to the criteria proposed by Yin (1989) this study was exploratory in nature examining a “new area of inquiry, including new and previously unintegrated social phenomena as well as techniques of data collection and measurement”.

Participant Observation

The role of the researcher in participatory action research is quite different from traditional research. Whyte (1984) suggests there are three approaches for the presentation of the researcher to the participants : overt, semi-overt and covert. This research was conducted from a clearly overt position aimed at achieving full participation and co-determination. Brown & Tandon (1983) emphasise participants being in charge of the inquiry through the researcher facilitating the process allowing the participants to define and create the learning process.

Jorgensen (1989) reported in Abraham (1994) suggested the participant observation research technique is appropriate when:

- little is known about the phenomenon;
- there are important differences between the views of insiders as opposed to outsiders;
- the phenomenon is somehow obscured from the view of outsiders; or
- the phenomenon is hidden from public view.

Action Research & Health

There has been little systematic research examining the outcomes of an Aboriginal & Torres Strait Islander partnership in health service planning. A literature search of the major health data bases found no studies describing the use of action research as a method for Indigenous health service development. Nor were any studies identified that examined the efficacy and outcome of an Indigenous participative planning model.

O'Connor (1994) cites examples of successful Indigenous health programs and identifies the importance of ownership of health care programs by Aboriginal & Torres Strait Islander people. Pratt et al., (1992) as reported in O'Connor (1994) noted the rapid improvement in infant mortality rates following a community health care program. Neilson et al., (1993) also cited by O'Connor (1994) reported that a health care program reduced the prevalence of rheumatic fever attributing much of the success to the community ownership and participant aspect. O'Connor (1994) cited a culturally appropriate Women's Health Program that employed Aboriginal & Torres Strait Islander educators and was successful in gaining the involvement of 85% of the female Aboriginal & Torres Strait Islander local community. O'Connor (1994) concurs with Devanesen (1992) and Houston & Legge (1992) that Indigenous health programs should rely on Aboriginal & Torres Strait Islander people who have the skills and experience to undertake them, whether or not they are formally educated.

Several international health and action research studies were identified. One study proposed that engagement with participatory action research had the potential to bring about transformative cultural shifts in nursing culture (Robinson, 1995). A Mexican study by Ysunza-Ogazon et al., (1993) discussed the importance of research in community participation as a part of primary health care. They concluded that positive results were obtained from community participation with the local health auxiliary. The researchers noted that action research is most appropriate where people are both the object and the subject of the research. Smith (1993) in a Canadian study proposed that participatory action research combines adult education with investigation and sociopolitical action and has a goal of personal and social

transformation. Denz-Penhey et al., (1993) in a New Zealand project examined service delivery for people with chronic fatigue syndrome using an action research pilot study. The pilot study used repeated action or cycles to identify culturally and contextually sensitive forms of language and models of service delivery for people in a general practice setting. The study identified self management options acceptable to both doctors and patients.

Donavan et al., (1993) in a New York social and health needs assessment study, described action research as helping to create both social services and social change for “low income women of colour”. An Australian study by East et al., (1994) examined change in health care through action research. The study describes hospital managers and senior ward nurses initially having different agendas for change and the research process facilitating the development of common ground. Eng et al., (1994), in a North Carolina study examining community competence and the interface between program evaluation and empowerment suggests an action research design enhances a community empowerment agenda. An Indianapolis study by Flynn et al., (1994) employed action research to empower communities to take action for health. They proposed there are five concepts that link community empowerment and action research. These concepts are a focus on community, citizen participation, information and problem solving, sharing of power and quality of life. Abraham (1994) in a study applying action research in Indigenous management development concluded that an action research method could be used to design and implement a management training and development program that addresses the needs of Indigenous community leaders in Australia. Martin (1994) in a monograph reviewing

action research evaluation and health concluded that action research methodologies can make a unique contribution to the exploration and resolution of issues in contemporary nursing practice in Australia. She identifies the potential to involve consumers in action research.

The above literature provides evidence in support of action research as a useful vehicle for facilitating collaborative problem solving in settings that involve groups from diverse cultural backgrounds with different levels of influence. All of the above studies combined research with practice. Furthermore, the literature suggests that the employment of action research has a transformative quality where new and emancipatory knowledge can develop.

The Challenge of Rigour

The central challenge for qualitative action research is to meet standards of appropriate scientific rigour without sacrificing relevance. Argyris & Schon (1991:85) suggest action research needs three things: “a way of representing research results that enhances their usability, a complementary way of construing causality and an appropriate methodology of causal inference”. Karlson (1991) claims the classical experiment requires control of extraneous variables and often uses random assignment to achieve this end. This device, however, is not feasible in participation processes. Karlson (1991:154) maintains that, “An important issue is thus how to organise the interaction between research and action in such a way that valid knowledge can be obtained”. He goes on to describe the fundamental goal of action research as being to produce a plan with which one confronts plausible rival propositions. Action

research provides an alternative method for obtaining valid knowledge. Pragmatic validation occurs when the assumptions about the causal relationships on which measures will be based will continuously be tested, leading to a spiral design of action and research. Practitioners who are connected with the research take part in evaluating, interpreting and reflecting on the data which is tested through action in a process called consensual validation.

McTaggart (1996) says validation in participatory action research is accomplished through methods including the triangulation of observations and interpretations, by establishing credibility among participants, by participants' confirmation and by the establishment of an audit trail of data and interpretations. He suggests the testing of coherence is through a process of dialogue and an iteration between the data and the substantive and methodological literature informing the study. McTaggart (1996) specifies that an account is just one among several, thus acknowledging the various epistemological positions which might be presented. "Validity is a property of the interpretations and conclusions people make of information and the theoretical frameworks which guide its collection and use" (McTaggart 1996:15).

The cyclic process of action research has been identified by many workers over time (Lewin, 1946; Zuber-Skerritt, 1991; Hutt & Lennung, 1980; Argyris & Schon 1991; Whyte et al., 1991). The continual examination of alternative explanations can demonstrate the kind of rigour appropriate to action research (Argyris & Schon, 1991). The checking and validating of data with participants increases rigour (Whyte, 1991). Multiple sources of data and the use of different methods are seen to enhance

rigour in action research (Davies & Ledington, 1991; Patton, 1990) concurring with Yin's (1989) model for case studies. Action science provides a method for constructing and then testing hypotheses as well as the opportunity to test plausible alternative hypotheses thereby generating scientific theory (Argyris & Schon, 1991). Whyte (1991) maintains that participatory action research depends more upon "creative surprises" that emerge during the process and that new actions foster the emergence of new ways of thinking and feeling.

The challenge of appropriate rigour and the examination of alternative accounts of phenomena must be addressed satisfactorily in any action research that claims to build upon theory. To ensure rigour in action research, Swepson & Dick (1993) proposed that the process be cyclic, using multiple data sources with earlier interpretations tested in later cycles.

Summary

Case studies allow for the investigation of complex phenomenon in real life situations. Conducting social research requires careful selection of a research design and data collection measures. The methods proposed by Yin (1989) to assist in construct validity and reliability are the use of multiple sources of data, the documentation and organisation of the data and the development of a chain of evidence. In order to draw inferences from the data there should be a logical sequence from the initial research question through to the conclusions.

This section has outlined the benefits of the action research cyclic process and methods to reduce the possibility of bias in the results. A case study utilising an action research data collection process was considered to be an appropriate methodology for this study.

3. METHODOLOGY

This Chapter describes the methodology employed in this study. The research design represents a case study utilising action research which gains validity by drawing data from multiple sources using a variety of methods. The unit of analysis was a partnership between the local Aboriginal & Torres Strait Islander community and the TVHS. The Aboriginal & Torres Strait Islander community is estimated to be between 900 - 1900 members. The numbers are estimated because of a discrepancy between the ABS, 1991 data and a local 1991 population survey. The Aboriginal & Torres Strait Islander Health Outcome Committee represented this community. The steps involved in setting up the action research project and the sources and methods of data collection are described. The operational and feedback links with the local Aboriginal & Torres Strait Islander community are outlined. The role of the researcher as a participant observer and the methods used to analyse the data including pattern matching, content analysis and time series analysis are described.

Research Question

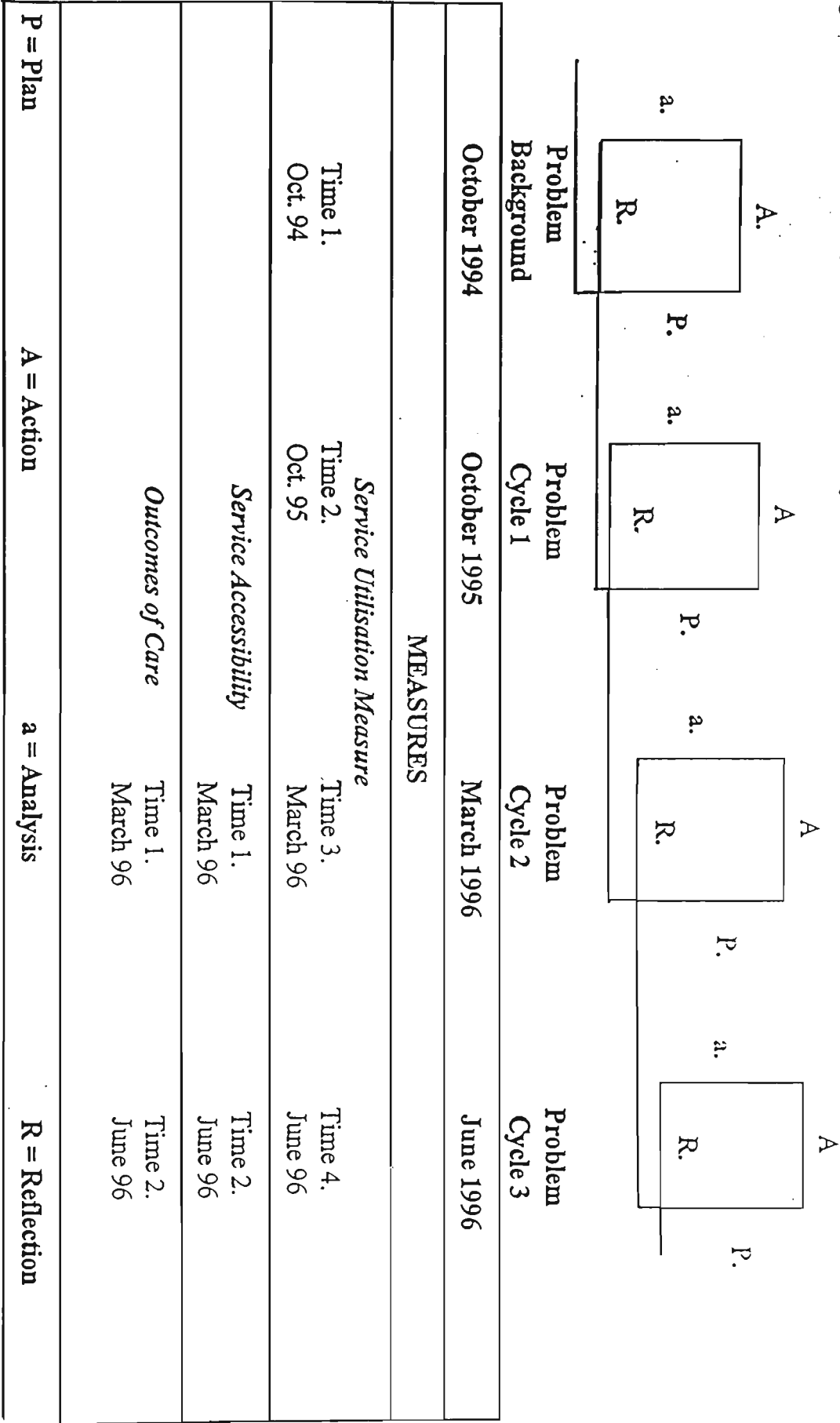
The stress level survey outlined in Chapter 1 (p 12), identified high levels of stress and distress in the local Aboriginal & Torres Strait Islander community and, importantly, almost non-existent public Mental Health Services provided to the community. Barriers to the utilisation of public Mental Health Services by the Aboriginal & Torres Strait Islander community were also identified. The serious nature of the problems identified in this survey created the impetus for this study. The public health question which confronted the local regional health service was “What action should the service take to make its services more acceptable and useful

to members of the Aboriginal & Torres Strait Islander community?” From literature search and consultation with members of the Aboriginal & Torres Strait Islander community it was apparent that change could best be achieved through genuine community participation. Participatory action research was selected as a methodology that would provide a suitable process for researcher/ Aboriginal & Torres Strait Islander community collaborative problem solving; a research partnership. The initial problem was defined as identifying barriers to utilisation and trialing strategies to make the service more acceptable and useful to members of the Aboriginal & Torres Strait Islander community. Addressing this problem represented the first action research cycle. Two subsequent cycles followed and with each cycle a new problem was defined. In cycle 2 the problem was the challenge of providing culturally acceptable services and cycle 3 addressed the need for culturally appropriate methods of healing. Figure 3.1 (p 60) outlines the three cycles of research and the time frame associated with each. Each cycle followed a similar process of 1) problem definition and planning, 2) action, 3) analysis, and 4) reflection. As indicated in Figure 3.1, measures used to assist analysis were utilisation of mental health services, satisfaction with accessibility and reported outcomes/of care.

Setting up the Action Research

The first stage of the research process involved the pre-establishment of a “Research Reference Group”. The Aboriginal & Torres Strait Islander Health Outcome Council had developed from a group of interested Aboriginal & Torres Islander persons who volunteered to be members of the Aboriginal & Torres Strait Islander Hospital Liaison Committee. There were 14 members of the group. The majority of these persons

Figure 3.1 Participatory Action Research Cycles



were key stakeholders in the local Aboriginal & Torres Strait Islander community. This group of people became the Research Reference Group who worked with the principal researcher who was supported by two part time project officers. The group were community representatives and representatives of community agencies: Chairperson, Community Representatives, Elders, Spiritual Advisor, Community Representative - Youth, Tweed Aboriginal Housing Co-op, Tweed Shire Women's Refuge, Aboriginal Health - TVHS, Mental Health Team - TVHS, Islander/Aboriginal Community Liaison Officer - Tweed Heads Police, two Project Managers and the Principal Researcher.

The basis of the partnership in this study was a relationship of mutual benefit to both the TVHS and the Indigenous community representatives, who were the Aboriginal & Torres Strait Islander Health Outcome Council. The partnership was based upon Labonte's (1989) view of empowerment, where it is suggested that to be empowered, means to have increased capacity to define, analyse and act upon one's problems. It was proposed that the establishment of a 'partnership', based upon these principles would facilitate Indigenous community participation in health service planning and delivery. If the Mental Health Services were judged as culturally acceptable by the local Aboriginal & Torres Strait Islander consumers, it was proposed there would be increased service utilisation. In the longer term it was envisioned that increased utilisation would result in improved health outcomes for people with mental health problems. To achieve this type of 'partnership' the TVHS had to be willing to enter the partnership and to give authority to the Aboriginal & Torres Strait Islander Health Outcome Council to seek and trial solutions on Aboriginal & Torres Strait Islander

Mental Health matters. This represented a structural change and a sharing of power, something which health professionals are known to resist. In addition, the TVHS facilitated cooperative planning through the provision of up to date information in a suitable format. The participatory action research approach provided a structure for the joint examination of health problems by the TVHS and the Aboriginal & Torres Strait Islander Health Outcome Council. Solutions were generated and the outcomes reviewed within a supportive framework. The Aboriginal & Torres Strait Islander Health Outcome Council provided advice on culturally acceptable and appropriate practices. The Council were the 'voice' of the Aboriginal & Torres Strait Islander community and became the Research Reference Group. The partnership offered the opportunity for representatives of the Aboriginal & Torres Strait Islander community to critically review the Mental Health Services and create a self determined service.

Research Reference Group

The Research Reference Group included representatives of the local Aboriginal & Torres Strait Islander community and the TVHS. The Aboriginal & Torres Strait Islander members were also members of Aboriginal & Torres Strait Islander community groups, and were thus able to provide a perspective of the views of the wider Aboriginal & Torres Strait Islander community. The Research Reference Group met monthly for two years to examine the provision of Mental Health Services by the TVHS to members of the Aboriginal & Torres Strait Islander community. The group were given a mandate by the TVHS to review its services. Hence, the project had access to the Aboriginal & Torres Strait Islander community and the TVHS. The Research Reference Group considered barriers to Mental Health service delivery for

Aboriginal & Torres Strait Islander people. In the manner of action research they suggested solutions, trialed ideas, and then reviewed the outcomes.

Throughout the study period the Research Reference Group was provided with timely information about the number of Aboriginal & Torres Strait Islanders using the TVHS and feedback from the Indigenous community, as to the acceptability of health services. Ongoing dialogue with community representatives was considered essential as a validity check and to facilitate community discussion of the issues under consideration. The process of Reference Group discussion of a problem followed by gaining the opinions of the Elders was considered by the Research Reference Group to be culturally appropriate, because it provided a form of cultural surveillance and consensus validation. The action research cycles flowed from one stage to the next naturally. However, the researcher imposed a process of constant review and documentation of the process while the Research Reference Group remained focused on Mental Health Service delivery and practical solutions. There were times when the researcher facilitated brainstorming guided by Gustavson's principle's of Democratic Dialogue; a process in which all persons present are encouraged to voice their opinion with all ideas initially accepted as valid. The group then discusses each issue and in the process ideas are refined.

Each cycle of data collection, problem definition and strategy development and testing generated new knowledge. When the Research Reference Group found new knowledge to be valid over time and setting, the findings were considered in the context of the theories underpinning the research proposition.

In summary, this study utilised cycles of action research, employed both qualitative and quantitative methods of data collection and analysis, collected evidence from multiple sources over two years, used consensus validation and pattern matching based on theoretical propositions and generated new knowledge.

The Aboriginal & Torres Strait Islander Community

Location

The Tweed Valley Health Service serves a population of 60,020 immediately south of the NSW border with a further 25,000 persons in South East Queensland.

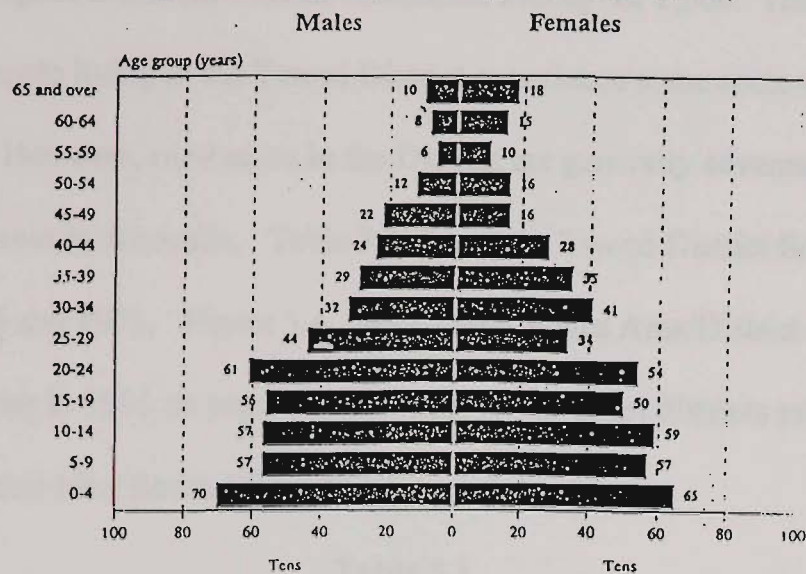
Aboriginal Population

In 1991 the 7,906 Aboriginal and Torres Strait Islanders (ATSI) resident on the North Coast, comprised 12% of the total New South Wales Aboriginal population and 2% of the total North Coast population (ABS,1991). Figure 3.2 shows the TVHS District Aboriginal & Torres Strait Islander population by age group and sex in 1991. In 1991, 986 Aboriginals and Torres Strait Islanders lived in the TVHS District (representing 1.8% of the District population). A local survey of the Aboriginal & Torres Strait Islander population estimated the numbers at approximately 1900 in 1991, suggesting that Aboriginality is underreported in the ABS census.

Demographically, the Aboriginal & Torres Strait Islander population is notably different from the non-Aboriginal & Torres Strait Islander population as indicated in Figure 3.2 on page 65. The population is relatively young compared to the District population reflecting higher death rates and higher fertility. The Aboriginal & Torres

Strait Islander population remained relatively stable during the period of the study.

Figure 3.2
The Tweed District Aboriginal and Torres Strait Islander Population by Age Group and Sex (1991)

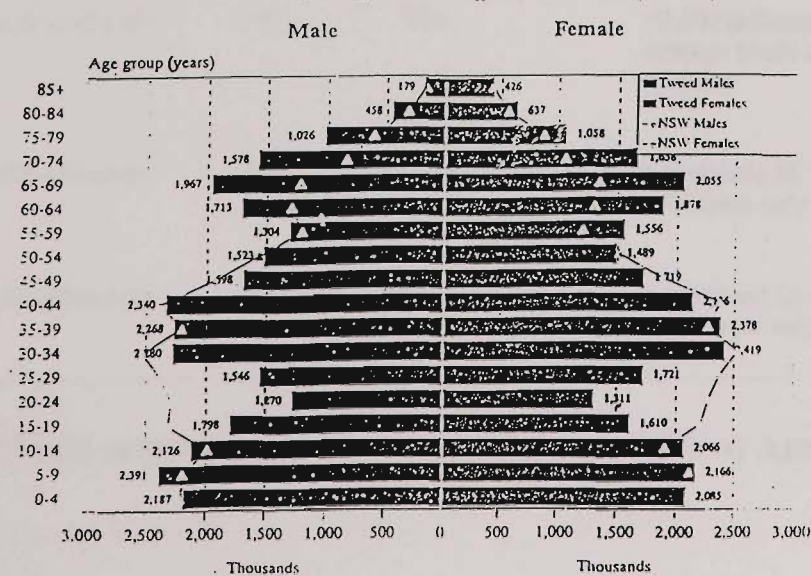


Source: Australian Bureau of Statistics, 1991.

Tweed Valley Population

In 1994 the estimated population for the Tweed Valley Health Service District was 60,020 people. Figure 3.3 shows the Tweed District population, by age group and sex, in 1991. This population is expected to grow to 123,083 by the year 2000.

Figure 3.3
The Tweed District Population Compared with the New South Wales Age Structure by Age Group and Sex (1994)



Source: Projection from Australian Bureau of Statistics 1991 Census.

Socio-economic Status

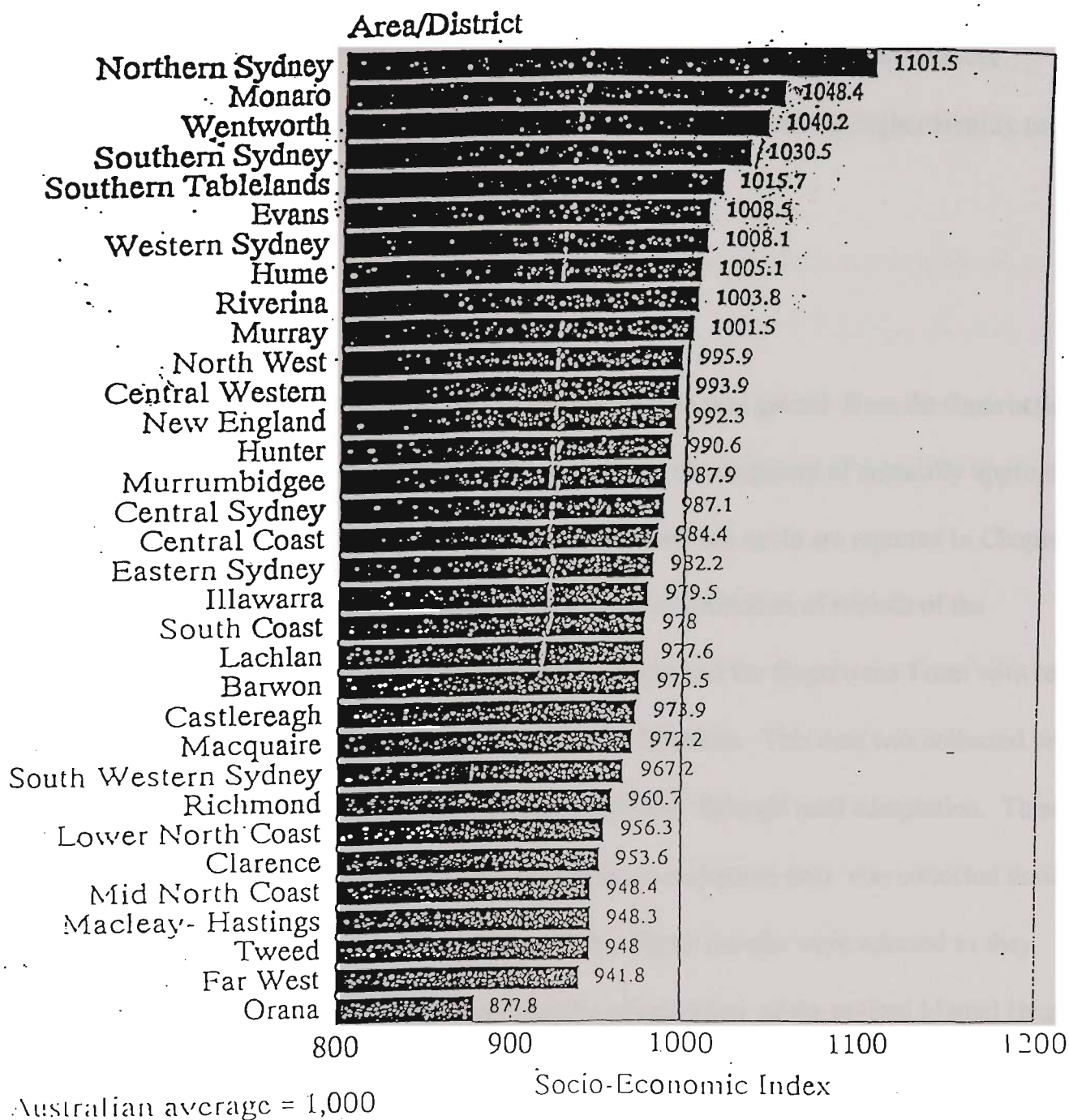
The Australian Bureau of Statistics (ABS) has developed socio-economic indices that compare geographic localities with an Australian average of 1,000. These indices suggest that people living in the Tweed District experience some socio-economic disadvantage. However, rural areas in the District are generally advantaged compared to other rural areas in Australia. Table 3.1 shows the Tweed District Socio-economic indices in 1986 and 1991. Figure 3.4, New South Wales Area/District Socio-economic indices in 1991 on page 67 shows all North Coast districts rate poorly when compared to other New South Wales Districts and Areas.

Table 3.1
Tweed District Socio-economic Indices

Indices	1989	1991	Comment
Relative Socio-economic (SE) disadvantage	948	948	<1,000 indicates lower than average levels of income, Tertiary educational attainment, trained occupation, & higher levels of unskilled, unemployed workers
Economic resources	954	949	<1,000 indicates lower than average levels of income and assets
Education & occupation	940	924	<1,000 indicates lower than average levels of skilled workers
Rural - relative SE advantage	1,065	1,065	a combined SE index for rural areas only
Urban - relative SE advantage	950	961	a combined SE index for urban areas only

Source: Socio-economic Indices for Small Areas (SEIFA) ABS.1991

Figure 3.4
New South Wales Area/District Socio-economic Indices (1991)



Source: Socio-economic Indices for Small Areas (SEIFA) ABS.1991

In summary, the Aboriginal & Torres Strait Islander community of the Tweed Valley comprises 900 - 1900 local residents. The indicators suggest the general population in the Tweed Valley is socioeconomically disadvantaged when compared to other districts in New South Wales. The local Aboriginal & Torres Strait Islander population experiences higher standardised death rates and has higher fertility rates than the local non-Aboriginal population.

Sources of Data

There were four sources of data. Qualitative data was gained from the three action research cycles, and focused on the review and development of culturally appropriate Mental Health Services. The key findings from each cycle are reported in Chapter 4. Secondly, quantitative data was gained from examination of records of the Community Health and Mental Health Services and the Bugalwena Team with respect to utilisation by Aboriginal & Torres Strait Islanders. This data was collected prior to the commencement of the action research cycles through until completion. Thirdly, Aboriginal & Torres Strait Islander consumer evaluation data was collected during the months of March 1996 and June 1996. These months were selected as they represented three months and six months of operation of the revised Mental Health Services. Throughout the two years of the study, members of the Research Reference Group sought feedback from the wider community at a variety of Aboriginal & Torres Strait Islander community group meetings and from the Elders.

Methods of Data Collection

The key findings arising from the action research cycles were analysed at each

‘reflection’ stage. The main themes were identified and fed back to the Research Reference Group for validation and checking against alternative explanations. Only concepts and theme’s found to be consistent over the two years were retained as key findings. Following the implementation of changes in methods of delivering Mental Health Services recommended by the Research Reference Group, data about the reformed service was gained from:

- a. The Aboriginal & Torres Strait Islander community as to acceptability of services;
- b. TVHS records of Community Health and Mental Health Service utilisation statistics;
- c. Consumer Evaluation of the reformed services. This provided a further measure of service acceptability.

The utility of the participatory action research as a method for facilitating Aboriginal & Torres Strait Islander participation in health service planning and delivery was measured in two main ways. Firstly, the method was evaluated in terms of the feasibility of engaging the Research Reference Group and establishing commitment to participate over an extended period of time. Some of the ground work had already been done as a relationship already existed between the health service and Aboriginal & Torres Strait Islander community. Since 1991 (three years) a community representative group had been meeting with members of the TVHS. However, the task of developing a partnership to review the health service was new to both parties. Initial participation was examined after the first action research cycle. The production of ideas and solutions to be trialed provided the evidence that engagement had been established.

Secondly, the research method (ie. participatory action research) was evaluated in terms of its usefulness in maintaining the active and objective participation of members of the Research Reference Group over the two years.

Service Utilisation

Throughout the project Community Health and Mental Health Service utilisation data was made available to the Research Reference Group. The information was drawn from the monthly statistics provided by the Community Health and Mental Health staff at regular intervals and recorded the number of people using the service, the number of visits and the type of service provided.

Service Acceptability

The task of designing an evaluation instrument for assessing consumer satisfaction with the revised services was undertaken by the Research Reference Group. Only a very brief questionnaire was designed because the group felt strongly that change in service utilisation was a superior outcome measure to consumer satisfaction. Of particular concern to the Research Reference Group was client confidentiality. They considered that confidentiality must be maintained at all times within the new telephone support service and that they did not wish to ask callers their names or require them to disclose information. As a result it was decided that the best way to evaluate changes in service delivery were to invite only those people who were referred to the TVHS following a telephone consultation. After these people were discharged from the TVHS, they were invited to complete the evaluation form. This resulted in 14 people being invited and agreeing to complete the consumer evaluation

questionnaire.

Data Analysis

Four methods of data analysis were employed, namely content analysis, pattern matching, time series analysis and consensus validation.

Content Analysis

Qualitative data was analysed for content and identification of new ideas.

This process of data analysis was ongoing and occurred at all stages of the research cycles. The beginning and ending of each cycle was somewhat arbitrary with each new cycle involving recognition that a new challenge had been identified. The researcher analysed the themes that emerged during each cycle and made note of any consistent themes and any inconsistencies. These findings were then presented to the participants for validation or for the proposal of plausible alternative explanations.

Only findings that remained consistent and valid over time were accepted as contributing new knowledge (Chapter 4). In other words, the knowledge gained during the research cycles represents the beliefs of the Research Reference Group that survived discussion, review, testing in action and surveillance from the wider Aboriginal & Torres Strait Islander community.

Pattern Matching

This study was based upon the proposition that a partnership between the TVHS and the Aboriginal & Torres Strait Islander community would provide advice on culturally appropriate methods of service delivery, improve access and thereby increase

utilisation of the TVHS by Aboriginal & Torres Strait Islander people, provide a forum for ongoing review of the TVHS and increase participation in decision making and planning of the TVHS by members of the Aboriginal & Torres Strait Islander community. It was assumed, if the 'partnership' based on Labonte's (1989) view of empowerment was effective, it would result in the TVHS's being more acceptable to the Aboriginal & Torres Strait Islander community. Hence, it would be more utilised by members of the community and perhaps in the long term the health status of Aboriginal & Torres Strait Islanders would improve.

This was an exploratory study and the propositions were theoretical rather than empirically based. Linking the data to the propositions involved comparing the empirically based pattern with the predicted one. The degree to which the study's findings confirm the predicted pattern is seen to provide support for the findings. Pattern matching the research findings with the theoretical concepts underpinning the study was completed independently by the researcher.

Time Series Analysis

Time series analysis was used to examine actual occasions of service by Aboriginal & Torres Strait Islanders. There were four measures of service utilisation over 2 years, and 2 surveys of service accessibility and outcomes of care. The data was collected and analysed four times in namely, October 1994, October 1995, March 1996 and June 1996. These times represented the beginning of the study and one year later. Following the commencement of the new service there were two measures after three months and six months of operation.

Consensus Validation

At all stages of the action research, shared knowledge was generated through the cogenerative dialogue process where the consistent themes were reported to the participants for evaluation, validation and consideration against plausible alternative explanations. Emergent knowledge and themes that survived the test of time and surveillance by the Elders and wider Aboriginal & Torres Strait Islander community were documented. This process of 'consensus validation' was used throughout the two year study period. During this time the group remained focused on improving services and changing practices.

Researcher Impact

Because participatory action research involves people conducting research upon themselves, it is inevitable that participants impact on the process and are impacted upon. The researcher was strongly committed to the research being a process that allowed for the development of an Indigenous perspective. Initially this meant encouraging group discussion, but not leading the process. After 6 months of regular research meetings discussion was self generating whether the researcher was present or not. A vital element in the researchers's dual role as a TVHS employee and researcher was to ensure the effective implementation of organisational changes resulting from the participatory action research process at both the service level and the administrative level.

The commitment to Aboriginal & Torres Strait Islander Health Service delivery changes by the TVHS executive required ongoing advocacy from the researcher and

included securing separate funding. The researcher remained committed to working within the Aboriginal & Torres Strait Islander research guidelines outlined in the National Aboriginal Health Strategy (1989). In addition, the researcher's role included assisting in documenting the research process from the Indigenous perspective and providing employment for an Aboriginal & Torres Strait Islander project officer.

The researcher was impacted upon and often overwhelmed by the energy and commitment of the group for their local community. The researcher had not previously experienced a process that required collective community validation and support at every stage. No decision was undertaken without a consensus being reached within the Research Reference Group. These discussions then occurred in many separate Aboriginal & Torres Strait Islander community gatherings and remained open for review. Action was not taken until approval to proceed was granted from the Elders and other Aboriginal & Torres Strait Islander community members. This process of community cultural surveillance allowed for increased dissemination of knowledge and increased trust.

The researcher became a subject in the research process and a part of the collective discourse, that represented a new shared reality. It was assumed and encouraged that the reporting of the research process would be from different perspectives. The richness of the dialogue about the project in the local Aboriginal & Torres Strait Islander community, along with visits from ministers of government, changed the previous 'them and us' position in relation to the local health services. The project

became “Aboriginal & Torres Strait Islander people being there for one another at times of distress”. The researcher cannot claim complete objectivity in attempting to make valid theoretical inferences from the data, rather the research sought to make subjectivity explicit.

Summary

Participatory action research involves participants in the research process from the initial design of the project through data collection and analysis to final conclusions and actions arising out of the research (Whyte, 1991). The Research Reference Group was made up of 14 people who met over the two years of the study and generated three cycles of action research. Consistent with the principles applying to action research outlined by Whyte, (1991) and Dick, (1993) this study involved a cyclic process that drew on multiple sources of data and tested interpretations from earlier cycles in later cycles. This study involved three cycles of Problem, Planning, Action, Analysis and Reflection over two years, and was based on the cogenerative model as outlined in Figure 2.1 page 36.

Data collection and analysis methods used during the cycles of action research were participant observation, qualitative data generated during ‘reflection times’, pattern matching, consensus validation, and time series analysis. Members of the Aboriginal & Torres Strait Islander Health Outcome Council were not experienced researchers nor were they familiar with action research. The action research model focused on problems, action and solutions. Ideas developed during cycles were tested against knowledge gained in previous cycles. Conclusions were tested for validity by

examining them against plausible alternate explanations. Quantitative methods were used to record and analyse utilisation data, service accessibility data and outcomes of care data. This information was reported to the group monthly.

Throughout the two years of the project, the Research Reference Group met monthly to review and evaluate the Mental Health Services. They sought Aboriginal & Torres Strait Islander community feedback and validation through presenting the progress of the study at Aboriginal & Torres Strait Islander community meetings and with the Elders. This process of Aboriginal & Torres Strait Islander community validation was continual and ensured that the Research Reference Group were able to confirm their decisions with the wider Aboriginal & Torres Strait Islander community. The members of the (Aboriginal & Torres Strait Islander Health Outcome Council) Research Reference Group were key stakeholders in the local Aboriginal & Torres Strait Islander community and had all expressed an interest in health issues.

4. RESULTS

4.1 Action Research Cycles

This Chapter reports the findings arising from three action research cycles. Each cycle includes six sections, namely;

- problem definition
- planning
- action and analysis
- reflection
- knowledge gain
- summary

Movement through the stages is a continuous process involving ongoing analysis of action and reflection. The beginning and ending of each stage cannot be clearly defined.

Following the presentation of the findings of the Stress Survey (1994), members of the Aboriginal & Torres Strait Islander Health Outcome Council decided to meet regularly to address the serious issues raised by the study. At the same time the TVHS reviewed the findings of the study and decided that action was needed to develop more acceptable services appropriate for use by members of the Aboriginal & Torres Strait Islander community. Discussions were held involving the Aboriginal & Torres Strait Islander Health Outcome Council, the TVHS and the wider community. It was agreed that action should be taken about the problem of high stress in the Aboriginal & Torres Strait Islander community and low levels of service provision by the public

mental health service. A submission was developed and a grant received from the NSW Health Department (Health Outcome Program) to facilitate health service improvements in provision.

The Health Outcomes Research Grant (received in May 1995) provided for the employment of two part-time project managers. The recruitment process was managed by the Tweed Valley Community Health Service in partnership with two of the Aboriginal & Torres Strait Islander Health Outcome Council members. One person selected was an Aboriginal & Torres Strait Islander person with considerable standing in the local community and the other was an ex- health service manager with considerable experience in health service delivery methods.

The grant was welcomed by the Aboriginal & Torres Strait Islander Health Outcome Council and the TVHS. It was determined by the Aboriginal & Torres Strait Islander Health Outcome Council that there would be two major methods of disseminating the information from this project. One approach would be to write a research report for submission to a university. The other approach would be to write a history of the process from the TVHS perspective and from the Aboriginal & Torres Strait Islander perspective. This history is called *The Bugalwena Service : Our Story of a Partnership in Health*. Each chapter was divided into the two perspectives so that a reader may select only the Aboriginal & Torres Strait Islander perspective or the TVHS perspective and gain an understanding of the process.

Cultural Awareness Training was introduced and attendance was made compulsory

for all Tweed Valley community health workers by the community health administration. In the early stages of the project several health initiatives were attempted including, an immunisation program and a women's health program. However, little improvement occurred in service utilization by members of the Aboriginal & Torres Strait Islander community. It was agreed that a more concerted and effective approach to improving service delivery was required in addition to the cultural awareness training. Participatory action research was considered by the Aboriginal & Torres Strait Islander Health Outcome Council to be a suitable process to follow. From this point on the Council became the Research Reference Group.

Cycle One - October 1995, Barriers to Service

Problem

The problem to be addressed was described by the Research Reference Group as the identification and reduction of barriers to health services, for Aboriginal & Torres Strait Islander people including lack of transport, mistrust, fear, racism, discrimination and unemployment. The question was: Could the Tweed Valley Mental Health Services be useful to Aboriginal & Torres Strait Islander persons and if so, could services be provided in a culturally appropriate way to improve access and satisfaction with the process?

Planning

In order to explore pre-cursors to the problem the Research Reference Group participated in a structural analysis. This involved all 14 members brainstorming ideas about the problem and why it existed. Furthermore, members of the group

sought validation and feedback from relevant Aboriginal & Torres Strait Islander community groups and individuals.

The main themes resulting from the structural analysis were factors associated with discrimination and racism, as shown in Table 4.1, on page 81. Following identification of the major issues, a brainstorming session was held to explore possible solutions. This activity involved the Research Reference Group in creating a vision of an 'Ideal Mental Health Service'; one that they felt would be acceptable to the local Aboriginal & Torres Strait Islander community. They suggested many alternative approaches to the provision of public Mental Health Services. This process involved the use of the "democratic dialogue guidelines"; a methodology which provides for all members of a group to brainstorm about how the problem arose and what actions would make a difference. All ideas were written on a white board. The process proved to be exciting and energising for the group with individuals shouting their ideas. It was as if a floodgate had been opened through which ideas flowed. One of the participants reflected:

"This meeting started off slowly and then people opened up. The group had grown used to having their say. They had grown as a group together and everyone made each other feel that whatever you had to say was OK. There were a whole range of people, some were anti-hospital but they were coming together in harmony and felt the freedom to disagree and not be ostracizedeveryone's ideas and feelings were incorporated".

Table 4.1 Structural Analysis : Identifying barriers for Aboriginal & Torres Strait Islander people in using the Mental Health Service.

History of Discrimination <ul style="list-style-type: none">• being hurt• treated rudely• ignored• colonisation• racism• white supremacy• Mental Health not a good name
Non-Aboriginal <ul style="list-style-type: none">• Non-Aboriginal, would not understand• need someone they can relate to• Aboriginal time different• too many stressful events• different beliefs• needs whole of life view• not enough Aboriginal workers
Lack of Trust <ul style="list-style-type: none">• culturally unsafe• worst atrocities perpetrated by institutions• safer to deal with ourselves• frightened of being locked up• different beliefs - no trust of whites passed on by Elders• people would not come alone• fear• last resort to come to hospital• fearful of dying

Action

Members of the Research Reference Group and other members of the Aboriginal & Torres Strait Islander community set up a new service which sought to include many of the ideas generated during the brainstorming session. The new service was staffed on a voluntary basis by members of the Research Reference Group. The service included telephone access by any Aboriginal & Torres Strait Islander person in distress. This service facilitated referrals to existing health professionals. The TVHS supported the service offered by the community by offering crisis backup on a 24 hour per day basis. Over time, staff members of the TVHS began to attend the monthly meetings of the Research Reference Group which resulted in the development of personal and trusting relationships between members of the Research Reference Group and members of the TVHS.

The name chosen for the newly created Aboriginal & Torres Strait Islander service was 'The Bugalwena Team' which means "to heal" or "to recover". Most members of the Research Reference Group became members of the Bugalwena Team and they chose to work on a voluntary basis. The issue of payment for the provision of service was questioned by the researcher. However, the idea was vehemently rejected by members of the group, who felt that it was culturally unacceptable for them to receive money and that it would reduce their credibility. The sentiments of the group are exemplified by the following comment of one team member:

"We are providing this support because we care, not because we are being paid."

(Bugalwena Team Member, 1996)

The Bugalwena Team developed a pamphlet (Appendix 2) saying this was an Aboriginal & Torres Strait Islander Service for people in distress. They provided their names, phone numbers and the hours that they were available. They distributed the pamphlet to all of the key Aboriginal & Torres Strait Islander agencies and places where people in distress may go for help e.g. Aboriginal & Torres Strait Islander families, Accident & Emergency Department, General Practitioners, Minjungbal Museum, Department of Social Security. The Health Outcomes Grant Project was officially launched. The General Manager of the TVHS attended and the Minister of Health visited the Bugalwena team at the Minjungbal Museum.

Analysis

The group recommended that:

- a. the first point of contact for a distressed Aboriginal & Torres Strait Islander person had to be with an Aboriginal & Torres Strait Islander person.
- b. the service for distressed Aboriginal & Torres Strait Islander people could not be called Mental Health .
- c. if non- Aboriginal & Torres Strait Islander staff were involved they had to be aware of the Aboriginal & Torres Strait Islander history and local cultural practices.
- d. Aboriginal & Torres Strait Islander people are not going to use any services for distress which are not known and trusted by the Aboriginal & Torres Strait Islander community.
- d. such a 'distress' service would need to be away from the hospital, available 24 hours and free.

- e. any distress service has to have absolute confidentiality.
- f. the service required an Aboriginal & Torres Strait Islander name.
- g. information about the service needed to be disseminated throughout the key agencies in the community and at places where people may go at times of crisis.
- h. they would not discriminate against non-Aboriginal if they phoned.

Reflection

The Bugalwena Team had been established and the Research Reference Group awaited the reaction and feedback from the Aboriginal & Torres Strait Islander community.

Table 4.2 Cycle One : Knowledge Gained
<ol style="list-style-type: none"> 1. A relationship of trust between Aboriginal & Torres Strait Islander communities and health services takes time to develop. 2. The first contact with health services for an Aboriginal & Torres Strait Islander person needs to be provided by Aboriginal & Torres Strait Islander people, available 24 hours per day and not hospital based. 3. Local Aboriginal & Torres Strait Islander people will use a public health service if it is recommended by Aboriginal & Torres Strait Islander people they know and trust. 4. A service for Aboriginal & Torres Strait Islander people experiencing distress, must not be called mental health or bring sanity into question. 5. Aboriginal & Torres Strait Islander people have knowledge about healing their own people.

Summary of Cycle One

This cycle involved the identification of the reasons for the existence of barriers to the use of health services by members of the Aboriginal & Torres Strait Islander community and the establishment of an Aboriginal & Torres Strait Islander support service.

Cycle Two - March 1996 : The Challenge of Increased Utilisation

Problem

The Aboriginal & Torres Strait Islander community began to utilise the Bugalwena Team immediately, which was different from their previous low utilisation of the public health service. There were 31 calls in the first month which raised the challenge of staff training and support for Bugalwena Team members. The Bugalwena Team referred 9 people to the Community Health Services, 5 people to the Mental Health Service and provided a support/counselling service for 17 people. The issues of providing a service to 'real' people in distress became known along with the consequent pressure on Bugalwena Team members. Section 4.2 reports the increase in utilisation of Community Health and Mental Health Services.

Planning

In association with the Mental Health Team the Bugalwena Team developed a list of issues which might be covered in a training program. There was a need to know more about the TVHS and its programs if the Bugalwena Team were to refer callers to them. The Bugalwena Team reflected that they would need some support and assistance with callers they didn't know how to deal with.

Action

The need for knowledge of the TVHS staff and services was identified, including services for domestic violence, sexual assault, sexual health, Department of Community Services and Department of Social Security and a resource list of contact phone numbers was developed by the Aboriginal & Torres Strait Islander project

manager. The need for 'debriefing' the Bugalwena Team members was identified and a service was provided by the TVHS Mental Health Team where a member of the Mental Health staff selected by the Bugalwena Team provided small group and individual sessions.

The Bugalwena Team were involved in the ongoing Cultural Awareness program for Community Health workers. This was a one day program run by the senior Aboriginal & Torres Strait Islander Health educator at Minjungbal museum. The program covered the history of colonisation, personal histories', Aboriginal & Torres Strait Islander dances and drama. Other community groups requested invitations to attend i.e. the Police and local schools. The Cultural Awareness program became a community focus for the Aboriginal & Torres Strait Islander community. It also provided an opportunity for interagency networking.

The need to evaluate the work of the Bugalwena Team in a culturally appropriate manner was identified and a strategy devised by the Bugalwena Team. They determined that it would be detrimental to attempt to access the phone numbers or name and addresses of telephone callers, so the group to be evaluated were only those people who were referred to the TVHS and agreed to complete a one page questionnaire.

Ongoing support was required from the management of the TVHS to provide funds for pamphlets, brochures, photocopying and office space. Input by two members of the Research Reference Group into the processes of recruitment for Aboriginal &

Torres Strait Islander workers became the status quo for the Tweed Valley Community Health Service. Each panel contained more Aboriginal & Torres Strait Islander persons than non-Aboriginal & Torres Strait Islanders.

Analysis

The Bugalwena Team were becoming a part of the TVHS. Status was accorded to their service through visits from the General Manager and Minister of Health. A formal launching of the Health Outcomes Project was held at the Minjungbul Centre in October 1995 and there was a media announcement. The Bugalwena Team was identified in the Tweed Valley Mental Health Plan and the TVHS strategic plan.

Reflection

The Bugalwena Team was providing an Aboriginal & Torres Strait Islander interface and way into the Tweed Valley Community & Mental Health Services. The Bugalwena Team felt strongly that Aboriginal & Torres Strait Islander persons were contacting them because they wanted an “Aboriginal” solution. They provided support and listened to callers. Where they felt a referral was necessary to the Community Health Service or the Mental Health Service they were able to facilitate this process because they knew the worker they were suggesting. Mental Health workers had also offered to go with a Bugalwena Team member to see a person in distress. The Bugalwena Team were offering a support service in its own right.

The Bugalwena Team had requested counselling skills training and this was provided by the Institute of Psychiatry and one of the Tweed Valley Mental Health workers. It

ran over three days and was held at Minjungbal Museum. Following this training the Mental Health worker involved provided short sessions as requested by the Bugalwena Team on specific interpersonal counselling topics i.e. how to terminate a call, how to recognise when to refer on. As part of the reflection stage of the participatory action research cycle the new service was evaluated after three months. The evaluation revealed that:

- 1) The service was being utilised by the local Aboriginal & Torres Strait Islander community, for example three months after the implementation of the Bugalwena Service, 91 people had sought assistance. The Bugalwena Team reported they believed that people were using the service because it was Aboriginal & Torres Strait Islander people who were providing the first point of contact and importantly because those Bugalwena Team members valued their community enough to do this work.
- 2) Trust had developed between the Aboriginal & Torres Strait Islander community in relation to the Community Health Service. Members of the Aboriginal & Torres Strait Islander Bugalwena Team reported they felt more comfortable to have meetings in the Community Health building. An Aboriginal & Torres Strait Islander community group, was working in partnership with the TVHS. Control of crucial decisions regarding Aboriginal & Torres Strait Islander issues had been taken by the group, representing the community. The Cultural Awareness day, was reported by the Bugalwena Team as very encouraging to the Aboriginal & Torres Strait Islander community as it was seen that people were interested and willing to listen and learn. The Bugalwena Team reported that the trust shown by Aboriginal & Torres Strait Islander people who were being referred by the

Bugalwena Team to Community Health and Mental Health did not extend to the hospital. They reported Aboriginal & Torres Strait Islander people still avoided attending the Accident & Emergency Department.

- 3) Referrals to TVHS staff known and trusted by Aboriginal & Torres Strait Islander people had increased.
- 4) Effective ‘healing’ for Aboriginal & Torres Strait Islander people occurred in a group context e.g. group outings and social days. Furthermore, this was a culturally appropriate method of healing which was supported by the TVHS with the provision of two counsellors.

Table 4.3 Cycle Two : Knowledge Gained.
<div>1. Where possible power over decisions affecting Aboriginal & Torres Strait Islander persons should be transferred to them and their decisions supported, for a relationship of trust to grow between Aboriginal & Torres Strait Islander communities and health services</div> <div>2. Aboriginal & Torres Strait Islander participation in service delivery has resulted in a partnership where Aboriginal & Torres Strait Islander persons do use the service.</div>

Summary of Cycle Two

This cycle involved the Bugalwena Team becoming an integrated part of the TVHS with a referral network to other community agencies. There was increased interaction with Bugalwena Team members and health staff. People knew each other by sight and name. More Aboriginal & Torres Strait Islander persons came to the centre. Aboriginal & Torres Strait Islander meetings began to be held in the Community Health building. The Bugalwena Team requested counselling training and debriefing. The Bugalwena Service was facilitating referrals to the TVHS and providing an ‘Aboriginal’ solution.

Cycle Three - June 1996 : Addressing Special Needs

Problem

The Bugalwena Team had identified a number of essential components for a successful partnership in the provision of culturally appropriate services. The most important element was the identification of Aboriginal & Torres Strait Islander knowledge and wisdom regarding methods of healing.

Planning

The Bugalwena Team identified there was a need to establish and formalise culturally appropriate methods of healing along with a need to establish access to the Bugalwena Service for children and adolescents. Men's health was identified as a concern by members of the Bugalwena Team. An application to the new Area Health Board for two Aboriginal & Torres Strait Islander representatives was made resulting in one Aboriginal & Torres Strait Islander being appointed to the new Area Board.

Action

Three members of the Bugalwena Team proposed a group method of healing. They described this as a day where a group of the Aboriginal & Torres Strait Islander community i.e. an aged group, went out for a day to the beach. During this time support and counselling occurred. It was planned to have a 'stress' day once per month. This day was to be supported by two counsellors. Further to this method two members of the Bugalwena Team suggested a group approach to grief and loss. It was proposed that there were two losses felt when somebody died. The first was the loss of the individual and the second was the loss of the family support when family

members went home or weren't available. The group approach was an initiative where Aboriginal & Torres Strait Islander women would go to the grieving person and stay as long as they were needed. The Bugalwena Team supported this initiative. A children's pamphlet was designed by a reference group of Aboriginal & Torres Strait Islander teenagers and distribution of pamphlets was planned. The TVHS had approved the identification of the Aboriginal & Torres Strait Islander Health Service as the Bugalwena Service and signs were ordered for the Community Health building and outside the hospital. The TVHS offered a cottage on the hospital grounds for the Bugalwena Service. The Bugalwena Service was now defined by space, staff and healing methods. A Bugalwena Team Member commented:

"It was a real achievement getting that space and the community people are prepared to come into the service, people are coming in all day. The Hospital is recognising us, the community is starting to recognise us and that's without the signs! Just eighteen months ago it was just me in Community Health and now look at all the other staff and things going on. The Bugalwena Team has been advertising our service. When people get inside (to the new building) they feel comfortable."

Analysis

A final evaluation of the two (2) year project was undertaken in June 1996. It involved staff of the Bugalwena Service, some Mental Health staff and some Community Health staff. There was a presentation outlining changes in service utilisation, actions taken, type and number of referrals and the time taken for each

telephone call. The evaluation also included feedback from Aboriginal & Torres Strait Islander clients of the TVHS and the Bugalwena Service. The knowledge gained from each action research cycle was reviewed.

The Bugalwena Team remained committed to responding to the needs of the Aboriginal & Torres Strait Islander community. They received feedback from the community through a network of Aboriginal & Torres Strait Islander community agency meetings such as the Land Council and the Housing Co-operative.

The final reflection phase of the project was contained in the Evaluation Day.

Reflection - Themes from the evaluation June 1996

1. The Bugalwena Service is working well, and has received requests from 147 Aboriginal & Torres Strait Islander persons. Many community members had visited the new building.
2. The evaluations show the Bugalwena Service is being used by the Aboriginal & Torres Strait Islander community. This has resulted in increased utilisation of the Community Health and Mental Health Services by Aboriginal & Torres Strait
3. Islanders, although they prefer to remain with the initial worker regardless of the health problem. This finding led to a discussion regarding the Aboriginal & Torres Strait Islander workers having to provide generalist services rather than specialist services. It was decided that this issue should be reviewed regularly.
4. The service has to be run by Aboriginal & Torres Strait Islanders.
5. Trust between the Aboriginal & Torres Strait Islander community and the Community Health and Mental Health Service is reported by the Bugalwena Team

to be increasing and developing greater solidarity.

- 6. The Bugalwena Team are responding to the changing needs of the Aboriginal & Torres Strait Islander community. Some Bugalwena Team members are identifying areas where they feel more comfortable providing support, and are referring callers to other Bugalwena Team members for special issues, such as men’s issues.
- 7. The Cultural Awareness day was considered a successful day with over 100 people attending.
- 8. A name for the report, the format and the cover design were chosen.
- 9. Further training is required.

Table 4.4 Cycle Three : Knowledge Gained.

- | |
|---|
| <ul style="list-style-type: none">1. The Aboriginal & Torres Strait Islander Service needs to be identifiable by name, space and healing methods.2. Cultural awareness training for all community health staff was seen as a positive, respectful sharing of knowledge by the Aboriginal & Torres Strait Islander community.3. The Aboriginal & Torres Strait Islander Health Service needs to be fully supported by the TVHS in terms of debriefing, training, provision of resources, affirmative recruitment strategies and given status at Board and Executive level. |
|---|

Summary of Cycle Three

This cycle involved the development of a culturally appropriate method of accessing the TVHS. The Bugalwena Team offered an Aboriginal & Torres Strait Islander first point of contact for the TVHS which facilitated and increased access to and utilisation of traditional western medical health services. The culturally different methods of health service provision came in the form of the group healing days, the group grief model and the ‘Aboriginal’ solution provided to 54% of the callers. Two hundred and

thirty eight Aboriginal & Torres Strait Islander people in this area accessed a Community Health Service or Mental Health Service in the first six months of the Bugalwena Team functioning. The participatory action research allowed for the application of Aboriginal & Torres Strait Islander ideas and solutions, that were supported by the local Aboriginal & Torres Strait Islander community.

The Summary of the Cycles of Research

The following diagram shows a summary of the cycles of the participatory action research. The beginnings and ending of each stage are not clearly defined events and flow into one another.

Table 4.5 Background - October 1994

Problem	Planning	Action	Analysis	Reflection
<p>The monthly meetings became distressing for the members as each committee member seemed to have had a recent death in the family. The meeting was not like that of any other attended that did not involve Aboriginal & Torres Strait Islanders. The constant grief and loss experienced by the Aboriginal & Torres Strait Islander committee members was identified as the problem.</p>	<p>The Aboriginal & Torres Strait Islander Health Outcomes Council discussed the grief and loss which they had been experiencing. The Aboriginal & Torres Strait Islander Health Outcomes Council requested further information to examine whether their experience was the same as that of the Non-Aboriginal & Torres Strait Islander community. It was agreed that a study should be undertaken comparing the life events and stresses of the Aboriginal & Torres Strait Islander community</p>	<p>A study was undertaken comparing the life events and stresses of the Aboriginal & Torres Strait Islander community and the non-Aboriginal & Torres Strait Islander community.</p>	<p>The findings of the study were analysed and written down. The results of the survey were presented to the Aboriginal & Torres Strait Islander Health Outcomes Council and a meeting of the Aboriginal & Torres Strait Islander community. The results of the survey were considered. The meeting was also informed that the Tweed Valley Mental Health Service had assessed the level of involvement of the Aboriginal & Torres Strait Islander community with the service and found negligible participation rates. Discussion then took place as to the mechanisms for supporting people in extremely stressful situations. The group was asked whether they wanted to be involved in a process of improving/changing the Mental Health Service. They agreed.</p>	<p>The Health Outcomes Council decided to support an application for a Research Grant to investigate the development of Aboriginal & Torres Strait Islander participation in service delivery methods. Cultural Awareness Training was planned and made compulsory for all Primary Health Care staff. The Health Outcomes Grant was awarded and two Project Managers were appointed. Recruitment and management was made in partnership with the Aboriginal & Torres Strait Islander Health Outcomes Council.</p>

Table 4.6 Cycle One - October 1995

PROBLEM	PLANNING	ACTION	ANALYSIS	REFLECTION
<p>The partnership agreement led to the discussion of the format of the study and its potential audience and use. It was agreed that there should be a history of the process which was taking place and also a document of research at the University level. The meeting then focused on whether the traditional Mental Health Services could be helpful to the Aboriginal & Torres Strait Islander community. A structural analysis was then undertaken of the Mental Health Service. Issues which arose were: "mental health" and "disturbed" were not good names; a lack of transport; service needs a whole of life view; person would not come alone but would feel better with family or other community members; there is no trust; need someone they can relate to and known in the community; women will talk to men but men won't talk to women; only other men; needs to be quickly accessible;</p>	<p>The question remained whether the Health Service could be helpful and useful to local Aboriginal & Torres Strait Islanders in distress.</p> <p>There was considerable reflection on the barriers to service delivery and the potential solutions which had been discussed earlier and which of these might be considered to be of highest priority to implement. A meeting was then planned to discuss.</p>	<p>The group then planned the ideal service. Which included:</p> <ul style="list-style-type: none">* first point of contact for a distressed member of the community had to be with an Aboriginal & Torres Strait Islander.* service could not be called Mental Health* if non-Aboriginal & Torres Strait Islander staff were involved they had to be aware of Aboriginal & Torres Strait Islander history and local cultural practices* Aboriginal & Torres Strait Islanders when they are distressed will not use a service they don't know and trust.* that such a 'distress' service would need to be away from the hospital, be available 24 hrs and be free.* absolute confidentiality must be ensured* service must have an Aboriginal & Torres Strait Islander name* information about the service would be distributed in agencies throughout the community* all calls would be received whether they were from Aboriginal people or non-Aboriginal people.	<p>Members of the Aboriginal & Torres Strait Islander Health Outcomes Council then offered themselves as providers of the described service. The Health Outcomes Council members offered to do this for 24 hrs a day, 7 days a week and without pay. The Tweed Health Service offered backup from the CrisisMental Health Service 24 hrs a day. Two additional staff members from theMental Health Service began to attend monthly meetings and develop a more personal and trusting relationship with the Health Outcomes Council members. The name chosen for the newly created service was the 'Bugalwena Team; which means to "heal" or "recover".</p>	<p>The new service began to function. Pamphlets were developed and distributed to key agencies. The General Manager of the Tweed Valley Health Service attended the launch of the project.</p>

Table 4.7 Cycle Two - March 1996

PROBLEM	PLANNING	ACTION	ANALYSIS	REFLECTION
<p>The team began to discuss the possible scenarios with which they would be presented as a telephone support service. The team identified a need for training. Issues of service delivery and support for team members were also discussed.</p>	<p>In association with the Mental Health Team the Bugalwena Team developed a list of issues which might be covered in a training program. There was a need to know more about the health service and its programs if the Team were to refer callers to them. The Team reflected that they would need some support and assistance with callers they didn't know how to deal with.</p>	<p>The Bugalwena Team in conjunction with the Health Service and project managers then prepared the following:-</p> <ul style="list-style-type: none"> * resource list of community contacts * development of information about the Team * distribution of information about the Team to the community * information about each of the Community Health Teams and services * a way to collect information about the nature of the calls and what then happened for callers in a culturally appropriate manner * an appropriate training course was completed. * the Minister for Health, Dr Refshauge attended opening at Minjungbal Museum and offered support for the project. 	<p>The Team decided that there had been:</p> <ol style="list-style-type: none"> 1. A number of actions implemented, 2. The Team was functioning and a number of calls were being processed. They felt an evaluation of these changes was necessary after three months. <p>This evaluation would also include Aboriginal & Torres Strait Islander client evaluations of the Health Service and the Bugalwena Service, analysis of types of callers and information and counselling assistance.</p> <p>The Team was determined to meet the Aboriginal & Torres Strait Islander community needs and in that they had to remain flexible in their strategies and operations. The Team were committed to retaining a strong relationship with the community they represented. The evaluation was a whole day and involved the Bugalwena Team and Health Service staff.</p>	<p>The evaluation reaffirmed that the process was working and the local Aboriginal & Torres Strait Islander community was using the service.</p> <p>The evaluation confirmed that:-</p> <ol style="list-style-type: none"> 1. The first point of contact had to be with Aboriginal & Torres Strait Islander persons. 2. A partnership had developed. Aboriginal & Torres Strait Islander Health Outcome Council felt supported by Health Service. 3. Identity was needed and that the Aboriginal & Torres Strait Islander Health Service would be known and identified as the Bugalwena Service with a logo. 4. That the group model of healing was the most appropriate. 5. Initiatives in child and adolescent and men's health be developed. 6. The reaffirmation of the importance of the Cultural Awareness Day for health staff and Aboriginal & Torres Strait Islander community.

Table 4.8 Cycle Three - June 1996

PROBLEM	PLANNING	ACTION	ANALYSIS	REFLECTION
Bugalwena Team functioning as a support service in own right. Referrals through to a range of Community Health and Mental Health Services were occurring.	1. Need to establish the group method of healing i.e. camp days/stress days with support from counselling/Mental Health staff at Tweed Heads Community Health.	Plan of action resulting from <u>Evaluation Day</u> . <u>Initiatives</u> 1. Group healing to happen once per month with two Community Health workers trained in the Narrative Method.	A formal and final analysis and evaluation of the project, to date, was planned for half a day in June 1996.	June 1996 The reflection confirmed that the Bugalwena Service was working very well. The separate building had encouraged the Aboriginal & Torres Strait Islander community to visit more frequently.
Counselling from Bugalwena Team occurring on a one to one basis and in groups.	2. Need to establish school children access to the service.			
A number of essential components for an effective Aboriginal & Torres Strait Islander Health Service had been identified.	3. Planning and date set for Cultural Awareness Day. 4. Men's camp proposed and planning initiated. 5. Application for two Aboriginal membership's of the new Area Health Board.	2. Process to develop Bugalwena Services for adolescents and children. A reference group to design a children's pamphlet. 3. Aboriginal & Torres Strait Islander Health now to be called The Bugalwena Service. Signs outside hospital, and Community Health and on actual rooms. 4. Separate rooms provided. 5. Support for Aboriginal & Torres Strait Islander membership on the Area Health Board from Health Service.		There was a large increase in Community Health and Mental Health Service utilisation. Trust and partnership were in place and solidarity was growing. Further training was requested. The name and format for the Report were chosen.

Summary

In this section the findings arising from the three action research cycles have been reported. This process of problem definition, action and analysis spanned 2 years.

Table 4.9 Action Research Cycles - Summary of Key Findings, draws together the essential findings arising from each cycle including the knowledge gained (p 101). As a result of this analysis six components were identified as being essential for an effective Aboriginal & Torres Strait Islander Health Service.

- ▶ that the health service develop a 'culture' that is accepting of Aboriginal & Torres Strait Islander community participation in health service planning and delivery;
- ▶ that the health service acknowledge that life is experienced as stressful for Aboriginal & Torres Strait Islander's with grief and loss being experienced more frequently by members of the Aboriginal & Torres Strait Islander community than by members of the non-Aboriginal & Torres Strait Islander community;
- ▶ that the health service acknowledge their existing facilities discriminate against Aboriginal & Torres Strait Islander persons;
- ▶ that the first point of contact with the health service for an Aboriginal & Torres Strait Islander person in distress should be with an Aboriginal & Torres Strait Islander person;
- ▶ that the service should be available 24 hours per day and able to provide an

outreach service;

that the re-designed health service represents an Aboriginal & Torres Strait
Islander solution to health problems.

Table 4.9 : Action Research Cycles - Summary of Key Findings

Cycle	Problem	Action	Knowledge Gained
Back-ground	High stress and low levels of service provision	Grant application to investigate the problem	<ul style="list-style-type: none"> Life rated as more stressful for Aboriginal & Torres Strait Islander people High prevalence of grief and loss Low use of health services Health Services culturally unsafe for Aboriginal & Torres Strait Islander people
1.	Strategies to address barriers to the use of health services	Establishment of an Aboriginal & Torres Strait Islander support service	<ul style="list-style-type: none"> Trust takes time to develop First contact with Health Services needs to be with an Aboriginal & Torres Strait Islander person and available 24 hours/day Aboriginal & Torres Strait Islander people will use a service recommended by a person they know and trust Aboriginal people in distress will avoid services which are labelled "Mental Health" Aboriginal & Torres Strait Islander people have knowledge about healing their own
2.	The challenge of success - increased utilisation for staff training and support	Identification of appropriate referral services and the development of training and staff support	<ul style="list-style-type: none"> Trust requires a transfer of power from Health Service staff to the Aboriginal & Torres Strait Islander community.
3.	Need for culturally appropriate methods of healing for : <ul style="list-style-type: none"> ▶ children ▶ adolescents ▶ adults 	Development of a group method of healing for people in distress	<ul style="list-style-type: none"> Aboriginal & Torres Strait Islander services need to be identifiable by name, space and healing methods Cultural Awareness training lead to improved working relationships between Aboriginal & Torres Strait Islander people and Health Service staff To succeed Aboriginal & Torres Strait Islander run Health Services need to be fully supported by local non-Aboriginal & Torres Strait Islander Health Service providers, including status at Board and Executive level.

4.2. Service Utilisation and Acceptability

This section reports changes in service utilisation and acceptability of the TVHS.

Utilisation was measured using patient record data. Acceptability was measured using consumer satisfaction scales which addressed accessibility, process and outcomes of care.

Service Utilisation

Utilisation of the Mental Health Services and the Community Health Services was based on registration of service use and was collected four times over the two years of the study, i.e. from January 1994 to June 1996. A month of service utilisation data was collected in: October, 1994, October, 1995, March, 1996, and June, 1996. A registration was recorded for each person who received at least one occasion of service. The range of services included Child & Family Counselling, Dietetics, Drug & Alcohol, Home Nursing, and Sexual Assault. These services were provided by members of the Community Health and Mental Health Teams and included consultations with nurses, allied health professionals and psychiatrists. All Mental Health Services were provided on an outpatient basis as there were no inpatient psychiatric beds in the district. This data is displayed in Figures 4.1 (p 103) and 4.2 (p 103).

Figure 4.1

Aboriginal & Torres Strait Islander
Utilisation of Mental Health Services by month

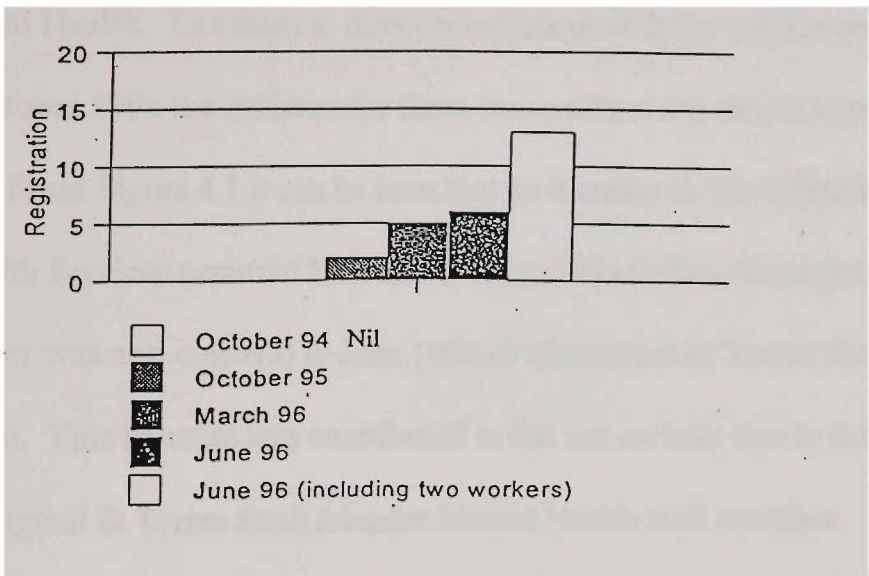
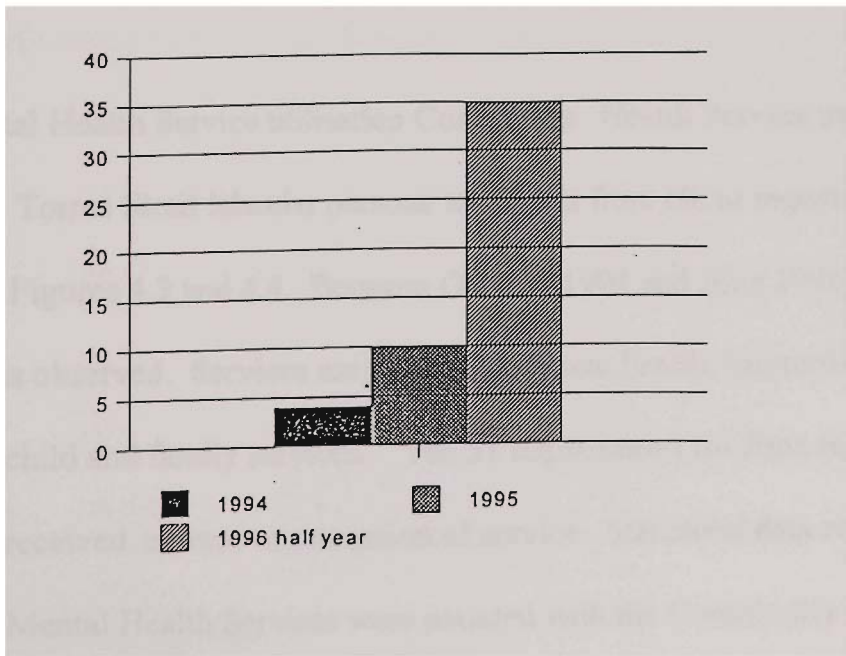


Figure 4.2

Aboriginal & Torres Strait Islander
Utilisation of Mental Health Services : 1994, 1995 and 1996 (Jan - June)



It should be noted that during cycle 2 of the study two additional staff, both Aboriginal & Torres Strait Islanders were appointed to the TVHS because the demand for services had increased. One position was in Mental Health and the other position was in Sexual Health. To enable a direct comparison with the service and staffing levels of October 1994 the statistics for these two workers are shown separately in Figure 4.1. From Figure 4.1 it can be seen that an increase in the utilisation of the Mental Health Services occurred between October 1994 (when Aboriginal & Torres Strait Islander was non-existent) to June 1996 (6 Aboriginal & Torres Strait Islander registrations). This increase was contributed to but not entirely due to the acquisition of one Aboriginal & Torres Strait Islander Mental Health staff member. During the time frame that utilisation data was collected the Research Reference Group estimated that the Aboriginal & Torres Strait Islander population had remained stable. Hence, it was considered that increases in utilisation were due to factors other than change in population size.

As with Mental Health Service utilisation Community Health Service utilisation by Aboriginal & Torres Strait Islander persons was taken from client registration data and it reported in Figures 4.3 and 4.4. Between October 1994 and June 1996, a substantial utilisation was observed. Services used included mental health, immunisation, dietetics and child and family services. The 51 registrations for June represented 51 persons who received at least one occasion of service. Statistical data collection required that Mental Health Services were counted with the Community Health Services.

Figure 4.3
Aboriginal & Torres Strait Islander
Utilisation of Community Health and Mental Health Services by Month

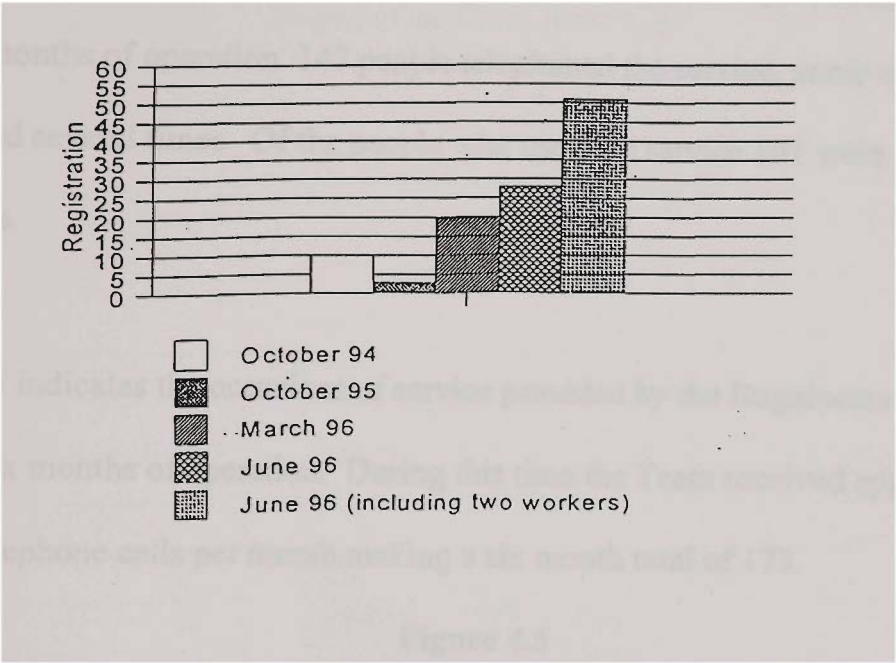
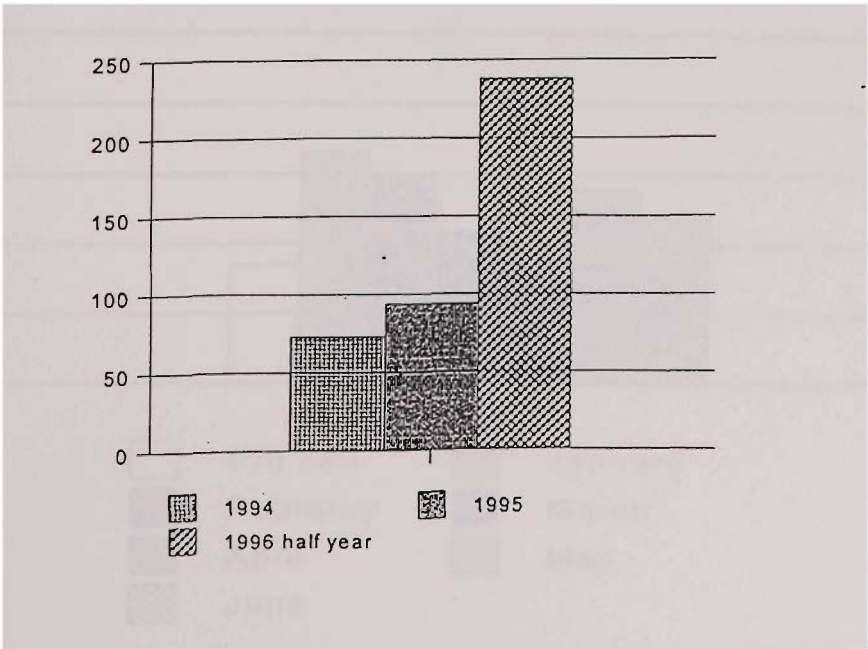


Figure 4.4
Aboriginal & Torres Strait Islander
Utilisation of Community Health and Mental Health Services : 1994, 1995 and
1996 (Jan - June)

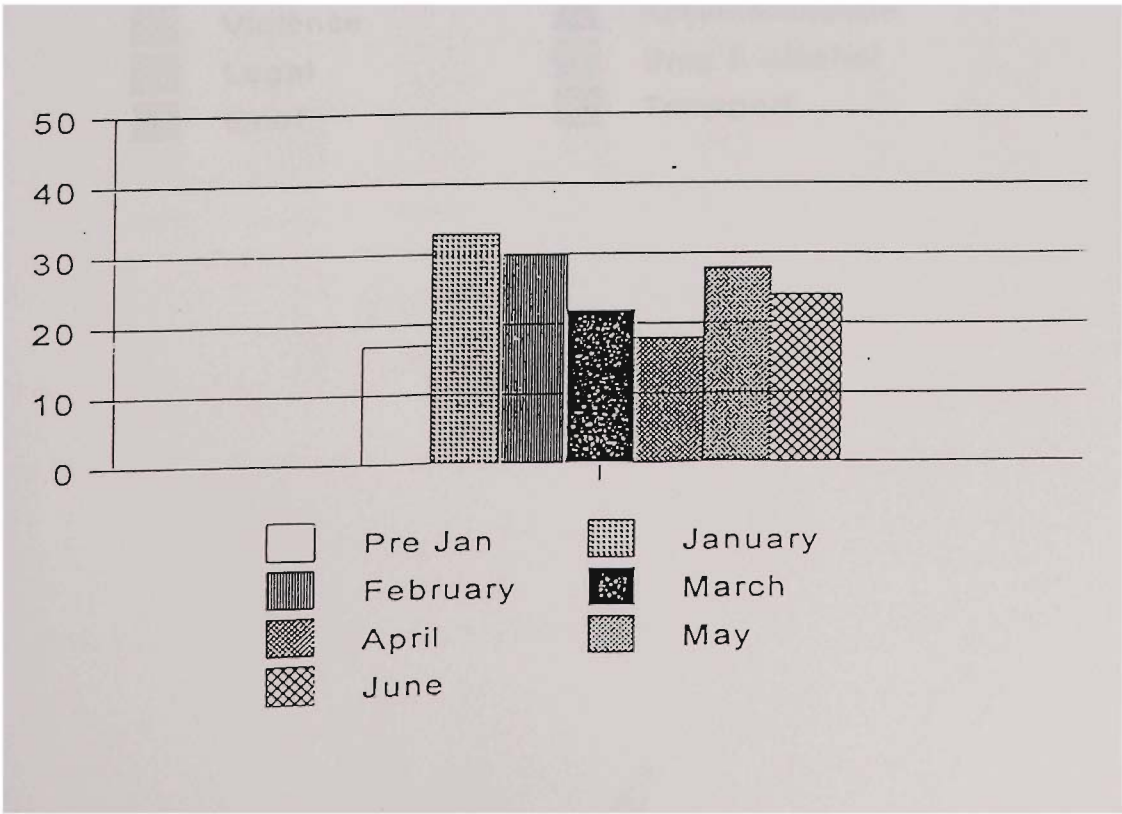


Service Utilisation - Bugalwena Team

During Cycle 2 of the study the Bugalwena Team was established (January 1996). The team provided telephone counselling. Utilisation data of this new service for Aboriginal & Torres Strait Islander people was collected in March, 1996 (after three months of operation) and in June, 1996 (after six months of operation). During its first six months of operation 147 people telephoned the service, some of whom telephoned several times. Of the people who used the service 101 were female and 46 were male.

Figure 4.5 indicates the occasions of service provided by the Bugalwena Team during its first six months of operation. During this time the Team received approximately 20 - 30 telephone calls per month making a six month total of 173.

Figure 4.5
Bugalwena Team
Occasions of Service : Jan - June 1996



The type of services provided by the Bugalwena Team are displayed in Figure 4.6. Use of these services was demand driven and the most frequent type of service used was counselling followed by child and family issues. Counselling was a separate category and not an aggregate of the other types of service reported.

Figure 4.6
Bugalwena Team Statistics
Type of Service

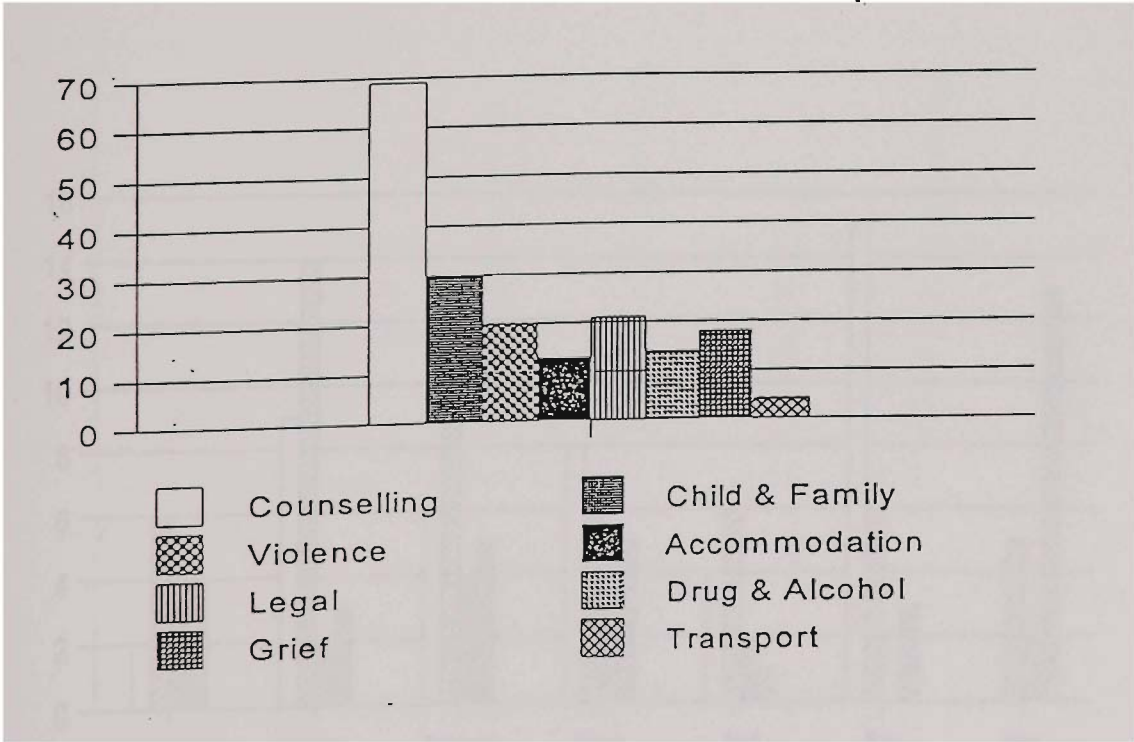
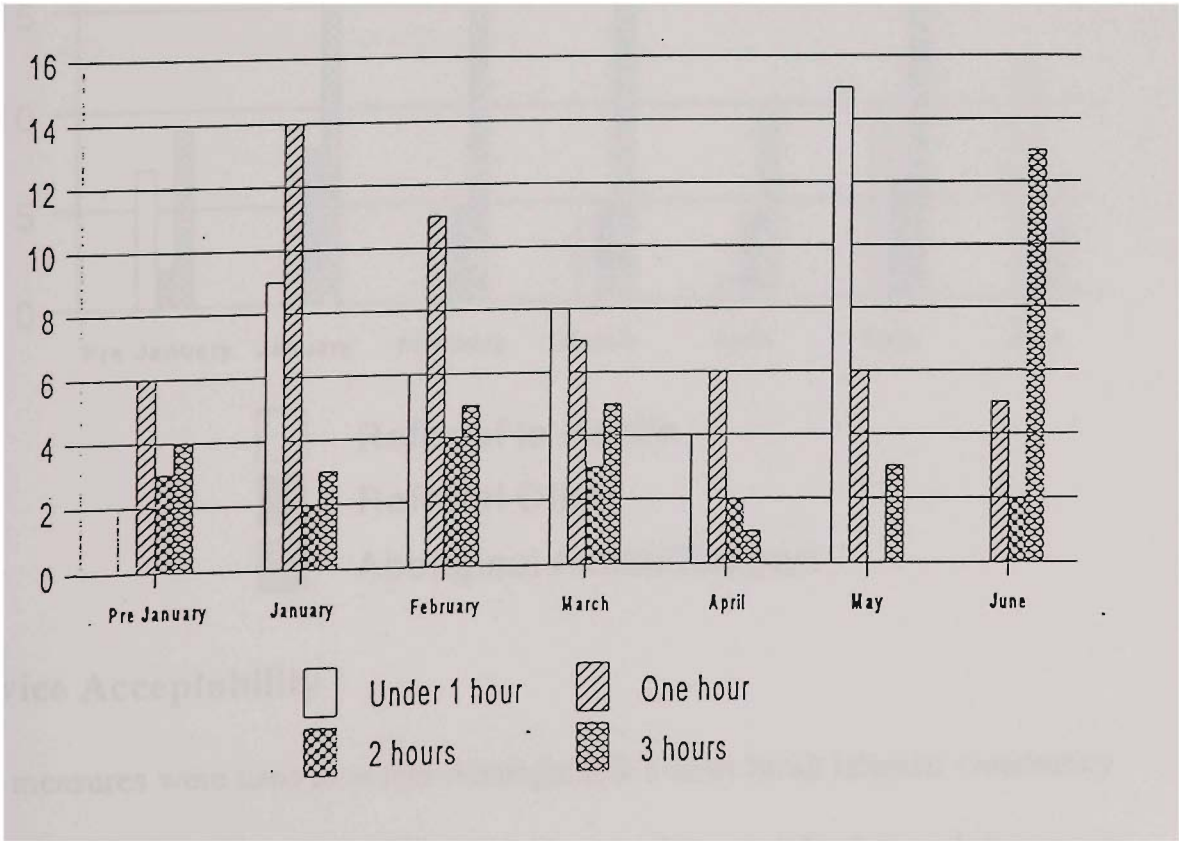


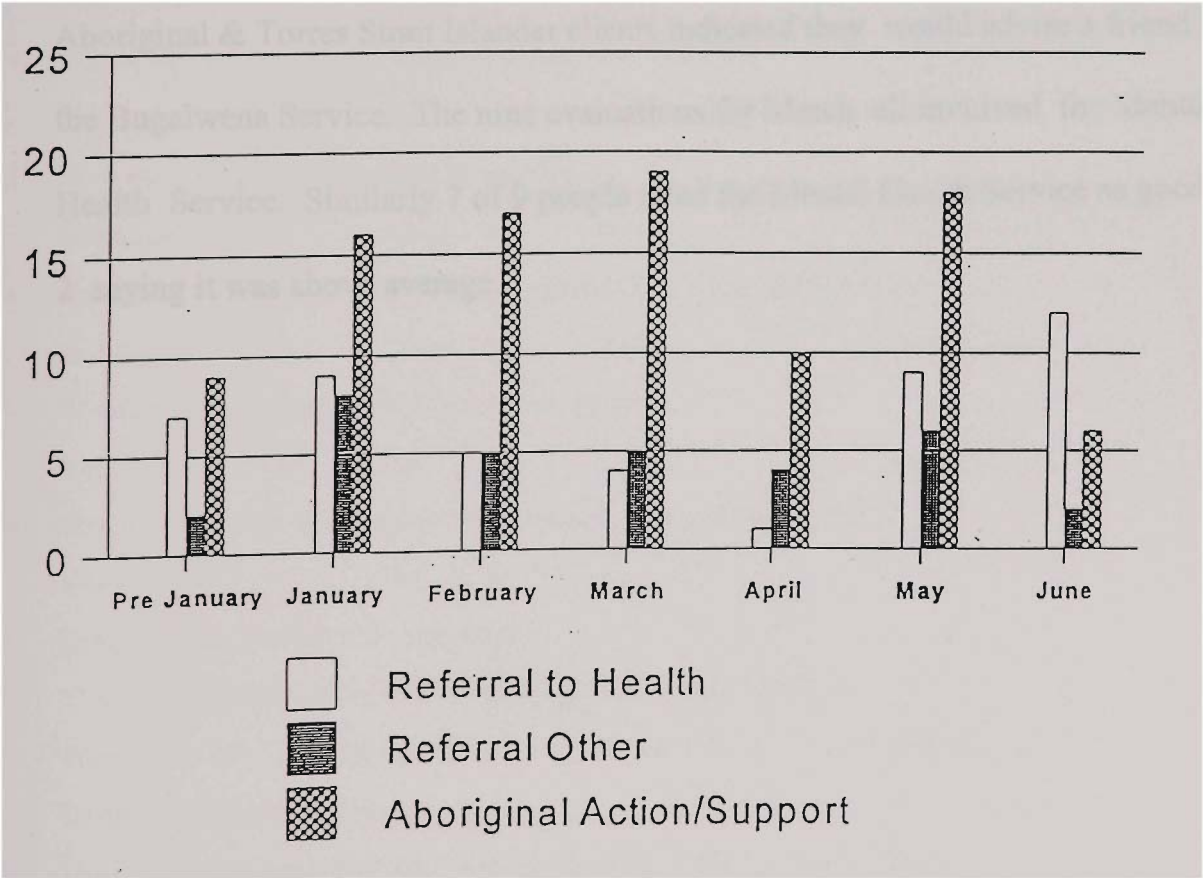
Figure 4.7 reports the amount of time taken for each occasion of Bugalwena Team service. Of note is the number of occasions of service that required 3 hours or longer of Team member time. The June figures reflect a particularly stressful situation that arose during this period of data collection. It involved several Aboriginal & Torres Strait Islander families and a considerable number of persons were referred to the TVHS.

Figure 4.7
Bugalwena Team Statistics
Time Taken



The actions taken by the staff of the Bugalwena Team are outlined in Figure 4.8 . Predominately, the Team was engaged in providing support (54% of actions taken). 27% of actions involved referrals to TVHS, and 18% of actions involved referral to other agencies.

Figure 4.8
Bugalwena Team Statistics
Action



Service Acceptability

Two measures were used to assess Aboriginal & Torres Strait Islander community perceptions of service acceptability, namely, consumer satisfaction evaluation and community reputation. Consumers of the Bugalwena Team who were referred to the TVHS were invited to participate in these evaluations which were conducted in March and June, 1996. All 14 Aboriginal & Torres Strait Islander persons referred by the Bugalwena Team to the TVHS during March and June completed evaluations. A

copy of the Consumer Evaluation Form is provided in Appendix 1. This data is reported in Table 4.10 (p111)

The data shows that 9 of 14 people reported their contact with the Bugalwena Service was helpful and 5 of 14 people reporting it was very helpful with appropriate access. Satisfaction with the Bugalwena Service was high with 7 of the 14 people reporting 'being happy' and 3 of 14, 'very happy'. Thirteen out of fourteen Aboriginal & Torres Strait Islander clients indicated they would advise a friend to use the Bugalwena Service. The nine evaluations for March all involved the Mental Health Service. Similarly 7 of 9 people rated the Mental Health Service as good with 2 saying it was above average.

Table 4.10

Consumer Evaluation

Of those fourteen respondents the responses were as follows:

1. Was your first contact with the Bugalwena Service

Not Helpful	0	Okay	0	Helpful	9	Very Helpful	5
-------------	---	------	---	---------	---	--------------	---
2. Was the Bugalwena Service easy to get hold of

Difficult	3	Okay	3	Easy	7
-----------	---	------	---	------	---
3. Were you happy with what happened when you spoke to the Bugalwena Team

Not Good	0	Okay	4	Happy	7	Very Happy	3
----------	---	------	---	-------	---	------------	---
4. Would you advise a friend to use the Bugalwena Team?

Yes	13	No	1
-----	----	----	---
5. How would you rate the mental health service?

Not Good	0	Okay	0	Good	7	Above Average	2
----------	---	------	---	------	---	---------------	---
6. How would you rate the community health services ?(June Quarter Only)

Not Good	0	Okay	0	Good	4	Above Average	1
----------	---	------	---	------	---	---------------	---
7. Would you use the mental health services again?

Yes	9	No	0
-----	---	----	---
8. Would you use the community TVHS again? (June Quarter Only)

Yes	5	No	0
-----	---	----	---
9. Community Mental Health consumers

The problem that you first went to the Bugalwena Team with, is it.....

Worse	0	Same	2	Better	5	Resolved	2
-------	---	------	---	--------	---	----------	---
10. Community Health consumers

The problem that you first went to the community health service with is it...

Worse	0	Same	0	Better	5	Resolved	0
-------	---	------	---	--------	---	----------	---
11. Community mental health consumers

Would you say you had a....

Poor Outcome	0	Good Outcome	7	Above Average Outcome	2
--------------	---	--------------	---	-----------------------	---
12. Community Health Consumers (June Quarter Only)

Would you say you had a.....

Poor Outcome	0	Good Outcome	5	Above Average Outcome	0
--------------	---	--------------	---	-----------------------	---

Community Reputation was assessed by members of the Research Reference Group formally consulting with members of the Aboriginal & Torres Strait Islander community. Evaluation Days were held in March and June 1996. Table 4.11 summarises the pertinent information.

Table 4.11 Community Reputation

- Aboriginal & Torres Strait Islander people reported the Bugalwena Service was being used because it was Aboriginal & Torres Strait Islander people providing the first point of contact.
- Aboriginal & Torres Strait Islander community members reported that the Bugalwena Team were seen as people who valued their community enough to do this work.
- The Bugalwena Team increased trust and safety in using the Community and Mental Health Service.
- The Aboriginal & Torres Strait Islander community members could 'see' the partnership in service delivery.
- The Cultural Awareness Day was reported by members of the Aboriginal & Torres Strait Islander community to show that the TVHS valued and respected the Aboriginal & Torres Strait Islander culture.
- Referrals to TVHS staff known and trusted by Aboriginal & Torres Strait Islander people had increased.
- Discussion of the Bugalwena Service at other Aboriginal & Torres Strait Islander community meetings was positive.

It is evident from the comments reported in Table 4.11 that the reputation of the TVHS had changed markedly since 1992 when the stress survey was undertaken.

Summary

The information reported in this section demonstrates a substantial increase in the utilisation of Community Health and Mental Health Service by members of the Aboriginal & Torres Strait Islander community during the two years of the project. While the TVHS implemented changes in the way services were delivered in December 1995, only limited increases occurred in the utilisation of services by Aboriginal & Torres Strait Islanders until the Bugalwena Service commenced in December 1995. From this time the level of utilisation per month increased substantially. For example during the 4 weeks of June 1996, 51 Aboriginal & Torres Strait Islander persons used the services of the TVHS. This represented 6% to 3% of the Aboriginal & Torres Strait Islander population of 900 -1900 persons. Whereas for the 12 months of 1994, 73 Aboriginal & Torres Strait Islander persons accessed the TVHS. During the 12 months of 1995 this figure increased to 94 and during the first six months of 1996, 238 Aboriginal & Torres Strait Islander persons utilised the TVHS (26% - 13% of the population).

Utilisation of the Bugalwena Service began immediately the Team became operational. Within six months the Team had assisted 147 Aboriginal & Torres Strait Islander persons, and had provided 215 hours of counselling and support. Of the people who used the service 27% (47 people) were referred to the TVHS. During the same period an additional 144 Aboriginal & Torres Strait Islander people used the

services provided by the TVHS.

Because there was no change in the size of the Aboriginal & Torres Strait Islander population during the study period (1994-1996) it was concluded that increases in the utilisation of services were attributable to the changes brought about by the action research partnership. The Research Reference Group agreed that the Bugalwena Team had promoted utilisation of the TVHS through consultation and referral.

Furthermore the reputation of the TVHS had changed to the extent that people began to self refer to the Community Health Service suggesting that trust had developed between the local Aboriginal & Torres Strait Islander community and the TVHS. It appears that the Bugalwena Team acted as an advocate for the Aboriginal & Torres Strait Islander community and was perceived as a high status initiative. Reports appeared in the local paper that the 'Black Health Service was a success'.

Discussion of the factors contributing to the increase in TVHS utilisation by Aboriginal & Torres Strait Islander people is provided in Chapter 5.

5. DISCUSSION

This study sought to contribute to knowledge concerning the utility of action research as a method for facilitating Aboriginal & Torres Strait Islander community participation in mainstream health service planning and delivery. Participation was achieved through the development of an “action-research partnership” between representatives of a local Aboriginal & Torres Strait Islander community and representatives of the regional public sector health service. It was proposed that participation, based on a partnership of equals, would promote the capacity of those involved to define, analyse and act upon the problems that concerned them, in particular, the inadequate response of the local health service to the mental health needs of the Aboriginal & Torres Strait Islander community.

Secondly, the study sought to contribute to public health practice by assessing the extent to which an action-research partnership resulted in changes in the delivery of mainstream health services, increased acceptance and utilisation of services by members of the Aboriginal & Torres Strait Islander community and improvements in consumer satisfaction with service delivery.

This Chapter discusses the findings of the study under the following headings:

- Assessment of mental health needs
- Empowerment through partnership
- The outcomes of partnership
- Action research as a method of promoting partnership
- Implications for public health practice

- Limitations of the research design and methodology.

Assessment of Mental Health Needs

This study began with the presentation of the findings of the TVHS “Stress Survey” in 1994 (Salisbury & Follent, 1996) which assessed mental health needs using life events and self reported levels of stress among the local Aboriginal & Torres Strait Islander community. A representative sample of the Aboriginal & Torres Strait Islander community was obtained through the concerted actions of the Aboriginal & Torres Strait Islander Health Outcomes Council. Reliability of the findings were enhanced through the use of a questionnaire administered by members of the Aboriginal & Torres Strait Islander Health Outcome Council.

The use of a questionnaire to assess stress levels in the Aboriginal & Torres Strait Islander community was considered appropriate given the role and status of the members of the Health Outcome Council. The type and depth of the information provided by Aboriginal & Torres Strait Islander residents was given within a relationship of trust and knowledge of the Aboriginal & Torres Strait Islander person needing the information. The request for the comparison of stress levels came from within the Aboriginal & Torres Strait Islander Health Outcome Council, which had been meeting with the TVHS representatives for three years, therefore a relationship based on trust preceded the survey. It would not have been appropriate for non-Aboriginal & Torres Strait Islander health service staff to conduct such a survey. However, the members of the Aboriginal & Torres Strait Islander Health

Outcome Council argued that it was only appropriate to assess the stress levels and health needs of the community within the context of possible service development. Needs analysis for its own sake was considered by the Aboriginal & Torres Strait Islander community to be of little value, even unethical. Hence, it was essential that a process be established which facilitated changes in the way health services were delivered if they were to become more acceptable and utilised by members of the community. Furthermore, members of the Aboriginal & Torres Strait Islander community placed a high value on community and family support. Hence, it was important that any planning process seek to enhance these existing suppliers of mental health support.

Empowerment through partnership

Indicators of successful empowerment through partnership were 1) the extent to which the partnership was developed and maintained over the two year study period and 2) the extent to which problems were defined and acted upon in a manner which resulted in outcomes satisfying to the Aboriginal & Torres Strait Islander community.

Partnership development and maintenance

The National Consultancy Report on Aboriginal & Torres Strait Islander Mental Health (Swan & Raphael, 1995), claims that traditional Mental Health Services are not culturally appropriate for Aboriginal & Torres Strait Islander consumers because they do not encompass an holistic view of health. My study was premised on the view that the development of culturally appropriate Indigenous Health Services requires establishment of a partnership by the traditional health service with the local Aboriginal & Torres Strait Islander community. The theoretical basis for the

partnership developed between the TVHS and the local Aboriginal & Torres Strait Islander community was Labonte's, (1980) interpretation of empowerment, where empowerment means to have increased capacity to define, analyse and act upon one's problems. This partnership was the focus of the case study.

McKendrick & Thorpe (1994:220) describe Aboriginal culture as encompassing the physical, emotional, social, spiritual and cultural aspects and claim that "the separation of services on the basis of age, social and medical factors is artificial and not consistent with Aboriginal culture". In order that an Aboriginal & Torres Strait Islander 'solution' to Aboriginal & Torres Strait Islander health problems and psychological distress could develop, the TVHS as the traditional experts needed to step back from their primary leadership role and become the providers of support and backup.

The members of the Aboriginal & Torres Strait Islander Health Outcome Council initially had come forward in response to a call for Aboriginal & Torres Strait Islander community members who were interested in liaising with the TVHS. These persons had been meeting with the TVHS since 1991. The TVHS staff who initiated this process were the researcher and the then CEO. The TVHS staff and the Aboriginal & Torres Strait Islander community representatives were focused on the quality of the service provided for the Aboriginal & Torres Strait Islander community. Both groups shared the common goal, of improving the TVHS's for Aboriginal & Torres Strait Islander people. The relationship progressed and the group became the Aboriginal & Torres Strait Islander Health Outcome Council and called for a comparative

examination of the stress levels between an Aboriginal & Torres Strait Islander group and a non-Aboriginal Torres Strait Islander group. The results of the Salisbury & Follent (1996), survey led to the formation of a partnership for reviewing and developing the services provided by the TVHS to Aboriginal & Torres Strait Islander persons.

Traditional, health services tend not to support community development. However, effective community development implies meaningful participation, something which is essential if Aboriginal & Torres Strait Islander health is to improve. As stated by Eckermann et al., (1992:173) “A sense of community appears essential to a sense of oneself, and this in turn is essential to health”. Consistent with a community development approach, the Tweed Valley Aboriginal & Torres Strait Islander Health Outcome Council counselled that “*accountability had to be back to the local Aboriginal & Torres Strait Islander community*” (Aboriginal & Torres Strait Islander Health Outcome Council member, 1995). However, community development raises issues for those involved such as ensuring confidentiality in situations where most of the community know each other. As the partnership in the Tweed Valley progressed critical points emerged and difficult decisions had to be made. For example, the TVHS supported the Bugalwena Service in their rejection of a Aboriginal & Torres Strait Islander Health program from another district that was not within the Bugalwena Service’s priorities for that year. In this way trust and co-operation was strengthened; characteristics which can only develop over time. The case study approach to research provided opportunity to observe these developments.

The World Health Organisation (1991) described a continuum of community participation, which focus's on the organisation rather than the individual (Figure 5.1 p 121). Each level at which participation may occur is described from the perspective of the actions of the organisation. The partnership process in this study occurred at the highest level of the continuum. Hence, it conformed with the principles of the National Health Strategy (Commonwealth Department of Human Services and Health 1993:9), where it states, "Adopting a democratic approach to participation in health care requires the validity of other approaches and gives consumers a 'voice'". It outlines three principles necessary for the establishment of a suitable environment and describes mechanisms needed to make health services's more responsive and accountable to the public. These are public participation, a focus on consumers and communities and an open system. This study facilitated a voice for some of Australia's most disadvantaged people through working in partnership.

Figure 5.1

**A CONTINUUM OF
COMMUNITY PARTICIPATION**

<i>Degree</i> <i>High</i>	Participation Has control	Organisation asks community to identify the problem and make all key decisions on goals and means. Willing to help community at each step to accomplish goals.
	Has delegated	Organisation identifies and presents a problem to the community, defines the limits and asks community to make a series of decisions which can be embodied in a plan which it will accept.
	Plans jointly	Organisation presents tentative plan subject to change and open to change from those affected. Subsequently expects to change plan at least slightly and perhaps more.
	Advises	Organisation presents a plan and invites questions. Prepared to modify plan only if absolutely necessary.
	Is consulted	Organisation tries to promote a plan. Seeks develop support to facilitate acceptance or give sufficient sanction to plan so that administrative compliance can be expected.
	Receives information	Organisation makes a plan and announces it. Community is convened for informational purposes. Compliance is expected.
<i>Low</i>	None	Community is told nothing.

World Health Organization, (1991). Global Strategy for Health for All by the Year 2000. Geneva: WHO

The Effective Consultation Guide (Commonwealth Department of Human Services & Health 1995:113) states “for Aboriginal & Torres Strait Islander people, community control is essential. This may include control of the consultation process”.

Control of the consultation process was with the Aboriginal & Torres Strait Islander Health Outcome Council who were the Research Reference Group. Attendance and participation at meetings was facilitated through the use of the principles of Democratic Dialogue (described on page 34) where all views are received and there is a commitment to reciprocity. The meetings began to be discussed in the wider Aboriginal & Torres Strait Islander community especially as status was awarded to the project through the New South Wales Health Department Ministerial visits.

Partnership is different from consultation, in that it requires the development of ideas together rather than consulting after a plan has been created. This partnership took four years for a trusting relationship to be built and was facilitated through the participatory action research process. Credibility in genuine handing over of decision making had to grow from mistrust to confidence, and be shown to exist on numerous occasions. The structural changes then had to be enshrined in the processes of the TVHS, i.e., the appointment of an Aboriginal & Torres Strait Islander representative on the new Area Health Board, and at Community Health management level. Aboriginal & Torres Strait Islander Health issues were to be resolved by the Bugalwena Service with full support of the TVHS.

Changes were required to the traditional methods of resources allocation and planning to ensure that the Aboriginal & Torres Strait Islander community's perspective on

health problems was the guiding principal. Decentralised planning based on locally identified needs through a participatory planning model (Broadhead et al., 1989) is a first step. The redistribution of power (Pearse & Stiefel, 1979) necessary to allow meaningful participation in this project has meant the establishment of an Aboriginal & Torres Strait Islander Health Outcome Council, who had strong and close links with their community. Representation on this Council was open to all members of the Aboriginal & Torres Strait Islander community and advertised in the local newspapers at key agencies in the area. Efforts were made to ensure there was adequate representation of both genders and all age groups.

The TVHS provided understandable and up to date information of local health matters to the Aboriginal & Torres Strait Islander Health Outcome Council and the Council selected the priority Aboriginal & Torres Strait Islander health goals for each year. The development of appropriate Mental Health Services was one of these goals. The representatives on the Aboriginal & Torres Strait Islander Health Outcome Council took the responsibility for decisions and actions affecting resource allocation. The bureaucracy was acting as an advocate to ensure equity for a disadvantaged group (Eagar & Garrett 1995), and had opened its processes up for review, meeting a shared common goal and contributing to the partnership process.

The development of the Bugalwena Service followed a community development approach aligned with Broadhead et al.,'s (1989:255) description of the participatory process including the flow of information between the Aboriginal & Torres Strait Islander community and the health service.

The production of an Aboriginal & Torres Strait Islander history of the processes contributes to a sense of legitimacy by the Aboriginal & Torres Strait Islander representatives and community. The Aboriginal & Torres Strait Islander perspective in The Bugalwena Service : Our Story of a Partnership in Health was written by the Aboriginal & Torres Strait Islander project officer.

The engagement of the Aboriginal & Torres Strait Islander community to develop their own solutions to an identified need was not seen as a consultation process. It was not a TVHS initiated 'solution' with input sought from those it affected, it was the sharing of the problem with the Aboriginal & Torres Strait Islander community, along with the resources to support their solution. Bureaucratic agreement was gained in advance to honour the decisions reached during the participatory action research process. This approach contributed to maintenance of the partnership.

The Bugalwena Team were seen in their community as being successful, and providing solutions which contributed to the maintenance of the partnership. This status, respect and recognition contributed to the well being of the Aboriginal & Torres Strait Islander community as a whole. The Bugalwena Service resulted in increased utilisation of other Community Health Services such as immunisation, dietetics, physiotherapy and psychiatric services. These activities were able to strengthen the Aboriginal & Torres Strait Islander community's social and cultural identity and advance community empowerment. The Cultural Awareness Training was personally enlightening for individual workers and provided a further valuing of the Aboriginal & Torres Strait Islander social and cultural identity. Increased

knowledge of Aboriginal & Torres Strait Islander history and individual people and increased trust of the TVHS staff contributed to maintaining the partnership.

Participation in the partnership was seen as learning together from both sides. Many events confirmed the respect shown to the Aboriginal & Torres Strait Islander community particularly the visit by the Minister of Health and the official launch of the project. Affirmative employment strategies and the changes to methods of service delivery for an Aboriginal & Torres Strait Islander Health Service.

The principles of Democratic Dialogue described by Gustavsen. (1985) were demonstrated to encourage verbal participation of the members of the Research Reference Group. The principles created a culture where personal experience of the health system was considered as valid information. This process assisted in overcoming the barrier where some members felt they could not contribute because they had not worked in a health service. Subsequently, ideas presented to improve service delivery were based upon actual experiences.

Democratic dialogue facilitated the willingness of people to contribute to the process. All ideas and views were accepted, with solution selection evolving out of group discussion. All thoughts and ideas were recorded and circulated in the minutes of meetings, therefore acknowledging the authority of thoughts and ideas. Agreement was continuously produced which created the platform for further investigation and practical action. This process was integrated into the plan/act/review action research cycles. The principles of Democratic Dialogue were found to encourage participation from all group members.

Problem Definition and Action Taken

The Aboriginal & Torres Strait Islander Research Reference Group defined the problem to be addressed in the joint research process as: “Could the TVHS be helpful and useful to Aboriginal & Torres Strait Islander persons in distress?”. They agreed with the findings in Salisbury & Follent, (1996) where a large difference in psychosocial distress was identified, particularly the continual cycle of grief. The group reviewed the Mental Health Services provided to Aboriginal & Torres Strait Islander persons and suggested ‘solutions’ from their own knowledge and perspective. Their links back to other Aboriginal & Torres Strait Islander community groups and Elders were strong and they were able to canvass the wider local Aboriginal & Torres Strait Islander community easily and quickly.

The Research Reference Group review of the barriers to utilisation of the Mental Health Services by Aboriginal & Torres Strait Islander people, resulted in the following suggestions:

- a. The first point of contact for a distressed member of the Aboriginal & Torres Strait Islander community had to be with an Aboriginal & Torres Strait Islander person available 24 hrs per day and able to provide an outreach service. The action taken was to establish an Aboriginal & Torres Strait Islander telephone support service for Aboriginal & Torres Strait Islander persons in distress. TVHS workers agreed to see people off site and a 24 hour Mental Health backup service was established.
- b. The service could not be called Mental Health, and had to have an Aboriginal

name. The action taken by the group was to select a local Aboriginal & Torres Strait Islander name, which was approved for use by the Elders and the TVHS.

- c. That if non-Aboriginal & Torres Strait Islander staff were involved they had to be aware of Aboriginal & Torres Strait Islander history and local cultural practices. The action taken was to establish compulsory attendance for Community Health and Mental Health staff at annual Cultural Awareness Training at the local museum with the day being run by local Aboriginal & Torres Strait Islander people.
- d. That Aboriginal & Torres Strait Islander people when they are distressed will not use a service they don't know and trust. The action taken was to establish an Aboriginal & Torres Strait Islander interface of support people and the TVHS. These persons were the members of the Bugalwena Team who had established relationships of trust with TVHS workers over the previous five years. The Bugalwena Team trusted the TVHS workers and gave the TVHS credibility in the local Aboriginal & Torres Strait Islander community. Accountability was back through the Bugalwena Team, where issues could be raised directly with the TVHS staff.
- e. That absolute confidentiality must be ensured. The action taken by the Bugalwena Team was to ensure that Bugalwena Team members had access to other Aboriginal & Torres Strait Islander persons and to TVHS staff for debriefing in confidence. Clinical and personal client information was not shared with the

whole team.

- f. That the information about the Bugalwena Service would be distributed widely. The action taken was the provision and distribution of information pamphlets at all agencies and key places throughout the local community.
- g. That all calls to the Bugalwena Team would be received whether they were from an Aboriginal & Torres Strait Islander person or not. The action taken was to accept all calls and refer on when the need arose.

These changes involved the name of the service, the persons who provided the first part of contact, the interface with the Aboriginal & Torres Strait Islander community and Aboriginal & Torres Strait Islander ownership of the process. The clinical or medical type of service provided did not change. What did change was the method of accessing the service and the ability to chose an Aboriginal & Torres Strait Islander solution within the TVHS.

Mainstream health workers were motivated to change the way they provided their services through compulsory attendance at Cultural Awareness Training and through offering training to the Bugalwena Team. The teaching became a two way process where both sides reported they benefited. Mainstream health workers reported they valued having a Bugalwena Team member supporting and facilitating initial contacts with Aboriginal & Torres Strait Islander consumers, and Bugalwena Team members reported they felt relief when they could refer a person to a TVHS staff member they

knew well and trusted.

The changes that occurred in the way TVHS's were accessed by Aboriginal & Torres Strait Islander persons were directly attributable to the Aboriginal & Torres Strait Islander involvement in the action research partnership and could not have come into being through separate TVHS service review.

The problem considered by the Research Reference Group in cycle two was concerned with the demands of increased service provision such as, the need for training of the Bugalwena Team members, issues of confidentiality and debriefing. The action taken by the TVHS was to provide the requested training, supply rooms and support the new service.

The third cycle of action research centred upon the development of Aboriginal & Torres Strait Islander methods of healing. Two TVHS workers were provided to assist in group healing days and new initiatives were supported through the provision of more specialised training, on issues, such as grief and loss counselling and identification of a person's suicide intent and risk. This focus is ongoing with further cycles of review and action.

In order that the TVHS would become a place of cultural safety it was essential to firstly acknowledge the reality, that it did not know how to provide cultural safety. This was outside its area of expertise and it needed to seek assistance through the local Aboriginal & Torres Strait Islander community. The TVHS had the

responsibility to develop a workplace context where racist remarks and jokes were not tolerated. Every complaint was be addressed and action taken. Cultural Awareness Training was an excellent forum to break down barriers and increase understanding and trust. Evidence of celebration and respect for the Aboriginal & Torres Strait Islander culture in the form of signs, paintings and separate space essential. The partnership in this project suggested many changes that allowed a structural redistribution of power to occur. It was more than 'Aboriginalising' the services or providing an Aboriginal & Torres Strait Islander face in a white system, it was providing the space for a separate Aboriginal & Torres Strait Islander way of healing to co-exist and be supported within and by the TVHS.

Paolo Freire (1974) noted, that the important thing is to help men (and nations) help themselves, to place them in consciously critical confrontation with their problems, to make them agents of their own recuperation. This would seem to suggest a method of community development. Others, having attempted community action are more cautious, with Labonte (1989:80) stating "you can't empower anyone. To presume so strips people of their capacity for choice". He suggests the role may be to nurture this process and remove obstacles; the first being our own need to define health problems for the community: "The power of defining health belongs to those experiencing it" (Labonte 1989:80).

The collaborative component ensured that the Aboriginal & Torres Strait Islander local health problems were seen from the perspective of the local community (Legge, 1995). The needs and problems were identified locally with local people considering

the situation and trialing solutions, thereby moving from a technical health planning position to a level of community development. The study confirmed the proposition that adoption of Labonte's (1989) principles of empowerment within an action research partnership was a method for operationalising Indigenous involvement in health service planning and service delivery.

The changes made by the TVHS to the way that health services were provided for Aboriginal & Torres Strait Islander persons has created an opportunity for Aboriginal & Torres Strait Islander health to be defined by those persons experiencing it. This study confirmed the work of other researchers in that, the solutions were found from within the Aboriginal & Torres Strait Islander community (Eckermann et al, 1992) and were based on services being provided by people who were known and trusted by members of the Aboriginal & Torres Strait Islander community (McKendrick & Thorpe, 1994). The changes ensured there was a sense of cultural safety (Eckermann et al, 1992) where acknowledgment of the Aboriginal & Torres Strait Islander culture was evident to Aboriginal & Torres Strait Islander consumers.

Promoting self help runs parallel with decentralised decision making. This is the task for health: can the health professionals and bureaucrats give away control, in order that other's may experience it? Empowerment is a noble word but the reality of political and economic redistribution of power does not yield win-win scenarios. Socially disadvantaged communities empower themselves, in part, by reducing the constraints imposed on them by wealthier and more powerful interests. As Rudolf Virchow once commented. "All diseases have two causes; one pathological, the other

political” (Pinchuk & Clark, 1984:19). This means there needs to be a transplantation of power and influence from those who have too much to those with little or none. The epistemological proposition underlying this study is that Aboriginal & Torres Strait Islander persons have always known what they need and, given the opportunity, will create and use a unique, culturally acceptable, health service.

The Outcomes of Partnership

The measures used to assess the outcomes of the partnership covered four areas, firstly the actual utilisation of the Community Health or Mental Health Services, secondly, the utilisation of the Bugalwena Service, thirdly, consumer satisfaction with the services received and finally feedback relating to the community reputation of the Bugalwena Team.

1. TVHS utilisation by Aboriginal & Torres Strait Islander persons.

The first year of the project was 1994, when the Aboriginal & Torres Strait Islander Hospital Liaison Committee had been meeting since 1991 and there were two Aboriginal & Torres Strait Islander staff members. In 1994, the Aboriginal & Torres Strait Islander Hospital Liaison Committee became the Aboriginal & Torres Strait Islander Health Outcome Council and services were provided to a total of 73 Aboriginal & Torres Strait Islander people. Sixty nine Aboriginal & Torres Strait Islander persons received a Community Health Service and 4 Aboriginal & Torres Strait Islander persons received a Mental Health Service.

The second year of the project was 1995 when 94 Aboriginal & Torres Strait Islander persons received a TVHS service. Eighty four Aboriginal & Torres Strait Islander

people received a Community Health Service and 10 Aboriginal & Torres Strait Islander people received a Mental Health Service. There were two Aboriginal & Torres Strait Islander health workers.

The third year of the project was 1996, when 238 Aboriginal & Torres Strait Islander people received a TVHS in the first half of the year. Two hundred Aboriginal & Torres Strait Islander people received a Community Health Service and 38 Aboriginal & Torres Strait Islander people received a Mental Health Service. There were two additional Aboriginal & Torres Strait Islander staff appointed in March 1996. The Bugalwena Team began functioning in January 1996 and assisted 147 people in the first six months. They referred 47 Aboriginal & Torres Strait Islander persons to the TVHS, between January 1996 and June 1996.

The increase in Mental Health Services on an annual basis represents services provided to approximately 76 Aboriginal & Torres Strait Islander persons from a community of 600 - 900 adults (approx.), compared to the almost non-existent service levels in October 1994. If the corresponding large increase in the rate of Aboriginal & Torres Strait Islander Community Health Services utilisation remains at the level of the first six months, of 1996 for one year it would represent 400 of the total Aboriginal & Torres Strait Islander local adult population of 600 - 900 persons.

The Bugalwena Team have referred 47 persons onto the TVHS for additional assistance. During the same 6 months the Community Health and Mental Health Services have provided service to an additional 194 Aboriginal & Torres Strait

Islander persons, totalling 241 persons. The increase in utilization of Community Health and Mental Health Services is far greater than those Aboriginal & Torres Strait Islander persons being referred to the TVHS by the Bugalwena Team. The local Aboriginal & Torres Strait Islander community feedback reports this is due to the high profile of the Bugalwena Team in the community. They report the Bugalwena project has achieved social and political change, which has raised the status of local Aboriginal & Torres Strait Islander people. When Aboriginal & Torres Strait Islander people are visiting the Bugalwena Cottage they have begun to seek health advice from the mainstream health services. It is assumed the large increase in general Community Health Service utilisation by Aboriginal & Torres Strait Islander people may result in improved health status.

The Bugalwena Service is functioning as an Aboriginal & Torres Strait Islander support service in its own right and has facilitated access to mainstream Community and Mental Health Services. This has not generalised to the Accident and Emergency Department suggesting that knowing and trusting the people (staff) has been an important factor. The number of Aboriginal & Torres Strait Islander persons accessing the Community Health and Mental Health Services compares favourably with 10% of the non-Aboriginal & Torres Strait Islander population who access the service.

Population estimates of incidence of mental illness would suggest approximately 5% of an adult population would suffer a mental illness (Sumich et al., 1995). The utilisation of the Mental Health Service by Aboriginal & Torres Strait Islander

persons is approximately 12 % of the estimated adult population. Given the higher levels of stress and stress related symptoms identified by the local Aboriginal & Torres Strait Islander community (Salisbury & Follent, 1996) a higher utilisation of services would be expected if the service provided is valued by the Aboriginal & Torres Strait Islander community.

While it would appear appropriate to claim that service utilisation had increased as a direct result of the project, one must always be cognisant of threats to validity, such as other factors impacting upon or changing service utilisation. Efforts were made to identify extraneous variables that may have contributed to the increase in service utilisation by Aboriginal & Torres Strait Islander people of the Community Health and Mental Health Services. It was concluded that there were no extraneous variables contributing to increases in service utilisation by Aboriginal & Torres Strait Islander people.

2. Bugalwena Team Utilisation

The Bugalwena Team had been functioning for six months at the conclusion of the project. The Bugalwena Team had received 173 of calls from 147 people in the first six months of operation and they referred 47 people on to the TVHS for further assistance. The Bugalwena Team provided counselling to 147 people and have provided 30 sessions of 3 hours or longer . There was 101 calls from females and importantly 46 calls from males. The action research process provided for continual review of the skills and training needed to respond adequately to the caller's needs. The Aboriginal & Torres Strait Islander population estimates range from 900 (ABS

1991) to 1900 (local survey, 1991) with the adult population estimated to be between 600 - 900 persons. The provision of service to 147 Aboriginal & Torres Strait Islander adults in the first 6 months of 1996 suggests that 16% - 24% of the local adult Aboriginal & Torres Strait Islander community contacted the Bugalwena Team.

3. Consumer Satisfaction with Service Accessibility and Processes.

Each month the Bugalwena Team were providing counselling and support to approximately 20 - 30 Aboriginal & Torres Strait Islander persons. They were referring approximately 27% of these on to the TVHS for further assistance.

Consumer satisfaction evaluations were completed by those consumers who were referred to a Community Health or a Mental Health Service by the Bugalwena Team in March 1996 and June 1996. They completed the evaluations after their contact with the TVHS. The number of respondents was 14 and represented the 9 & 5 persons who had received a Health Service in March and June 1996. They were contacted by their TVHS staff member and asked if they would complete the evaluation. The Bugalwena Team felt it was not appropriate to request evaluations from the 147 Bugalwena Service telephone callers as confidentiality of the Bugalwena Service was crucial for trust to develop in the Aboriginal & Torres Strait Islander community.

The Consumer Evaluation Form evaluated the care received from the Bugalwena Team, the TVHS and gave an indication of perceived outcome of care. The Bugalwena Team assisted in the development of the Consumer Evaluation form. It is acknowledged that the instrument did not reflect equal rating intervals, but the Bugalwena Team felt strongly that getting it completed easily was the principle focus.

While the sample was small, it represents 14 out of 47 (approximately 30%) persons referred on to the TVHS. Table 4.10 Consumer Evaluation on page 111, displays the service accessibility, process and self reported outcome of care data. The data indicates high levels of reported satisfaction with the Bugalwena Service. Notably all of the 9, March Aboriginal & Torres Strait Islander Mental Health clients reported they would use the Mental Health Service again. This finding is startling considering the initial barriers to Mental Health Service noted in Salisbury & Follent's (1996) survey.

4. Community Reputation

The criteria used by the Bugalwena Team to determine and evaluate effectiveness was 'ongoing utilisation' and community reputation. The ongoing utilization of the Bugalwena Service demonstrated that the service has been accepted by the local Aboriginal & Torres Strait Islander community and maintains a good community reputation. This type of community validation is considered to have much more relevance than a satisfaction survey.

The continued utilization of the Bugalwena Team by the Aboriginal & Torres Strait Islander local community suggests the service has been accepted. The Bugalwena Team report:

"There have been a lot of people coming into the Centre since the Bugalwena Team has been operating...Aboriginal and Torres Strait Islander people feel a lot more comfortable in coming here...they know we care and that we are trying to do something about our Health Service..."

"I think the Aboriginal community has confidence in what we are doing and know that we can be trusted to do the right thing."

"A lot of people have become aware of the service, I have been to a few houses where the people have not used the service but have the pamphlet on their fridge".

"The community feels a lot more comfortable because they have become familiar with you...they see your name on the pamphlet...then they see you in the street and want to talk..."

"A lot of people ask about the Bugalwena Team and what it does and also what we provide..."

"We need to get the message through to the youth...they need someone they can trust and talk to them about their problems...the young ones do not know much about the Bugalwena Service.." (Bugalwena Team members, 1996)

The continued dialogue and feedback about the service in the Aboriginal & Torres Strait Islander community suggests the Bugalwena Service operates as an 'Aboriginal' solution for those Aboriginal & Torres Strait Islander persons in distress. "Legitimacy in the eyes of the community is difficult to measure. A particular indicator of success is the continued participation by members of the community at the various meetings and favourable comments received from those participating" (Broadhead, 1989:255).

Summary

The important conclusions drawn from these findings are that the Aboriginal & Torres Strait Islander and TVHS action research partnership identified barriers to the TVHS for Aboriginal & Torres Strait Islander consumers and recommended changes. The partnership process facilitated the implementation of these changes resulting in the TVHS becoming acceptable to Aboriginal & Torres Strait Islander consumers with increases in utilisation. The findings support the propositions that the action research partnership between the TVHS and the Aboriginal & Torres Strait Islander community provided advice and culturally appropriate methods of service delivery, facilitated access to the TVHS for Aboriginal & Torres Strait Islander consumers, created a forum and a dialogue for continual TVHS review and improvement and increased access to decision making and planning of the local TVHS for the Aboriginal & Torres Strait Islander community.

Action Research as a Method of Promoting Partnership

The researcher remained aware of the issues surrounding research with Aboriginal & Torres Strait Islander communities and endeavoured through the principals of symmetry and reciprocity (McTaggart, 1993) and ‘democratic dialogue’ (Gustavsen, 1985) to ensure that the views expressed were an Indigenous perspective. The collaboration between the local participants and the researcher produced theory that the participants then tested out by implementing the service changes and reviewing the outcomes.

The action research method facilitated the use of these principals which reduced the

risks of cultural imperialism. The model worked well in the cross cultural setting where there were different views on what constitutes health and research. The action research model was able to accommodate the culture of the Aboriginal & Torres Strait Islander participants through acknowledgement of their forms of language, discourse, activity, practice, social relationship, and organisation.

The validation of key findings occurred in the wider Aboriginal & Torres Strait Islander community by the Elders who were not present at the Research Reference Group meetings. This community validation and approval to proceed was accommodated in the continuous action and review nature of the model, suggesting the model is particularly applicable in cross cultural settings. The Aboriginal & Torres Strait Islander community cultural surveillance increased dissemination of knowledge about the TVHS thereby increasing trust in the TVHS and its practices. McTaggart (1993) describes action research as a commitment to observe and problematise and in cross cultural work, through engagement of local knowledge it can result in as the practice of emancipation.

The action research method was found to facilitate equality and was a forum for a redistribution of power from the TVHS to the Aboriginal & Torres Strait Islander representatives. The method required that solutions were found from within the Research Reference Group's own experience, thereby ensuring ownership and validity of the change process. It was considered essential that the outcome of the review of Mental Health Services provided to Aboriginal & Torres Strait Islander people represented an Indigenous approach. To achieve this within the context of very

different power bases required the exchange of information in a format that was acceptable and understandable to either side, before a new shared view could be developed. The cogenerative process facilitated learning and created an appropriate context resulting in the production of new knowledge, which the Research Reference Group then tested out by implementing the changes. The action research model required continual feedback and review allowing for the exclusion of those ideas found not to be valid in a positive manner. This process encouraged a partnership based on trust and enhanced the commitment to remaining in the partnership. The action research method operationalised empowerment and provided the forum for increased capacity to define, analyse and act upon problems.

The method was able to accommodate different perspectives on health and research and be responsive to an Aboriginal & Torres Strait Islander cultural context, where self is defined in a different manner from western, more individualistic ways. The action research process worked well with the holistic, cyclic, spiritual and whole of life view of health held by the Aboriginal & Torres Strait Islander participants. The wider complex interrelated kinship links were also able to be incorporated in research process through the ability to include and respond to new information throughout each cycle. The basic tenets of the action research model are similar to Aboriginal & Torres Strait Islander world view, where self is not considered independently but in relation to the whole community. The research 'work' is not detached rather a collaborative involvement is sought with the participants. The collaboration component is essential for the Aboriginal & Torres Strait Islander community to be able to contribute in a meaningful way, rather than feel as if they are being studied or

reported on again. This methodological contribution can be generalised. The participatory action research method was described by the Aboriginal & Torres Strait Islander participants as a culturally appropriate method of research.

“This was the first time the Aboriginal & Torres Strait Islander voice had been listened to and heard”. (Bugalwena Team Member, 1996)

Pearse & Stiefel (1979) describe the redistribution of power that has to occur in order that problems can be viewed from the local community perspective. Participatory action research can provide a forum for this dialogue to occur providing there is health service executive commitment to the outcome. This dialogue was necessary to identify those processes which allow the expression of the Indigenous view. The research model ensures participation occurs and not consultation. Further more the research model allowed for the testing out of actions upon those views, and subsequent adoption or rejection of those actions, within a safe environment.

To operationalise Indigenous empowerment, the TVHS entered into a partnership, provided complete and full information, and agreed to accept the decisions made by the Aboriginal & Torres Strait Islander Health Outcome Council. The representatives of the Aboriginal & Torres Strait Islander population were not in a position to empower themselves. It was those who already have access to power (the TVHS) who had to redistribute their power. Legge (1995) argues for relationships which are not asymmetrical helping relationships, and that to intervene as experts will not result in a satisfactory outcome for Aboriginal & Torres Strait Islander Health. Knowledge,

power and the construction of reality are context bound, and without the genuine acknowledgement of the adverse social situation in which Aboriginal & Torres Strait Islander people exist in Australia, a partnership is not possible. To operationalise the New South Wales (1995) Partnership Agreement the current TVHS structures, processes and attitudes had to change.

Summary

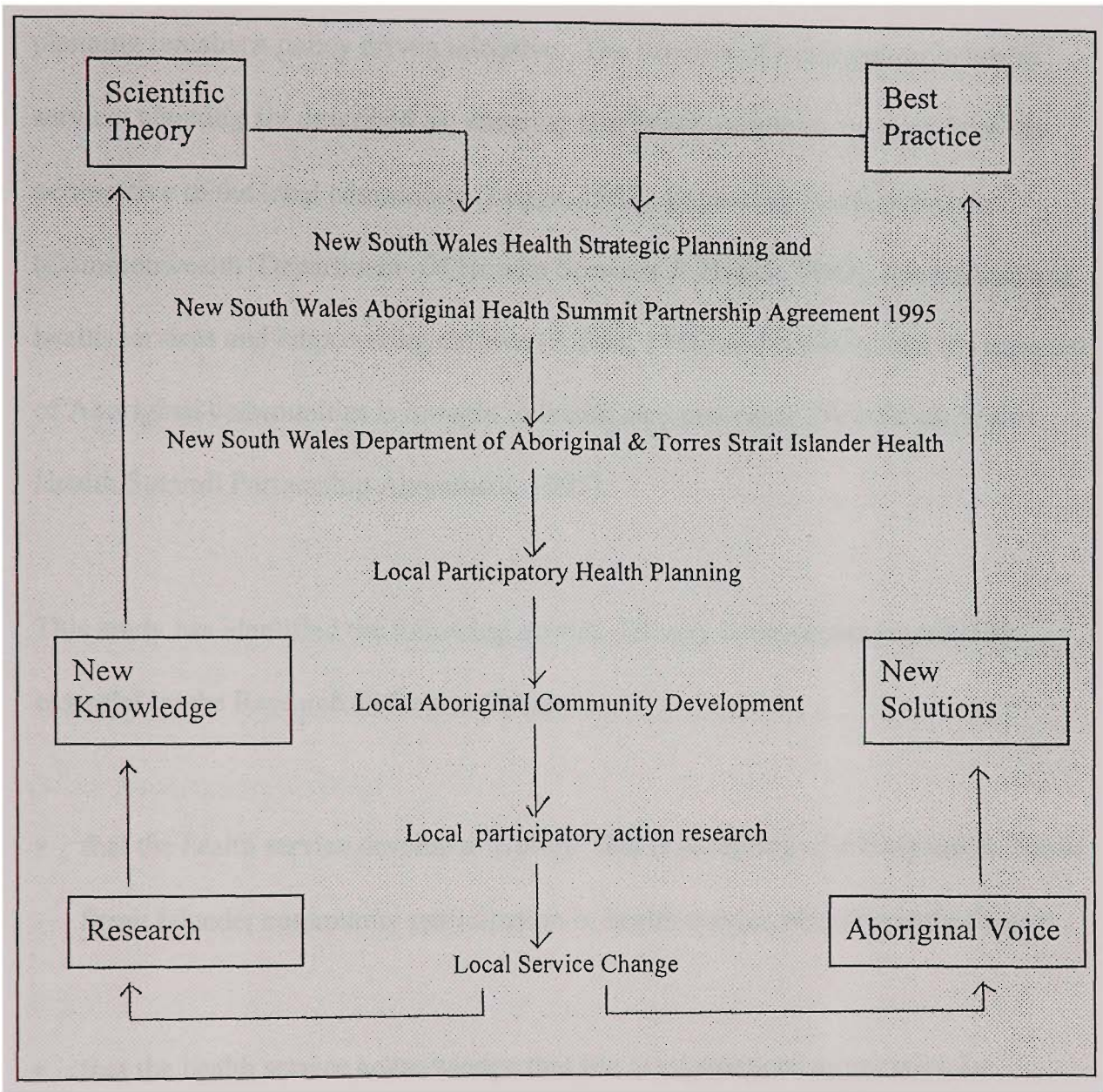
This study has confirmed that the action research method achieved Indigenous participative planning in health services, that identified the need for significant change and resulted in increased acceptability and utilisation of the TVHS's by Aboriginal & Torres Strait Islander people. The model demedicalised health and provided greater control for the community. The Aboriginal & Torres Strait Islander Research Reference Group created social change, empowered the community and democratised decision-making. The process of cogenerative dialogue was advantageous for liberating learning and cross cultural research. The new knowledge is the creation of a shared framework of local theory. This knowledge has not been available to either the researcher or the Research Reference Group previously. The new knowledge about culturally appropriate health service provision contributes to general scientific theory and to the empowering of the Aboriginal & Torres Strait Islander participants. New ways of implementing actions and changes were discovered. The Research Reference Group in this process were committed to the results of their systematic investigation and the resulting action long after the research has finished. The new knowledge is appropriately placed in the social context. The opportunity to develop an appropriate and helpful Indigenous Health Service

provided by Aboriginal & Torres Strait Islanders for their community is a step towards community development. Improving the community's status may assist in health improvement.

A model is proposed that links health planning and participatory action research to produce new knowledge and shared framework of local knowledge. The participatory planning model was integrated into the New South Wales Health Department Planning process and is shown in Figure 5.2 on page 145, Health Planning in Partnership.

Figure 5.2

Health Planning in Partnership



Implications for Public Health Practice

The theoretical propositions and operational steps underlying community participation in health service planning and delivery remain at the conceptual level. While the literature outlines the benefits of community participation into health planning, (Broadhead et al., 1989; Rifkin, 1986; Legge, 1992) studies are necessary to identify

those processes and methods that operationalise and facilitate community involvement. Aboriginal & Torres Strait Islander participation in health service planning remains a policy driven initiative. The benefits of participation in health service planning are described as; ensuring that health problems are seen from the perspective of the local community (Legge, 1992), improving health outcomes (Commonwealth Department Of Human Services & Health, 1993), de-medicalising health services and empowering citizens (Rifkin, 1986) and ensuring that the expertise of Aboriginal communities is brought to health care processes (New South Wales Health Summit Partnership Agreement, 1995).

This study has identified the following service delivery components regarded as essential by the Research Reference Group.

- ▶ that the health service develop a ‘culture’ that is accepting of Aboriginal & Torres Strait Islander community participation in health service planning and delivery;
- ▶ that the health service acknowledge that life is experienced as stressful for Aboriginal & Torres Strait Islander’s with grief and loss being experienced more frequently by members of the Aboriginal & Torres Strait Islander community than by members of the non-Aboriginal & Torres Strait Islander community;
- ▶ that the health service acknowledge their existing facilities discriminate against Aboriginal & Torres Strait Islander persons;

- ▶ that the first point of contact with the health service for an Aboriginal & Torres Strait Islander person in distress should be with an Aboriginal & Torres Strait Islander person;
- ▶ that the service should be available 24 hours per day and able to provide an outreach service;
- ▶ that the re-designed health service represents an Aboriginal & Torres Strait Islander solution to health problems.

Acknowledgement by the TVHS that life is experienced as more stressful with grief and loss being experienced frequently by members of the Aboriginal & Torres Strait Islander Community.

Health services for Aboriginal & Torres Strait Islander persons cannot be considered in isolation from the historical context in which Aboriginal & Torres Strait Islander people exist. On all health measures Aboriginal & Torres Strait Islander persons experience poorer outcomes (Thompson 1984). Aboriginal & Torres Strait Islander persons are over represented in the prisons, have higher unemployment rates, poorer housing, shorter life spans and higher morbidity rates. Expectations of lifespan at birth are 15 - 20 years less if you are born Aboriginal & Torres Strait Islander with a much higher mortality experienced by young adults (Thompson, 1984; Hunter, 1993). There is gross social inequality experienced by Aboriginal & Torres Strait Islander people in Australia. Grief and loss issues are frequent, with many Aboriginal & Torres Strait Islander people losing a family member by the age of 10 years.

The Aboriginal & Torres Strait Islander community retain extended family and kinship links, so that each death is experienced as a loss to the whole community. The deaths of young people especially in custody are felt by many members of the community. "A number of people spoke of these deaths in terms of genocide. They stressed that the Aboriginal community simply cannot afford any more deaths. The size of the community is so small already that each death is an irreplaceable loss to the community, and people have a fear that the very existence of the Aboriginal people is under threat. This is particularly the case where the deaths of young people are concerned" (Aboriginal Health Council of South Australia, 1995:8).

"The loss of 4 - 5 adults who were family to you by the age of 25 years has a major effect" (Aboriginal & Torres Strait Islander Health Outcome Council member, 1995).

The local Aboriginal & Torres Strait Islander community report they hold onto each member as precious *"especially the men, we don't know how long they are going to be there"* (Aboriginal & Torres Strait Islander Health Outcome Council member 1995). There is a sense that just surviving is hard. "Several people talked about the sense of 'death lurking'. One family which had lost several brothers in a short period of time talked about looking at the other brothers and wondering who was going to be next. There was so much death in their lives that there was never enough time to get over one before another occurred resulting in an overwhelming depression" (Aboriginal Health Council of South Australia, 1995;10).

Salisbury & Follent's (1996) findings that 72% of the Aboriginal & Torres Strait Islander sample were unemployed or on a benefit with income levels of 71% below \$15,000 per annum concur with others that poverty contributes to the extreme

disadvantage for Aboriginal & Torres Strait Islander persons. (Eckermann et al., 1984; Reid & Lupton 1991). High unemployment contributes to depression, alcohol abuse, loss of purpose, poverty and poor health (Hunter, 1991, 1992 & 1993). “We have always known poverty. We are born in poverty, live in poverty and die in poverty. Aborigines and poverty mean the same thing” (Gale & Binnion, 1975:1).

“Many people live long distances from their relatives and cannot afford to own a car and don’t have a telephone. Poor health and poverty mean that Aboriginal people are often very isolated,.....” (Aboriginal Health Council of South Australia, 1995:10).

Suicide among Aboriginal & Torres Strait Islanders is increasing (Hunter, 1991) along with parasuicide (Radford et al, 1990) interpersonal violence (Hunter, 1992) and self mutilation (Hunter, 1990). Eckerman et al., (1984) in their survey of urban/rural Aboriginal communities in New South Wales and Queensland, found high levels of anxiety, irritability and insomnia as well as 14 - 23% of individuals reporting high levels of anomie (hopelessness, helplessness and disorientation). Salisbury & Follent (1996) report alarmingly high levels of self reported stress symptoms where 64% of their Aboriginal & Torres Strait Islander sample reported they felt moderately to severely depressed, with 68% reporting they experienced recurring, upsetting distressing memories and 69% reporting irritability and outbursts of anger. The number of self reported stressful events that had occurred in the past 12 months was significantly different between the Aboriginal & Torres Strait Islander sample and the non- Aboriginal sample at the $P < .01$ level. The greatest difference was noted where 69% Aboriginal & Torres Strait Islander sample had lost more than one person in the previous 12 months compared to 5% of the non- Aboriginal sample.

“One loss is all our loss”.

“When somebody from the community dies we all grieve because it is most likely to be an aunt or an uncle or a close relative because we retain our second, third and fourth line relation”. (Bugalwena Team Members, 1996)

In the delivery of health services there must be an acknowledgement that life for Aboriginal & Torres Strait Islander people is stressful with grief and loss issues being frequent. This acknowledgement is essential for the provision of a valid and useful service, and represents a respectful beginning point. While the literature provides limited work into the psychological distress experienced by Aboriginal & Torres Strait Islander persons, it abounds with an overriding view of despair; extreme socioeconomic deprivation and relative powerlessness (Thompson, 1984); a much deeper psychological malaise, evidenced by substance abuse, anxiety and depression (Slattery 1987); oppression and exclusion resulting from European conquest (Cawke, 1972); a particularly stressful and painful relational vertigo (Reser, 1991); and hopelessness, helplessness and disorientation (Eckerman et al., 1984). In order to provide culturally appropriate services, acknowledgement of the reality of the context of Aboriginal & Torres Strait Islander persons is essential.

Acknowledgement that Aboriginal & Torres Strait Islander persons experience public health facilities as discriminatory and not culturally accepting.

Throughout this work many Aboriginal & Torres Strait Islander community members reported that they would only go to the hospital as a last resort and that the hospital

was seen as *“a place where you do not come out - a place to die”* (Aboriginal & Torres Strait Islander Health Outcome Council member 1995). They also reported many experiences of discrimination from TVHS staff over many years, contributing to a general perspective within the Aboriginal & Torres Strait Islander community that the hospital particularly the Accident & Emergency Department was not a culturally accepting place.

“Aboriginal people are afraid of hospitals..”

“It was not long ago when my grandchild had trouble with the hospital from sheer lack of service, I feared for her life...she was a new born baby at the time and it was known in the community that another baby had a similar problem and she died...”

“Aboriginals fear the hospital...they become frightened of rejection when they enter the hospital.” (Bugalwena Team members 1996)

The use of public Mental Health Services by the Aboriginal & Torres Strait Islander community is even more fearful, given the stigma attached to Mental Health labels and fear of being locked up (Salisbury & Follent 1996). Aboriginal & Torres Strait Islander people are reluctant to utilize conventional Mental Health Services (McKendrick, 1993; Redfern Report, 1991, Dunlop, 1988).

Towler (1994) suggests Aboriginal people do not see doctors because of medical

jargon, cost, unfriendly environments, difficulty getting appointments and racism. Salisbury & Follent's (1996) survey identified that 80% of their sample of Aboriginal & Torres Strait Islander respondents reported experiencing an episode of discrimination every week of their lives. Eckermann et al., (1992:89:94) describes Aboriginal people as "a definite out-group in Australian society, subject to discrimination and prejudice" and further, "There is no doubt that the level of stress and anxiety, based as it is in the position of 'devalued' minority, social economic and political discrimination, leading to structural violence, has led to many of the deaths in custody investigated by the Royal Commission".

Mobbs (1991) acknowledges that many of the communication difficulties in health care encounters between Aboriginal & Torres Strait Islander persons and health care professionals are due to the racist attitudes of the professional, while some are due to misunderstanding and mutual mistrust. The Royal Commission reported that many Aboriginals experience Australian society as highly racist and that an atmosphere of hostility, prejudice and ignorance on the part of the non- Aboriginal community will not result in respect and trust (RCADIC 1989:9). A cycle is in place where Aboriginal & Torres Strait Islander persons experience extreme adversity in the social environment, making it unlikely that at times of sickness or psychological vulnerability they would approach the 'adversary' for assistance. *"The community pull closer together and we prefer to deal with it ourselves - privately"* (Aboriginal & Torres Strait Islander Health Outcome Council member 1995).

The first point of contact for an Aboriginal & Torres Strait Islander person in

distress should where possible be with an Aboriginal & Torres Strait Islander person, available 24 hours per day and able to provide an outreach service.

McKendrich and Thorpe (1994:220) outline the success of the Victorian Aboriginal Mental Health Network where they stress the importance of the involvement of Aboriginal Mental Health workers and Aboriginal general health workers in the network. They propose that meaningful participation and Aboriginal community control of their own Mental Health Services has been essential for the existence and continual validation of the service. They comment: "It is vital to Aboriginal people that they know and are known by those they trust to work with them".

Salisbury & Follent (1996) found in their survey that 26% of the Aboriginal & Torres Strait Islander sample would not use public Mental Health Services because the staff were not Aboriginal & Torres Strait Islanders. A further 55% reported it would be shameful and embarrassing to contact a public Mental Health Service and fears of being labelled as mad kept 60% of the sample away.

It is well documented that Aboriginal & Torres Strait Islander people are reluctant to utilise public Mental Health Services (McKendrich, 1993; McKendrich et al., 1992; New South Wales Aboriginal Mental Health Report, 1991; Towler, 1994; Eastwell, 1985; Salisbury & Follent, 1996). General health and welfare services are implicated in the ongoing oppression of Aboriginal & Torres Strait Islander people and this acts as a barrier to Aboriginal & Torres Strait Islander people's willingness to use mainstream services, such that: "There is a feeling that these services are either not intended for their (Aboriginal) use or are actively hostile to their needs" (Aboriginal

Health Council of South Australia, 1995:25). This study found that Aboriginal & Torres Strait Islander community members repeatedly stressed, *"Our people want to see their own people in times of stress or trouble"* (Member of Aboriginal Health Outcome Council 1995). An Aboriginal & Torres Strait Islander person in distress seen by the Bugalwena Service may be later referred on for more specialised non-Aboriginal treatment, and they were willing to engage in this if that service provider was also known and trusted by the Aboriginal Service. The Aboriginal & Torres Strait Islander Service for people in distress needed to be available 24 hours per day and not only centre based. They reported that Aboriginal & Torres Strait Islander community members *"often take a long time to build up the courage to seek help and that they won't phone back or come to an appointment in 7 - 10 days time"* (Aboriginal & Torres Strait Islander Health Outcome Council Minutes, April 1995).

The Bugalwena Team reported that Aboriginal & Torres Strait Islander people felt that actually coming to the Community Health Centre was embarrassing, uncomfortable and difficult to access before the Bugalwena Team began. Transport difficulties were identified as contributing to isolation and added to the difficulties in accessing services. Eckermann et al., (1992:167) describes a concept of cultural safety where "you need someone (Aboriginal) there so that they are comfortable and can see something familiar". They defined cultural safety as the need to be recognised within the health care system and to be assured that the system reflects something of you - of your culture, your knowledge, your customs, attitudes, beliefs and preferred way of doing things.

This study found having an Aboriginal & Torres Strait Islander worker as the first point of contact was essential, but more importantly the Aboriginal & Torres Strait Islander Health Services had to have a respected position within the TVHS. The choice of an Aboriginal solution had become available within a public health service. The data shows that the local Aboriginal & Torres Strait Islander community are accessing and utilising the Bugalwena Service where 27% are referred to the TVHS and 54% are receiving an Aboriginal & Torres Strait Islander “solution”. The Bugalwena Service provided the opportunity to bring Aboriginal & Torres Strait Islander knowledge and wisdom about healing to their own community.

The elements that should characterise primary health care identified by the National Aboriginal Health Strategy Working Party Meeting (1989) were considered in this study. Appropriateness, access and acceptability were defined by the members of the Aboriginal & Torres Strait Islander Health Outcome Council rather than by the TVHS. Standards and methods of service provisions were modified in accordance with this advice. The process of the participatory action research allowed for the contribution to social development through community participation and control. The Bugalwena Team are providing a valuable service to the Aboriginal & Torres Strait Islander community such that “their special knowledge and skills might be more fully developed and made more widely available to the whole Aboriginal community” (Aboriginal Health Council of South Australia, 1995:6). These methods of healing were introduced into the range of services available ensuring the provision of appropriate counselling services. In addition to the support service the Bugalwena Team worked in partnership with the Mental Health Service and established two

duplexes for long term accommodation.

The service must represent an Aboriginal & Torres Strait Islander solution with Aboriginal & Torres Strait Islander control.

The service needs to be identified by name, workers and space as an Aboriginal & Torres Strait Islander response. “Solutions can be found from within Aboriginal strategies: those that are imposed by outsiders frequently fail” (Eckerman et al, 1992:188). The growth of the Aboriginal & Torres Strait Islander Service that has been developed in this project, relied on the knowledge and wisdom of the Aboriginal & Torres Strait Islander Elders and Aboriginal & Torres Strait Islander Health workers. The solution was unique to this local area and involves one to one counselling, group healing days, and the reliance on a network of trusted workers provided by the TVHS. The service was renamed and became known as the Bugalwena Service which means to recover or heal.

The network of resources allows choice for the Aboriginal & Torres Strait Islander community and facilitates access to the whole range of health services. The Aboriginal & Torres Strait Islander Health Outcome Council voiced a strong concern that the service should not be called a Mental Health Service due to the stigma and fear expressed by the Aboriginal & Torres Strait Islander community (Aboriginal Health Outcome Council Minutes April 1995). This is consistent with a holistic approach and changing the name was the first step in providing an Aboriginal & Torres Strait Islander response to the high levels of distress experienced in the local community. They reported *“just because you are stressed, doesn’t mean you have to*

be mad” (Aboriginal Health Outcome Council member April 1995).

The TVHS supports the Bugalwena Service through the provision of separate office space, employment, training, administrative and clerical support. The acknowledgment of the culture occurs through compulsory Cultural Awareness Training for all Community Health staff and the provision of an environment where racism is not tolerated. The service needs to be supported by the General Manager (CEO) and TVHS executive. The Minister for Health has visited the Bugalwena Team and the official launch of the Health Outcome Council Project was held at Minjungbal Museum. A partnership with the co-existence of two cultures and two separate healing/health responses is developing.

The TVHS must provide a context that is accepting of Aboriginal & Torres Strait Islander people.

The key to Aboriginal & Torres Strait Islander utilisation of the TVHS is that it must be provided within an Aboriginal & Torres Strait Islander framework, that allows for Aboriginal & Torres Strait Islander knowledge and wisdom to be utilised. A relationship of mutual trust takes time to develop and needs to acknowledge the adverse social environment of the local Aboriginal & Torres Strait Islander community. Providing some support for those people experiencing high levels of psychosocial distress was an essential first step before the provision of other health services. This requires that the Bugalwena Service trust the TVHS and vice versa and that the Aboriginal & Torres Strait Islander community trust the Bugalwena

Service.

This partnership resulted in an agenda for change which was legitimate in the eyes of the Aboriginal & Torres Strait Islander community. The Aboriginal & Torres Strait Islander Health Outcome Council had the opportunity to provide a responsive service that met the needs of their local community and to encourage more involvement of their community in their health issues. The structural changes regarding the protocol for the delivery of Aboriginal & Torres Strait Islander Health Services have been enshrined into TVHS policy through representation at Community Health management level.

Those processes found to facilitate Indigenous community participation were firstly, the willingness of the TVHS to enter into a partnership and support the research outcomes. Secondly, ownership of the process by the Aboriginal & Torres Strait Islander representatives through action research method. This process allowed for a ‘trial and error’ approach within a supportive environment, where the researchers were conducting research on themselves, removing the threat of external evaluation by the dominant western culture. Thirdly, the employment of an Aboriginal & Torres Strait Islander Project Officer and the production of a report, validated by the key stakeholders in the local Aboriginal & Torres Strait Islander community. Finally, the respect shown for the Aboriginal & Torres Strait Islander culture through Cultural Awareness training, renaming the service and the provision of a separate space. Working in an action research partnership resulted in:

- the identification of a set of essential service components for an effective

Aboriginal & Torres Strait Islander Health Service.

- the development of a self determined Aboriginal & Torres Strait Islander TVHS.
- increased utilisation of Community Health and Mental Health Services by the local Aboriginal & Torres Strait Islander population.
- the identification of participatory action research as a method for operationalising Aboriginal & Torres Strait Islander empowerment.
- the identification of a planning model integrated into the New South Wales Health Department planning process.

The implications for public health practice in developing and delivering Aboriginal & Torres Strait Islander Health services are that services can no longer be planned, provided and reviewed in isolation from the Indigenous group they are meant to be servicing. To continue to do so, when Aboriginal & Torres Strait Islander people find the services culturally unsafe, is to contribute to oppression. Low public health utilisation by Aboriginal & Torres Strait Islander persons does not necessarily mean there are low needs. Culturally appropriate determination of 'need' is required to identify the health requirements.

The adoption of an action research partnership as a method for promoting a relationship of equals and generating trust, has been demonstrated to be valuable in this study. A holistic approach to Aboriginal & Torres Strait Islander health can be accommodated in the action research partnership approach particularly if key stakeholders in the Aboriginal & Torres Strait Islander community are involved. The action research partnership approach extends the NSW Summit Partnership agreement and contributes to health service planning in NSW.

The cogenerative participatory action research was demonstrated to be a method that ensured adequate Indigenous involvement and ownership of the participatory process. The process operationalised empowerment of the Aboriginal & Torres Strait Islander community. This method is based on the principles of increased democracy, political equality and social justice and was described by the Aboriginal & Torres Strait Islander participants as culturally acceptable. The method provided a forum for dialogue about the different perspectives on health and research in a responsive and respectful manner. The responsiveness of participatory action research in this study suggests it is a good research model for cross cultural and emancipatory work. It is a method that allows for research not only on Indigenous groups but also for Indigenous people.

It is essential that improvements are achieved in Aboriginal & Torres Strait Islander health status. One very positive goal would be that improvements in Aboriginal & Torres Strait Islander health status result in future Aboriginal & Torres Strait Islander people having the opportunity to enjoy the same level of health as non-Aboriginal people. The desire of Aboriginal & Torres Strait Islanders to take responsibility for their own health care must be encouraged, in order that health solutions can be developed which are effective, affordable, accessible and culturally appropriate. The solution provided by this Aboriginal & Torres Strait Islander Health Outcome Council was a self determining unit within a public health service, where Aboriginal & Torres Strait Islander wisdom and knowledge could flourish.

Limitations of the Research Design and Methodology

A case study design using a cogenerative action research process was considered appropriate for the investigation of an Indigenous partnership in the development and delivery of Mental Health Services because the process was exploratory and in a real life setting. The major limitations of this study are that 1) the findings and conclusions arise from a study of only one health service / Aboriginal & Torres Strait Islander community partnership, and 2) the researcher was both 'objective' observer and participant in the partnership. To overcome the limitations associated with case study research, the researcher followed the guidelines developed by Yin (1989). The steps taken to improve rigour are outlined in Table 5.1 on p 162.

To examine the data against the propositions this study utilised multiple sources of evidence including 3 cycles of action research with findings validated through consensus validation. Quantitative analysis of service utilisation data was considered separately and numerical trends were noted. Continued health service utilisation by Aboriginal & Torres Strait Islander consumers provided another measure of service acceptability as well as feedback regarding the community reputation of the Bugalwena Service.

The study was of two years duration with key findings being fed back to the Research Reference Group for validation. There was integration of the action research findings and the Aboriginal & Torres Strait Islander community feedback, which established a chain of evidence.

Table 5.1 : Strategies to Improve Rigour

Tests	Case-Study Tactic	Phase	Action
Construct Validity	Use multiple sources of evidence	Data collection	<ul style="list-style-type: none"> · 3 research cycles of : action and review · Statistical analysis of service utilisation by Aboriginal & Torres Strait Islander consumers · qualitative data from consumer evaluations · consumer feedback and community reputation · key findings were fed back to the participants for review and validation · those findings that were not sustained over time were dropped · integration of action research findings and community feedback · logical progression from research questions and data collection to conclusions. · each chapter of The Bugalwena Service:Our Story of a Partnership in Health, was read in draft by the Bulgawena Team and Aboriginal & Torres Strait Islander community members.
	Establish chain of evidence	Data collection	
	Have key informant review draft case study report	Composition	
Internal Validity	Do pattern matching	Data analysis	<ul style="list-style-type: none"> · service utilisation by Aboriginal & Torres Strait Islander consumers was available before, during and after the outcomes of the action research process were introduced. · service utilisation data was provided by Health Staff who were not involved in the study. · alternative/rival explanations were considered by the participants for all key findings · alternative hypothesis were proposed and considered for explaining events ie. other reasons for increased service utilisation. · service utilisation date was gathered over the 2 years.
	Do explanation building	Data analysis	
	Do time series analysis	Data analysis	
External Validity	Use replication logic in multiple case studies	Research design	<ul style="list-style-type: none"> · the methodological process can be generalised, not the outcome. · the key findings can be tested in other sites. · the service components can be tested in other sites. · this study was exploratory. · it was not expected that group dynamics would be replicated.
Reliability	Use case study protocol	Data collection	<ul style="list-style-type: none"> · the case study protocol was followed with detailed reporting · data collection was explicit and described in detail. · group interactions were guided by the 'democratic dialogue' guidelines, which were reported in detail. · the commitment to 'reciprocity' was detailed · a data base was established with pre and post measures.
	Develop case study data base	Data collection	

Source: Yin, R.K. (1989), Case Study Research Design and Methods. London Sage.

The production of the report titled The Bugalwena Service : Our Story of a Partnership in Health was edited by the principal researcher and each section was reviewed by the Research Reference Group. In this manner the information was 'checked' for validity by an extended group of the local Aboriginal & Torres Strait Islander community.

Through the process of consensus validation the Research Reference Group considered the causal line between the partnership and the increase in health service utilisation by the local Aboriginal & Torres Strait Islander community. They concluded the increase in health services being accessed by Aboriginal & Torres Strait Islander community members did not occur until the Bugalwena Team began to offer its telephone and support service in January 1996. The quantitative service utilisation data shows a marked increase at this time.

Substantial increase in service utilisation did not occur when the partnership was in existence from June 1994 - December 1995 rather when the recommendations resulting from the partnership were implemented. These recommendations involved Aboriginal & Torres Strait Islander people being the first point of contact for Aboriginal & Torres Strait Islander people in distress. Furthermore, the Bugalwena Team had come to know and trust the TVHS personnel they were recommending to their community.

Other concurrent activities may have been implicated in the increase in TVHS service utilisation by Aboriginal & Torres Strait Islander people, such as, the pamphlet

distribution advertising the Bugalwena Service and targeting Aboriginal & Torres Strait Islander groups. Media articles also gave a profile to the TVHS Aboriginal & Torres Strait Islander health role in general. Cultural awareness training and the appointment of an Aboriginal & Torres Strait Islander Mental Health worker contributed to the increase in health services being accessed.

To ensure the study had adequate internal validity, the findings were considered against the relevant literature informing the original proposition, namely that Indigenous participation based on a partnership of equals would promote the capacity of those involved to define, analyse and act upon the problems that concerned them, in particular, the mental health needs of local Aboriginal & Torres Strait Islander community members. Pattern matching with the literature is fully described in the Discussion section and concludes that this study confirms the work of other researchers such as, McKendrick et al., (1994), Eckermann et al., (1992), Legge (1992) and Labonte (1989).

The Research Reference Group considered alternative explanations and built explanations over time. Some data was sampled over time and the case study protocol was followed. However, this study was explanatory and based on a single site. The findings are confined to this one site although the process used to generate them is generalisable to other sites. As the principle researcher was a participant in the group process, it is likely that this participation affected what was being observed and the objectivity of the interpretations generated. While, the theoretical findings provided by this study are the result of the continued examination of internal findings against

other propositions, they represent one view among several potential explanations.

Yin (1989) suggests that three conditions be considered in the selection of a research methodology. They are, the type of research question, whether control over behavioural events is required and whether the research focuses on contemporary or historical events. The answers to these questions will direct the researcher to the most appropriate research method. The research question in this study was exploratory and informed by limited theoretical concepts as Indigenous participation in health service's is relatively unresearched. As in all real life contexts control over behavioural events was not considered possible. There were many variables from a wide range of sources that could potentially have impacted on the process under investigation. The study was not based on a historical review and was contemporary. These factors resulted in the selection of the case study model as an appropriate method to investigate Indigenous participation into health service delivery and planning.

One of the strengths of the case study design is that the method can accommodate tracing operational links over time and utilise multiple sources and types of data. This process adds to the internal validity of the findings. In this study, internal validity was strengthened through the collection of multiple sources of evidence over time, namely two years. The sources of data included; the Community Health and Mental Health Service utilisation data, the Bugalwena Service utilisation data, consumer evaluation data, (the Research Reference Group) and feedback from the wider Aboriginal & Torres Strait Islander community.

A further strength of the case study methodology is the ability to provide an in depth view of the context and dynamics of a given phenomenon over time. For example, the inter relationships between the dominant western medical ideology and the minority Indigenous populations' view of health and illness were complex and required a research model able to accommodate differing perspectives and clarify the important issues.

Case studies have been criticised (Bryman, 1989) for allowing equivocal evidence and biased views to dictate the findings and conclusions. A method used to avoid bias and increase rigour in this study was, the constant matching of key findings with the literature. In addition the findings were systematically reported back to the study participants where they were critically evaluated and checked against alternative propositions. This process of consensus validation occurred throughout the two years of the study.

With case study research, the issue of replicability is problematic because of the unique characteristics that may apply. Furthermore, the personal and idiosyncratic nature of human interactions involved in the action research process introduces the potential for a biased perspective. The interpersonal group dynamic was a combination of the committed Aboriginal & Torres Strait Islander Health Outcome Council and the personal commitment of the researcher. Trusting relationships cannot be imposed through a research process and depend on the people involved. While the findings from this study cannot be generalised to other situations involving Aboriginal & Torres Strait Islander communities and public health services, it does

provide new insights into the relational dynamics required for constructive multi-cultural dialogue. This could only be achieved through the use of research methodology that facilitates focused observation over an extended period of time.

The findings arising from the evaluation of Aboriginal & Torres Strait Islander consumer satisfaction suffered considerable limitations due to the small numbers (14 persons). However, the high levels of satisfaction expressed with the TVHS and the Bugalwena Service were consistent with the subsequent utilisation and add weight to the conclusion that the Aboriginal & Torres Strait Islander community are experiencing the TVHS as appropriate.

The amount and variety of the data that was produced over a two year period made data management and analysis difficult because of the enormity of the task. The time, energy and commitment required (Locke, 1989) were considerable. The entire exercise would not have been possible without the allocation of resources by the TVHS which allocated four hours per week of one TVHS staff member throughout the project. The Grant from the Health Outcomes Branch (NSW Health Department) facilitated the production of a report that documented the process.

The set of essential service components that led to the development of an acceptable and utilised service must be considered along with the building of the relationship of trust which may have had a far greater impact on the local Aboriginal & Torres Strait Islander community. The knowledge obtained in this study is valid for the Aboriginal & Torres Strait Islander community and the TVHS who participated.

6. CONCLUSION, RECOMMENDATIONS AND AREAS FOR FURTHER RESEARCH

Conclusions

This study confirms the proposition that the development of an Aboriginal & Torres Strait Islander / public health service partnership based upon Labonte's (1989) principles of community empowerment would result in changes in health service delivery and increased service utilisation and satisfaction by members of the Aboriginal & Torres Strait Islander community.

The study demonstrates that a partnership between the TVHS and the Aboriginal & Torres Strait Islander community provided advice on culturally appropriate methods of service delivery, facilitated access to the TVHS for Aboriginal & Torres Strait Islander consumers, created a forum and dialogue for continued TVHS review and improvement and provided increased access to decision making and planning of local TVHS's for the Aboriginal & Torres Strait Islander community.

The participants in the cogenerative participatory action research produced a set of components for the development of effective Aboriginal & Torres Strait Islander Health Services. In order to adopt these components, the TVHS was required to assume a facilitative role rather than a leadership role. The service requirements were:

- ▶ that the health service develop a 'culture' that is accepting of Aboriginal & Torres Strait Islander community participation in health service planning and delivery;

- ▶ that the health service acknowledge that life is experienced as stressful for Aboriginal & Torres Strait Islander's with grief and loss being experienced more frequently by members of the Aboriginal & Torres Strait Islander community than by members of the non-Aboriginal & Torres Strait Islander community;
- ▶ that the health service acknowledge their existing facilities discriminate against Aboriginal & Torres Strait Islander persons;
- ▶ that the first point of contact with the health service for an Aboriginal & Torres Strait Islander person in distress should be with an Aboriginal & Torres Strait Islander person;
- ▶ that the service should be available 24 hours per day and able to provide an outreach service;
- ▶ that the re-designed health service represents an Aboriginal & Torres Strait Islander solution to health problems.

The adoption of these service components resulted in the development of a new Aboriginal & Torres Strait Islander Service. The choice of an Aboriginal solution became available. The Bugalwena Service provided the opportunity to bring Aboriginal & Torres Strait Islander knowledge and wisdom about healing to their own community.

It was concluded that the three action research cycles of problem, planning, action, analysis and reflection over two years provided a context for the application of solutions developed and suggested by local Aboriginal & Torres Strait Islander people for their own community. As each change was implemented, the group were able to check the information for validity. The process was Aboriginal & Torres Strait Islander generated and owned. The outcome resulting in the formation of Aboriginal & Torres Strait Islander persons into the Bugalwena Service, is unique to this local area, however the participatory action research method for health service development and review is applicable for use by any health service.

This study concludes that participatory action research is a useful method for facilitating Aboriginal & Torres Strait Islander community participation in health service planning and delivery. The action research method differs from prevailing, consultative approaches to community participation in health care planning and delivery. Unlike consultation which implies that decision making power remains with the Area Health Service, action research provides a forum for the development of a genuine partnership. Furthermore, the action research method provides a context for democratic dialogue over time.

This study concludes that participatory action research facilitates continuous service review and improvement as the needs of the local community change and concludes that participatory action research can empower citizens and demedicalise health service as long as the recommendations generated by the Research Reference Group are honoured by the health service. Most health services are inexperienced and under

resourced for this type of planning. If health services fail to honour the recommendations of the partners the process could end up consolidating the power of professionals and reinforcing the status quo. In so doing those people most in need of health services will remain poorly served.

The study concludes that the decision to share power is a political position. To move towards shared or community ownership of health services requires a genuine redistribution of power. For health services to provide culturally acceptable methods of practise it is necessary first to acknowledge they are not 'cultural experts'.

Furthermore, there is not a single Aboriginal & Torres Strait Islander culture or knowledge. Each community is in some respects unique. Hence, no white health service holds the necessary expertise to make decisions on behalf of the community and advice needs to be sought from the local Aboriginal & Torres Strait Islander communities. Experience in group dynamics and the ability not to solve issues but to pose questions is required by the health service personnel. To provide solutions was considered to have further obscured the Aboriginal & Torres Strait Islander view.

This may be a limitation when most health service managers are very good at managing and problem solving. However managers trained in quality improvement can resist becoming 'experts' and assist in the creation of the new explanatory framework.

This study concludes that participatory action research can contribute to local Aboriginal & Torres Strait Islander community development and empowerment through validation of the wisdom and knowledge of the members of the Aboriginal &

Torres Strait Islander community. This study confirms the recommendations of the New South Wales Health Summit Partnership Agreement, particularly the recommendation which states that health providers should “ensure that the expertise of Aboriginal & Torres Strait Islander communities is brought to health care processes (Guiding Principle No 2).

Recommendations

It is recommended that health services actively support culturally appropriate practices by all staff, including the appointment of Aboriginal & Torres Strait Islander persons to Health Outcome Committees, affirmative employment practices and Cultural Awareness Training.

It is recommended that health services identify their local Aboriginal & Torres Strait Islander community key stakeholders and develop a forum and a dialogue for continual service review in partnership with their local Aboriginal & Torres Strait Islander community.

It is recommended that health services acknowledge the adverse social environment and history of discrimination for Aboriginal & Torres Strait Islanders.

It is recommended that access to health services for Aboriginal & Torres Strait Islander communities be identified at the local health service level and that these issues be resolved in partnership with local Aboriginal & Torres Strait Islander communities.

It is recommended that wherever possible health services for Aboriginal & Torres Strait Islander persons be provided by Aboriginal & Torres Strait Islander trained staff and that Aboriginal & Torres Strait Islander self determination be the goal for health services.

It is recommended that local Aboriginal & Torres Strait Islander communities be involved in the strategic planning of the health service to inform needs analysis and service planning. Strategies to address identified health needs must be developed in partnership with local Aboriginal & Torres Strait Islander communities, to allow for Aboriginal & Torres Strait Islander knowledge and wisdom to be utilised.

It is recommended that health services give appropriate attention and time to build up a relationship of trust and respect with their local Aboriginal & Torres Strait Islander community. This process may take up to 5 years, as there is a history of institutional discrimination to overcome.

It is recommended that health services utilise participatory action research as a method for operationalising Aboriginal & Torres Strait Islander empowerment as this results in Aboriginal & Torres Strait Islander community development and increases health service utilisation with the potential to improve health status in the long term.

Areas for Further Research

This study facilitated increased access to and utilisation of Community Health and Mental Health Service by Aboriginal & Torres Strait Islander consumers. Further

research is recommended to examine whether this increased service provision results in improved Aboriginal & Torres Strait Islander health status. Health outcome based research is in the initial stages and needs further investigation. This study resulted in the creation of an Indigenous Health Service. Further studies taken from a health gain perspective could examine outcomes of care with a holistic treatment method.

Action research was demonstrated to be a valuable tool in establishing constructive partnerships where the perspectives on health and research are different. It was a method that was particularly applicable in a cross cultural setting requiring the blending of the dominant western ideologies and the minority Indigenous view.

Further work with Indigenous groups would be valuable. The case study approach using action research as a method for health service development and planning has been demonstrated to be valuable. It may be that the model is suitable where there are identifiable differences in power and knowledge such as, the development of Cardiac Rehabilitation Services where surgeons and consumers can both provide essential but different perspectives.

This study is an example of the establishment of an Aboriginal & Torres Strait Islander partnership and replication of the method in additional sites would add validity. Further studies are necessary to examine durability of the partnership process. The participatory action research method facilitated access to the traditional health service with its distinctions based on artificial medical categorisation. Further work is required to facilitate Aboriginal & Torres Strait Islander holistic healing methods within the TVHS. The service components thought to be essential, can now

be tested and validated in other sites.

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APPENDICES

- Appendix 1. Consumer Evaluation Form
- Appendix 2. Bugalwena Team Pamphlet
Bugalwena Kids Pamphlet

HAS THE BUGALWENA SERVICE BEEN HELPFUL?

WE WOULD LIKE TO KNOW YOUR OPINION

questionnaire is anonymous so please do not put your name on it. Post it in the envelope, or put it in the box at the front of the Minjungbal Centre or the box at the reception desk of Tweed Community Health.

Was your first contact with the Bugalwena Service

☐ not good ☐ okay ☐ helpful ☒ very helpful

Was the Bugalwena Service easy to get hold of

☐ no, difficult ☒ okay ☐ easy

Were you happy with what happened when you spoke to the Bugalwena Team?

☐ not good ☐ okay ☐ happy ☒ very happy

Did they suggest you see or talk to someone else.

☐ Yes ☐ No

Did you see someone else

☐ Yes ☐ No

Which Service did you see

Would you rate the health service as

☐ not good ☐ okay ☐ good ☒ above average

Would you use this health service again

☒ Yes ☐ No

Would you advise a friend to use the Bugalwena Service

☒ Yes

☐ No

If no - why not _____

The problem that you first went to the Bugalwena team with - is it

☐ Worse

☐ the same

☐ better

☒ resolved

Would you say you had

☐ a poor outcome

☐ a good outcome

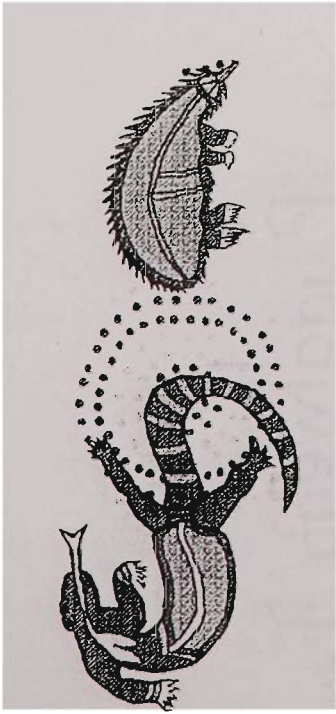
☒ an above average
outcome

Any comments:

_____ very good keep it up _____

Thank you for completing this evaluation. We need your ideas to improve the service.

We que



This Team is here
to help you, in
confidence

Are you feeling distressed, blue,
sad, lonely, do you feel there
is no one to turn to?

This is Aboriginal people being
there for one another.



People to Contact

MONDAY

Dale - *anytime*

(07) 55 247497

MONDAY - SATURDAY - 5.00am - 9.00pm

Desrae (07) 55246398 home

(07) 55242275 work

Carol (07) 55364264 home

(07) 55250099 work

Aunty Kath (07) 55243058

THURSDAY

Leweena *Evening* (07) 55 365535 H

MONDAY - FRIDAY 9.00am - 5.00pm

Sue Follent (07) 55 362434 W

Dana Williams (07) 55 360597 W

Terry (07) 55 369955 W

Kevin (07) 55 360577 W

SUNDAY

Margaret *Anytime* (07) 55 245198

Geof Togo *Anytime* (07) 55 360 999

Pastor Allan Watego

Spiritual Advisor (07) 55242966

If you cannot
contact anyone
please call

(07) 55 360 444

and ask
for the Crisis
Service
for

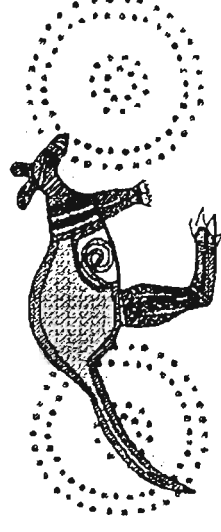
an emergency

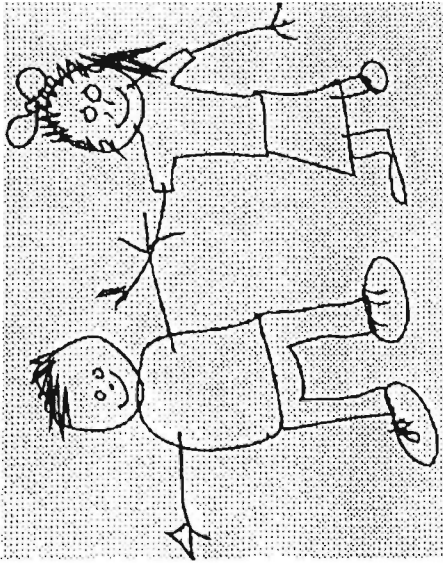


The Bugalwena Tears

Do you need to talk to someone?

*This is Aboriginal people being
there for one another.*





THIS TEAM IS
HERE
TO
HELP YOU, IN
TRUST

ARE YOU FEELING
STRESSED OUT,
DOWN, SAD, LONELY
YOU FEEL THERE IS NO
ONE TO TURN TO?

THIS IS KOORI PEOPLE
BEING THERE AND
CARING
FOR ONE ANOTHER.

People to Contact

MONDAY

Aunty Dale - anytime (07) 55 247497

MONDAY - SATURDAY - 5.00am - 9.00pm

Aunty Desrae (07) 55246398 home

(07) 55242275 work

Aunty Carol (07) 55364264 home

(07) 55250099 work

Aunty Sue (066) 761185 home

Aunty Kath (07) 55243058 home

5.00PM - 10.00PM ONLY

Selwyn (07) 55346770 home

David (066) 761185 home

THURSDAY

Leweena Evening (07) 55 365535 H

MONDAY TO FRIDAY - 9am - 5.00pm

Aunty Sue (07) 553623424 W

Dana 9 - 5 (07) 55 360597 W

Terry Corowa (07) 55 369955 W

Kevin Slabb (07) 55 360577 W

SUNDAY

Aunty Margaret Anytime (07) 55 245198

Uncle Geof Togo Anytime (07) 55 360 999

PASTOR ALLAN WATGGO

SPIRITUAL ADVISOR

(07) 55242966

IF YOU
CANNOT
CONTACT
ANYONE
PLEASE CALL
(07) 55 360444
AND ASK
FOR THE
CRISIS
SERVICE
FOR
AN
EMERGENCY

KIDS ONLY

DO YOU NEED TO
TALK TO SOMEONE?



THIS IS ABORIGINAL
PEOPLE BEING THERE
FOR ONE ANOTHER.