

PROJECT EVIDENCE

PROJECT EVIDENCE for Prevention of Mental Disorders.

[2] Selective Programs are indicated for situations where subjects are at high risk of developing mental disorders unless there is preventive intervention.

[2 c] Social factors

- i Indigenous families
- ii Immigrant families, especially asylum-seekers
- iii Children involved with bullying
- iv Children in out-of-home care

[2 c i] Indigenous families

The project coordinator is Dr Suzie Dean. The current version can be modified by consent. If you wish to contribute to the project, please email admin@mhyfvc.org or contact Suzie on 0412 030 347 or suz.dean@bigpond.net.au

Indigenous peoples are known to have been established in Australia and its islands for over 70,000 years, and probably longer. Many nations and language groups flourished, enjoying rich and complex family and cultural life.

Today, however, Australian indigenous communities experience disadvantages at all levels of health, educational, economic, occupational, and psychosocial life. This situation is believed to be a product of colonisation and associated dispossession and traumatisation over some two hundred years. The life expectancy of indigenous people is significantly shorter than for the average Australian. Rates of physical ill-health, family disruption, unemployment and imprisonment are higher than average. The rate of mental ill-health is also high. There is an ongoing cycle of social disadvantage. Through transgenerational processes, psycho-social expectations are eroded by the trauma of the past and by ongoing disadvantage perpetuated by society at large. Children, adolescents and adults alike are affected.

Scope of the problem

The last census reported 47,333 indigenous persons in Victoria, of whom about 20,000 are children and adolescents. The prevalence of child mental health disorders is known to be high, with surveys showing about one quarter of the whole child population affected in any year. Children and adolescents are found to be at high risk of depressive and anxiety disorders, along with behavioural disorders and substance misuse.

Less than one-in-ten disturbed children and adolescents in overall Australian society receive appropriate treatment, and those of indigenous communities experience very significant barriers to utilisation of services. Some recover spontaneously from their difficulties, but others go on to become more severe. Even those who recover may have significant consequences, such as dropping out of school or failing to achieve to the level of their ability. Some are dealt with by other agencies, such as school counsellors, engagement officers, or youth work or family support agencies, and some may enter the youth justice system. Another dimension here is the relatively high rate of indigenous children placed in out-of-home care, not always in kinship care.

Though treatment is important, prevention is just as important. It is not suggested that all children with psychosocial problems should be treated by specialist mental health services, but it is suggested that the network of community supports should have the capacity to recognise and respond to children's emotional needs and have the option of referring those children who are not responding to appropriate community-based management. This means that community agencies should be assisted to incorporate a positive mental health and wellbeing dimension to their work through the availability of consultation services.

MHYFVic has established a Project Group to assist in improving this situation.

AIMS

- To work with indigenous communities to identify the mental health needs of Indigenous children in Victoria, especially where further support or funding of services is required
- To support indigenous communities in addressing service shortcomings by advocacy in various forms, especially to government
- To uphold and promote the principles outlined by the Council of Australian Governments (2009) in the “National Framework for protecting Australia’s Children 2009-2020” concerning protection of children from abuse and neglect.

PROPOSED ACTIVITIES

- Meetings with individuals and groups with special knowledge or expertise concerning the mental health of children in Victorian indigenous communities — including parents and indigenous workers — to pursue the above aims
- Development of opportunities to meet with indigenous communities elsewhere in Australia, with the help of our national body, ‘Emerging Minds’, previously known as AICAFMHA (Australian Infant, Child, Adolescent and Family Mental Health Association)
- Facilitation of indigenous representatives to present concerns at relevant conferences, including joining with the indigenous peoples of other countries to help set an international agenda relating to mental health and indigenous children around the world through the Working Party for Indigenous Children and Youth of the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP).
- To advocate for improvements in mental health services for indigenous communities, through various means including consultation.

Dialogue is complemented by a process of gathering information about best practice methods of dealing with such issues, by then progressively publishing selected documents on this website, and progressively formulating relevant policies for MHYFVic to advocate in its lobbying of authorities concerned.

SELECTED DOCUMENTS

The following publications highlight some important aspects of provision of both preventative and treatment service for the indigenous community:

[1] “Stability within chaos: the Koori Kids Mental Health Network” by David Mushin, Carol Potter, Anne Boothe, Kaye Geoghegan, Ola Krupinska, Campbell Paul and Nareida Wyatt, published in Australasian Psychiatry Volume 11 Supplement 2003.

[2] “Gayaa Dhuwi (Proud Spirit) Declaration, National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH)” [Download pdf]. This declaration builds upon earlier statements which include guiding principles for indigenous services which are acknowledged in the Best Practice model.

[3] “Federal Responsibility to Aboriginal and Torres Strait Islander Australians” Statement 30 August 2018 by Secretariat of National Aboriginal and Islander Child Care (SNAICC).

[4] “Submission to the Government of South Australia on the Children and Young People (Oversight and Advocacy Bodies) (Commissioner for Aboriginal Children and Young People) Amendment Bill 2018”, September 2018 by Secretariat of National Aboriginal and Islander Child Care (SNAICC).

[5] “IACAPAP Declaration on the Rights of Indigenous Children, Adolescents and Families to Mental Health and Wellbeing” International Association for Child and Adolescent Psychiatry and Allied Professions, July 2018.

[6] "Not one size fits all: Understanding the social and emotional wellbeing of Aboriginal children", by Muriel Bamblett, Margarita Frederico, Jane Harrison, Annette Jackson and Peter Lewis, 2012 . Report of research funded by Australian Institute of Aboriginal and Torres Strait Islanders (AIATSIS).

[7] "Working with Indigenous Communities in Australia: A personal perspective" by Dr Suzanne Dean, psychologist and psychotherapist, a paper presented at the IACAPAP Congress in Durban in the symposium on Indigenous Mental Health.

[8] "Culturally informed case conceptualisation: Developing a clinical psychology approach to treatment planning for non-indigenous psychologists working with Aboriginal and Torres Strait Islander clients", by Megan Killcullen and Andrew Day. Clinical Psychology, 22 (2018), 280-289.

[9] "Barreng Moorop": The aboriginal children family justice program"

References:

[1]

Stability within the chaos: the Koori Kids Mental Health Network

David Mushin, Carol Potter, Anne Booth, Kaye Geoghegan, Ola Krupinska, Campbell Paul and Nareida Wyatt

Australasian Psychiatry Volume 11 Supplement 2003

Introduction: The Koori (Aboriginal term for indigenous people from South Eastern Australia) Kids Mental Health Network is a child, adolescent and family psychiatric service based at the Victorian Aboriginal Health Service, a community health service which is controlled by the Victorian Koori community and based in Melbourne. The Koori Kids Mental Health Network is a collaborating group of indigenous mental health workers from the Victorian Aboriginal Health Service and other health services together with a network of non-Indigenous workers from mainstream child and adolescent mental health services.

Method: This article is a distillation of a 3-hour workshop involving seven members of the Koori Kids Mental Health Network. It comprised an introduction regarding the development of the Network, a section on the process by which indigenous and mainstream workers have developed their working relationships and fostered each other's development according to the needs of Indigenous families, and a section on the nature of the service provided to these patients.

Results: A child and adolescent psychiatric service, relevant to the needs of the Victorian Aboriginal community, has developed through the collaborative functioning of mainstream and aboriginal mental health workers. It has been critical for the development of such a service that it be coordinated by an Aboriginal mental health worker and located within a health service administered by the Aboriginal community. The workshop enabled presentation and discussion of material leading to an understanding of the Service and its development.

This article is a distillation of a 3-hour workshop involving seven members of the Koori Kids Mental Health Network, a child and adolescent psychiatry service run under the auspices of the Victorian Aboriginal Health Service. The workshop and this paper proceed in three sections, the first section dealing with the development of the Koori Kids Mental Health Network within the Victorian Aboriginal Health Service, its origins, goals, and objectives, and the areas of responsibility on both the health service and the network. The second section describes the process by which

indigenous and mainstream workers developed through working towards providing a culturally and clinically appropriate mental health service for Aboriginal children, adolescents and families in Victoria. This involved both individual and team development as a working and mutually supportive unit. The last section focuses on clinical work with clients and the role of network members in its provision.

HISTORY AND DEVELOPMENT OF THE SERVICE

The Victorian Aboriginal Health Service was established in 1973. A particular impetus to its development was that members of the Aboriginal community in Victoria had difficulty in finding and accessing health services that were appropriate to their cultural and clinical needs. There were particular issues facing Aboriginal children and adolescents whose families sought appropriate mental health services. Professionals from mainstream facilities had little knowledge and understanding of the family and community culture in which aboriginal children developed and lacked expertise in relating to Aboriginal families. There were often misunderstandings and misperceptions, for instance the assumption of neglect if Aboriginal children were left to be cared for by other community members, a process very much part of Aboriginal culture. Furthermore, Aboriginal parents had major difficulties in trusting Caucasian professional authority figures given the prior history of Aboriginal children being forcibly removed.

Towards the end of the 1980s, Carol Potter, Campbell Paul and Margaret Rowell (a paediatrician), together with medical practitioners at the Health Services, established a series of meetings in an attempt to formalise a network of people who would be able to work with Aboriginal children and their families. This involved developing a sense of shared knowledge and trust with subsequent involvement of mental health professionals from child psychiatry clinics around Victoria. Part of the agenda was an exploration of what professionals might have to offer Koori families and their children. It was clear that mainstream professionals would not automatically be accepted simply because of their professional status. They would need to be experienced as suitable for the task. The meetings have continued and have been an important part of developing and consolidating the network. They have provided a forum in which network members can feel linked with each other and other parts of the Victorian Aboriginal Health Service. They have also facilitated the working through of sensitive cross-cultural issues relevant to the members of the Koori Kids Mental Health Network. A particular unifying and facilitating factor has been the role of the Aboriginal co-coordinator, initially Carol Potter and more recently Les Corlett. An important development was the success of applications to the Commonwealth for funding of the coordinator's position, two Aboriginal mental health workers and for mainstream mental health workers. Specialist services have been donated by mainstream psychiatric services as listed above and by a private practitioner.

The goals of the Koori Kids Mental Health Network are:

1. to ensure early detection and proper management of behavioural and emotional disturbances among Koori children;
2. to search actively for these problems in the Koori Community, and
- 3 to combine child psychiatric expertise with a knowledge of the Aboriginal culture in developing the optimal management of mental health problems in Koori families.

Objectives of the service are:

1. to promote community participation and control;
2. to develop and support a network of child mental health professionals for case work and consultation;
3. to liaise with other Koori community and mental health services;
4. to raise awareness in the community of mental health issues affecting Aboriginal children and families.

It has been our experience that these objectives are best achieved by a team coordinated within and under the control of an Indigenous agency, the Victorian Aboriginal Health Service. The membership of the Koori Kids Network includes the coordinator and the two Aboriginal liaison health workers who are involved with mainstream paediatric services. Mainstream staff include two child and adolescent psychiatrists, three psychologists, two social workers and a paediatrician. The psychiatrists, psychologists and social workers provide assessments and treatment, individual and family psychotherapy, and agency consultation. The network also includes Aboriginal staff from other settings (Aboriginal liaison health workers) and mainstream professionals who may conduct their clinical work with Aboriginal clients in other settings including one child psychiatrist who is able to offer an alternate private venue, which is required for some families. Aboriginal mental health workers from the network are also members of committees planning clinical services in mainstream facilities.

THE PROCESS OF DEVELOPMENT OF THE NETWORK

The formation of the network involved a coming together of Aboriginal mental health workers working within an Aboriginal agency and professionals whose education and experience had occurred within traditional mainstream child and adolescent psychiatric settings. The synthesis of the differing backgrounds, experiences and ways of thinking together about the service took time and was challenging for all. The non-Aboriginal workers found themselves in a situation which was quite unfamiliar. They each had their professional background and experience and through the meetings had learnt quite a lot about Aboriginal issues. They had become aware of heartbreaking stories of dispossession, stolen children and cultural breakdown resulting in parents and their children having serious psychological and emotional problems. However, they were not prepared for the personal impact of the experience. Each of the mainstream workers involved in the early days in the network experienced a profound sense of displacement and alienation. Aboriginal workers appeared uninterested that these professionals had come for meetings to start a service and it took a long time to arrange client work, leaving the mainstream professionals feeling undervalued and unwanted with feelings of anger for having put themselves out.

Common to experiences of working this through was that it required an understanding that Aboriginal people had long experience of others expressing interest in them and then disappearing. It took time for outsiders to become relevant. Time was spent engaging in conversation with Aboriginal people who happened to be around, often in the waiting area, a process that had a complex significance, enabling these workers to learn something of the people at the Health Service and to feel more familiar with the setting. It is possible that it also enabled non-aboriginal workers to be more visible within the Aboriginal Health Service.

Part of the experience for the non-Aboriginal workers was that the work does not necessarily take place in the usual defined clinical setting. Patients and family members were found to raise important issues in what appeared to be informal discussion. A second common theme was the importance of the support and input from the Aboriginal mental health workers and the coordinator, and the mutual support experienced in the network meetings. This was critical in helping mainstream workers accept difference and adapt to the new cultural environment. A third factor was the capacity to think about the experience, to understand that things took time and that sporadic contact can be meaningful. An important aspect of the professional development of mainstream workers has been to be able to better manage themselves in situations which are found to be emotionally threatening and where they cannot fall back on a sense of professional authority. Each commented in different ways that this process has led to a sense of having a role and function and a sense of belonging within the network, and that the process of self-management was an important part of the professional development. Locating and contextualising is an important aspect of the culture in Aboriginal communities and managing personal inquiries in an appropriate and non-defensive manner becomes an essential part of the interaction within the work setting.

A parallel set of issues was experienced by the Aboriginal mental health workers, who were professionals with specialist expertise and qualifications. It was important for them to learn what the mainstream workers did and whether this would be acceptable to the Aboriginal community. Part of their task was to help mainstream colleagues adapt their ways of working. This was a daunting task for an Aboriginal mental health worker who may not have

completed secondary education. It involved supervising and modifying the work of professionals who had a tertiary education and a sense of professional authority. The coordinator, whose commitment to the network played a large part in everyone persevering, commented that the recognition of her role and status by mainstream colleagues helped her both in her role and in acquiring mainstream knowledge and expertise. She and other Aboriginal workers have undertaken further education through a training course set up for mental health workers within mainstream child and adolescent psychiatry facilities leading to a Graduate Diploma in Mental Health Sciences - a significant challenge given the general lack of experience in later secondary arid tertiary education.

ASPECTS OF CLINICAL SERVICE PROVISION

Much of this service involves clinical work with children, adolescents and families. In 2000/2001 there were 560 appointments with clients seen at the Health Service. There were quite a number of missed appointments, frequently for a first session, and the figures do not include clients seen in other venues. In addition to direct clinical work, the network provides primary and secondary consultation to Aboriginal and non-Aboriginal agencies with regard to their work with the Aboriginal Community. Tertiary consultation (for instance, through workshops) is also undertaken and some mainstream Network members provide advice to their organisations regarding services to the Aboriginal community. Together, these combine mainstream knowledge with Aboriginal cultural perspectives to develop notions of service delivery that are acceptable to the Aboriginal community. Since the inception of the Network, there have been significant changes in the response of the Victorian Aboriginal community to the child psychiatry services. Families are found to better recognise their children's mental health problems and there is a much greater openness to approaching the service for help.

The clinical work involves both Aboriginal and mainstream workers. The Aboriginal mental health workers are involved in a broad range of functions including intake, assessment, psychotherapy (either individually or in conjunction with mainstream workers), family counselling and crisis intervention. They also provide liaison within the Victorian Aboriginal Health Service and with outside agencies, case conferencing, co-work with the paediatrician and with the general practitioners at the health service and are involved in committees and network meetings both in-house and externally. The mainstream workers provide clinical case work, secondary consultation and assistance to Aboriginal staff including training and supervision. In turn, the mainstream mental health workers are reliant on their Aboriginal colleagues for supervision of their work. Part of this is to do with their development of a sensitivity and understanding of relevant cultural issues. Direct consultation also involves issues such as the understanding of a particular family structure and its links with the community or the process of placing clinical material concerning a particular family within a cultural and historical context.

Child arid adolescent mental health problems are often found to involve issues of attachment, identity and loss. The following clinical example relates to aspects of loss that might be found pertinent to such families.

Albert (not his real name), a prep grade boy, had problems following instructions in the classroom and sometimes lashed out at other children when he became frustrated. He was referred to the Koori Kids Mental Health Network by the Victorian Aboriginal Health Service paediatrician for an assessment of his problem-solving skills. Audiometry tests indicated that Albert had fluctuating hearing loss. His mother Natasha said that Albert had always had difficulties discriminating sounds and pronouncing words. During infancy he was hospitalised with a serious lung infection and he had suffered from recurrent ear infections and asthma.

Albert was easily distracted in the classroom and was seen to be shy, timid, unhappy and withdrawn. He sat by himself and only spoke if the teacher spoke directly to him. Initially, there was a meeting with Albert, his mother, an Aboriginal mental health worker and the mainstream mental health worker to whom he was referred. The first impression was of an appealing, serious, cautious boy who was tall for his age. He was reluctant to play with the toys and avoided using pencils and paper. He stayed near his mother and watched her as if protecting her. He hardly spoke but when his mother mentioned him lashing out at other children, Albert suddenly threw the toys into the toy box. His mother

seemed overwhelmed by sadness. She attributed this to her use of alcohol and yandi (cannabis) during her pregnancy and to his missing kindergarten following the death of his father.

A cognitive assessment was undertaken which showed that Albert had skills similar to those of children his age. A speech pathology assessment indicated some communication difficulties which could affect his learning, but not enough for eligibility for special assistance. The story then evolved that the date on which Albert had been assessed was his birthday, which was also the anniversary of his father's death while in custody. A Coronial Enquiry was under way and it became apparent that the family was in mourning and making frequent graveside visits. The family story also revealed that Albert's mother had been reared in foster care and that her mother had been forcibly removed from her family. The work with the family thus involved a focus on profound issues of loss together with school consultation regarding the emotional factors impacting on his communication difficulties.

Many issues relevant to the assessment and management of Albert will be familiar to those working in mainstream psychiatry. However, it is likely that the members of this family were more comfortable in an Aboriginal agency with an Aboriginal health worker present. This case required mainstream expertise [a psychologist], but also the input and expertise of the Aboriginal mental health worker who could assist her mainstream colleague's understanding and provide input and a sense of reassuring familiarity for the family.

DISCUSSION

This paper has outlined the evolution, context and functioning of the Koori Kids Mental Health Network in Victoria, in which people from quite different personal and professional backgrounds have formed a collegial network focusing on the task of providing a child, adolescent and family mental health service for the Aboriginal community of Victoria. The group has had the opportunity to develop within the context of the Victorian Aboriginal Health Service. The development of any such group or network requires an interchange of knowledge, skills and ideas. In this case, the process of merging and integration has occurred in a situation where Indigenous issues are always present. Indeed, as a function of location and administration, the dominant culture of the network is Aboriginal, as is the coordinator. It is felt that this situation has been important for the development of both Aboriginal and mainstream mental health workers. From the mainstream workers point of view, all had the experience of having to understand themselves in coming as outsiders to an Aboriginal context. They have had to learn to accept and deal with their anxieties in this situation and to confront their usual defence mechanisms.

Acknowledgements of differing beliefs, understanding and experience requires a capacity to see the other person or group as quite separate from one's self. This acknowledgement can be a difficult process as it undermines one's sense of certainty about the world and of being able to control the other in a relationship. Such responses, in one form or another, occur in health professionals. They can arise from quite primitive anxieties such as separation anxiety or fear of abandonment. Gillman writes that the need to maintain the sense of integrity in such situations can be seen to lead to the production of stereotypes that arise when self-integration is threatened. In such situations, the sense of one's own 'badness' can be ascribed to others. Feelings of uselessness and helplessness in professionals can lead to distortions in their understanding of material presented by families and constrain the communications from their patients or clients. It has been important for mainstream workers to have a chance to explore such issues in themselves and to do so with the support and guidance of Aboriginal mental health workers. It has also been important for the Aboriginal mental health workers to experience being valued by mainstream professionals. This process has been enhanced through undertaking training in mainstream concepts of child and adolescent psychiatric issues. The location within the Victorian Aboriginal Health Service enables them to do so from their own cultural base.

The location of the Network is important for the clinical work itself. It has enabled a community which previously had significant concern about trusting child psychiatric services, to utilise them appropriately. It provides a venue for other Aboriginal organisations to consult, and a focus for the various members of the network who come from disparate places to put their minds to issues concerning the Aboriginal community. Overall, a critical issue in the evolution of

the Network has been the development of trust between mainstream and Aboriginal mental health workers. Locating the Network within the Victorian Aboriginal Health Service has provided a context in which such trust can develop.

[2].

GAYAA DHUWI (PROUD SPIRIT) DECLARATION

from The National Aboriginal and Torres Strait Islander Leadership in Mental Health, Australia, August 2015.

This Declaration builds upon earlier statements which include guiding principles for indigenous services which are acknowledged in the Best Practice model. It is a companion Declaration to Wharerata Declaration for use by Aboriginal and Torres Strait Islander people. [\[Download pdf\]](#).

[3].

“Federal Responsibility to Aboriginal and Torres Strait Islander Australians”

Statement 30 August 2018 by SNAICC ('Secretariat of National Aboriginal and Islander Child Care)."

Self-determination - Aboriginal and Torres Strait Islander-led initiatives, working to meet the needs of communities - is the path to ensuring that all of our children can achieve their potential.

National Congress of Australia's First Peoples is an organisation underpinned by self-determination, committed to ensuring the voices of Aboriginal and Torres Strait Islander people are heard. This week National Congress voiced its concerns regarding the Prime Minister's appointment of a Special Envoy on Indigenous Affairs.

Any politician tasked with a responsibility to our people carries a great deal of influence as a key decision-maker, whose choices directly impact children and families. Appointments to such roles cannot be taken lightly.

We know what has to be done. We have been asking for self-determination for years, and to date no government has really attempted to take on this challenge. Ask Aboriginal and Torres Strait Islander community-controlled organisations how to work with our people. Collaborate with us. Listen to our voice, and you will hear the answers.

Now, more than ever, we need a Prime Minister who is going to be a champion for our children's rights.

If, as suggested, a Special Envoy on Indigenous Affairs is to focus on improving the lives of vulnerable Aboriginal and Torres Strait Islander children, working alongside our community-controlled organisations seems a logical start.

As the national peak body for Aboriginal and Torres Strait Islander Children, SNAICC invites the Prime Minister, the Indigenous Affairs Minister, and Special Envoy on Indigenous Affairs to meet with us - and with National Congress, and with every member of the Redfern Statement Alliance - to discuss how the Federal Government can support our community-led solutions.

In order to create positive change for our children, the Federal Government must work with the people who understand these issues better than anyone.

[4].

“Submission to the Government of South Australia”.

"Submission to the Government of South Australia on the Children and Young People (Oversight and Advocacy Bodies) (Commissioner for Aboriginal Children and Young People) Amendment Bill 2018", September 2018 by SNAICC ('Secretariat of National Aboriginal and Islander Child Care).

SNAICC welcomes this opportunity to make a submission to the South Australian Government on its children and Young People (Oversight and Advocacy Bodies) (Commissioner for Aboriginal Children and Young People) Amendment Bill 2018.

SNAICC has been encouraged by the foresight of the South Australian Government to appoint a Commissioner for Aboriginal Children and Young People. By specifying this role in legislation with an appropriate mandate, the South Australian Government will be taking a leading role nationally to promote the best Interests and protect the rights of Aboriginal and Torres Strait Islander children.

Establishing the role is a critical step to ensure a whole of state and systems focus on responding to the needs of Aboriginal and Torres Strait Islander children, which is essential in the context of widely recognised and unacceptable disparities in levels of disadvantage and opportunities for First Nations children to thrive. However, there are aspects of the Bill that SNAICC believes currently fall short of what is necessary to ensure both appropriate requirements for the position and the requisite functions and powers to carry out important work. As such, this submission makes recommendations to strengthen the Bill.

FILED UNDER: CHILD PROTECTION POLICY PAPERS, FAMILY AND COMMUNITY SUPPORT - POLICY PAPERS, NEWS, POLICY PAPER.

[5].

The International Association for Child and Adolescent Psychiatry and Allied Professions IACAPAP DECLARATION ON THE RIGHTS OF INDIGENOUS CHILDREN, ADOLESCENTS AND FAMILIES TO MENTAL HEALTH AND WELLBEING, July 2018

IACAPAP declares recognition of certain fundamental mental health rights of children, adolescents and families of indigenous communities everywhere, in concert with the United Nations Convention on the Rights of the Child (1990) and the United Nations Declaration on the Rights of Indigenous Peoples (2007).

Indigenous communities are identified as those within nation states that can regard themselves and be regarded by others as indigenous on account of their descent from the people who inhabited a particular territory (land and waters) at the time of conquest or colonisation of that territory, and who, regardless of their legal status, retain some or all of their own social, economic and cultural traditions. This statement follows United Nations policy, set out by the Indigenous and Tribal Peoples Convention of the International Labour Organisation (1989) and by the website of the UN Permanent Forum on Indigenous Issues (2018).

IACAPAP's Declaration on Children's Rights (Jerusalem, 2001) asserts that all children have the same and equal human rights. Additionally, IACAPAP calls for special recognition of the rights of children affected by Maltreatment, War, Terrorism and Disaster in its Rome Declaration (2003). In this context, **indigenous children, youth, and their families face unique challenges to mental health and wellbeing, challenges stemming from colonisation and dispossession**, often involving warfare which only sometimes resulted in a treaty. The sustained brutality of associated massacres, poisonings, rapes and genocide campaigns commonly leads to transgenerational trauma in communities. Of course, for some, warfare is ongoing today, but wherever colonisation has occurred within the memory of the community, we find that children and youth can continue to experience emotionally its horrific impacts. In addition, colonial dispossession of homeland and of traditions of culture, language, spirituality, kinship structures, and child rearing practices has typically left communities with an abiding sense of loss, affecting group identity and individual self-

identity and dignity. Continuing colonisation by modern, globalised culture and policies of assimilation can further erode traditional culture, often bringing a continuing questioning of basic values by the young.

With remarkable resilience, creativity and commitment to their children, indigenous communities live with an awareness of the great effort required for survival in the face of unemployment, physical and mental health problems, family discord, substance abuse, and justice and welfare issues. The lives of their young can be challenged by absence of hope, even despair, fuelled by negative discrimination, frequent racist persecution by society and governments, and in some places extremes of trafficking, sexual exploitation and child labour.

It is acknowledged here that one of the barriers to addressing the damage wrought by colonisation is that the beneficiaries of colonists appear to inherit, in parallel with indigenous people, disturbing effects of oppression and dispossession. **Members of mainstream society remain victims too, often experiencing deep-seated and largely unconscious anxiety and guilt related to their ongoing failure to act with humanity, if not to historical wrongs.** This awareness of their own loss of humanity in relation to indigenous people is kept at bay both by denial of their own people's history and by a dissociation of feelings accompanying continuing processes of colonisation and oppression.

Of course we cannot speak of attempting to heal the ongoing trauma of colonisation while such processes remain at play. However, indigenous children, as infants and growing young people, may benefit from the special acknowledgement offered by this Declaration. Members of IACAPAP, which represents child and adolescent mental health organisations across the world, can **use this Declaration to join with indigenous groups to advocate, at many and varied levels, for recognition of the rights of indigenous children and youth to mental health and wellbeing. Such advocacy is an ongoing responsibility of the mental health field.**

Indigenous mental health professionals and community leaders have been consulted in the formulation of this Declaration. It is a **Living Declaration, to be discussed and amended in a continuing spirit of collaboration through regular reviews by indigenous communities and mental health professionals**, to ensure clarification of its complexities and to ensure its expanding relevance internationally.

Accordingly, IACAPAP declares special recognition of the following rights to mental health and wellbeing of children, adolescents and families of indigenous communities everywhere.

1. Indigenous children, adolescents and families have the right to experience good developmental health, mental health and wellbeing, in addition to safety and general social and emotional wellbeing in daily life, as identified by the indigenous community to which they belong.
2. Indigenous children, adolescents and families have the right to be recognised and respected as members of the indigenous culture which they identify as their heritage.
3. Indigenous children, adolescents and families have the right to good quality legal, justice, health and welfare services that are appropriately culturally sensitive and competent, as determined by the indigenous community to which they belong.
4. Indigenous children and adolescents have the right to be consulted as individuals about matters affecting their own mental health and well-being and consulted collectively in groups regarding institutions and services involving them; indigenous families have the right to collaborate in institutional decision-making regarding their young.
5. Indigenous children, adolescents and families have the right to expect indigenous community leadership and self-determination in mental health services, supported by high standard clinical and cultural training of both indigenous and non-indigenous professionals in the mental health area.
6. Indigenous children, adolescents and families have the right to expect provision of institutions and policies enabling parents, extended family systems and guardians to care appropriately for their children.
7. Where indigenous children, adolescents and families are educated within a government education system, they have the right to full engagement in preschool, primary and secondary school education

which involves, in both planning and review, consultation with the extended families and community of those indigenous children and adolescents, and which provides opportunity for the education of the young in their own languages.

8. Indigenous children, adolescents and families have the right to access, when a government education is provided, inclusive learning programs embracing the culture, history, language and religion of their traditional heritage, especially regarding healthcare and healing; programs should also include relevant current affairs, especially as these feature participation and achievement by indigenous individuals and groups seeking positive and creative change in society that aligns with indigenous self-determination.
9. Indigenous children, adolescents and families have the right to recognition and consideration by society of the historical community transgenerational trauma which they and their ancestors have experienced through colonisation by the mainstream culture, and to expect such consideration to be built into health, educational and welfare services offered to them, with understanding extended to them by those services, and with affirmative action as determined to be appropriate by their communities.
10. Indigenous children, adolescents and families have the right to expect that these rights inform the relevant laws of the mainstream government concerned, and in the structure and delivery of government services at all levels.
11. Indigenous children, adolescents and families have the right to have their human rights communicated to them by governments in a consultative way, with opportunity for any related concerns to be addressed as determined by indigenous communities themselves.

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[6].

“Not one size fits all: Understanding the social and emotional wellbeing of Aboriginal children”

“Not one size fits all: Understanding the social and emotional wellbeing of Aboriginal children”, by Muriel Bamblett, Margarita Frederico, Jane Harrison, Annette Jackson and Peter Lewis, 2012 . Report of research funded by Australian Institute of Aboriginal and Torres Strait Islanders (AIATSIS).

[7]

Working with Indigenous Communities in Australia: A Personal Perspective

By Suzanne Dean PhD, Clinical Psychologist and Psychotherapist

The challenges facing child and adolescent mental health workers interested in working with children of indigenous heritage, who are probably living within their own communities, may be similar from country to country.

Having worked with Aboriginal and Torres Strait communities in Melbourne for about 13 years, and having shared my experiences with other mental health workers and educationalists who have had a similar privilege, I want to mention some of my experiences of the challenges I've met.

First, some brief comments on the history of Australian Indigenous communities since colonisation

British colonisation of Australia commenced in 1788 with a penal colony in Sydney Cove. At that time there lived in the continent of Australia (including the large island of Tasmania) many separate groups of indigenous peoples. Later, it was found that these peoples had been settled in Australia for up to 70,000 years, since migration from central Asia. There were discovered to be well over 210 distinct tribes, as well as numerous tribes across the small group of islands in the Torres Strait, towards Papua New Guinea. Each tribe, consisting of several clans, had a unique language, and its own religion and culture, although there were profound links between cultures. Each tribe was identified with a definite territory, whose borders were carefully maintained. Within that territory, family groups moved around with the seasons, creating villages where food was plentiful. In desert regions, such movement was more frequent due to the relative aridity. Each feature of the land carried a special spiritual significance. The people were hunter-gatherers, with what has been labelled a stone-age skill base. Many groups developed ways of using fire and other means to cultivate areas of bush for food, some developed complex fish harvesting trap systems, and some built stone villages. These people lived in harmony with the land, surviving successfully in changing environments for, as I said, up to 70,000 years in Tasmania alone.

This stable state of affairs was disrupted by the arrival of the British, who quickly got to know the people settled in the Sydney and Parramatta River area. The indigenous people, soon to be known as Aborigines, were very curious about the building, activity and exploration of the visitors. But they were quickly moved along and came to know what a gun and an invader can do. The British considered that these people lived in makeshift dwellings, lived mainly by random fishing, and were nomadic. They were considered therefore to not possess the land. The land was declared "terra nullius" and ripe for general colonisation. Nomadic people could lay no legitimate claim to "ownership". On this argument, the British Crown took ownership and the colonial government gave out or sold tracks of land as it saw fit. Ironically, the indigenous people themselves laid no claim to ownership, but saw their country as actually owning them, the people.

This dispossession was the first of the atrocities committed by the colonisers. It was swiftly followed up by attacks on Aboriginal groups — even to the extent of poisoning of flour sold to them. This has come to be recognised by a program of genocide — sometimes declared and bloody, and sometimes covert. In many places, the people were rounded up and detained in Mission Centres, ostensibly for conversion to Christianity, sometimes taken as virtual slaves, throughout the nineteenth century, into domestic service or farming for the colonising Europeans. Aboriginal stockmen and trackers actually became legendary. In the twentieth century, complete assimilation became the aim, and government force was the game. Government removal of children from Aboriginal families, and placement of them in white communities, continued until the 1950s. This is our horrifying legacy in Australia — by its nature it involves every citizen, even the most newly arrived immigrant. And little wonder that when Australia celebrated its bicentenary in 1988, indigenous people everywhere stood back and set up celebrations of survival as proud cultural groups. Survival of genocidal policies has required astounding community strength.

Australian Indigenous communities today, despite the gradual enshrinement of Aboriginal Land Rights, are still struggling against tremendous odds. The cost of survival has been heavy. Shameful poverty, both material and cultural, afflicts many indigenous groups. Infant mortality, chronic illnesses and drastically shortened lifespan are still outstanding medical challenges. But the most powerful legacy of dispossession, exploitation and attempted genocide is psychological trauma, passed on from parent to child, through successive generations, and experienced by almost all indigenous individuals today. The shroud of silence drawn over the oppressing and guilty experience of the colonisers, the beneficiaries of the atrocities, was maintained until the 1960s, when breezes of social change began to stir.

The terrible history is now openly acknowledged by many. And an important nation-wide movement towards "reconciliation" has been afoot for several decades, in many places where indigenous and non-indigenous live near each other. This mainly involves the need for the non-indigenous to apologise for the atrocities and abuses of their predecessors, and for the indigenous elders to consider what response can be made, perhaps in terms of requests for support in preserving Aboriginal heritage. However there are many places where reconciliation is a dirty word, and racial prejudice is alive and well.

In many parts of Australia, educational programs are trying to facilitate indigenous children and young people in fulfilling their potentials. Aboriginal sportsmen and women are stars, and Australian society has seen a flowering of indigenous art and culture — in the visual arts, film, drama, dance and music. Our indigenous children and young people have some great role models.

The challenge to the Australian nation is how to free us all from the psychological horrors of the past, in order to grow in strength and to join in with the multicultural mix that Australian society has become. This points to a role for child and adolescent mental health workers.

As a professional in the field with an awareness of the special needs of indigenous children, I find I face a series of special challenges, which I have discovered I share with others. A fifth generation Australian myself, whose immigrant ancestors became farmers, for many years I felt a paralysing guilt in relation to indigenous people. I held back from getting involved in work with them, until in a workshop I met an Aboriginal elder who gently told me that guilt was part of our mutual problem, and I asked me if I could lay it aside and help. Although I did not have the chance to act on this straight away, about a year later such a chance did come my way, and I was welcomed into a community to work with indigenous men recovering from substance abuse.

My next challenge was to set aside my professional priorities around my professional role. I found myself invited to join this community as myself, a person concerned to find out what was going on. Priorities around time-keeping had to be set aside, and we entered a time zone in which plans for action were allowed to emerge from a commitment to mutual understandings and mutual expression of feelings. Plans could not be rushed, and the usual sense of urgent pressure to determine next steps and get on with the job evaporated. This was a liberating experience of course. A while later, some of the men were able to joke with me about the "Aboriginal time" they kept, but seriously connected this with an awareness of the "Dreamtime", the timeless period of creation of the world, when rivers were carved out by the Rainbow Serpent, and mountains were raised. Immersion in a creative process was felt to be the proper way to initiate action.

And so it was. Bye and bye, a place for me emerged and I was entrusted with the precious role of "counsellor". I found I could offer myself openly as an individual psychotherapist with individuals, working in a psychoanalytic framework. I was called on, too, to conduct what were called professional development sessions with rehab centre staff. More recently I have been trying to discover how to connect across indigenous communities on issues relating to children, which means parents and families too. Here again the question of custom and time are paramount. Meetings cannot be held out of certain hours, and the existing links and barriers between indigenous groups must be learned about, understood and fully respected. Professional expectations in these areas must be set aside. One of the challenges in this case is to demonstrate to the indigenous communities that we are not merely interested in scientific or historical research which, in past times, has objectified and thus dehumanised indigenous people.

The goal now is to join with willing indigenous communities, which includes several health and childrens' centres, to request of them the appropriateness of their developing a manifesto of indigenous childrens' rights to strong mental and physical health — a manifesto that can be presented and further discussed at IACAPAP at the Calgary Congress in 2016.

The idea is to share the concerns of Aboriginal children and families with indigenous people from other countries — and see whether a joint manifesto is possible, one that could be endorsed by IACAPAP itself and then shared at a public level.

I now am learning over again how the desire to reach goals must be allowed to inspire rather than drive actions. This is a lesson, I believe, in becoming more truly ourselves. I will be interested to know whether the challenges I have identified so far ring a bell with professionals in other countries engaged in similar learning.

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“Culturally informed case conceptualisation: Developing a clinical psychology approach to treatment planning for non-indigenous psychologists working with Aboriginal and Torres Strait Islander clients”

“Culturally informed case conceptualisation: Developing a clinical psychology approach to treatment planning for non-indigenous psychologists working with Aboriginal and Torres Strait Islander clients”, by Megan Killcullen and Andrew Day. Clinical Psychology, 22 (2018), 280-289.

[9]

Barreng Moorop

THE ABORIGINAL CHILDREN FAMILY JUSTICE PROGRAM (ACFJP)

Jesuit Social Services is in partnership with the Victorian Aboriginal Legal Service (VALS) and the Victorian Aboriginal Child Care Agency (VACCA) to deliver the Aboriginal Children Family Justice Program (ACFJP). The program will provide integrated and intensive case management support to Aboriginal children, aged 10-14 years of age who have current involvement with the justice system. The program is a three-year pilot project funded by the Department of Prime Minister and Cabinet; and is being evaluated by Griffith University.

The purpose of this support is to address the issues underlying the young person’s criminal behaviour. These may include however not limited to; family dysfunction, mental health issues, trans-generational trauma, attachment difficulties, intellectual disabilities, experiences of violence and abuse, poverty, disengagement with the education system and lack of social connection.

In addition, the purpose is to bring together different service providers and the family around the young person in a comprehensive way, to provide ‘wrap-around support. We recognise the importance of an approach that engages with all members of the family including siblings, parents, careers, and Elders. Through the program, young people and their families access relevant welfare, housing, family and education services. Partnership with Aboriginal controlled agencies, and experienced staff members are seen as an essential part of the model. Trauma specific counselling and family therapy will be available through partner agency VACCA.

Criteria:

- Aboriginal or Torres Strait Islander Young People
- Aged 10-14 years of age who are at risk of becoming further involved in the criminal justice system. This may include justice system contact for the young person, or members of their family - or simply at risk for a variety of other factors (eg. low school attendance).
- Reside in the North West Metropolitan Area

Referral:

- The referral will be triggered through the D24 notification VALS - new or existing), OR identified risk by other organizations

- The referring agencies must send through a "Barreng Moorop Referral Form" (attached) to the email address: mailto:ACFJP_Referrals@jss.org.au or call Tamara on 0417 520 293
- Jesuit Social Services will then contact the young person and their family to ascertain whether they are willing to be a part of the program. and start the intake process.

For further information contact: Tamara Hanson (mobile) 0417 620 293

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