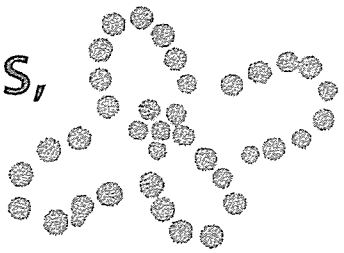
CHAPTER 4

ABORIGINAL YOUTH: CHALLENGES, STRENGTHS AND OPPORTUNITIES



David Vicary and Tine Hoult

Overview

There is a growing awareness of the health disparities between Aboriginal and non-Aboriginal Australians. Addressing disparities in health outcomes presents many challenges but also provides opportunities for Aboriginal people, and particularly for Aboriginal youth, to become involved in the development of programs. Aboriginal youth often grow up in circumstances that may inhibit successful uptake of those opportunities because, in comparison to the wider population, they fare poorly in terms of life expectancy, housing, employment, physical and mental health, education and exposure to racism. They also are over-represented within the justice and welfare systems, and have greater exposure to substance abuse and violence, as well as family and cultural upheaval. Despite this, they have demonstrated remarkable resilience in their ability to achieve goals and make a significant difference to their families, communities and personal future.

This chapter will provide a brief synopsis of the challenges, strengths and opportunities confronting Aboriginal youth in a number of areas including **health** (both physical and mental), education and the justice system. A model of engagement for non-Aboriginal professionals working with Aboriginal youth also will be presented as a potential tool for facilitation and advocacy.

Introduction

Aboriginal youth are confronted by many challenges that may inhibit the achievement of life goals. Despite these challenges, increasing numbers are demonstrating their leadership and their potential by achieving personal, family and community recognition. Some Aboriginal youth are not only demonstrating leadership within their communities but also an influence and impact at state and national levels. Tanya Major, the 2007 Young Australian of the Year, is an example of a young Aboriginal woman whose ability to inspire others, coupled with her forthright eloquence, is having an impact beyond her own community in Cape York, Queensland. As with all Young Australians of the Year, she provides a great role model for Aboriginal and non-Aboriginal young people, and some of her achievements will be outlined later in this chapter.

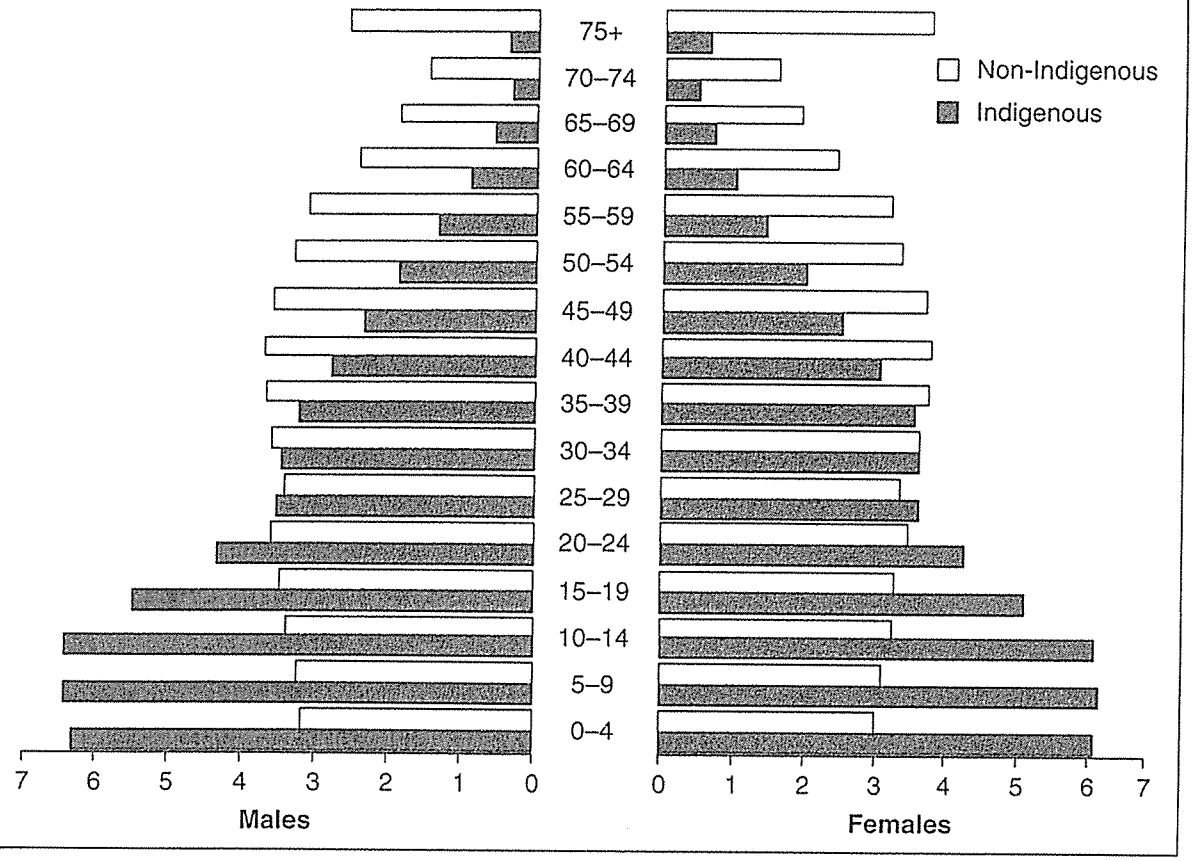
Aboriginal youth are making their presence felt in the arts (especially dance and theatre), education, sport, business and politics. The success of some Aboriginal youth, however, is a poignant reminder of the many who, because of the overwhelming challenges they face, are struggling to reach or, in some cases, even set goals.

For the purposes of this chapter, youth will be defined as those persons between the ages of 15 and 24 years, under the definition prepared for International Youth Year (1985) and endorsed by the General Assembly of the United Nations (United Nations, 1985). Interestingly, the definition of the term 'youth' often varies from country to country, depending on the specific social, economic, political and cultural circumstances. For example, in some Aboriginal communities young people are considered to have achieved adulthood much earlier than their mainstream counterparts, who are generally considered adults when they reach 18 years of age. In some cases Aboriginal young people are considered as adults by their family and community (due to completion of cultural obligations and initiations), but as adolescents by the majority of the non-Aboriginal community. In this chapter the term 'youth' is more inclusive and considers young adolescents as part of the youth cohort. The following section will provide an overview of the demographics of Aboriginal youth in Australia.

The demographics of Aboriginal youth in Australia

Data on Aboriginal youth (15–24 years) sometimes is difficult to extract from government reports as this age group forms a sub-set of other age categories. Figure 4.1, however, which records age distribution by Indigenous status, does

Figure 4.1 Estimated resident population, by Indigenous status and age – 2006 (preliminary)



Source: ABS & AIHW (2008), *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, p. 4. © Commonwealth of Australia.

identify this group and reveals a higher proportion of Indigenous youth in the 15–19 year and 20–24 year categories compared to their non-Indigenous counterparts. The Australian Bureau of Statistics and the Australian Institute of Health and Welfare (ABS & AIHW, 2008, p. 4) also note that the Indigenous population is relatively young. The median age is 21 years compared to 37 years in the non-Indigenous population. This reflects shorter life expectancy and higher fertility rates in the Indigenous population, as is clearly evident in Figure 4.1.

It is widely recognised that education is a key determinant of improved health outcomes. Education is linked to enhanced health information and knowledge, and also to employment prospects. As discussed later in this chapter, efforts to encourage Aboriginal youth to remain at school beyond the compulsory leaving age are having a positive effect (ABS & AIHW, 2008, p. 17). Table 4.1 indicates that while school retention rates for Indigenous students lag considerably behind those for non-Indigenous students, the trends between 1998 and 2007 reveal a narrowing of the gap. When comparisons are made with older Aboriginal people it is readily apparent that some

Aboriginal youth are benefiting from initiatives to improve school retention rates. 'The proportion of Indigenous people who have completed Year 12, as shown in the 2006 Census, ranged from 36% of people aged 18–24 years to 9% of people aged 55 years and over' (ABS & AIHW, 2008, p. 17).

Table 4.1 **Apparent school retention rates by Indigenous status – 1998–2007**

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
	%	%	%	%	%	%	%	%	%	%
To Year 9										
Indigenous	95.0	93.9	95.5	96.5	97.8	96.8	97.2	99.2	98.4	97.5
Non-Indigenous	99.7	99.9	99.8	99.9	99.9	99.9	99.9	99.9	100.0	100.4
Difference (percentage points)	−4.7	−6.0	−4.3	−3.4	−2.0	−3.1	−2.7	−0.7	−1.6	−2.9
To Year 10										
Indigenous	83.3	82.0	83.0	85.7	86.4	87.2	85.8	88.3	91.4	90.5
Non-Indigenous	97.4	97.9	98.0	98.4	98.5	98.9	98.5	98.6	98.9	99.7
Difference (percentage points)	−14.1	−15.9	−15.0	−12.7	−12.1	−11.7	−12.7	−10.3	−7.5	−9.2
To Year 11										
Indigenous	52.3	56.0	53.6	56.1	58.9	61.4	61.1	62.3	67.7	69.7
Non-Indigenous	85.4	86.4	86.2	87.6	88.7	89.5	89.0	88.3	88.8	89.4
Difference (percentage points)	−33.1	−30.4	−32.6	−31.5	−29.8	−28.1	−27.9	−26.0	−21.1	−19.7
To Year 12										
Indigenous	32.1	34.7	36.4	35.7	38.0	39.1	39.8	39.5	40.1	42.9
Non-Indigenous	72.7	73.2	73.3	74.5	76.3	76.5	76.9	76.6	75.9	75.6
Difference (percentage points)	−40.6	−38.5	−36.9	−38.8	−38.3	−37.4	−37.1	−37.1	−35.8	−32.7

Source: ABS & AIHW (2008), *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, p. 16. Reproduced with permission. Editors' explanatory note: due to rounding and confidentiality issues related to small numbers, some discrepancies may be apparent, including reference to 100.4% in the final column.

The association between education and employment prospects is strong, and the ABS & AIHW (2008, p. 20) have observed that 'Indigenous people who had completed Year 12 were more than twice as likely as those who had completed school to Year 9 or below to have a full time job'. For Aboriginal youth (18–24 years) the difference is striking, with the rate of full-time employment being four times higher for those who have completed Year 12.

Despite the advances in education and employment outcomes, many Aboriginal youth remain disadvantaged in comparison with their non-Aboriginal counterparts. The impact of past policies and practices weighs heavily on many affected families and as a result young people may be living in social contexts that are not conducive to their health and wellbeing. The impact of social environments upon health and behaviour is examined in the following section.

The social context of Aboriginal youth

In order to appreciate the challenges facing many Aboriginal youth it is important to understand the contexts in which they find themselves. These contexts, of course, vary enormously across the country, and the impact of past policies and practices is felt differently. While there has been an increasing recognition of Aboriginal disadvantage during the last 20 years, and successive government attempts to address these inequities, Aboriginal people remain considerably disadvantaged compared to their non-Aboriginal counterparts. Quality of life, life expectancy and equality of opportunities remain significantly lower for this population. Numerous studies over the last 20 years have highlighted the fact that Aboriginal people continue to experience greater poverty than non-Aboriginal Australians, and have higher rates of unemployment, more inadequate housing, poorer participation in and completion of education, and poorer access to clean water, waste disposal and utilities than other Australians (ABS & AIHW, 2005; AIHW, 2004; AMA, 2002; Raphael & Swan, 1997; Task Force on Aboriginal Social Justice, 1994; Vicary & Andrews, 2000, 2001).

Kosky (1997) noted that Aboriginal young people were over-represented in prisons by a factor of 14 and in police custody by a factor of 26. Almost a decade later it appeared that little had changed. In 2006 the Australian Bureau of Statistics noted that Aboriginal people were 13 times more likely than their non-Aboriginal counterparts to have been incarcerated. Further, the ABS recorded that there were 6091 Aboriginal people incarcerated in Australia, representing 24% of the total prisoner population (ABS, 2006e). Of those

prisoners, 91% were males, with the highest age standardised rates of incarceration found in Western Australia (3385 per 100 000), New South Wales (2382 per 100 000) and Queensland (1877 per 100 000) (ABS, 2006e).

The ABS found that 21% of Aboriginal youth reported that they had been arrested by police in the last five years, with 8% being incarcerated. The rates of incarceration and arrest for young Aboriginal males were more than twice as high as those for young females (ABS, 2004). Aboriginal youth continue to be over-represented in the Australian prison system. Contact with the criminal justice system is associated with poorer health and socioeconomic outcomes for young Aboriginal Australians. Those aged 15–24 years who had been arrested or incarcerated in the last five years were more likely than those who had not been arrested and/or incarcerated to be unemployed, to have left school before Year 10, to have relatives who were removed from their natural families and to have been a victim of physical or threatened violence (ABS, 2006d).

Another example of the inequality between Aboriginal and non-Aboriginal people can be observed through the practice of removal. Australian children and young people in general continue to enter out-of-home care at an alarming rate. Since 2002 there has been a 51% increase in the number of children and young people residing in alternative care (AIHW, 2008). In mid-2006 there were 28 411 children and young people living in departmentally sanctioned placements in Australia (AIHW, 2008). The number of Aboriginal children residing in out-of-home care was over six times the rate for children in the wider community (AIHW, 2009). It should be noted that the AIHW's use of the term 'children' refers to those up to the age of 17 years.

The Australian Institute for Health and Welfare (AIHW, 2009, p. 63) report notes that:

> At 30 June 2008, there were 9074 Aboriginal and Torres Strait Islander children in out-of-home care, an increase of 1182 since 30 June 2007. The rate of Aboriginal and Torres Strait Islander children in out-of-home care across Australia at 30 June 2008 was 41.3 per 1000 Indigenous children aged 0–17 years. The rates ranged from 11.3 per 1000 in the Northern Territory to 66.3 per 1000 in New South Wales. In all jurisdictions, there were higher rates of Aboriginal and Torres Strait Islander children in out-of-home care than other children.

Many Aboriginal young people remain victims of past policy and practices (Blair, Zubrick & Cox, 2005). Some have indicated that factors described previously are now affecting their generation. This generation ultimately will

produce the Aboriginal leaders of the future and many will have had personal experience of the legacy of recent Aboriginal history. For example, earlier studies have suggested that about 20% of Aboriginal children and youth have diagnosable mental health issues (Webber, 1980) and more recent evidence indicates that emotional and behavioural difficulties are likely to be found in this cohort (Zubrick et al., 2005). Such difficulties clearly impact on their potential for learning and forming close relationships.

Furthermore, abuse and neglect also affect Aboriginal young people (Ford, 2000). The Secretariat of National Aboriginal and Islander Child Care (SNAICC) have developed a prevention plan to combat these issues. Notably this action plan emphasises the importance of both current and historical issues and strongly argues the case for prevention as opposed to reaction. This plan recommends strategies that are grounded in the issues associated with colonisation, the Stolen Generations, racism, self-determination and Aboriginal child rearing practices, including the contribution of kin and Elders. Importantly, the program recognises the requirement of a holistic approach, a synthesis of both Indigenous and Western methodologies, to deal with the prevention and treatment of child abuse and neglect amongst Aboriginal children and youth (SNAICC, 1996, 2006).

In some cases there are similarities in the frequency of mental and behavioural problems experienced by Aboriginal youth compared with those experienced by their non-Aboriginal peers (Hunter, 1993). Hunter notes that while there may be a similar frequency between the two populations, Aboriginal children and youth are often disadvantaged in that they and their families are not able to access appropriate services. Further, Hunter highlights that some behaviours and mental illnesses, including depression and anxiety, may be reactions to racism, dispossession, disadvantage and perceived oppression. Many authors have argued (Brady, 1991; Brown, 2008; Harris & Robinson, 2007; Vicary & Andrews, 2000, 2001; Vicary, 2002; Vicary & Westerman, 2004) that psychosocial health problems, historical and contemporary issues, early parenthood, poor environment, interpersonal and family violence, and poor physical health all contribute to, and exacerbate, negative outcomes for Aboriginal youth.

Past policies continue to affect subsequent generations of Aboriginal youth. This perhaps is exemplified by victims of the Stolen Generations (Human Rights and Equal Opportunity Commission Report, 1997). The effects upon victims and families of the Stolen Generations are both profound and ongoing. Children who were removed, and families who had members

taken, continue to feel deeply affected by the experience and demonstrate a wide range of psychological symptoms as a result of this practice (Zubrick et al., 2005). Psychological reactions include inconsolable grief and loss, post-traumatic stress disorders, low self-esteem, powerlessness, anger, depression, anxiety, suicide and self-harm. While the practice of removing children ceased in the 1970s, today's youth are often affected by the experiences and suffering of their parents and grandparents. Subsequent alienation from cultural and kinship ties and poor relationship skills may further exacerbate the situation for vulnerable youth (ALS, 1995; Swan & Raphael, 1995; Zubrick et al., 2004).

The social and cultural problems experienced by victims of the Stolen Generations have caused further disadvantage to those who were removed from their families (ALS, 1995; Zubrick et al., 2005). Some of these social and cultural consequences include lack of quality education (at missions, reserves and in the public education system), identity confusion and inability to fit into the non-Aboriginal or Aboriginal communities, abuse and neglect experienced while in care, lack of access to cultural information and heritage, involvement in the criminal justice and welfare systems, and poor parenting role models (Swan & Raphael, 1995). Aboriginal people continue to have a higher rate of suicide than non-Aboriginal Australians. Western Australian data indicate that the number of recorded suicide deaths for Aboriginal young people is disproportionate to that of non-Aboriginal young people (Hillman et al., 2000). The suicide rate within Aboriginal communities is approximately twice that of other Australians (ABS & AIHW, 2005).

Aboriginal deaths continue to exceed those of non-Aboriginal people at all ages (Aoun & Johnson, 2002; Harris & Robinson, 2007; Swan & Raphael, 1995). Attention has been drawn to the prevalence of chronic diseases in this population in other chapters of this book. It has been noted that communicable and preventable diseases contribute to higher levels of hospitalisation and premature death among the Aboriginal population compared with the non-Aboriginal population. The trauma associated with untimely deaths perpetuates cycles of grief that are often associated with past and present policy failures. Further, the effects of discrimination and racism create levels of uncertainty, low self-esteem and distress among many Aboriginal people (Noel Pearson, personal communication, November 2009).

The historical losses and separations experienced by Aboriginal families are compounded by adverse health conditions. In the 1990s, the Royal

Commission into Aboriginal Deaths in Custody (1991) and the Burdekin Report (1993) focused attention on the range of mental health issues that arise from, or are associated with, the previously described adverse circumstances (see Zubrick et al., 2005). As Raphael and Swan (1997) point out, to further understand Aboriginal mental and physical health, Aboriginal people's conceptualisations of the notion of health must be explored. This understanding will enhance health service delivery for all Aboriginal people, but in particular services directed to those youth who exhibit signs of vulnerability.

Concepts of health

Aboriginal people may view the concept of health differently from their non-Aboriginal counterparts. These different views pertaining to health may impact on the way Aboriginal youth engage with the mainstream health system and their potential health outcomes. For example, Smith (2007, p. 109) notes the importance of spirituality in an Aboriginal conception of health. She suggests that Aboriginal concepts of health are holistic and refers to the definition by the National Aboriginal Health Strategy Working Party (1989), which states that

> health is not just the physical well-being of an individual, but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life–death–life' (Smith, 2007, p. 109, citing NAHS Working Party, 1989, p. x).

Waldegrave (1985; 1990) states that Westerners wedded to a biomedical model of health (unlike Aboriginal or other First Nations' Peoples) have generally ignored the relationship between the physical and spiritual world and the potential for an interrelationship between the two. Further, Shelldrake (1990) observes that the Western preoccupation with obtaining material acquisitions is detrimental to understanding the importance of spiritual values and their interrelationship with physical health. Sambono (1993), among others (see Vicary & Andrews, 2000, 2001; Vicary, 2002; Westerman, 2000, 2003), concluded that the Aboriginal **world view** is different from the Western world view, and argued that physical and mental health services should be integrated so that Aboriginal clientele have the best of both worlds. According to Seru (1994), Aboriginal and Torres Strait Islander people have the right to health care that is appropriate to their **culture**, location, age, gender and level

of education. She stated that those health workers intending to work in remote communities should listen, observe and show respect. If this process is undertaken appropriately, acceptance by the community should follow. Like Seru, other authors (Vicary & Andrews, 2000, 2001; Vicary, 2002; Westerman, 2000, 2003; Zubrick et al., 2004) also have stressed that Aboriginal people are not a homogenous population; instead they have a range of languages, lifestyles, cultural beliefs and practices that may differ from one community to the next. An understanding of this diversity, particularly as it relates to health beliefs and practices, is essential for all health care practitioners working in Aboriginal contexts.

The physical and emotional health status of Aboriginal youth

The National Aboriginal and Torres Strait Islander Health Survey (ABS, 2006c), which was conducted in 2004–05, revealed that Aboriginal youth generally enjoy good physical health. This survey found that 59% reported being in excellent or very good health. Thirty-two per cent reported that they were in good health, with 9% considering they had poor health. Despite these relatively promising results, it is important to note that these findings are based upon self-perceptions of health that may be influenced by more frequent exposure to episodes of illness. Therefore these findings should be interpreted with some caution.

The Western Australian Aboriginal Child Health Survey (Zubrich et al., 2004) is a seminal research project that investigated both the physical and mental health status of Aboriginal children and young people in Western Australia. It is the first survey of its type in Australia and given the logistics and cost it is unlikely to be repeated in the near future. What WAACHS provides is a unique window into the physical and emotional health of Aboriginal children and young people.

As part of the survey process 5289 children were studied and of these 1480 were between the ages of 12 and 17 years. The WAACHS found that many Aboriginal young people suffer from recurring gastrointestinal, ear and skin infections (Blair, Zubrick & Cox, 2005). Recurrent ear infections resulted in speech, hearing and learning difficulties in the young people interviewed. Further, the survey found that Aboriginal young people are more likely to be asthmatic (24.4% versus 17.3%) and use medication (12.9% versus 8.7%) when compared with their non-Aboriginal peers. The WAACHS also found

that many Aboriginal youth had poor oral health and vision compared to non-Aboriginal youth (Zubrick et al., 2004).

In terms of preventative health the WAACHS found that Aboriginal young people had insufficient physical exercise compared to their non-Aboriginal counterparts (Zubrick et al., 2004). The researchers found that these young people also had less contact with all types of health professionals apart from Aboriginal Health Workers, community controlled health services and nursing staff. Just over 74% of all Aboriginal young people surveyed had had sexual intercourse and of these, half had had sexual intercourse before 16 years of age. They did note, however, that over 70% of Aboriginal young people had received information on the prevention of pregnancy and sexually transmitted diseases. Of the young people who were sexually active, most relied upon condoms to prevent pregnancy, with this declining in proportion with age (Blair, Zubrick & Cox, 2005). The WAACHS (Zubrich et al., 2004) also found that 33% and 21.9% of 17- and 16-year old females respectively had been pregnant at least once.

In an early study of psychosocial problems involving interviews with 172 Victorian Aboriginal adolescents, Gault, Krupinski and Stoller (1970a) found that the degree of psychoneurotic disorders evident in this cohort did not differ significantly from those found in a similar non-Aboriginal population. The authors noted, however, that there was significantly more social maladjustment, antisocial behaviour and delinquency among the Aboriginal respondents. The prevalence of psychosocial disturbances found by the authors was hypothesised to relate to the family and social backgrounds of the Aboriginal adolescents interviewed in the study. Another study by Gault, Krupinski and Stoller (1970b) compared the social background of Aboriginal and non-Aboriginal adolescents living in the Kimberley town of Derby in Western Australian. They found that Aboriginal adolescents with strong traditional ties were more likely to demonstrate greater rates of psychosocial disturbance, delinquency and antisocial behaviour compared with other Aboriginal and non-Aboriginal adolescents. The authors found that this rate was related to the Aboriginal youth's poor socioeconomic environment, rapid life changes resulting from their family's recent move to town, and their lack of preparation for school and work.

Zubrick et al. (2004) found that when they administered a 'Strengths and Difficulties Questionnaire' to carers, they rated 20.5% of Aboriginal young people as being at high risk of behavioural and emotional problems. This was markedly different from their non-Aboriginal peers, of whom only 7% were at risk of emotional and behavioural problems.

Suicides and misadventure

Studies investigating self-harm among the Aboriginal population have indicated that the rates of suicide and self-harming behaviour are in the range of 6–21% higher than for the non-Aboriginal population. Kyaw (1993) reflected that a number of studies investigating suicide found that high risk factors for self-harming behaviours included previous attempts, alcohol abuse, living in a town and being a young Aboriginal male. Precipitating factors for self-harm were identified as family rejection, domestic violence, intoxication and marital disharmony. Dominant psychological experiences at the time of a suicide attempt include fear, anger, sadness, shame and hallucinations. Kyaw concluded that the combination of intoxication, shame, fear and anger are influential triggers for Aboriginal people with suicidal intent.

Although heart disease is the most common cause of death in the Aboriginal population, there also has been an alarming increase in deaths from external causes (Hunter, 1991a; Hunter & Milroy, 2006; McCoy, 2008). Hunter noted that suicide, homicide and motor vehicle accidents in the Kimberley region of Western Australia were major contributors to premature mortality during young adult life, particularly for males. He suggested that alcohol-affected behaviour by males was one of the factors behind the increasing rate of suicide, homicide and motor vehicle accidents. Hunter (1991b, p. 661) notes that 'statements regarding the absence of suicidal and other self-harmful behaviour among Australian Aborigines are now untenable'. Further, Hunter (1991b) found that 76.4% of the males and 45.6% of the females over 15 years of age were current drinkers; with only 5.0% of these males and 3.3% of these females drinking within safe levels. This extensive use of alcohol has a mediating sociocultural effect upon family and child development according to Hunter (1991b). Many families are increasingly matriarchal and unstable. Such environments may predispose family members, particularly boys, to psychological problems. Hunter contends that male violence to self and to female partners or family members may be indicative of a compromise to the male identity and role. In many Kimberley families it is the women who are finding employment, while their partners remain unemployed, and this pattern continues today. This, combined with the largely unchanged female carer's role, affects the traditional sources of self-esteem and economic security for males that were linked with having employment. The subsequent disenfranchisement of the Aboriginal male role leads to increased substance abuse and psychological vulnerability of Aboriginal young males and adults.

In Western Australia, Aboriginal Australians continue to have a higher rate of suicide when compared to non-Aboriginal Australians (Hillman et al., 2000). According to Hillman et al., the suicide rate within Aboriginal communities is 32 deaths per 100 000, compared to 16 deaths per 100 000 in the wider community. Although evidence suggests that in the wider community there are signs that the suicide rate is stabilising, the rate in Aboriginal communities continues to rise. Data describing suicide trends among Aboriginal young people should be interpreted cautiously, however, as it is incomplete due to cultural factors (NHPA, 1998) impacting on the collection of such information (for example fear, stigma, interpretation of the suicidal act, distrust of Westerners, shame, and traditional law). If anything, the rates identified are an underestimate of true incidence rates.

Social isolation has also been identified as a major risk factor for suicide, with most research indicating that the decrease of traditional social support networks is likely to exacerbate the effects of stress and the engagement in suicidal behaviours (Hunter, 1988). It has been suggested that Aboriginal people are psychologically vulnerable to suicidal behaviours as a result of a devaluing of a sense of community (Durkheim, 1952; Huffine, 1989; Hunter & Milroy, 2006; McCoy, 2008). Evidence also suggests that membership of a minority group contributes significantly to the high rates of distress associated with suicidal behaviours (Cawte, 1969). Studies have demonstrated that other indigenous colonised cultures experience disproportionately high rates of suicide and mental health problems similar to those of Aboriginal Australians (Berry & Kim, 1988; Johnson, 1994). The National Health Priority Areas (NHPA, 1998, p. 51) report on mental health states that

> in studies of non-Indigenous communities, the extent of such traumatic separation, loss, abuse, dislocation and dehumanisation can only be found in populations subjected to systematic torture, genocide, concentration camps or urban or family violence.

Aboriginal youth continue to be confronted by a range of risk factors that may increase self-harm and suicidal behaviour (Westerman, 2003). Those living in remote regions of Australia may be further disadvantaged by the lack of sustainable mental health service provision (Harris & Robinson, 2007) or culturally/developmentally appropriate services aimed at dealing with the specific mental health requirements of Aboriginal youth. Further, the lack of

such appropriate services is likely to disadvantage Aboriginal youth because they may prefer to attempt to manage their condition within their community and family (Vicary, 2002). These challenges are further exacerbated by the misuse of alcohol and illegal substances which create a volatile and dangerous environment conducive to Aboriginal youth self-harm (Hunter & Milroy, 2006; McCoy, 2008; Westerman, 2003).

Substance misuse

Alcohol

The Australian Bureau of Statistics' National Aboriginal and Torres Strait Islander Social Survey (NATSISS) (ABS, 2002) demonstrated that many Aboriginal youth engage in risk-taking behaviour by consuming large amounts of alcohol (see Hunter, 1991b; Hunter & Garvey, 2002). The NATSISS found that 35% of Aboriginal youth reported drinking high-risk amounts of alcohol during the two weeks before the survey was undertaken. Perhaps not surprisingly, male Aboriginal youth displayed more likelihood of at-risk binge drinking than their female counterparts. Further the NATSISS found that youth binge drinking was more likely to occur in the non-remote regions of Australia. Importantly, the National Aboriginal and Torres Strait Islander Health Survey conducted in 2004–05 (ABS, 2006a) found that Aboriginal youth were less likely than their non-Aboriginal counterparts to consume alcohol. However, this survey illustrated that the rates of at-risk drinking behaviour were similar for both Aboriginal and non-Aboriginal youth (16% versus 14%).

Smoking

Smoking is another major health issue for Aboriginal youth given its association with serious negative health outcomes. The Australian Bureau of Statistics (ABS, 2006a) revealed that 50% of Aboriginal young people were regular and current smokers. Importantly, this data also suggests that Aboriginal young people smoke at the same rate as Aboriginal adults. Aboriginal young people were nearly twice as likely as non-Aboriginal young people to smoke (50% compared with 26%). The National Aboriginal and Torres Strait Islander Social Survey (ABS, 2002) illustrated that some Aboriginal young people who were regular smokers were more likely (42% versus 20%) than non-smokers to have used illicit substances.

Illicit substances

The 2004–05 NATSISS found that 36% of Aboriginal young people living in remote communities had reported experimenting with an illicit substance. Marijuana has been cited by many as a huge issue for the Aboriginal community – particularly amongst youth. Blair, Zubrick and Cox (2005) reported that 40.8% of Aboriginal young people surveyed in the WAACHS had experimented with marijuana compared to 33% of their non-Aboriginal counterparts. The NATSISS reported that marijuana was the drug most commonly used by Aboriginal youth. Further, this survey found that amphetamines were the next most commonly used substance.

The changing environment and opportunities for Aboriginal youth

Over the last 10 to 20 years there has been a growing awareness and emphasis on bridging the health gap between the Aboriginal and the non-Aboriginal community. There is a raft of policies, programs and projects aimed at improving the life outcomes for Aboriginal youth and their communities. Much of this interest has focused on improved education, health, housing, welfare, justice, sporting and cultural outcomes. A brief scan and search of the internet clearly demonstrates the proliferation of sites aimed at improving life chances for this population. These initiatives, however, must be sustainable and undertaken in partnership with Aboriginal people if there are to be long-term and demonstrable changes to lifestyle and experiences. This section will briefly explore some of the changes and opportunities for Aboriginal youth that have emerged over this period.

One major thrust towards improving the life outcomes and potential for Aboriginal youth has been a concerted focus on education beyond Year 10 to improve vocational opportunities (ABS & AIHW, 2005). The Australian Bureau of Statistics (ABS, 2006a) reports that the number of Aboriginal youth continuing on past Year 10 steadily increased between 1990 and 2004, with the gap beginning to close between Aboriginal youth and their non-Aboriginal peers. Further, the NATSISS (ABS, 2002) illustrated that 28% of Aboriginal youth reported having completed Year 12 and 45% reported completing Years 10 or 11. As noted earlier in this chapter, Aboriginal youth who complete Year 12 have higher levels of employment. They also have less financial stress and an increased likelihood of being in

full-time employment or further study. Over half of the Aboriginal youth surveyed (57%) reported that they were fully engaged in education and/or work, with females more likely than males to be fully engaged and/or employed (ABS, 2002).

While increasing numbers of Aboriginal youth are finding themselves in employment, they also are becoming more involved in their communities. The majority of young people (94%) surveyed in the NATSISS (ABS, 2002) reported being involved in social activities prior to the survey interview. Sixty-seven per cent indicated that they participated in sport or recreational (physical) activities, although Zubrick et al. (2004), as noted earlier, suggest that physical activity for this group remains less than for their non-Aboriginal counterparts. Participation in social, sporting and cultural activities is a way of building resilience, improving health, and strengthening cultural identity and community and family networks.

There have been recent developments within government, non-government and private organisations to improve the vocational, health and educational outcomes for Aboriginal youth. Organisations and programs include the Indigenous Youth Leadership Program, David Wirrpanda Foundation, Rio Tinto Aboriginal Fund, Gugan Gulwan Youth Aboriginal Corporation, Australian Football League Kickstart Program for Indigenous Youth in Cape York and the Polly Farmer Foundation. These organisations and programs focus on a range of areas including leadership, mentoring, education, employment, lifestyle (for example, exercise and diet), physical and mental health, social participation, arts and culture, and community governance. Some websites are listed in the reference list at the end of this chapter and provide more detailed information on each organisation's vision, mission, rationale, programs and activities.

A positive role model – Tanya Major

As discussed earlier, many Aboriginal youth are making a positive contribution not only to their communities but also to the broader Australian community. Many have been supported and encouraged through their involvement with the programs identified above. Others have had positive role models, mentors and community support that assisted them in achieving their goals. Many successful Aboriginal young people have demonstrated drive, commitment and resilience to make a difference not

only for themselves but also for their family and community and in the broader Australian context. One such successful role model and leader is Tanya Major, who has been able to harness opportunities and utilise these to make a significant contribution to our community.

One example of Aboriginal youth leadership is Tanya Major, the 2007 Young Australian of the Year. Tanya is from the remote Far North Queensland (Cape York) community of Kowanyama and has obtained a degree in criminology from Griffith University. She became the youngest elected regional councillor in the Aboriginal and Torres Strait Islander Commission (ATSIC) at 21 years of age. Tanya has addressed state, national and international audiences through a variety of media (for example television, radio and print media), highlighting Aboriginal youth affairs and social welfare issues. Together with Noel Pearson, Tanya has challenged thinking and ways of working with Aboriginal communities by illustrating the day-to-day difficulties and inequities that Aboriginal people living in these communities face. Her ability to communicate her message with passion and conviction has resulted in ordinary mainstream Australians, together with politicians, government departments, for-profit and not-for-profit companies and agencies, challenging both thinking and practice with regard to Aboriginal communities. Tanya continues to advocate on behalf of Aboriginal young people living on the Cape York Peninsula (and, through this advocacy, all young Aboriginal people). She works to build resilience and opportunity for these communities through projects that focus on self-help, self-determination and leadership role models.

While still very young, Tanya has won a raft of awards which recognise her contribution to her community and the broader Australian community. Some of these include:

- 2006 Queensland Young Australian of the Year
- 2007 Young Australian of the Year
- 2007 Young Leader of the Year – Deadly Awards
- 2007 winner of the Political Legal and/or Government Affairs section of the Junior Chamber, International Outstanding Young Persons of the World contest held in India in 2007
- 2008 Young Woman of the Year for Community Vision.

Tanya is currently studying for a Masters degree in Public Policy at the University of Sydney, after which she intends to establish a private consultancy and establish a youth leadership foundation to support other young Indigenous people with leadership potential. Tanya's ability to inspire others is ensuring that both non-Aboriginal and Aboriginal people take into account the unique circumstances faced by Aboriginal youth. While still early in her career, Tanya's profound influence in the realm of Aboriginal social welfare is continuing to impact upon social welfare practice and policy for the betterment of Aboriginal people – particularly children and young people.

Source: Compiled from several websites including <www.australianoftheyear.org.au/pages/page310.asp> and <www.cshisc.com.au> ('Making a Difference...' Convention 2009, 21–22 October).

Aboriginal youth engagement

Health care practitioners who work with Aboriginal youth need to recognise the central importance of culture and community relationships if they are to effectively engage with Aboriginal youth. Vicary and Andrews (2000, 2001) describe a model designed to build rapport with Aboriginal people and the model has been applied to Aboriginal children, youth and adults. The model was developed to provide a guide for mental health practitioners and is not intended as the definitive model of engagement – rather it is a starting point. While developed for non-Aboriginal mental health practitioners it does appear to have some application beyond the realm of mental health.

Principally Vicary and Andrews' model focuses upon the importance of rapport and the development of relationships with Aboriginal youth and their family and community. Aboriginal youth may be very distrustful of professionals and may take some time to engage with a service or professional. Once this rapport has been established and the young people's concerns and preferred way of relating is acknowledged (for example, this may take into account the importance of peer group), a relationship with individuals and groups can be enhanced and consolidated. The model is intended as a transparent, client-centred approach aimed at facilitating engagement and empowerment. The model in Table 4.2 (overleaf) is adapted from Vicary and Andrews (2001).

Table 4.2 **A model of Aboriginal youth engagement**

Introductory preparation – Research and development of knowledge and skills. Be aware of issues relevant to the youth of the area.	Networking, gaining an understanding of own belief systems, research, identifying appropriate cultural consultants (members of the local Aboriginal community) and asking for guidance. The stages outlined below should all be carried out with the direction and guidance of a cultural consultant.
Stage One – The reason for the contact (e.g. work, research)	Examining the nature of the reason for the contact with Aboriginal young people; the appropriateness of strategies and other more culturally appropriate strategies for service provision (e.g. 'Am I the right person to do this work?')
Stage Two – Initial research	Preparation of the local history, current and past factors impacting upon youth, and local context with assistance of the cultural consultant. This is a critical stage as it prepares the worker and warns about sensitive youth, family, community and cultural issues prior to engagement.
Stage Three – Potential limiting factors	Identification of those factors that may prohibit the establishment of a sound relationship with local youth.
Stage Four – Methodology	The nature and method(s) to be employed and preferred by the local youth for the initial contact by the worker, inclusive of nature, frequency, location, names of workers, cultural consultants, activities, duration, place and time. The nature of the relationship, reasons and expectations should be delineated and explored with the youth.
Stage Five – Identification of desired outcomes	Identify the outcomes required for the youth. It is imperative that the youth set their own goals and desired outcomes and the timeframe they would like to achieve these targets within. A transparent process of empowerment is central to the success of this stage.
Stage Six – Follow-up (evaluation)	Reciprocal feedback/evaluation process is initiated with the young people.
Stage Seven – Closure	Successful engagement with youth and the development of a relationship are often a source of new contacts with this cohort and are further indicators of the efficacy of the intervention.

Source: Based on Vicary & Andrews (2001), 'A model of therapeutic intervention with Indigenous Australians'. *Australian and New Zealand Journal of Public Health*, 25(4), 349–51.

As identified above, Vicary and Andrews' model (2000, 2001) is provided as a guide to practice rather than a set of prescriptive and definitive stages. Discussions with the Aboriginal community, Elders and youth are important to establish the need for modifications to the model which reflect local circumstances. The model may be successfully applied in a range of Aboriginal youth contexts including leadership programs, mental health and resilience workshops, community capacity building, research, counselling, suicide prevention workshops, grief and loss workshops, education and vocational development.

Conclusion

Aboriginal youth may be exposed to a range of negative life events that can impact upon their plans for the future. Some of these negative events can damage their physical and mental health status, increasing their vulnerability and reducing their chances of leading fulfilling lives. There is now increasing recognition of the health disparity that exists between Aboriginal youth and their non-Aboriginal counterparts and a growing sense of urgency directed at reducing this disparity. New programs are being developed in areas such as health, education and justice that are aimed at altering current practices and improving the potential outcomes for Aboriginal youth. Programs to enhance vocational outcomes and leadership potential are also being developed.

Crucially, the federal and state governments (and in some cases local governments) are beginning to tackle seriously the disparity between Aboriginal and non-Aboriginal youth with changes to policy and programs designed to improve life outcomes (Vicary et al., 2004). However, these changes must be sustainable, not tokenistic, and developed in partnership with Aboriginal youth. Aboriginal youth have the right to determine their own future by designing policy and programs which represent their personal, cultural and community requirements. Anything less than the full engagement of Aboriginal youth may well be destined to fail and become yet another addition to the long, and growing, list of policies, programs and projects imposed upon, rather than conducted with, Aboriginal people. The challenge for all Australians is to get this process right and this can only be done in real partnership with Aboriginal youth, their families, community and Elders. Such partnerships will provide a catalyst for change and sustainable outcomes that take into account the importance of culture in the development of youth and community aspirations.

REFLECTIVE PRACTICE

Case study 1: Building a future

Gary is 18 years old and lives in a remote Aboriginal community in Northern Australia. The nearest service centre to his community is over four hours away by four-wheel-drive. Gary left school when he was 14 and has not found any employment since this time. He has a large extended family and most of his relatives live in the same small community. Very few of his adult male relatives have full-time work and most spend their days undertaking activities which include hunting and painting. While not many of his male role models have employment, a number of his female relatives have work in the community. Some of his adult relatives and peer group have turned to alcohol and illicit substance use to deal with the boredom and lack of opportunity in their community. Gary, a non-drinker, is becoming more withdrawn and concerned that this may well be his future unless he is able to secure meaningful employment.

Gary's family is encouraging him to further his education so that he might achieve his goal of working for a mining company that has recently commenced operations near his community. However, in order to undertake further educational and on-the-job training Gary will have to move from his community to the town some four and a half hours away. Gary is resistant to moving to a town away from family and support and into an environment that is unfamiliar and largely non-Aboriginal.

Discussion questions

1. As a non-Aboriginal community worker, what are some of the strategies you might employ to engage Gary? What are some of the considerations you should take into account?
2. What are some of the risk factors Gary faces, and some of his (and the community's) strengths that will assist him in working towards his future?

3. Consider some of the strategies that might be employed to ensure that Gary is able to achieve his goal while remaining in contact with his family and community. Consider the use of technology to facilitate this ongoing contact and factors to increase his resilience.

Case study 2: Circle sentencing

Context

Circle sentencing (2009) was introduced to Australia from Canada in 2002 where it was developed from traditional sanctioning and healing practices. Circle sentencing is a more **culturally appropriate and sensitive** approach to dealing with criminal offences perpetrated by Aboriginal people. It aims to engage the offender, Elders, police, magistrates, community and victim. The schemes provide sentences that are commensurate with the crime but generally do not include time in jail. The focus is on rehabilitation, healing and reduced recidivism. Circle sentencing schemes can now be found in all states and territories in Australia. The program attempts to avoid jail time and further disenfranchisement of Aboriginal offenders. Circle sentencing is derived from a circle of community stakeholders and representatives (for example, Aboriginal Elders, prosecutors, police, magistrates) sitting together to decide a culturally appropriate sentence which does not include a term of incarceration. Members of this group work together to examine the context and outcomes of the offence, which can involve meeting the victim to explore the impact the offence has had upon them. Circle sentencing is generally only for those who admit their guilt and who have a commitment to rehabilitation. Sentences where possible will include community work.

(continued)

Case

Jim, a 19-year-old local Aboriginal youth, has been charged with shoplifting and is to have his case heard before a circle court. This is his fourth charge of shoplifting over the last eight months. Previously he was fined but now faces a potentially more serious and far-reaching outcome.

Discussion questions

1. How might circle sentencing improve outcomes for Jim in the short, medium and long term?
2. What do you consider to be the impact that Aboriginal Elders may have upon Jim and other young offenders when they are part of the circle and involved in determining a sentence?
3. How might circle sentencing be strengthened and enhanced in Australia through the active involvement of Aboriginal youth, Elders and community members?

GLOSSARY

Culture – according to the Task Force on Aboriginal Social Justice (1994), this definition incorporates the following dimensions:

- traditional beliefs, practices and customs;
- song, dance, language and food;
- family structure, kinship, relationships and obligations;
- stories, beliefs, religion, spiritual dimension: in Aboriginal culture both the Dreaming and Christianity have a place; and
- traditional law, rules and conduct.

Culturally appropriate and culturally sensitive – as defined by Dudgeon, Garvey and Pickett (2000, p. 12), 'the positive inclusion of and taking direction from Indigenous people and their cultures in any given issue, programme, model or service'.

Health – 'Health is not just the physical well-being of an individual, but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view that includes the cyclical concept of life–death–life.' (Smith, 2007, p. 109, citing the National Aboriginal Health Strategy Working Party 1989, p. x).

World view – 'A world view is a holistic concept that ties together the belief systems, values, lifestyles and modes of problem solving of a particular cultural group' (Pedersen, Fukuyama & Heath, 1989, p. 37).

REFERENCES

Aboriginal Circle Sentencing (2009), *What is Circle Sentencing?* Retrieved October 2009 from <www.creativespirits.info/aboriginalculture/law/circle-sentencing.html>.

Aboriginal Youth Mean Business Forum (2009), Melbourne, Vic.: May.

ABS (Australian Bureau of Statistics) (2002), *NATSISS (National Aboriginal and Torres Strait Islander Social Survey)*. Canberra, ACT: Australian Bureau of Statistics.

ABS (Australian Bureau of Statistics) (2004), *Experimental Population Estimates and Projections, Aboriginal and Torres Strait Islander Australians*. Cat. No. 3238.0. Canberra, ACT: Australian Bureau of Statistics.

ABS (Australian Bureau of Statistics) (2006a), *Australian Social Trends – Young Aboriginal and Torres Strait Islander Peoples*. Retrieved 9 July 2009 from <www.abs.gov.au/AUSSTATS/abs@.nsf>.

ABS (Australian Bureau of Statistics) (2006b), *Australian Bureau of Statistics 2006 Census of Population and Housing: Age by Indigenous Status by Sex*. Retrieved 15 September 2009 from <www.censusdata.abs.gov.au>.

ABS (Australian Bureau of Statistics) (2006c), *National Aboriginal and Torres Strait Islander Health Survey, 2004–05*. Canberra, ACT: Australian Bureau of Statistics.

ABS (Australian Bureau of Statistics) (2006d), *Law and Justice Statistics – Aboriginal and Torres Strait Islander People: A Snapshot*. Canberra, ACT: Australian Bureau of Statistics.

ABS (Australian Bureau of Statistics) (2006e), *Prisoners in Australia*. Cat. No. 4517.0. Canberra, ACT: Australian Bureau of Statistics.

ABS & AIHW (Australian Bureau of Statistics & Australian Institute of Health and Wefare) (2005), *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Cat. No. 4704.0. Canberra, ACT: ABS & AIHW.

ABS & AIHW (Australian Bureau of Statistics & Australian Institute of Health and Welfare) (2008), *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Cat. No. 4704.0. Canberra, ACT: ABS & AIHW.

AIHW (Australian Institute of Health and Welfare) (2004), *Australia's Health 2004*. AIHW Cat. No. AUS 44. Canberra, ACT: Australian Institute of Health and Welfare.

AIHW (Australian Institute for Health and Welfare) (2008), *Child Protection Australia 2006–2007*. Canberra, ACT: Commonwealth of Australia Press.

AIHW (Australian Institute for Health and Welfare) (2009), *Children and Youth*. Retrieved 7 May 2009 from <www.aihw.gov.au/indigenous/community/child.cfm>.

Alexander, K. (1990), *Aboriginal Alcohol Abuse and Related Problems: Report and Recommendations Prepared by an Expert Working Group for the Royal Commission into Aboriginal Deaths in Custody*. Canberra, ACT: Alcohol and Drug Foundation.

ALS (Aboriginal Legal Service of Western Australia) (1995), *Telling Our Story – A Report on the Removal of Aboriginal Children from their Families in Western Australia*. Perth, WA: Aboriginal Legal Service.

AMA (Australian Medical Association) (2002), *Public Report Card 2002 Aboriginal and Torres Strait Islander Health: No More Excuses*. AMA Media. <www.ama.com.au/web.nsf/doc/WEEN-5GJ3CZ>.

Aoun, S. & Johnson, L. (2002), 'Capacity building in rural mental health in Western Australia'. *Australian Journal of Rural Mental Health*, 10, 39–44.

Berndt, R.M. & Berndt C.H. (1983), *The Aboriginal Australians: The First Pioneers*. Sydney, NSW: Pitman.

Berry, J. & Kim, U. (1988), 'Acculturation and mental health'. In R. Dasen, J. Berry & N. Satorius (eds), *Health and Cross-Cultural Psychology: Toward Applications*. Newbury Park: Sage, pp. 172–91.

Blair, E.M., Zubrick, S.R. & Cox, A.H. (2005), 'The Western Australian Aboriginal Child Health Survey: Findings to date on adolescents'. *The Medical Journal of Australia*, 183(8), 433–5.

Brady, M. (1991), 'Drug and alcohol abuse among Aboriginal people'. In J. Reid & P. Trompf (eds), *The Health of Aboriginal Australia*. Marrickville, NSW: Harcourt Brace Jovanovich, pp. 204–26.

Brown, R. (2008), 'Australian Indigenous mental health'. *Australian and New Zealand Journal of Mental Health Nursing*, 10(1), 33–41.

Burdekin, B. (1993), *Human Rights and Mental Illness*. Report of the National Enquiry into the Human Rights of People with Mental Illness. Canberra, ACT: AGPS.

Cawte, J.E. (1969), 'Psychological adjustment to cultural change: The case of the Australian Aborigines'. *Australian and New Zealand Journal of Psychiatry*, 3, 343–7.

Dudgeon, P., Garvey, D. & Pickett, H. (2000), 'Indigenous mental health across the life span'. In P. Dudgeon, H. Pickett & D. Garvey (eds), *Working with Indigenous Australians:*

A Handbook for Psychologists. CIRC, Centre for Aboriginal Studies, Curtin University of Technology, pp. 85–90.

Durkheim, E. (1952), *Suicide: A Study in Sociology*. London, UK: Routledge & Kegan Paul.

Ford, D. (2000), 'Aboriginal child sexual abuse and support services'. In P. Dudgeon, H. Pickett, & D. Garvey (eds), *Working with Indigenous Australians: A Handbook for Psychologists*. CIRC, Centre for Aboriginal Studies, Curtin University of Technology, pp. 69–84.

Gault, E.I., Krupinski, J. & Stoller, A. (1970a), 'Psychosocial problems of adolescent Aborigines in Victoria'. *Australian and New Zealand Journal of Psychiatry*, 4, 24–33.

Gault, E.I., Krupinski, J. & Stoller, A. (1970b), 'Psychosocial problems of Aboriginal adolescents and their sociocultural environment'. *Australian and New Zealand Journal of Psychiatry*, 4, 174–82.

Harris, A. & Robinson, G. (2007), 'The Aboriginal Mental Health Workers Program: The challenge of supporting Aboriginal involvement in mental health care in the remote community context'. *Australian e-Journal for the Advancement of Mental Health*, 6(1), 1–11.

Hillman, S.D., Silburn, S., Zubrick, S. & Nguyen, H. (2000), *Suicide in Western Australia, 1986–1997*. Perth, WA: Youth Suicide Advisory Committee, TVW Telethon Institute for Child Health Research, and the Centre for Child Health Research, Faculty of Medicine and Dentistry, University of Western Australia.

Huffine, C. (1989), 'Social and cultural risk factors for youth suicide'. In L.D.M. Linnoila (ed.), *Report of the Secretary's Task Force on Youth Suicide*. Washington, USA: Department of Health and Human Services, pp. 46–87.

Human Rights and Equal Opportunity Commission (1997), *Bringing them Home – Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*. Canberra, ACT: HREOC. Retrieved 11 March 2010 from <www.hreoc.gov.au/social_Justice/ bth_report/report/ch1_part1.html>.

Hunter, E.M. (1988), 'Aboriginal suicides in custody: A view from the Kimberley'. *Australian and New Zealand Journal of Psychiatry*, 22, 273–82.

Hunter, E.M. (1991a), 'Out of sight, out of mind. Emergent patterns of self-harm among Aborigines of remote Australia'. *Social Science and Medicine*, 6, 655–9.

Hunter, E.M. (1991b), 'Out of sight out of mind – 2. Social and historical contexts of self-harmful behaviour among Aborigines of remote Australia'. *Social Science and Medicine*, 6, 661–71.

Hunter, E.M. (1993), *Aboriginal Health and History: Power and Prejudice in Remote Australia*. Melbourne and New York: Cambridge University Press.

Hunter, E.M. & Garvey, D. (2002), 'Indigenous Suicide in Australia, New Zealand, Canada and the United States'. *Emergency Medicine*, 14, 14–23.

Hunter, E.M. & Milroy, H. (2006), *Aboriginal and Torres Strait Islander Suicide in Context*. Archives of Suicide Research, 10, 141–57.

Johnson, D. (1994), 'Stress, depression, substance abuse, and racism'. *American Indian and Alaska Native Mental Health Research*, 6(1), 29–33.

Kosky, R. (1997), 'Adolescents in custody: A disciplining or disabling experience'. In R. Kosky, H. Salimi Eshkevari & G. Kneebone (eds), *Breaking Out: Challenges in Adolescent Mental Health in Australia*. Canberra, ACT: AGPS, pp. 121–37.

Kyaw, J. (1993), 'Mental health problems among Aborigines'. *Mental Health in Australia*, 5(2), 30–6.

McCoy, B. (2008), 'Suicide and desert men: The power and protection of kanyirninpa (holding)'. *Australasian Psychiatry*, 15, 63–7.

NAHS (National Aboriginal Health Strategy) Working Party (1989), *National Aboriginal Health Strategy*. Canberra, ACT: AGPS, Commonwealth of Australia.

NHPA (National Health Priority Areas) (1998), *Mental Health: A Report Focusing on Depression*. Commonwealth Department of Health and Aged Care, Australian Institute of Health and Welfare.

Pearson, N. (2009), Personal communication, November.

Pedersen, P.B., Fukuyama, M. & Heath, A. (1989), 'Client, counsellor and contextual variables in multicultural counselling'. In P.B. Pedersen, J.G. Draguns, W.J. Lonner & J.E. Trimble (eds), *Counselling Across Cultures*, 3rd edn. Honolulu, USA: University of Hawaii Press, pp. 23–52.

Raphael, B. & Swan P. (1997), 'The mental health of Aboriginal and Torres Strait Islander people'. *International Journal of Mental Health*, 26(3), 9–22.

Royal Commission into Aboriginal Deaths in Custody (1991), *National Report*. Canberra, ACT: AGPS.

Sambono, H. (1993), 'Providing mental health services to Aboriginal communities'. *Mental Health in Australia*, 5(2), 42–5.

Seru, G. (1994), 'Mental health issues for Elders with a focus on grannies'. *Aboriginal and Islander Health Worker*, 18(1), 13.

Shelldrake, R. (1990), *The Rebirth of Nature*. London, UK: Rider, Random Century Group Ltd.

Smith, J. (2007), *Australia's Rural and Remote Health. A Social Justice Perspective*, 2nd edn. Croydon, Vic.: Tertiary Press.

SNAICC (Secretariat of the National Aboriginal & Islander Child Care) (1996), *Proposed Plan of Action for the Prevention of Child Abuse and Neglect in Aboriginal Communities*. Canberra, ACT: Commonwealth Department of Health and Family Services, AGPS.

SNAICC (Secretariat of the National Aboriginal & Islander Child Care) (2006), *Briefing to State and Territory Governments Development of a National Action Plan for Aboriginal and Torres Strait Islander Communities to Prevent and Respond to Child Abuse and Neglect*. Retrieved 11 March 2010 from <www.snaicc.asn.au/_uploads/rsfil/00062.pdf>.

Swan, P. & Raphael, B. (1995), *Ways Forward. National Consultancy Report on Aboriginal Mental Health and Torres Strait Islander Mental Health*. Part 1. Australian Government Publishing Service.

Task Force on Aboriginal Social Justice (1994), *Report of the Task Force*. Government of Western Australia.

United Nations (1985), *General Assembly Resolution 36/28 Applied in International Youth Year*. Geneva, Switzerland. Retrieved 4 June 2010 from <www.un.org/events/youth2000/def1.htm>.

Vicary, D. (2002), 'Engagement and intervention for non-Aboriginal therapists working with Western Australian Aboriginal people'. Unpublished PhD dissertation. Perth, WA: Department of Psychology, Curtin University of Technology.

Vicary, D. & Andrews, H. (2000), 'Developing a culturally appropriate psychotherapeutic approach with Indigenous Australians'. *Australian Psychologist*, 35(3), 1–5.

Vicary, D. & Andrews, H. (2001), 'A model of therapeutic intervention with Indigenous Australians'. *Australian and New Zealand Journal of Public Health*, 25(4), 349–51.

Vicary, D. & Westerman, T. (2004), '"That's just the way he is": Some implications of Aboriginal mental health beliefs'. *Australian e-Journal for the Advancement of Mental Health*, 3(3), 1–10.

Vicary, D.A., Stilling, J., O'Meara, M., Garvie, T., Guard, N. & Cronin, J. (2004), *Cultural Grants Review*, Perth, WA: Government of Western Australia Press, Office for Children and Youth and Healthway Foundation.

Waldegrave, C. (1985), 'Mono-cultural, mono-class and so called non-political family therapy'. *Australian and New Zealand Journal of Family Therapy*, 6(4), 197–200.

Waldegrave, C. (1990), 'Just therapy'. *Dulwich Centre Newsletter*, 1, 10–15.

Webber, D.I. (1980), 'Mental health problems amongst Aboriginal children of North Australia'. *International Journal of Psychiatry*, 26(2), 118.

Westerman, T. (2000), *Working with Suicide and Depression in Aboriginal Populations: The Cultural Manifestations of Disorder*. Sydney, NSW: Suicide Prevention Conference.

Westerman, T. (2003), *Development of an Inventory to Assess the Moderating Effects of Cultural Resilience with Aboriginal Youth at Risk of Depression, Anxiety and Suicidal Behaviours*. Perth, WA: School of Psychology, Curtin University of Technology.

Zubrick, S.R., Lawrence, D.M., Silburn, S.R., Blair, E., Milroy, H., Wilkes, T., Eades, S., D'Antoine, H., Read, A., Ishiguchi, P. and Doyle, S. (2004), *The Western Australian Aboriginal Child Health Survey: The Health of Aboriginal Children and Young People*. Perth, WA: Telethon Institute for Child Health Research.

Zubrick, S.R., Silburn, S.R., Lawrence, D.M., Mitrou, F.G., Dalby, R.B., Blair, E.M., Griffin, J., Milroy, H., De Maio, J.A., Cox, A. & Li, J. (2005), *The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People*. Perth, WA: Curtin University of Technology and Telethon Institute for Child Health Research.