

An Aboriginal family and community healing program in metropolitan Adelaide: description and evaluation

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Abstract

This paper describes and evaluates the process, impacts and outcomes of an Aboriginal Family and Community Healing (AFCH) Program based in metropolitan Adelaide, South Australia. The evaluation used participatory action oriented methodology, mixed methods and multiple data sources. The AFCH comprised complex and dynamic activities for Aboriginal men, women and youth built around community engagement, and hosted by the regional primary health care Aboriginal outreach service. The AFCH Program was designed to develop effective responses to family violence that took into account the complexities within Aboriginal families and communities. The evaluation identified strengths of the program including: evidence-based design, holistic approach, clinical focus, committed staff, intersectoral linkages, peer support, mentoring, Aboriginal cultural focus, strategic partnerships and creative use of resources. Clients and workers were unanimous in their enthusiastic support for the program; their stories highlight beneficial impacts on Aboriginal clients, families and community. Other services may be able to adapt strategies from this AFCH to address the needs of their Aboriginal communities.

Context / literature overview

Family violence seriously impacts on the lives of many Indigenous people at substantially higher rates than other Australians. In some areas, Indigenous women are 45 times more likely to experience violence, and ten times more likely to die as a result [1]. High family violence rates help to 'effectively disable many communities and deny future generations a basic chance for health, happiness and prosperity' [2 p.1]. Understandings of unacceptably high rates of family violence occur within the historical context of European colonisation: dispossession of land and culture; breakdown of community kinship systems and Aboriginal law; racism and vilification, economic exclusion and entrenched poverty; breakdown of gender roles; intergenerational effects of institutionalisation, oppression and child removal policies, have resulted in ongoing trauma, loss and unresolved grief, alcohol and drug abuse and a range of other health and well being problems and issues, including violence [3]. While not excuses for violence, these factors help to understand its manifestations and inform programs addressing the situation in Australia [3] [4] and elsewhere [5] [6].

Family violence involves the use of force, whether physical or non-physical, aimed at

controlling another family or community member and undermining that person's well-being... Family violence... also includes cultural and spiritual abuse. There are interconnecting and trans-generational experiences of violence within Indigenous families and communities' [7 p.5].

Unacceptably high rates of family violence in Aboriginal communities persist despite two decades of recognition [7]. Mainstream strategies for addressing family violence fall short because Indigenous women's experience of violence relates to skin colour as well as gender. Identifying as Aboriginal often binds women more to their community, including the men, than to their experiences of sexism, as experienced by non-Indigenous women [7].

Numerous reports describe responses to disproportionately high and widespread levels of Indigenous family violence in Australia [2] [8-11].

Over the past decade Australian governments have undertaken significant enquiries and initiatives. The Federal government now oversees most mainstream family violence prevention initiatives and related programs [12]. Distribution of government funding to community based Indigenous family violence programs reflects the complexity of the problem and ideally requires a holistic approach that includes understanding of underlying historical and social issues and interagency collaboration [13]. There are also non-government programs that address family violence, eg the Yarrabah Family Wellbeing Empowerment Program [4].

Few program evaluations are published in Australia, partly because few anti-violence programs target the Indigenous community, and because they rarely include a funded evaluation component. One seminal review [2] identified elements of good practice including cultural and community grounding, group approaches, engagement of men, involvement of Elders, capacity building through networking, and partnerships to raise self-empowerment and self-esteem. Other key elements included narrative approaches to healing, effective communication, training and skills acquisition, project flexibility and adaptability.

It is important to describe program shortcomings to avoid repeating ineffective programs [2]. Indigenous programs face significant challenges to effective implementation, eg: suitable sectoral partnerships, inter-agency coordination, staff training and skills, funding, community politics, predominantly reactive rather than proactive program elements, staff safety concerns, and staff 'burn out' [2]. These factors/challenges are consistent with other reports [3, 7]. The Aboriginal Family and Community Healing Program which is the subject of this paper recognised the above elements in its design and evaluation.

Background, planning and ethics

The aim of this Aboriginal Family and Community Healing (AFCH) Program was to develop effective responses to family violence that address the levels of complexity within Aboriginal families and communities in a northern metropolitan region of Adelaide. The Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) contracted the South Australian Department of Health's Central Northern Adelaide Health Service to develop and implement an AFCH Program through its primary health care Aboriginal outreach

services.

The AFCH Program was developed as an integral part of the South Australian Government's Regional Aboriginal Health Plan; itself based on the work of the South Australian Aboriginal Health Partnership (SAAHP) [14]. SAAHP identified three strategic areas of action (social and emotional wellbeing, substance misuse and diabetes). Regional service delivery approaches, plans and reporting frameworks were developed to address community, family and individual priorities for each strategic area. The AFCH Program addressed social and emotional wellbeing and substance misuse at community and family levels.

The purpose of the external evaluation was to provide information on the AFCH Program at 12 and 24 months, and it was an integral part of the program design, required by the funding body. The evaluation focussed on the six program objectives identified by the funding body:

Objective 1: Build community capacity to support 'safe families'

Objective 2: Equip Aboriginal people with the skills for effective communication and conflict resolution

Objective 3: Support families in crisis

Objective 4: Build capacity of mainstream agencies and services within the region.

Objective 5: Workforce development

Objective 6: Data and evaluation

The health service hosting the AFCH Program invited Flinders University Aboriginal Health Research Unit to tender for the external evaluation. The detailed evaluation plan was then developed collaboratively with the AFCH team leaders. A participatory action-oriented methodology using multiple methods and data sources was selected in line with Indigenous research reform principles [15, 16], optimising the credibility and utility of the evaluation and enabling ongoing program improvements. Flinders University Social and Behavioural Research Ethics Committee, SA Aboriginal Health Research Ethics Committee and the Department of Education and Children's Services approved the evaluation project in March 2007.

Involvement of Aboriginal members of the AFCH team throughout increased the evaluation capacity of the host health service and enhanced the relevance and rigour of the evaluation. The AFCH team provided data, discussed interim findings and commented on draft plans and reports. Two former clients of the program, now working part-time in the Aboriginal health team, were selected by program leaders to work alongside the non-Aboriginal external evaluators. These Aboriginal co-evaluators, a male and a female, contributed unique experiences, knowledge and skills, and their assistance in engaging participants and facilitating interviews proved invaluable. 'On the job' two-way teaching and learning about research techniques and cultural issues via role modelling and observation, critical reflection and comment, constructive feedback and capacity exchange occurred when possible throughout the project.

Evaluation data were collected from February 2007 to March 2008. A total of 22 interviews and focus groups with 27 workers (some participated more than once) and 19 clients of the AFCH Program were conducted. In addition, the evaluators attended AFCH activities eg a 'Nunga Women U R Special' event, a Women's Wellness Camp,

and meetings of the Zebra Finch Men's Group and the Women's Group, which are all parts of the AFCH Program. Notes from the interviews and focus groups, as well as evaluators' reflective field notes, information shared during numerous meetings with the AFCH Program team, and program plans and progress reports comprised the evaluation data. Qualitative thematic and content analyses of these data were conducted, and then collated for discussion and refinement by the team.

Description of the Aboriginal Family and Community Healing Program

A comprehensive picture of the range of courses, activities and groups provided under the umbrella of the AFCH Program is outlined in Table 1. Clearly this was an enormous amount of activity for a small team. The AFCH Program operated from three primary health care sites across the region. There were generally around 25 staff, over half on short term contracts, with high turnover. The majority were female, the few male staff worked exclusively with male clients. Staff roles included clinical, health promotion and early intervention work with Aboriginal women, men and youth.

Embedding of the AFCH Program into the wider regional plans and priorities [14] necessitated effective linkages within the Central Northern Adelaide Health Service and with external agencies, coordination, and strategic deployment of funding streams, resources and personnel. However, the ongoing restructure within the regional health organisation impacted on the integrity of the program, and was a great challenge and frustration for staff.

Table 1: Elements of the AFCH program

Work with Women	Work with Young People	Work with Community	Work with Men
Structured 8-week Family Wellbeing course	Leadership and well-being course with local high schools	Community peer support initiatives	Zebra Finch men's group
Women's healing group with narrative and art therapy	Kids Connecting with Community	Nunga nutrition lunches	Bush Mechanic (through Man Alive at Semaphore)
Stress management and cognitive therapy through GP partnership)	School Expo Events	Mini conferences – Family violence, Life Improvement Plan	Peer Support
Nunga Mi:Minar Women's Shelter – working with staff and women	Young people's drop-in (computer)	Clinic Services – adult and child health assessment	License for Life
Young women's group	Young Nungas Yarning	Lifestyle/Living Skills	Young Nungas Yarnin
Individual counselling – brief intervention	Holiday program		Kinship Program
			Boystown
Boystown			
Women's wellness camps			
Nunga Women U R Special pampering day			
Weekly art group including talking circles, peer-led			

Interagency partnerships outlined in Table 1 advanced the AFCH program, served as pathways for clients and also as strategic ways to share resources.

Findings

Objective 1: Build community capacity to support 'safe families'.

The AFCH Program comprised a complex range of programs, partnerships and activities (Table 1). Together they provided holistic and culturally appropriate strategies to enhance the safety and wellbeing of Aboriginal families and communities, evidenced by workers' and clients' testimonies.

Workers interviewed were asked about their understanding of 'building community capacity to support safe families'. Some emphasised the role of services and workers, eg:

Community capacity includes service capacity. Workers are part of the community.

Education, health promotion work. Bringing back values and acceptable norms through respectful communication.

Others emphasised how the clients' experiences and learning through the AFCH Program led to increased community capacity to support safe families, eg:

If the men are healing, that will help to heal the family and community. Participants in the AFCH Program have felt empowered to influence their own families and peers.

Letting others know that Safe Families is a possibility, a priority and a right. Sharing knowledge and skills for self-support. Sharing stories about family violence and how people have learned and coped, then taking those lessons home.

Interviews with workers provided many stories of how participation in the AFCH led to increased capacity to support safe families, eg:

Linda (not her real name) ... has participated in the women's group since it began and it has helped her to 'get back on track'...She realises that the healing process will take time. ... She needs the group to help her set and achieve her goals and return to work. ... Whilst it took her a while, she has learned to open up to people and to trust them. This in turn has given her confidence.

Two women's group clients had completed the 8-week women's structured program, went on to study at TAFE and gain satisfying employment, and now promote their learnings in their daily lives and through their networks as role models. Similarly, with the support of the Zebra Finch men's group and AFCH workers, a man with extensive, mostly negative, prior dealings with government services increased his sense of self-worth, found employment, and began addressing other issues in his life. Other clients' comments included:

Each session has made us (participants) stronger in self worth.

When I was in a violent relationship – I thought or was led to believe it was my fault ... [I] can put up boundaries now to protect myself.

The client journey

Workers talked about the 'client journey', ie. the pathways and roads clients travel once they are involved in the AFCH Program. This journey was seen as one that takes a client from a crisis, usually the trigger for entering the program, through to continued individual support as new issues arise, and development of self confidence and strategies for family and community safety.

The impacts of the AFCH on clients' lives are powerfully captured in their stories, eg:

Melissa (not her real name), like many Aboriginal women, has long experience of intimate partner violence. With peer support from the women's group she has resolved to throw her violent partner out. She was feeling strong about this decision as she now has people to back her up and be supportive. The women's camp enabled her to gain some relaxation, sort out some issues and become more clear-headed. Like many women, the group and camp are the only opportunities for companionship and time out from family. Through her group contact she now has access to counselling for loss and grief issues. She has on-going healing with one of the counsellors, and the group facilitator provides support and help when it is needed. Melissa has also gained knowledge about other services to help address violence in her life (crisis care and the GP at the Aboriginal Health Service) and support her with other health issues (eg dietician to help her manage diabetes).

Workers' comments echoed those of clients, eg:

Women walk in to the AFCH Program feeling hurt – it's in their eyes, face and body. In seven months they have changed so much. Some have been able to solve problems, moved on from rescuing everybody else to talking about themselves.

The women attending the groups have so much grief that no-one has been interested in before. They are hungry for healing in every way. I use a healing approach involving mind, body and spirit – all components are complementary. Healing gently opens doors, gives women permission to talk. The women are learning to trust again. The group is becoming like a family, they respect each other, there is no pressure, each woman is in control. Gradually the women open up, begin to heal, and then counselling can begin.

Objective 2: Equip Aboriginal people with the skills for effective communication and conflict resolution

This objective was addressed through most components of the AFCH Program. A good example is the structured Women's Family Wellbeing course that was delivered to groups of Aboriginal women meeting weekly during school terms. The course covered identifying precursors to violence, breaking the cycle of abuse, building self-esteem, and strategies for staying safe. Another less formal women's group met weekly for social interaction, peer support and opportunistic health promotion. Brief interventions such as individual counselling were offered through the women's

groups.

The men's groups (one group is known as the Zebra Finch group – an analogy for men looking after family and community, and there was also a separate group for younger men) offered a range of activities, and provided a safe environment to build skills around communication and conflict resolution. Talking circles, using a message stick, were part of the Zebra Finch men's group activities.

Clients told how they gained communication and conflict resolution skills through participation in the AFCH program, enabling them to address the reasons for and consequences of family violence. They identified peer support, learning to trust again within the safety of the groups, accessing counselling, role modelling respectful communication, formal and informal learning as key strategies. According to a facilitator of the women's groups, participants' skills and confidence in resolving conflicts developed, as illustrated by the following comments taken from her notes:

Coming to the group is like having a shot of vitamin B that keeps her going for the week and [she] is much more positive about her life and is making an assertive stand for herself.

A participant faces having put downs by family and is now willing to challenge the put downs.

Objective 3: Support families in crisis

The AFCH Program was more about prevention and healing than acute care. However, clients did present in crisis situations sometimes, and the AFCH team 'won't let people in crisis situations leave without sorting something out for them'. This often required the good will and voluntary work of AFCH staff in their own time, drawing on their personal, community and professional connections and knowledge. This commitment enhanced the reputation of the AFCH Program and team in the community, but risked volunteer 'burn out'.

A rapid response protocol was in place at the hosting primary health care services to deal with emergency situations. A range of brief interventions and supports were offered for families in crisis, eg. helping clients to find accommodation, access medical or counselling services, and obtain legal or financial assistance. Workers used their networks and knowledge to cut through red tape and ensure client safety. Partnerships with organisations such as Nunga Mi:Minar (an Aboriginal women's shelter), Metro Homelink and Disability SA assisted in this.

Objective 4: Build capacity of mainstream agencies and services within the region.

The AFCH Program relied on dedicated program funds, strategic use of other funding streams within the host health service, and partnership with key external agencies. Some partnerships were formed to share resources and planning for program components, eg Disability SA and Central Northern Adelaide Health Service both provided resources for their clients to attend the women's and men's groups. A leadership program for young Aboriginal women was conducted in collaboration with Department of Education and Children's Services and a local school.

Another example of networking and capacity building with mainstream service is the collaboration between the North East Division of General Practice. Under Access to Allied Psychological Services (Better Outcomes) funding, a women's group was established, co-convened by an occupational therapist from the Division and a facilitator from the women's group. It used a shared care model where medical and allied health workers cooperate in the care of clients. Clients were women with long term, chronic and complex mental health problems, referred by the GP. Women in the group worked with crafts whilst learning how to manage stress and learning new behaviours. These new skills then impacted on how they dealt with family situations at home. Women also learned a range of psycho-social skills including working and communicating within a group. Women's current strengths were reinforced, they learned new strategies, new ways of thinking and anger management skills, and they supported each other. Referrals to other services were provided as needed, including GPs, Centre Link, legal services and psychiatrists.

Objective 5. Workforce development

The workers interviewed had varied qualifications, experiences and roles. The senior workers had undergone specialised training already, more junior workers were extending their knowledge through TAFE courses, including the Family Wellbeing course. Several workers were training to become counsellors. Two peer support workers explained that Family Wellbeing training had been part of their own healing journeys. Families SA provided training to some workers about alcohol, pregnancy and foetal alcohol syndromes.

Workers were also community members, living with many of the same problems and challenges as their clients. Stress and burnout, grief and loss took their toll, leading to high staff turnover and unfilled positions. Therefore a proposal for a healing program for the staff was developed. Other ideas for strengthening team work and morale were also explored, eg bringing teams physically closer together.

The workers told how the women's and men's groups were facilitated by pairs of workers, allowing more experienced staff to mentor and train less experienced staff. Opportunities to debrief with colleagues, and having leaders that value a family wellbeing perspective and respect workers' life experiences and professional skills were reported as advantageous. Informal on-the-job training was often mentioned, including Aboriginal and non-Aboriginal people working alongside each other to enhance cultural safety, and interdisciplinary partnerships within the AFCH program to aid collaboration and enhance mutual understanding of roles and services.

One worker commented on the excellent collaborative working relationship between the Aboriginal health and disability teams and other agencies like Aboriginal Prisoners and Offenders Support Service, and how the holistic and cultural focus of the AFCH Program made that possible. Having health and disability staff working alongside each other provided the opportunity to learn from each other, in particular raising awareness of needs of people with a disability.

The worker's journey

A discussion with 10 members of the AFCH team identified the 'worker's journey' and

revealed the ways in which these workers were also dealing with similar issues in their own lives. It is a significant burden to be continually engaged in family and community problems. They saw the work of healing communities as long term, complex and multi-layered, highlighting the need for longer programs and funding cycles.

Apart from these elements, workers were often in the position of developing cultural awareness in mainstream workers. They believed the most effective way to do this was through collaborative work and role modelling.

The AFCH team had limited capacity due to the intense and extensive nature of their work, issues within their own families, and other responsibilities. Aside from insufficient staff and funds, there were also restrictions on how and where funding could be deployed. Continual restructure of the regional health service impacted greatly on staff morale and program integrity - many workers and clients commented on the resulting downgrading of popular program components and reduced staff capacity.

Objective 6: Data and evaluation

Although data collection was required as part of their jobs, many AFCH workers did not value, prioritise or set aside enough time for these administrative tasks. Most workers said they recorded only basic statistical information about client attendance, etc for the Community Health Information System. There was no systemic documentation of outcomes and impacts. Several workers kept personal diaries or notes for their own use, about clients and AFCH activities. The facilitator of the structured women's groups made detailed de-identified reflective observational notes about progress of individual clients for her own professional use.

There was no system to share essential client information within the host health service or with other agencies. Hence it was difficult to track client progress or demonstrate program outcomes for internal quality improvement and external evaluation purposes. Also, effective shared information systems are required for appropriate care planning, particularly involving multiple service providers.

Factors that enhance the effectiveness of the AFCH Program

The men's and women's groups were regarded as particularly effective, as they met regularly over a long time period, allowing development of trusting relationships with staff and peers, and a safe environment for discussing family violence – seen as an essential first step to taking responsibility and making change in one's personal life. It was stressed that healing takes time, and in turn requires ongoing support (staff and resources). Some clients attended a group for many months before developing that trust. The provision of transport by the host health service so that clients could attend the groups was named by both workers and clients as essential to program success.

The men's and women's groups allowed sharing of knowledge and information for clients to use if they choose and when they are ready. Having older and younger people together in the groups was seen as a positive by both workers and clients, as younger people tended to be more open, whereas older people could offer insights and solutions based on experience.

The holistic approach of the AFCH Program was also regarded by all as essential, addressing social, cultural, spiritual, emotional and physical dimensions of wellbeing of the individual in the context of family and community.

The AFCH Program provided an opportunity to link health and human service providers for the benefit of the client. The AFCH Program brought in external expertise and funds as required, reducing pressure on existing staff and resources. Co-location of a medical service (GP and allied health professionals) with AFCH Program components (women's group, Zebra Finch men's group, etc) supported holistic and timely care for clients.

Discussion

The AFCH Program had been operating for 2 years when the evaluation was conducted. It comprised a complex set of activities and programs offered according to available resources and demand. Strengths of the program included evidence-based design, committed staff, linkages, peer support, mentoring, and Aboriginal cultural focus. Strategic partnerships between health and human service sectors including creative allocation of funds and human resources, as well as a strong long-term vision for the AFCH Program in the context of wider plans for the region, kept the program going despite the challenges of ongoing organisational restructure, insufficient staff and short term funding.

Clients and workers were overwhelmingly unanimous in their support for the program, and their testimonies provided ample evidence for the beneficial impacts on clients, families and the community.

The evaluation showed clearly that the AFCH Program met its primary objectives, despite significant organisational challenges, and that there is scope for expansion and refinement in future. Recommendations developed collaboratively by the external evaluators and the AFCH team include: to continue, expand and sustain the AFCH Program; to resource Aboriginal health teams adequately to deal with complex health and social issues and manage crises; and to introduce systemic data collection and information management protocols. Some barriers were beyond the control of the AFCH team, eg sustainable funding and organisational support, and need to be addressed at a higher level [17].

The final evaluation report [18] was well received by the funding body, and the AFCH Program was lauded by the Productivity Commission as an effective strategy against Aboriginal family violence [19]. However, funding and organisational support has not continued for this program although it is known to be effective and is highly valued by the community. Such decisions beg the question of government commitment to evidence-based care.

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