Central Northern Adelaide Health Service

Family and Community Healing Program

Evaluation Report 31 March 2008

Flinders UNIVERSITY

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CNAHS
FAMILY AND COMMUNITY HEALING PROGRAM

Final External Evaluation Report

31 March 2008

Submitted by

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ISBN 978-0-7258-0780-1 CNAHS Family and Community Healing Program - Paperback
ISBN 978-0-7258-0781-8 CNAHS Family and Community Healing Program – Online

ACKNOWLEDGEMENTS

We thank all the CNAHS workers, supporters and clients who generously shared their experiences of the Family and Community Healing (FCH) Program, and their wisdom and ideas, for this evaluation. Special thanks to Terry Stewart and Irene Wanganeen who led and managed the CNAHS Family and Community Healing Program, and also to Cyril Coaby and Joanne Else our Aboriginal co-evaluators and cultural mentors. We particularly thank the women who generously shared their personal stories for this Report, also the clients who allowed us to illustrate the Report with their art, wood carving and poetry. Their stories and creative works demonstrate and symbolise their journeys of healing.

Members of the CNAHS Aboriginal health teams at Gilles Plains (above) and the Parks (below)

EXECUTIVE SUMMARY

The Family and Community Healing Program aims to develop effective responses to family violence that address the levels of complexity within Aboriginal families and communities in the Central Eastern/Western metropolitan region of Adelaide. The focus of the Program is on early intervention and capacity building for Aboriginal families, promoting the TAFE Family Wellbeing Model (a foundational counselling course) as a key approach and including a range of other therapies. Within the model, community health workers provide various group activities with the aim of building confidence, increasing personal skills in conflict resolution and increase awareness of forming positive relationships. As part of increasing wellbeing, individuals are also encouraged to join health lifestyle activities and participate in pre- vocational or employment initiatives and opportunities. As well as a focus on Aboriginal families, a range of options for men were proposed including accommodation options as an alternative to women and children needing to move in a crisis. Capacity building in mainstream agencies and services was a goal so that issues of family violence could be addressed within the broader community context. The key focus of the Program is on family and community healing, to equip people with the skills for effective communication and conflict resolution.

The information that forms the basis for this evaluation report was collected from February 2007 (following ethics approval) to March 2008. A participatory action-oriented evaluation design was chosen. The findings are presented in relation to the six objectives of the Program.

Objective 1: Build community capacity to support safe families

The FCH Program comprises a complex range of inter-related activities, programs and partnerships implemented by an enthusiastic and committed workforce. It provides holistic and culturally appropriate strategies that enhance the safety and wellbeing of Aboriginal families and communities in the northern metropolitan region of Adelaide. Workers and clients are unanimous in their support and enthusiasm for the FCH Program. Clients report how involvement in the Program increases self esteem, confidence and cultural connection, equips them with skills and knowledge to move out of a life of violence and on to a journey of healing. A positive ripple influence on clients' family members and peers was noted. Key factors required for FCH Program success were identified including: peer support and mentoring, cultural focus, long-term commitment, intersectoral linkages, sharing information, holistic approach, organisational support and adequate resources.

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

Clients gained communication and conflict resolution skills through participation in the FCH program, enabling them to address the reasons for and consequences of family violence. Peer support, learning to trust again within the safety of the groups, accessing counselling, role modelling respectful communication, formal and informal learning are key strategies.

Objective 3: Support families in crisis

Support for families in crisis is provided as needed, with care pathways and referrals organised on an ad hoc basis. Linkages between health and human service providers, ranging from formal service agreements to personal relationships between workers, are vital.

Objective 4: Build capacity of mainstream agencies and services within the region to address Aboriginal family violence issues within the broader community context

Collaboration with other agencies is the key to strategic advancement of the FCH Program for mutual benefit and sustainability. Linkages with a wide range of mainstream organisations have been developed to share resources, help with referrals and follow-ups

Objective 5: Workforce development

Informal on-the-job learning was the most common form of workforce development that occurred through the FCH Program. Peer support, mentoring by experienced workers and community elders, and interdisciplinary partnerships were identified as effective learning supports. Some workers already had appropriate qualifications, and a few undertook TAFE or other relevant courses. Workers described their own journeys through the FCH program, emphasising the importance of sustained funding and organisational support for the Program

Objective 6: Data and evaluation

At present there are limited quantitative data available that describe the activities and outcomes of the FCH Program. More regular and systematic data collection and review are needed. The qualitative information collected for the external evaluation, including first hand accounts from clients and workers, demonstrate how the FCH Program has changed lives and benefited the community.

Conclusions

The Aboriginal health teams in the central eastern and western regions of CNAHS have been conducting the FCH Program for 2 years now. The Program comprises a complex and dynamic set of group activities for Aboriginal women, men and youth built around community engagement, and is offered according to available resources and demand. Strengths of the Program include evidence based design, holistic approach, clinical focus, committed staff, inter-sectoral linkages, peer support, mentoring, and Aboriginal cultural focus. Strategic partnerships between health and human service sectors including creative use of funds and human resources as well as a strong long-term vision for the FCH Program in the context of wider Health plans for the region, have kept the Program going despite the challenges of ongoing organisational restructure, insufficient staff and short term, restrictive funding.

Clients and workers are overwhelmingly unanimous in their support for the Program, and their stories provide ample evidence for the beneficial impacts on Aboriginal clients, families and the community. This evaluation shows clearly that the FCH Program, while still in its infancy, is already meeting its objectives. There is also some scope for expansion and refinement in the future. The CNAHS FCH Program is clearly a successful model for family and community healing. It must be recognised that healing takes time, often many years, and that the Program should therefore be supported in the long term.

Recommendations

- Continue, expand and sustain the FCH Program
    - maintain the Program's regional approach to strategic planning and funding allocation
    - maintain and support aspects of the Program that contribute to its success, eg holistic approach, multiple components, cultural focus, clinical interface, inter-sectoral linkages, transport help for clients to attend
    - increase Program activities for men and male youth
- Resource Aboriginal health teams adequately to deal with complex health and social issues and manage crises.
    - include positions within the Aboriginal health teams that connect FCH Program clients with health services, eg occupational therapist, social worker, peer support workers
    - enable client/family centred care paths through referral protocols and information-exchange
    - provide workforce training, eg suicide intervention, mental health first aid

- provide cultural training for all workers, recognising the diversity of the Aboriginal people

- Introduce systematic data collection and information management protocols
  - provide workforce training, infrastructure support
  - develop a participatory action research approach to enhance the FCH Program, eg through continuous quality improvement and development of case management

CONTEXT / LITERATURE OVERVIEW

It is well accepted that family violence seriously impacts on the lives of many Indigenous individuals, families and communities. Indigenous people experience family violence at substantially higher rates than other communities in Australia. In some areas, Indigenous women are 45 times more likely to experience violence, and ten times more likely to die as a result (Apunipima, 1999:11). High rates of Family Violence help to "effectively disable many communities and deny future generations a basic chance for health, happiness and prosperity" (Memmott et al, 2006: 1). Understandings of unacceptable 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 vilifications, economic exclusion and entrenched poverty; breakdown of gender roles; intergenerational effects of institutionalisation, racism, 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" (NACCHO, 2006: 4). While not excuses for violence, these factors help to understand its manifestations (NACCHO, 2006). Such understandings also inform the approaches to programs aimed at changing the situation.

Defining Family Violence

Indigenous concepts of Family Violence are much broader than mainstream definitions of Domestic Violence and the term Family Violence better reflects Indigenous experiences. "Family Violence involves the use of force, be it physical or non- physical, which is aimed at controlling another family or community member and which undermines that person's well-being. It can be directed towards an individual, family, community or particular group. Family violence is not limited to physical forms of abuse, and also includes cultural and spiritual abuse. There are interconnecting and trans-generational experiences of violence within Indigenous families and communities" (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2006: 5). This same report recognises that there are significant deficiencies in the available statistics and research on the extent and nature of family violence in communities. Rates are unacceptably high and recognition of this situation has existed for two decades with no identifiable improvement (Aboriginal and Torres Strait Islander Commissioner, 2006). Mainstream strategies for addressing Family Violence are not sufficient because Indigenous women's experience of violence is related to the colour of their skin as well as their gender. Identity as an Aboriginal woman often binds women more to their community, including the men of their

community, than to their experiences of sexism, as experienced by non-Indigenous women.

Overview of responses to Family Violence

Awareness of the disproportionately high and widespread levels of Indigenous family violence was raised initially by the Royal Commission into Aboriginal Deaths in Custody in the late 1980's and early 1990's (Memmot et al 2006). Early reports on Indigenous Family Violence included the 1998 report "Working with Adolescents to Prevent Domestic Violence" (Indermaur, Atkinson and Blagg, 1998), "Violence in Indigenous Communities"(Memmott, Stacy, Chambers and Keys, 2001), "Rekindling Family Relationships, Forum Report" (Office of the Status of Women, 2001a), and the "Aboriginal and Torres Strait Islander Women's Task Force on Violence Report" (Queensland Dept. of Aboriginal and Torres Strait Islander Policy and Development, 2000).

Over the past decade, Federal, State and Territory levels of Government have undertaken significant enquiries and initiatives. Perhaps the most significant of these was the abolition of ATSIC (Aboriginal and Torres Strait Islander Commission) and ATSIS (Aboriginal and Torres Strait Islander Services) – previously the key bodies through which programs and services were provided to Indigenous Australians (Memmot et al, 2006). Mainstream government Departments now have responsibility for all Indigenous specific programs, and service delivery is coordinated through whole of government approaches. Family Violence initiatives are overseen by the Commonwealth Department of Families, Community Services and Indigenous Affairs (FaCSIA), with responsibility for prevention shared with the Attorney General's Dept (Minister Assisting the Prime Minister for Indigenous Affairs). Other programs run by FaCSIA that focus on strengthening Indigenous families and communities, and play a role in addressing family violence, include the Stronger Families and Community Strategy, the Family and Community Networks Initiative, Reconnect, the Indigenous Parenting and Family Wellbeing Program and the Responding Early Assisting Children (REACh) Program (FaCSIA, 2005a).

Distribution of funding to community based Indigenous family violence programs (National Indigenous Family Violence Grants Programme (NIFVGP), OSW, 2001b), reflects the complexity of the problem and recommends a holistic approach that includes an understanding of the historical influences alongside the factors of disadvantage that contribute to high prevalence rates. Culturally specific principles that are embedded in NIFVGP are:

- Cultural appropriateness
- Support for community based organisations and initiatives implemented at a local level
- Embracing all sections of the Indigenous community
- Increasing community capacity and leadership to respond to violence
- Embracing Indigenous culture and identity
- Enhancing family relationships

The approach also includes fostering collaborations between local community-based Indigenous organisations and other agencies, in government and non-government sectors.

Evaluating Indigenous Violence Projects

There are very few published evaluations of these programs in Australia. This is partly related to the lack of anti-violence grants programs specifically targeting the Indigenous community (Memmot et al, 2006). There is a lack of reporting on empirical evidence, and specifically the failings of violence programs. The conclusions reached by Memmot et al (2006) in their paper "Good Practice in Indigenous Family Violence Prevention – Designing and Evaluating Successful Programs" – was based on a review of the Aboriginal Remote Areas Night Patrols, Central Australia; The National Walking Into Doors Campaign, The Apunipima Project, Cape York; Yirra Yaakin Noongar Theatre, Western Australia and Circle sentencing as a form of community justice, NSW. Also included was the evaluation study of Partnerships Against Domestic Violence 1, and information provided by OSW on projects funded under NIFVGP, as well as on reviewed international projects. This review identified the following elements of good practice:

- Cultural grounding of projects
- Community grounding of projects
- The engagement of men into programs
- Ensuring the involvement of Elders
- Self-empowerment and self-esteem as capacity-building by-products
- Examining inter-generational family history and colonial experience as a healing element
- Cultural preference for group approaches
- Capacity building through networking and partnerships
- Information collection and dissemination
- Training and skills acquisition
- Flexibility and adaptability of projects (Memmot et al, 2006: 20).

These authors also state the importance of describing program shortcomings to avoid repeating ineffective programs. Indigenous programs face significant and real barriers to effective program execution including:

- Lack of suitable sectoral partnerships for program delivery
- Lack of coordination at the local level
- Lack of training and skills amongst program staff
- Lack of funding or insufficient funding
- Community politics interfering with program execution
- Programs not directly targeted at the worst forms of family violence in a community, which may appear too awesome to tackle
- Programs being predominantly reactive and not balanced with proactive components to reduce incidents of violence
- Lack of coordination or fragmentation between State and Commonwealth goals and programs
- Violence intervention staff themselves can be threatened and/or assaulted by violent persons
- 'Burn out' amongst staff caused by regularly dealing (Both during and out of work hours) with the constant, stress-inducing occurrences of violence in the community (Memmot et al, 2006: 20).

The Family and Community Healing Program Evaluation recognises the above elements of good practice and barriers to effective program implementation in its design and assessment of the program. These are consistent with other reports that have identified good practice including the Evaluation of the FVRAP (2005) and the NACCHO report (2006).


BALANCE

BACKGROUND, PLANNING AND ETHICS

The aim of the Central Northern Adelaide Health Service (CNAHS) Family and Community Healing (FCH) Program is to develop effective responses to family violence that address the levels of complexity within Aboriginal families and communities in the north western metropolitan region of Adelaide. The Commonwealth Government (FaHCSIA) contracted CNAHS to develop and implement the FCH Program, and external evaluation at 12 and 24 months is an integral part. This is the final (24 month) external evaluation report. It expands on the interim (12 month) report of March 2007.

The purpose of this 24 month external impact evaluation report is to provide information on the outcomes of the Program, as specified in the FCH Program schedule (attachment 1)

The external evaluators are Dr Inge Kowanko, Leader of the Flinders Aboriginal Health Research Unit and Dr Charmaine Power, Associate Professor in the School of Nursing and Midwifery, Flinders University. They have extensive experience of working with Aboriginal people on research and evaluation projects, and expertise in family violence, community wellbeing and women's health. In September 2006 the external evaluators met with leading CNAHS personnel responsible for the FCH Program (Terry Stewart, then Regional Manager, CW&E Regional Aboriginal Health Team: Irene Wanganeen, Manager of the Family and Community Healing Program since Feb. 2007; and Di Jones, then Director of Programs and Services: Primary Health Care) to discuss the Program and the process of evaluation. The Evaluation Plan (attachment 2) was developed in collaboration with the FCH team and finalised in November 2006. The evaluation plan included collection of qualitative and quantitative data using mixed methods, including:

- interviews with Aboriginal clients and participants of the Program
- interviews and focus groups with FCH workers, peer educators, volunteers and other stakeholders
- review of documents regarding FCH Program processes and outcomes.

The evaluation plan specifies how these methods were used to explore the impacts of each Program objective.

The evaluators sought research ethics approval from three relevant research ethics committees in December 2006. This meant preparing a detailed submission including information letters and consent forms for participants and indicative questions for

interviews (attachment 3). All approvals were gained:

- Flinders University Social and Behavioural Research Ethics Committee gave conditional approval on 21 December 2006 and final approval on 25 January 2007.
- SA Aboriginal Health Research Ethics Committee (AHREC) gave approval via email on 14 February 2007, and an official letter of approval was received 8 March 2007.
- Department of Education and Children's Services (DECS) indicated no need for its committee to consider the proposal and was satisfied with copies of approval letters from the other committees (emails and telephone calls during January-March 2007, official letter received 21 March 2007).

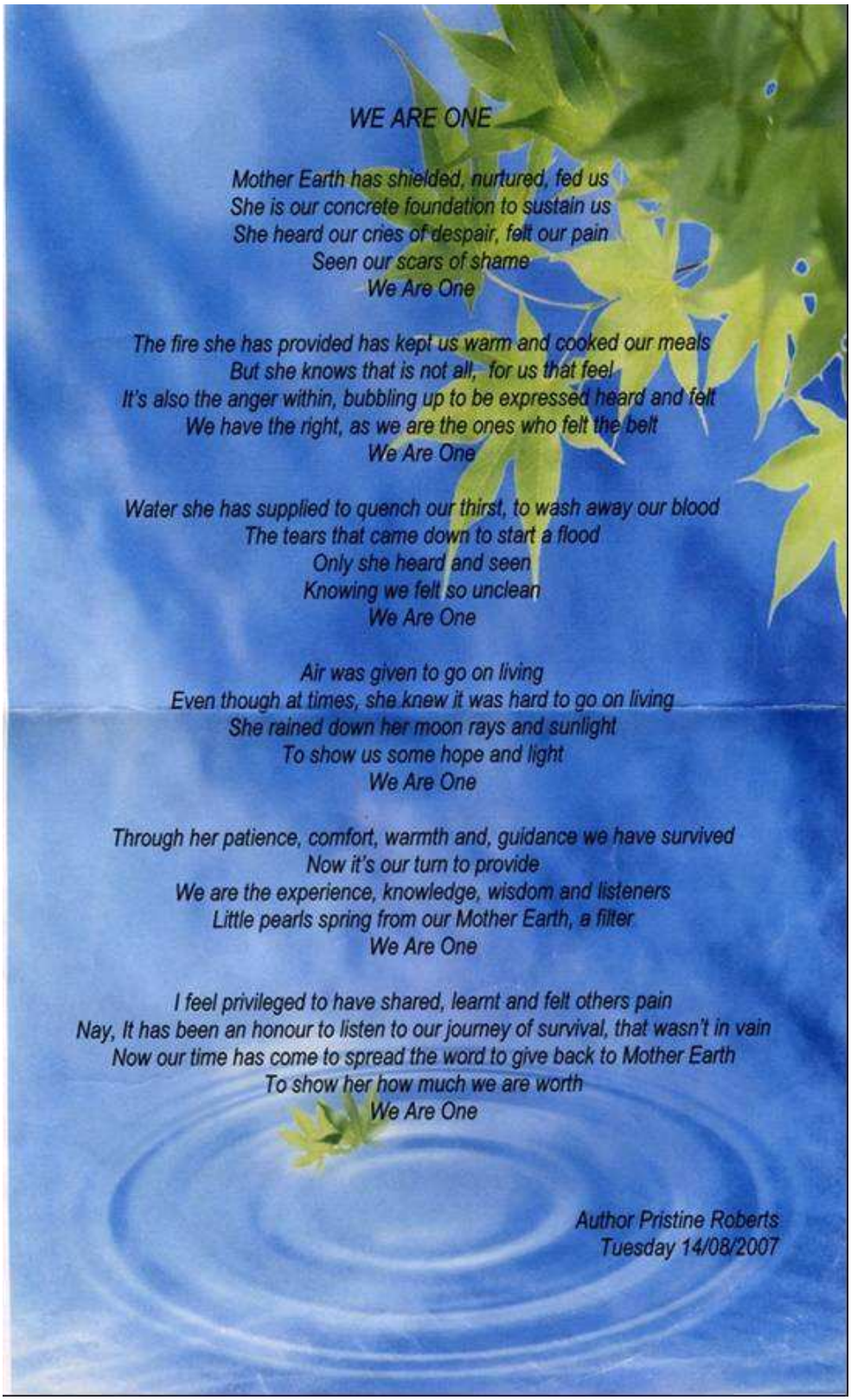
It should be noted that no interviews could be conducted until all ethics committees approved the evaluation project.

The contract between Flinders University and CNAHS for this evaluation was executed on 3 April 2007 following receipt of ethics approval letters.

Involvement of Aboriginal members of the FCH team throughout the evaluation is a key element of this evaluation, in order to:

- develop a range of evaluation skills of participating FCH staff and CNAHS as a whole
- enable ongoing improvements to the FCH Program based on interim evaluation findings (using an 'action research' approach)
- enhance credibility, rigour and relevance of the evaluation
- ensure that the evaluation is conducted in a culturally respectful and inclusive manner.

In January 2007 the FCH Program leaders identified Joanne Else and Cyril Coaby as Aboriginal co-evaluators to work alongside the external evaluators. They brought unique experiences, knowledge and skills to this evaluation, and their assistance in engaging participants and conducting interviews proved invaluable. 'On the job' teaching and learning about research techniques via role modeling and observation, critical reflection and comment, constructive feedback and capacity exchange occurred when possible throughout the project.


WE ARE ONE
Mother Earth has shielded, nurtured, fed us
She is our concrete foundation to sustain us
She heard our cries of despair, felt our pain
Seen our scars of shame
We Are One
The fire she has provided has kept us warm and cooked our meals
But she knows that is not all, for us that feel
It's also the anger within, bubbling up to be expressed heard and felt
We have the right, as we are the ones who felt the belt
We Are One
Water she has supplied to quench our thirst, to wash away our blood
The tears that came down to start a flood
Only she heard and seen
Knowing we felt so unclean
We Are One
Air was given to go on living
Even though at times, she knew it was hard to go on living
She rained down her moon rays and sunlight
To show us some hope and light
We Are One
Through her patience, comfort, warmth and, guidance we have survived
Now it's our turn to provide
We are the experience, knowledge, wisdom and listeners
Little pearls spring from our Mother Earth, a filter
We Are One
I feel privileged to have shared, learnt and felt others pain
Nay, It has been an honour to listen to our journey of survival, that wasn't in vain
Now our time has come to spread the word to give back to Mother Earth
To show her how much we are worth
We Are One
Author Pristine Roberts
Tuesday 14/08/2007

MAPPING THE SERVICES PROVIDED BY THE TEAM IN THE FCH PROGRAM

The evaluators met with available members of the FCH team in March 2007 and subsequently to develop a comprehensive picture of the range of courses, activities and groups that have been provided under the umbrella of the FCH Program. Table 1 below outlines these components – clearly this is an enormous amount of activity for a small team. Discussion of the issues and challenges for this team are discussed under Objective 5 below.

The FCH Program was developed as an integral part of the Regional Aboriginal Health Plan: Primary Health Care Services – Central Eastern & Western 2005-2010 (attachment 4), itself based on the work of the South Australian Aboriginal Health Partnership (2004). The Regional Plan outlines priorities for service delivery approaches at community, family and individual level, many of which are congruent with the FCH objectives. The embedding of the FCH Program into the wider plans necessitates effective linkages within CNAHS and with external agencies, coordination, and strategic deployment of funding streams, resources and personnel. However, the regionalisation and organisational restructure in CNAHS during the last year has impacted on the integrity of the Program, and its staff and resources have been split up between the regions. This has been a great challenge and frustration for staff.

Work with Women	Work with Young People	Work with Community	Work with Men
The women's groups (structured 8-week course; women's healing group)	Leadership and well-being in Windsor Gardens schools (Carol Omar, health info)	Community peer support initiatives	Zebra Finch men's group
Nunga Minimas Women's Shelter – working with staff and women	Kids Connecting with Community	Nunga nutrition lunches (weekly Nunga clinic same day and venue Gilles Plains)	Bush Mechanic (through Man Alive at Semaphore)
Young women's group	School Expo Events	Mini conferences – Family violence Life Improvement Plan (25 attended the first of 4 in a series)	Peer Support
Individual counselling – brief intervention	Young people's drop-in (computer)	Clinic Services – adult and child health assessment	License for Life
Boystown	Young Nungas Yarning	Lifestyle/Living Skills	Young Nungas Yarnin
Women's wellness camps	Holiday program		Kinship Program
Nunga Women U R Special			Boystown
Weekly art group including talking circles, peer-led			

Planned activities Peer support to be developed and extended across all areas of the Program Women's group activities eg trips, excursions	**Planned activities** DECS – interagency initiative to go into schools with large Aboriginal enrolments: Ocean View R-12, LeFevre HS, Woodville HS and Alberton PS		
Partnerships Kura Yerlo Kurruru Families SA: Strong Families, Safe Babies Women's health at Dale St, Pt Adelaide. Nunga Childsplay Disability SA Aboriginal Family Support Services Sturt Street Housing project (FV shelter) SA Dental Service	**Partnerships** DECS Families SA ADAC Young women's and young men's dance groups MAYF N Div GP – Aboriginal youth advisory groups eg Headspace TWIG (young Aboriginal mums outreach group)	**Partnerships** Div GP (via Nunkuwarrin Yunti of SA) - Provides the bridge between Aboriginal and mainstream health services and the bridge between primary health care and acute care services Men's Aboriginal Youth and Family Support Disabilities SA, Aboriginal Unit DECS: Aboriginal Western Districts Unit	**Partnerships** Strong Families, Safe Babies SA Youth Expo Nunka Warrin Yunti, Inside/Outside Centrelink: Cultural Connections Program Disability SA

The partnerships as outlined above serve two purposes: firstly as pathways for clients and secondly as strategic ways to share resources.

The team identified that the FCH Program provided two journeys, one for the clients of the Program (see Objective one below for details of this journey) and the second journey is that of the staff themselves (see Objective five below for details).

FINDINGS

Data collection began immediately following receipt of ethics approvals in mid February 2007 and continued until March 2008. A total of 22 interviews and focus groups with 27 workers (some participated more than once) and 19 clients were conducted. In addition, the external evaluators attended a number of FCH activities, e.g. a 'Nunga Women You R Special' event, a Women's Wellness Camp, and a meeting of the Zebra Finch Men's Group, which are all parts of the FCH Program. Notes from the interviews and focus groups, as well as reflective field notes of the evaluators, and information shared during numerous meetings with the FCH Program team comprise the evaluation data collected. These data were analysed and are presented below in relation to the original FCH Program objectives.

The impact of the FCH on individual participants' lives is powerfully captured in their stories, some of which are included as case studies in this report (see coloured boxes). Also included are examples of clients' art work, wood carving and poetry which symbolised and aided their journeys of healing.

***Melissa** (not her real name), like so many other Aboriginal women, has experienced intimate partner violence more than once. She has a teenage son, and the father of that child was physically violent to her. She was living in the country at that time and the police connected her with Crisis Care who enabled her to move to the city. Since that time she has had many violent relationships. Her previous partner was non-violent and was helping her, but he died and she is grieving the loss of her "soulmate". Her current partner is violent. With the peer support she has received from the group, and the time out made possible by the camp, she has resolved to throw him out. She was feeling strong about this decision as she now has people to back her up and be supportive. The women's camp had enabled her to gain some relaxation, to sort out some issues and become more clear-headed. Like many women, the group and the camp are the only opportunities for time out from family. The companionship is valued. As Melissa has a disability, the partnership between the Family and Community Healing Program and Disabilities SA has provided her with access to transport to be able to attend these activities.*

In relation to conflict resolution, new skills and understandings have been gained. Melissa says she was "looking to kill my son", but now she is re-building her relationship with him and has realised that she was taking her problems out on her son. Through her contact with the group she now has access to counselling for loss and grief issues related to loss of a former partner and loss of friends. She has on-going healing with one of the counsellors, the group facilitator provides support and help when it is needed. Melissa has also gained knowledge about other services related to the intimate partner violence in her life – crisis care, the GP at the Aboriginal Health Service. This access also supports her with other health issues – for example access to a dietician for support to manage her diabetes.

***Linda** (not her real name) was abused as a child but her mother didn't believe her until many years later. Her daughter has also been abused. Linda has had feelings of wanting to kill these men but has realised that is not helpful. She was in an abusive relationship with a man who 'messed up her work, and family. Her children are now with her family as she was drinking and had attempted suicide. Her abusive partner would not allow her to visit her own parents, but she was scared to leave him. Even though she has a restraining order she is sometimes 'sucked in by his charms' and because he is the father of her five children.*

Linda has participated in the women's group since it began and it has helped her to 'get back on track'. She has renewed childhood friendships and learnt about spiritual healing. She realises that the healing process will take time. The recent loss of more aunties has set her back. 'Everyone that I love is gone and most of my mates and I feel like I don't want to live anymore – I really miss my sister'. She feels she has too much grief – but she thinks of her children. They know that she is mentally and physically unwell and can't be with her at present. Linda has received a lot of help from the spiritual counsellor and just the day before we met her she had joined Alcoholics Anonymous. She is motivated to do positive things for her children and her five nieces. The women's group provides her with relaxation – colouring in and beading in a relaxed atmosphere among people that she has grown close to and can have a laugh with. This group is keeping her sane and 'keeping her off the drink'. She needs the group to continue to help her to set and achieve her goals and to return to work. Linda knows that other women have had similar or worse experiences. Whilst it took her a while, she has learnt to open up to people and to trust them. This in turn has developed her confidence. She finds participation in the group easier because there is a close group dynamic, a friendly atmosphere and trust. The women's camp has allowed her to reconnect with old friends.

Her participation in the group is possible because the Gilles Plains Health Centre organise a taxi for her and like many other Aboriginal people, this participation would not be possible with out this transport. Linda is aware of a range of services and supports which she uses, including emergency accommodation which she accessed recently because her ex-partner found out where she lived. This did not work out for her and she is now living with two of her sisters. Linda would like to secure some housing and get her children back to live with her when she is well enough.

***Helen** (not her real name) is an older woman who was taken from her family when she was about four years old. As a consequence she did not know most her siblings as a child. Forty years later, she traced her family herself. As a schoolgirl she experienced segregation – for example she was not allowed to travel on the same bus as the white kids. 'Those childhood years are lost forever, we'll never get them back'. Her Christian beliefs have taught her to be strong and face the challenges, and when she experienced domestic violence when she was in her 30's, her faith helped her to leave with her 10 children and start again. For the last 40 years she has been in a happy relationship. Helen participates in a range of groups for Aboriginal people and shares her experiences and knowledge – she talks about her life experiences to schools and has helped to make a DVD about domestic violence. Helen reflects that she has had a good life and is happy to share her experiences. She values the group because it is peaceful and relaxing, it's time out away from worries and she has made new friends. Participation in the group is only possible because the transport is provided. Although all the women have difficult issues in their lives, when they are together they share friendship and companionship in an environment of respect. Helen is aware of a range of services that are available – her choice has been to sort her own life out without counselling.*

***Jane** (not her real name) is a younger woman (she is the mother of three teenagers) who went to the women's camp in May 2007 and then joined the women's group a few weeks prior to her interview. Jane works with Aboriginal women with disability so her role at the camp and in the group is a dual one. She is 'having a go at everything – there is nothing hard about it'. The camp is time-out for Jane from the daily issues she deals with at home. Her confidence and self-esteem are growing – she has had to 'put the shame away' and tell herself that she can do it – she has been able to stand before the other women and speak. Jane does not find age a problem- she can help others by walking them through experiences that she shares with them. She wants to allow the women's stories to travel to the younger generations so that they can know how other women got through things.*

Jane has prioritised the raising of her children and now that they are young adults she feels it is time to find her own life. She feels she has a lot of skills and can do a lot as well as learn a lot. Currently Jane is doing the Family Well-being course with TAFE for the third time – the first time was 'for the domestic violence, the second for the things I have done to myself and this third time for the last seven years – I forgot to grieve so I am working on that'. Jane has leant to say 'I am sorry' to her children and they can now talk about their experiences. Whilst Jane has a good knowledge of services and how to link into them, she knows that many women who don't. She suggests that going to women's homes and talking to them about what they can access would be helpful – 'women need to take the step to get out of the "shame game" stuff'.

Jane's paintings below show how she felt before and after her involvement in the Program.

Cassandra *(not her real name) is a non-Aboriginal woman in her early 50's who was married to an Aboriginal man for 14 years and has 3 adult Aboriginal children. When Cassandra recalls her childhood she speaks of having been raised by her father. She was sexually abused as a child by her father, she never grew up with love, safety and protection. She left this to enter an abusive marriage where again she was unprotected and always in danger.*

Prior to meeting Rosalie she had been suffering with depression for years, "I was lost, I hated myself. I can say now that he broke my spirit, he destroyed me. I was mentally, sexually and physically abused, I had experienced every domestic violence you could possibly think of. He would sit and watch while other men raped me". By the time she left him she honestly believed that everything was her fault. When she first met Rosalie 4-5 years ago, she was suicidal. When she left her marriage, she had fled her husband with nothing. The counsellors that she had contact with at this time were not helpful, they did not understand domestic violence. She went to another town, where she went to the Sexual Abuse Clinic. This counsellor was helpful. Cassandra then returned to Adelaide, where she came face to face with one of the men who had raped her. At this point she felt she could no longer fight what had happened to her and that all the fight to go on left her. All she wanted was peace and the best way to get this was to die. It was at this time that Cassandra met Rosalie, who was working at Nunkin Warrin Yunti at the time. "The home visits at that time were very helpful as I did not want to leave my home, it was my safety net". Cassandra attributes Rosalie with saving her life. When Rosalie moved to the Parks, Cassandra began doing the women's group, The Family and Community Healing Program. Whilst her life had improved by then, Cassandra was not happy with herself. This group began the process of her self-healing. The opportunity to talk with other women was an important element of this.

She now knows that now she will never ever put her life in another person's hands, She has done this once and had everything taken form her, she is now confident that this will not let this happen again. She has learnt to like herself and to realise that what happened to her was not her fault. She has learnt to rid herself of guilt, to get up each day and feel good and happy. She now knows "I am going to achieve what ever I want to in life and not let others stop me. I am very proud of myself. Programs like the one that Ida and Rosalie run need to be better known in the community".

Cassandra remained in the women's group for 12 months. The most significant component of the group was learning about the drama triangle, it enables you to see and understand the dynamics of domestic violence. "It was like a light globe to learn that I was the victim, I used to believe that I was the perpetrator, I was at fault. The group also enables you to focus on getting to know yourself. I have not loved myself for the first 52 years, now I am learning to love myself and look after myself. I had lost my childhood and then the middle part of my life and now I am looking at all of me". She is also learning to receive love from others. Even though she still has on-going problems with some of her children she has learned to separate them from her own journey. The support of the other women in the group was central to the healing. "The two facilitators (Ida and Rosalie) are excellent and work well as a team".

Cassandra feels that she has "been re-born again, the world has been lifted off my shoulders, I am on the way to finding happiness for the first time". She now sees herself as a survivor, but it is only since last year that she can say this.

She is able to use the drama triangle in her relationships with her children and this has enabled her to free herself of feelings of responsibility for the issues they are dealing with. Two of the children are not able to speak about the past violence they

have lived with, they "have swept it under the blanket". Some of her children have problems with drug addiction, but Cassandra is now able to separate herself from feeling guilty about their behaviour. She is now able to 'stand up to them" and not let them "walk all over her". She no longer feels manipulated by them. Cassandra talked about the pain it took her to personally break the ties with her children. Even though Rosalie has met the children and informed them about services they could access, they have refused to at this time. There have been times in the past when Cassandra went without her medication for months at a time so that the children could have what they wanted, she no longer puts them before herself. Her one child who lives with Cassandra has benefited from the things that Cassandra has learned, she has been able to share aspects with him, and he knows where he can go if he wants support. She can also see that she has shared what she has learned with others in her life, and they too have benefited from this in that they have begun their own healing journey.

When asked about what she would like to see to improve the Program she felt that the 2 workers work so well together that they need to continue to offer the groups so that more women can have access to the group. She talked about the transformations that she saw in other women during the time that she was participating in the group. Cassandra felt that bringing older women and younger women into the group was a strength. The younger women can learn from the journey that the older women are taking. The format of the course works well and needs to be continued. Cassandra also felt that the elements of this Program need to be offered to children in schools. She hoped that this group continued to be funded, or programs similar to this one.

Cassandra is currently enrolled in the TAFE course, Family Well-Being, which is a certificate 2 Course. She said "I know where I am going now, and I am going to be out there to talk to people about this".

***Myra** (not her real name) has been attending the women's group since May 2007 when she first went to the women's camp. She found the opportunity to be away from home gave her an experience that was peaceful as well as a chance to renew old friendships, which she has maintained since. Here she finds she has people to talk to outside her family and where she has confidentiality and respect – she feels special. Myra commented on the value of having younger and older women as participants – 'it's very beautiful, it unifies and there is a two way understanding between the generations'. She feels it is important for Elders to show children that there is a different way. Myra is also undertaking the Family Well Being Course at TAFE, and along with the women's group, she has been able to assist herself with her own healing. For Myra, the art has been very important in her healing – she finds art a universal language. An important learning for Myra is that she no longer has to meet the expectations of others, she can take the time to think about herself and concentrate on her own growth. She has learnt trust, respect, caring, sharing and allowing herself to be herself. That is, she has learned to prioritise herself. She has learned that there are other ways to do things that are constructive and do not require conflict. Her healing from grief and loss is mostly self- directed using the learnings from the group – the group leaders and counsellors have been helpful when she has needed them. Myra's goal now is to focus on her own children and her grandchildren – she wants them to know who she is and 'not a grumpy old thing'. She wants to bring ritual and ceremony and traditions back to her family.*


BEGIN
WITHIN

Objective One: Build community capacity to support "safe families".

Summary – Objective 1

The FCH Program comprises a complex range of inter-related activities, programs and partnerships implemented by an enthusiastic and committed workforce. It provides holistic and culturally appropriate strategies that enhance the safety and wellbeing of Aboriginal families and communities in the northern metropolitan region of Adelaide. Workers and clients are unanimous in their support and enthusiasm for the FCH Program. Clients report how involvement in the Program increases self esteem, confidence and cultural connection, equips them with skills and knowledge to move out of a life of violence and on to a journey of healing. A positive ripple influence on clients' family members and peers was noted. Key factors required for FCH Program success were identified including: peer support and mentoring, cultural focus, long-term commitment, intersectoral linkages, sharing information, holistic approach, organisational support and adequate resources.

The FCH Program comprises a complex range of programs, partnerships and activities as indicated above in Table 1 (and as outlined in the Activity Performance Indicator Reports for the Program, dated August 2006, March 2007, and March 2008 [pending]?). Together these FCH Program elements provide holistic and culturally appropriate strategies that enhance the safety and wellbeing of Aboriginal families and communities in the northern metropolitan region of Adelaide.

The workers were unanimous in their enthusiasm for the FCH Program and their commitment to it. All strongly believed that the FCH Program can and has made a difference to family wellbeing and safety, and gave examples to illustrate. According to the workers, benefits to clients included:

- increased understanding that others are also living with family violence
- raised awareness of issues behind the cycle of violence
- understanding the connection between alcohol and family violence
- greater self esteem ('each session has made us stronger in self worth')
- access to shared information and knowledge about how to make change and begin the healing journey
- access to counselling and other services
- becoming role models for their peers and families.

One of the workers gave an example of positive impact of the Zebra Finch men's group on a client with complex mental health and disability problems and a history of

family violence. Prior to joining the group the client had lost connection with his family and community. Through participation in group activities he has gradually regained self esteem and cultural connection, become a talented woodcarver, and is now recognised for his special ability and personal growth. He now feels a part of the group, and this in turn has provided a platform for his case worker to address other issues. 'The group is like his family, getting involved in the group was a turning point for him.'

The women's group workers told of two clients who had completed the Women's program, are now continuing studies at TAFE, have gained satisfying employment, and continue to promote the Program and apply what they learned in their daily lives and through their own networks (role models). The men's group workers told of another client with extensive, mostly negative, prior dealings with social, health and correctional services, and how the support of the men's Zebra Finch group and other FCH workers has increased his sense of self-worth (and how that led to a more harmonious relationship with his partner), helped him find employment, and begin to address other issues in his life. Another men's group client has recently begun TAFE studies.

Workers were asked at interview about their understanding of 'building community capacity to support safe families'. Some responses emphasised the role of services and workers, eg:
'Community capacity includes service capacity. Workers are part of the community. However short term funding and a focus on service outcomes pressure workers to give up on clients who don't immediately engage with the Program. There is a need for patience and being there for the long haul. A consistent program with adequate, sustained core funding, and sufficient workforce and resources are required for success.' (primary health care worker)
'Partnerships between health and education providers are critical. Health is about relationships and connectedness. A commitment to the process as well as the outcomes of the Program is needed.' (worker involved with leadership and women's groups)
'Recruiting and building up a local workforce, infrastructure and services'
'The peer support workers are important, and the Family Well Being course.' (manager)
'Education, health promotion work. Bringing back values and acceptable norms through respectful communication within the group. Role modelling conflict resolution by being objective rather than personalising issues.' (worker)

‘The use of art activities, eg colouring mandalas at women’s group, is healing’.

Other workers emphasised how the clients’ experiences and learnings through the FCH Program lead 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 FCH Program have felt empowered to influence their own families and peers.’ (manager)
‘Sharing knowledge and skills for self-support. Sharing stories about family violence and how people have learned and coped, then taking those lessons home.’ (worker focus group)
‘Letting others know that Safe Families is a possibility, a priority and a right.’
‘Listening to women share their stories in the safe environment of the group empowers other women to talk up and open up to their families. One client has rebuilt some family connections and is showing her grandchildren all the love she never experienced herself’ (worker focus group)
‘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.’ (counsellor)

Some elements of the FCH Program are largely organised by community participants, highlighting how the Program has built their capacity to support safe families. For example, activities at the recent Women’s Wellness Camp at Nunyara, Belair, including the opening and closing ceremonies, were organised by the women’s group participants themselves. One of the workers said ‘The women have really grown to be able to do that. They had a say about what happens and set the direction.’ For some women the camp was their only opportunity to feel special, and gave them permission to enjoy some pampering, nicely presented meals and the fellowship of trusted friends.

Another example of how the FCH Program has built community capacity to support safe families is a weekly art group is run by community members, currently all are women. The FCH provides a driver who also participates in the group, the venue, some supplies, and makes health information available. The manager of the regional Aboriginal health team attends which ‘makes clients and staff feel special’. The

women take responsibility for the group and its activities, there is no facilitator. The morning always includes a 'talking circle' session. Participants provide peer support for each other and are empowered by taking control. The group organised a Christmas party where everyone brought food to share, and there was a great sense of togetherness, pride in participating and 'owning' the event. The group is applying for funding to sustain their activities themselves and extend the art program to include craft, guest teachers and excursions.

Factors that enhance the effectiveness of the FCH Program

The Men's and Women's Groups were regarded by workers as particularly effective as they meet regularly over a longer 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 that in turn requires ongoing support for the Groups. Some women took part in a group for many months before developing that trust. Through longer term involvement in the groups, clients have developed trust that the local service providers deliver holistic care, eg clients of the stress management group are generally happy to see the psychologist if their peers had a good experience. Providing help for clients to attend groups eg transport, disability support, is important.

The Men's and Women's Groups allowed sharing of knowledge and information for participants to use if they choose when they are ready. Having older and younger people together in the groups ('the wise and the naive') was seen as a positive, as younger participants tended to be more open whereas older ones could offer insights and solutions based on their experience. Older participants build and maintain their status and pass on cultural knowledge; younger ones learn tolerance, build social and community networks. In the same way, participation of peer support workers in the Program was considered invaluable. We were told how the FCH Program information and impacts spread into the wider community via participants' families and peer networks.

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

The FCH Program provides an opportunity to link health and human service providers for the benefit of the client. The FCH Program brings 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 FCH Program components (women's group, zebra finch men's group) at Gilles Plains supports holistic and timely care for clients. The GP involves the family violence worker in consultations with clients who have complex social and emotional needs. Nunga nutrition lunches are held on clinic days, making it easier for clients to access services.

The Client Journey

Workers talked about the 'Client Journey', that is the pathways and roads that the clients travel once they are involved in the FCH Program. This journey is seen as one that takes a client from a crisis, which is usually the trigger for the point of entry into the Program, through to continued support for the individual as new issues arise. This also includes a holistic approach that involves family members and peers. A significant commitment from each worker is required, as once a trusting relationship is established and issues are discussed with an individual, there are wider implications for families as they address the lifelong effects of marginalisation, racism and disadvantage that are widely experienced by whole communities.

The 'Client Journey' involves the following aspects:

- assessment following a crisis
- participation in FCH Program to build confidence and self esteem
- individual counselling and access to clinic services and mainstream human services
- access to an integrated system of care through the team
- access to continuity of care
- provision of continuing support whilst clients access other services, maintaining the connection
- empowerment
- peer support and friendship
- valuing the survival skills that individuals already have
- reduction in social and cultural isolation: gaining knowledge of the impacts of colonisation and valuing the old ways, adopting new ways for survival
- wellbeing and healing
- becoming a role model
- reconnecting with family and culture
- development of new skills
- can lead to employment
- can lead to further education: return to school, TAFE

- clients may experience racism as they interact with mainstream health services

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

Summary – Objective 2

Clients gained communication and conflict resolution skills through participation in the FCH program, enabling them to address the reasons for and consequences of family violence. Peer support, learning to trust again within the safety of the groups, accessing counselling, role modelling respectful communication, formal and informal learning are key strategies.

This objective was addressed through most components of the FCH Program. A good example is the structured Women's Group loosely based on the TAFE Family Wellbeing course, and modified to suit Aboriginal women meeting weekly during school terms. The structured Women's Group program covers all aspects of Family Wellbeing, identifying precursors to violence, breaking the cycle of abuse, building self-esteem, strategies for staying safe, etc. Since the regionalisation of CNAHS this structured women's group will be offered according to demand and available resources.

Another less formal women's group meets weekly at Gilles Plains for social interaction, peer support and opportunistic health promotion. Brief interventions such as individual counselling are 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 is also a separate group for younger men) offer a range of activities, and provide a safe environment to build skills around communication and conflict resolution. Talking circles, using a message stick, are part of the Zebra Finch men's group activities.

One Women's group participant reported how the structured course had helped her to understand the reasons behind her own family's history of violence, and how she was able to talk about what she had learned with her family and peers, eg that assistance is available and things can change if they want it. In particular she told how the Women's group had helped her understand and address controlling behaviour of her ex-partner, and how extensive counselling in the past had not achieved this.

Another worker describing the impact of the group on the women's healing journey said 'The women are moving on and making decisions about their lives. They learn what they need and move on. They may go somewhere else to learn what else they need'.

According to a facilitator of the Women's groups, participants' skills and confidence in resolving conflicts developed, as illustrated by the following comments/quotes 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.'
'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.'
'A participant faces having put downs by family and is now willing to challenge the put downs.'
'Women walk in to the FCH 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.'

A focus group was held with 12 participants of the Zebra Finch Men's Group and one worker, facilitated by Aboriginal and non-Aboriginal members of the evaluation team. This group meets fortnightly, a borrowed bus is used to transport the men to the group. The men were outside making boomerangs, throwing sticks and other items under the guidance of a couple of elders prior to the focus group. All men find the group an important part of their lives because it provides them companionship, fun, a reason to 'get out of the house' and learning new skills. The skills that are being learnt are in turn taken back into their community and family. A few men spoke of teaching the skill of working with the wood to their grandchildren – seen as very significant in the South Australian context, as they are concerned this skill will die out if it isn't passed on to the next generation. The group provides a venue for the men to discuss issues and problems that they would not be able to talk about anywhere else. Several commented that it has taught them to 'go home and listen'. They have learned about conflict resolution, consideration of others and how to be patient. Others talked of changed relationships with family members since attending the group. It was noted that people were 'coming out of themselves' and reconnecting with family members. The group was working with men that other services had put in the 'too hard basket', brothers were sticking up for each other and many of the men had 'mellowed right

out'. One man said 'we are a circle that will continue to extend'. Attendance at the group is significant in reducing social isolation, developing identity and confidence, learning new skills, building cultural awareness and connecting to the younger generations to pass on stories, skills and knowledge. All men were unanimous that their overall well-being had benefited from their participation. They would like to invite more men into the group but are limited in this because they do not have regular access to adequate transport. There is also a plan to bring the men from this Elder's group to meet and work with the younger men in their group at the Parks. The friendship, fun and enjoyment of each other was evident throughout the focus group. Links between Disabilities SA Aboriginal team and CNAHS have been developed during the FCH Program, and a number of Aboriginal clients with disabilities and their support workers participate in the Zebra Finch men's group. The group has sold artifacts at community events, which builds confidence, helps cover costs and in turn brings in other people who enquire about joining the group or accessing health services.

Another worker involved in the men's group spoke of plans to include targeted health promotion sessions, gardening and painting activities. Talking circles, led by an external facilitator, have become a regular part of the men's group, and have proved beneficial in men's healing journeys. The group is working with a consultant to apply for grants for equipment, eg a shed to store word carving materials, and funds for another trip to William Creek to collect mulga wood for carving and re-connect with culture. Local schools are interested in sending boys to the Group to learn about culture and woodwork.

Objective 3: Support families in crisis

Summary- objective 3

Support for families in crisis is provided as needed, with care pathways and referrals organised on an ad hoc basis. Linkages between health and human service providers, ranging from formal service agreements to personal relationships between workers, are vital.

The FCH Program is more about prevention and healing than acute care. However, clients do present in crisis situations, and the FCH team 'won't let people in crisis situations leave without sorting something out for them'. This often requires the good will and voluntary work of FCH staff in their own time, drawing on their personal and community connections, knowledge of other services, and relationships with workers in those other services. This commitment enhances the reputation of the Program and team in the community.

Sometimes clients approach Disability SA for help in crisis situations, particularly when they have not received the help they need from mainstream Health or Family Violence services. For example Disability SA was able to arrange 4 nights emergency accommodation and counselling for a client recently.

A rapid response protocol is in place for the whole PHC team to deal with emergency situations. A range of brief interventions and supports are offered for families in crisis, eg helping clients to find alternative accommodation, access medical services and counselling, and obtain legal or financial assistance. Workers use their networks and knowledge to cut through red tape and ensure that their clients are safe. Agencies such as ACIS are used, also Metro Home link for emergency or respite care. The GP at Gilles Plains sees emergency cases.

Nunga Mi:Minar is an Aboriginal women's shelter. A draft service agreement between CNAHS and Nunga Mi:Minar has been under consideration for about a year. Meanwhile FCH staff at the Parks work closely with Nunga Mi:Minar, eg Ida Love is running a structured women's group there, and will be training Nunga Mi:Minar staff to adapt and deliver future programs. She also facilitates Nunga Child's Play Therapy, a group that helps Aboriginal mothers work with their children. Many of the women at Nunga Mi:Minar are clients of the FCH Program and attend the Women's Group. Health checks are conducted at Nunga Mi:Minar.

At this time there is no crisis accommodation for Aboriginal men in the region.

Care pathways with external agencies for clients in crisis situations are developed on an ad hoc basis. For example, one worker described the assistance given to a client with a history of severe mental illness and substance use issues, estranged from family, isolated from community, homeless and suicidal. The FCH worker was able to work with ACIS and Catherine House (women's shelter) to ensure that the client received regular essential medication again without having to be detained.

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

Summary – Objective 4

Collaboration with other agencies is the key to strategic advancement of the FCH Program for mutual benefit and sustainability. Linkages with a wide range of mainstream organisations have been developed to share resources, help with referrals and follow-ups.

The FCH Program relies on dedicated program funds, strategic use of other funding streams within CNAHS, and partnership with key external agencies. According to one of the senior workers 'collaboration with other agencies is the key to strategic advancement of the FCH Program for mutual benefit and sustainability'. Through the FCH Program several linkages and partnerships with other agencies have been developed eg with DECS, MAYFS, Aboriginal Family Support Services, Sturt Street Housing project, Dale Street Women's Centre at Pt Adelaide, RDNS, Metro Home Link, Shine, ACIS, SA Dental Service, Disability SA. Maintaining these partnerships through the CNAHS restructure process has been difficult.

Some partnerships were formed to share resources and planning for components of the FCH Program, eg Disability SA and CNAHS both provide resources for their clients to attend the women's and men's groups. Disability SA and Health collaborated on the Walk the Health Line event. Other linkages help with referrals and follow-ups, enhancing continuity of care for clients in common, eg a medical clinic staffed by Nunkuwarrin Yunti was set up at Gilles Plains through the APHCAP scheme enabling easy referrals for clients attending the FCH Groups and the Nunga lunches. SA Housing comes to the Gilles Plains site every fortnight for convenient access by clients of the Program, and Shine is at Gilles Plains on Fridays.

A leadership program for young Aboriginal women was conducted in collaboration with DECS and a local school (Windsor Gardens Vocational College). Engaging the school principal, and working in partnership with senior teachers, Aboriginal education and health workers was critical. When funds and resources become available it is planned to run the leadership program again, and potentially expand to other schools with high Aboriginal enrolments in the region.

Another example of networking and capacity building with mainstream service is the collaboration between the North East Division of General Practice and the Women's Group. Under ATAPS (Better Outcomes) funding a women's group has been established that is co-convened by an OT from the Division and one of the facilitators from the women's group. This group began early 2007 and now uses a shared care model. Participants who require a referral from a GP, are women with long term, chronic and complex mental health problems. Some of the women attending the women's group are also involved in this group (Sisters of the Heart). Family violence is an underlying issue for many of the women. Women in the group work with crafts whilst at the same time learning how to manage stress, manage their emotions and learning new behaviours. These new skills then impact on how they deal with family situations at home. They are also learning a range of psycho-social skills including how to work and communicate within a group and group processes. Women have their current strengths reinforced, learn new strategies, new ways of thinking, anger management and support from each other. Referrals and support to a range of services are provided as needed including GP's, Centre Link, Legal Services and Psychiatrists where requested. Transport is an issue as women who live outside of the region are not eligible for transport from the health service. This partnership is an example of working with a mainstream health agency to build capacity to respond to family violence.

Objective 5. Workforce development

Summary – objective 5

Informal on-the-job learning was the most common form of workforce development that occurred through the FCH Program. Peer support, mentoring by experienced workers and community elders, and interdisciplinary partnerships were identified as effective learning supports. Some workers already had appropriate qualifications, and a few undertook TAFE or other relevant courses. Workers described their own journeys through the FCH program, emphasising the importance of sustained funding and organisational support for the Program.

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

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

The workers told how the Women's and Men's groups are facilitated by pairs of workers, and how that is beneficial, 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.

Interdisciplinary partnerships also helped workers learn from one another about the services and supports they provide, and how to address their clients' complex needs. 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 FCH Program has made that possible. Having health and disability staff working alongside each other provides the opportunity to learn from each other, in particular 'raising awareness of needs of people with a disability'. Informal, on-the-job training was often mentioned, eg Aboriginal and non-Aboriginal people working alongside each other enhances cultural awareness.

The Worker's Journey

A discussion with 10 members of the FCH Program team on 13 March 2007 identified the 'worker's journey' and revealed the ways in which these workers are also dealing with similar issues in their own lives and with their families. It was expressed as a significant burden to be continuously engaged in family and community issues around the problems that most Aboriginal families live with on a daily basis. They see the work of healing communities as long term, complex and

multi-layered. There are challenges around securing longer term funding to continue to develop the programs. The problems do not have short term solutions and they felt it is necessary to know that when they begin work with clients, they can continue with some assurances that they will not have to discontinue programs and services and further disadvantage clients.

The 'worker's journey was described as consisting of the following elements:

- holistic vs western (individualistic) approach
- education of staff: formal and informal through in-service education and professional development
- team building and self-care for staff (the latter in the planning stages)
- working on making interagency collaborations work and reducing duplication
- concerns about continuing funding
- gaining cultural respect
- managing on-going organisational restructuring
- living in 'two worlds' and the emotional energy that this takes, often involves conflict within self
- working with clients that often no other services want to deal with
- changing funding models
- challenges of integrating Aboriginal community health services into the mainstream
- challenges of delivering the FCH Program within a primary health care context

Apart from these elements these workers are 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, not by appointing an Aboriginal educator to a mainstream service.

Discussion around the long-term nature of healing from inter-generational trauma was linked to the unrealistic timeframes often expected to achieve results, this occurs with short term funding programs.

There are challenges with recruitment of staff for programs like this one, the team have limited capacity due to the intense and extensive nature of their work, their own work within their families toward healing and the responsibilities of family and community life.

Objective Six: Data and Evaluation

Summary – objective 6

At present there are limited quantitative data available that describe the activities and outcomes of the FCH Program. More regular and systematic data collection and review are needed. The qualitative information collected for the external evaluation, including first hand accounts from clients and workers, demonstrate how the FCH Program has changed lives and benefited the community.

FCH Program data

Most workers said they recorded only basic statistical information about client attendance, etc for the Community Health Information System (CHIS) system. According to senior managers the CHIS system needs to be updated to remove completed programs and add new ones. A training session for staff about CHIS was held.

Some of the CHIS data were included in the Activity Performance Indicator Reports for the FCH Program prepared by senior managers. Information about the content of the structured Women's groups and other elements of the FCH Program are kept on file also.

There is no service-wide system to share essential client information and hence it is difficult to track client progress or demonstrate Program outcomes for internal quality improvement and evaluation purposes. Also, effective shared information systems are required for appropriate care planning, particularly involving multiple service providers.

Several workers kept diaries or notes, generally for their own use, about clients and FCH activities. The facilitator of the Women's Groups keeps detailed de-identified reflective notes about progress of individual clients based on observation during the groups. Other workers wrote occasional brief reports for discussion with their managers. An evaluation framework was developed for the women's wellness camps.

Although data collection is a required as part of their jobs, many workers do not prioritise it or set aside enough time to document their work adequately, with adverse consequences for the FCH Program. It was also reported that recent restructures and

other upheavals in CNAHS 'have made staff reluctant to comply with routine administrative tasks'.

Evaluation

Planning and permissions to conduct the external evaluation took considerable time, as outlined in the 'Planning and Ethics' section above. Attachment 2 is the external evaluation plan and timeframes, and Attachment 3 is the Ethics application for the external evaluation and accompanying documents. The data collection for this external evaluation commenced in February, 2007 after ethics approval was received and continued when possible until February 2008. Rich qualitative data from a wide range of clients and workers was obtained during the external evaluation, and we are confident that data saturation was achieved even though not all key personnel were available for interview.

A participatory action research design was chosen for this evaluation because it would allow continuous Program improvement and develop evaluation skills within the FCH team. However, the splitting up of the FCH Program during the CNAHS restructure and competing pressures on overstretched workforce meant that there was limited interaction between the external evaluators and the FCH team. In particular, there was little opportunity for capacity development, and collection of evaluation data had to be compressed into short periods of time, and some information and people were not available in the evaluation timeframe.

DISCUSSION / RECOMMENDATIONS

The FCH Program has been operating for 2 years now. It comprises a complex set of activities and programs offered according to available resources and demand. Strengths of the Program include 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 FCH Program in the context of wider plans for the region, have kept the Program going despite the challenges of ongoing organisational restructure, insufficient staff and short term funding.

Clients and workers are overwhelmingly unanimous in their support for the Program, and their stories provide ample evidence for the beneficial impacts on clients, families and the community. This evaluation shows clearly that the FCH Program is already meeting its objectives, although there is scope for expansion and refinement in future. Some barriers are beyond the control of the FCH team, eg sustainable funding and organisational support, and need to be addressed at higher level (Hanusiak et al 2007).

Recommendations

- Continue, expand and sustain the FCH Program
    - maintain the Program's regional approach to strategic planning and funding allocation
    - maintain and support aspects of the Program that contribute to its success, eg holistic approach, multiple components, cultural focus, clinical interface, inter-sectoral linkages, transport help for clients to attend
    - increase Program activities for men and male youth
- Resource Aboriginal health teams adequately to deal with complex health and social issues and manage crises.
    - include positions within the Aboriginal health teams that connect FCH Program clients with health services, eg occupational therapist, social worker, peer support workers
    - enable client/family centred care paths through referral protocols and information-exchange
    - provide workforce training, eg suicide intervention, mental health first aid
    - provide cultural training for all workers, recognising the diversity of the Aboriginal people
- Introduce systematic data collection and information management protocols
    - provide workforce training, infrastructure support

- develop a participatory action research approach to enhance the FCH Program, eg through continuous quality improvement and development of case management

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ATTACHMENT 1

Central Northern Adelaide Health Service Family and Community Healing Program
Project Plan July 2006

Aim

To develop effective responses to family violence that address the levels of complexity within Aboriginal families and communities in the north western metropolitan region of Adelaide

Objective	Strategies	Time line	Measurement
1. Build community capacity to support "safe families"	• Raise awareness of "safe families" in the broader Aboriginal community • Engage peer educators as community advocates • Engage and educate young Aboriginal people through leadership programs • Provide an interface between prevocational F&CH and TAFE Family Wellbeing • Provide an interface with the Aboriginal Employment Program Prevocational training	Started and ongoing Ongoing Ongoing Ongoing Ongoing	**6 monthly process report due Sept 1st 2006** Number of health promotion activities and people reached Number of peer educators engaged Number of young people participating Number of people entering TAFE FW Course Number of people entering AEP Prevoc training

			12 monthly external impact evaluation report due March 2007:- Qualitative information about the health promotion activities work of the peer educators etc
2. Equip Aboriginal people with the skills for effective communication and conflict resolution	• Provide prevoc F&CH programs for Aboriginal women • Facilitate access to individual counselling services for Aboriginal women • Provide group programs for men • Facilitate access to alternative healing therapies	Ongoing Ongoing Sept 2006	**6 monthly process report due Sept 1st 2006** Number of women participating in programs Number of women referred for counselling Number of men participating Number taking up alternatives **12 monthly external impact evaluation report due March 07:-** Feedback from group participants
3. Support families in crisis	• Provide brief intervention support • Develop agreed care planning/ pathways within W and CE PHCS • Begin work towards the development of a service agreement with Nunga Miminas by providing services on site. • Investigate alternative crisis accommodation options for men • Develop care pathways with key agencies to be	Ongoing By Sept 2006 Start by Sept 2006 During 2007 During 2007	**6 monthly process report due Sept 1st 2006** Number of clients **12 monthly external impact evaluation report due March 08 :-** MOU with Nunga Miminars by end 07

	• identified		Care pathways developed Client stories of the experience of the pathways

4. Build capacity of mainstream agencies and services within the region to address Aboriginal family violence issues within the broader community context	Develop:- - a network of people in mainstream health services in CNAHS who are able to respond appropriately/effectively to family violence in Aboriginal families and - care pathways develop within CNAHS and with external agencies	During 2007/08	**6 monthly process report due Sept 1st 2007** Partnership agencies identified **12 monthly external impact evaluation report due march 08 :-** Evidence of Network operating Reported outcomes of meetings Partnership agreements developed where necessary
5. Workforce development	• Development of prevocational models • Train and support staff in core competencies of:- Brief intervention counselling skills Delivery of the prevoc models Trainer training skills • Train and support community peer educators as above	One completed 2005 Ongoing By October 2006	**6 monthly process report due Sept 1st 2006** Staff trained Peer support workers trained **12 monthly external impact evaluation report due March 07:-** Model developed

6 Data and evaluation	- Establish data collection systems that staff will use - Train staff in data collection - Engage external evaluator - Develop evaluation framework - Establish evaluation data collection methods	As soon as possible Asap Asap Asap Asap	**12 monthly external impact evaluation report due March 07:-** Systems established Staff using systems Framework developed

ATTACHMENT 2

Central Northern Adelaide Health Service Family and Community Healing Program

EVALUATION PLAN

17 January 2007

Prepared by

Inge Kowanko, Leader, Flinders Aboriginal Health Research Unit
Faculty of Health Sciences
Flinders University
and
Charmaine Power, Associate Professor
School of Nursing and Midwifery
Flinders University

Inge Kowanko and Charmaine Power, both from Flinders University and with wide expertise in research, evaluation, Aboriginal health and family violence, propose to lead the Evaluation component of the CNAHS Family and Community Healing Program. Inge and Charmaine hope to work alongside members of the CNAHS FV team to develop the evaluation plan, collect and analyse information about the process and impacts of the Program, and prepare evaluation reports. Involvement of FV staff (preferably Aboriginal) in the evaluation will:

- develop a range of evaluation skills of participating FV staff and CNAHS as a whole
- enable ongoing improvements to the Program based on interim evaluation findings (using an 'action research' approach)
- enhance credibility, rigour and relevance of the evaluation
- ensure that the evaluation is conducted in a culturally respectful and inclusive manner

The Program Reference Group will provide overarching guidance to the evaluation.

We propose to collect qualitative and quantitative evaluation data using mixed methods, including:

- individual interviews with Aboriginal clients and participants of the Program
- interviews and focus groups with FV workers, peer educators, volunteers and other stakeholders
- review of documents regarding Program processes and outcomes.

Indicative questions for interviews will be developed to elicit rich information about participants' experiences, impacts and contextual issues.

The objectives of the Program, evaluation milestones and due dates have already been set by the funding body (Commonwealth Government). Impact evaluation reports are due in March 2007 (objectives 1,2,5 and 6) and March 2008 (objectives 3 and 4). The following timetable outlines the major evaluation tasks and timelines for each objective.

PROPOSED TIMELINES 2006-2007

Evaluation tasks	September.	October	November	December	January	February	March
Planning and ethics							
Develop and finalise evaluation plan and data collection tools Obtain Ethics approval from Flinders Uni and AHREC							
Objective 1 Build community capacity to support "safe families"							
Focus group or 1:1 interviews with Program workers, peer educators							
Objective 2 Equip Aboriginal people with the skills for effective communication and conflict resolution							
Focus groups or 1:1 interviews with participants of • women's group • men's group • leadership program • young men's group							
Objective 5 Workforce development							
Focus group or 1:1 interviews with providers of training							
Objective 6 data and evaluation							
Interviews with workers and CNAHS							

PROPOSED TIMELINES 2007-2008

OBJECTIVE	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Objective 3 Support families in crisis												
Interview workers in program and Western and Central Eastern PHCS												
Collect face to face stories with clients												
Objective 4 Build capacity of mainstream agencies and services within region to address Aboriginal family violence issues within the broader community context												
Interviews with mainstream agencies in CNAHS and externally												
Review documented evidence of networks and agreements												

ATTACHMENT 3

FLINDERS UNIVERSITY ADELAIDE • AUSTRALIA
Social and Behavioural Research Ethics Committee*

APPLICATION FOR APPROVAL OF SOCIAL OR BEHAVIOURAL RESEARCH INVOLVING HUMAN SUBJECTS

A. A. RESEARCHER INFORMATION

A1. Name(s): ***List principal researcher first, (title, first name, last name)***	**Status :** ***eg Staff, Student, Associate***	**School / Department / Organisation**
Dr Inge Kowanko	Staff	Flinders Aboriginal Health Research Unit
Assoc. Prof. Charmaine Power	Staff	School of Nursing and Midwifery

A2. Students Only:

Student Record Number (SRN)	**Supervisor(s)**	**Supervisor's School / Department / Organisation**
Degree enrolled for		

A3. Contact Details: Researchers, Associates, Supervisors			
Name	**Daytime phone number**	**Fax**	**Email**
Inge Kowanko	82015898	82015891	Inge.kowanko@flinders.edu.au
	Postal Address:	GPO Box 2100 Adelaide 5001	
Name	**Daytime phone number**	**Fax**	**Email**
Charmaine Power	82013270		Charmaine.power@flinders.edu.au
	Postal Address:	GPO Box 2100 Adelaide 5001	
Name	**Daytime phone number**	**Fax**	**Email**
	Postal Address:		

Name	Daytime phone number	Fax	Email
	Postal Address:		
Name	**Daytime phone number**	**Fax**	**Email**
	Postal Address:		

B. B. PROJECT TITLE & TIMEFRAME

B1. Project Title: Evaluation of Central Northern Adelaide Health Service Family and Community Healing Program
B2. Plain language, or lay, title: Evaluation of CNAHS Family & Community Healing Program
B3. Period for which approval is sought. ***Note that approval is valid for a maximum of 3 years.***   **Date data collection is to commence: January 2007**   **Date data collection is expected to be completed: December 2007**   **Date project is expected to be completed: March 2008**

NB: All questions should be answered in the spaces provided (extended as necessary); attachments in lieu of response, with notations to 'see attached', are not acceptable.

C.

D.

E. C. PROJECT DETAILS

C1. Brief Outline of **(a) project; (b) significance; (c) your research objectives.**

The proposal is to conduct an evaluation of the Central Northern Adelaide Health Service (CNAHS) project: 'Aboriginal Family Wellbeing: Addressing underlying factors that contribute to family violence', known as the Family and Community Healing Program. The project objective is to develop effective responses to family violence that address the levels of complexity within Aboriginal families and communities in the central northwest region of Adelaide. This evaluation will provide information about the process and impacts of the program. The specific evaluation objectives are to determine the impact of the program to:

- Build community capacity to support 'safe families'
- Equip Aboriginal people with the skills for effective communication and conflict resolution
- Support families in crisis
- Build capacity of mainstream agencies and services within the region to address Aboriginal family violence issues within the broader community context
- Support workforce development for Aboriginal people (see Appendix A for Project Plan).

The use of culturally appropriate evaluation methods which reflect an understanding of recognised protocols for

evaluation with Aboriginal communities will be implemented. A Project Management Team, consisting of key stakeholders, will provide strategic guidance and support. The evaluation team is working closely with the regional Aboriginal health team which is running the Program. It is proposed to train one or two Aboriginal people who have completed either the leadership program or have participated in the women's or men's groups, to work alongside the evaluators as Research Assistants throughout this evaluation. This will develop research and evaluation capacity and skills within CNAHS and the community.

C2. Medical or health research involving the ***Privacy Act 1988*** **(s95 and s95A Guidelines)**

Is your research related to medical or health matters? yes

If you answered 'No', please go to item C4.

If 'Yes',

(a) Will personal information be sought from the records of a **Commonwealth Agency?**

No

If Yes, please also complete Part A of the Appendix 'Privacy legislation matters' that relates to compliance with the Guidelines under Section 95 of the Privacy Act 1988.

(b) Will health information be sought from a **Private Sector Organisation or a health service provider funded by the State Department of Health**? No

If Yes, please also complete Part B of the Appendix 'Privacy legislation matters' that relates to compliance with the Guidelines approved under Section 95A of the Privacy Act 1988.

The Appendix 'Privacy legislation matters' is available from the SBREC web page, www.flinders.edu.au/research/office/ethics/socialbehavioural.html

If you answered 'No' to both (a) and (b) please continue to C4.

C3. Does your project comprise **health research involving Aboriginal or Torres Strait Islander peoples**? If so, please read the NHMRC *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*, available from the NHMRC web site www.nhmrc.gov.au

yes

C4. **Data** *Please tick more than one box if appropriate*

Are data to be obtained primarily quantitative ☐ qualitative X ☐

(please tick)

Is information to be sought by

questionnaire	☐	interview	X ☐
experiment	☐	computer	☐
focus group	X ☐	other (please state) …….	

Will participants be video- or tape-recorded? No ☐ video ☐ tape ☐

C5. Outline of the **research method**, including what participants will be asked to do.

The evaluation will occur in stages that are connected to the objectives as outlined above (see Appendix B for the timelines for data collection for each of the six objectives). An action research approach will be used to enable ongoing improvements to the Program based on interim evaluation findings. The evaluators are working alongside Aboriginal and non-Aboriginal members of the CNAHS primary health care team to develop the evaluation plan, collect and analyse information and prepare reports. This will ensure that the evaluation is conducted in a culturally respectful and inclusive manner and enhance the credibility, rigour and relevance of the evaluation. All participants will be offered the opportunity to participate in either a focus group or individual interview, depending on their wishes. Qualitative and quantitative data will be collected in the following ways:

Objective One: Focus groups or individual interviews will be conducted with program workers and peer educators (see Appendix C for Information Letter, Consent Form and questions to be asked)

Objective Two: Focus groups or individual interviews with participants in the youth programs (Connecting Kids with Community and Leadership and Wellbeing Development Programs) (see Appendix D for Information Letter, consent forms for youth and their parents/guardians and questions to be asked), the women's group participants (see Appendix E for information Letter, Consent form and appendix D for questions to be asked) and the men's group participants (see Appendix F for Information Letter, consent form and Appendix D for questions to be asked)

Objective Three: Interviews with workers in the program and Western and Central Eastern Primary Health Care Services (see Appendix C above). We also plan to collect face to face stories with clients of the program about their experiences of the care planning/pathways that have been developed (See Appendix E for Information Letter, consent form and topics to be discussed)

Objective Four: Interviews or focus groups with workers from mainstream agencies in CNAHS and externally (See Appendix C above) and a review of documented evidence of networks established and working agreements reached.

Objective Five: Focus group or interview with providers of training (see Appendix C above)

Objective Six: Interviews with workers and CNAHS workers to describe data collection systems that have been developed and determine the effectiveness of these (see Appendix C above)

C6. Briefly describe how the information requested from participants **addresses research objectives**.

The information sought from the participants will provide data on the project objectives related to developing effective responses to family violence that address the levels of complexity within Aboriginal families and communities in the central eastern and western region of Adelaide premised on community consultation and collaboration.

D. PARTICIPANT INFORMATION

If the research involves <u>or impacts</u> upon Indigenous Australians, a copy of this application must be forwarded to the Executive Officer, Yunggorendi First Nations Centre at the same time that it is lodged with the SBREC. This has been done

D1. (a) **Who** are the participants? What is the **basis for their recruitment** to the study?

Objective One: The workers employed to facilitate this program (approx.15) as well as those who participated as peer educators (2)

Objective Two: The women who participated in the prevocational Family and Community Healing Programs (Approx. 100), and the men who participated in the group programs for men (approx. 40) and those young Aboriginal people who undertook the youth programs (approx 40 girls and 40 boys total in 2006 and 2007).

Objective Three: Workers in the Program as well as workers from elsewhere in Primary Health Care Services of CNAHS (15)

Objective Four: Workers from mainstream agencies within CNAHS and external agencies (approx.10)

Objective Five: Providers of youth program training, Staff training, peer educator training. These include the providers of the Aboriginal Employment Program Prevocational Training and the TAFE Family Wellbeing Course (approx.10).

Objective Six: Program workers and CNAHS staff (20)

(b) **How many** people will be approached? Please specify number (or an approximation if exact number is unknown) and the size of the population pool from which participants will be drawn.

The population pool of potential participants is as above, and as many as possible will be approached (see D4). We are aiming to interview 30-40 people in total.

(c) From what **source**?

As above

(d) What (if any) is the **researcher's role** with, or relation to, the source organisation? Comment on potential for conflict of interest.

Neither of the researchers have direct relationships with or roles in relation to the Family and Community Healing. There is no conflict of interest.

(e) If **under 18** years, what is the age range? Has the information been presented in a manner and format appropriate to the age group of participants?

The girls and boys who have completed the youth Programs will be less than 18 years but older than 16 years. Consent will be sought from parents/guardians as well as the youth participants. See attachments for age appropriate presentation and language.

(f) Do participants have the **ability to give informed consent**?

Participants will clearly be able to choose whether or not to participate in the evaluation process or any portion of it.

D2. Indicate whether the participant group comprises a specific **cultural / religious background**, for example Aboriginal or Torres Strait Islander, Indonesian, Catholic, Muslim etc…, or, if any such categories are likely to form a significant proportion of the population to be sampled. If the answer is yes and the group/sub-group is of Aboriginal or Torres Strait Islander background, **a copy of this application must be submitted to the Director of Yunggorendi for advice and comment.**

As described, Aboriginal people will be participants in this evaluation and this application will be submitted to the Director of Yunggorendi, as well as to the SA Aboriginal Health Research Ethics Committee.

D3. Are there particular issues with **language**? Do the forms or information need to be presented in a language other than English? If so, how will this be managed? If people other than the researcher will be involved in translating participants' responses, how will anonymity / confidentiality matters be managed? A footnote, signed by the researcher/supervisor, must be added to any translated document stating that it is an accurate translation.

Information and forms will be presented in clear English language. Those who are to be approached are known to speak English. No interpretation needs to be given and participants can contact a researcher at any stage with questions or concerns.

D4. How are participants to be **contacted and recruited**? *If by advertisement, please provide a copy of the ad. If contact is made through an organisation, the Committee expects that the organisation will not provide researchers with contact details of potential participants. The organisation may make the initial approach and invite potential participants to contact the researcher.*

All participants will be invited to participate by letter. Only those who have participated in the program either through service provision, or are recipients of the program's groups, training or counselling will be contacted for participation. Those receiving training, participating in group programs or counselling through the Program will be offered the opportunity to participate in the evaluation by the Program workers at the time they are receiving a service. This will be achieved through receipt of the Information Letter that invites people to participate in focus group or individual interview by contacting the researchers.

D5. What **information** will be given **to participants**? *Refer to statement of Guidelines and suggested templates for introduction letter, consent forms etc included in the application kit. Copies of relevant documents, questionnaires or list of interview questions, if applicable, must be attached. The objectives of the research and information about any relevant procedures, expected time commitment etc should be clearly stated for participants in language suitable for the lay person.*

All Participants will receive Information Letters and Consent Forms (please refer to the relevant appendices as outlined in C5.

D6. Indicate **confidentiality and anonymity assurances** to be given and procedures for obtaining the free and informed consent of participants. *Refer to Guidelines and suggested templates for introduction letter, consent forms etc included in the application kit. Copies of relevant documents must be attached. If anonymity is not able to be guaranteed due to the nature of the participant group, or because a participant may be identifiable in relation to their professional capacity or association with an organisation, there should be a clear statement to this effect for the participant.*

The voluntary nature of participation will be made clear, as will the right to withdraw at any time or choose not to participate in parts of the evaluation. Potential participants will be informed through the use of the Information Letter and Consent Forms, which clearly explain the purpose and nature of the research. Audio consent will be obtained for those people who are unable to complete a written consent.

All participants will be de-identified in reports. Participants in individual interviews will be assured of the confidentiality of their identities and their information. Participants in focus groups will be aware of each others' identities and confidentiality of information shared in the group cannot be guaranteed.

D7. Indicate any **permissions** required from or involvement of other people (employers, school principals, teachers, parents, guardians, carers, etc) and attach letters or other relevant documentation as applicable.

Permission is being sought through DECS to involve participants of the youth programs for young Aboriginal people (the programs are run in conjunction with Windsor Gardens Vocational College and potentially also Ross Smith Secondary School. No other permissions will be required

D8. Indicate any involvement of **incidental people** (eg in certain professional observation studies you might need to consider how you will inform such people about the research and gain their consent for their incidental involvement. An oral statement to the group incidental to the observation immediately prior to the commencement of the observation may be sufficient).

There will be no known involvement of incidental people

D9. Indicate the expected **time commitment** by participants, and proposed location, if being interviewed or required to complete a survey (include this information in the Letter of Introduction to participants)

It is anticipated that interviews or focus group with workers will take approx. 20-60 minutes. These interviews will take place at a place of their choosing, probably their workplace. Questions to be asked for Objective One, and Six will all be asked at the one interview. Further interviews lasting about 30 minutes will need to occur late 2008 to collect data for Objective Three and Four.

Focus groups or 1:1 interviews participants in men's and women's groups and youth leadership program groups will take approx 30-45 minutes and will occur at Program venues or other convenient locations as identified by participants. No interviews or focus groups will occur on School premises.

E. SPECIFIC ETHICAL MATTERS

E1. Outline the **value and benefits** of the project (eg to the participants, your discipline, the community etc…)

This research project will contribute to the development of effective responses to family violence that address the levels of complexity within Aboriginal families and communities in the north western region of Adelaide. The research will inform policy for the expansion of such models in the CNAHS and other regions in SA.

Participants in the research will have an opportunity to engage at a community level in making a difference in the future provision of crucial programs, where currently there are significant gaps. Participants will also receive the results of the study.

The Aboriginal research assistants who work with the evaluators will develop a range of evaluation skills, as will participating staff.

E2. Notwithstanding the value and benefits of the project, outline any **burdens and/or risks** of the project to your research participants and/or other people (eg issues of legal or moral responsibility; conflicts of interest; cultural sensitivities; power differentials; invasion of privacy; physical/mental stress; possible embarrassment).

There are no foreseen burdens or risks to the participants. Individuals will not be identified by name and as such will not experience invasion of privacy or embarrassment.

Participation is voluntary and the research is being conducted in partnership with the regional Aboriginal health team and relevant services in the CNAHS.

E3. If any issues are raised in item E2, detail how the researcher will respond to such risks. If deemed necessary, researchers should be prepared to offer encouragement, advice and information about appropriate professional counselling that is available and/or to encourage participants to report negative experiences to appropriate authorities. *If it is envisaged that professional counselling may be recommended, please nominate specific services.*

If sensitive issues are raised during the focus groups/interviews the evaluators will offer initial support and inform participants of appropriate services that they may wish to contact. These services are: Yvonne Clark, Carol Omer (external counsellors who have worked with CNAHS previously)

E4. Describe any **feedback or debriefing** to be provided to participants that may be relevant to the research.

Participants will be thanked for their participation, invited to comment on the draft report, and copies of the final report will be made available to them.

E5. If participants are required to complete a **questionnaire**, indicate the arrangements for ensuring the secure and confidential return of the questionnaire to the researcher (eg sealable, addressed envelope; personal collection by the researcher; other). Also indicate how participants will be informed of the arrangement (eg verbal instruction; written instruction in Letter of Introduction or at the end of the questionnaire; other). If information is to be provided via electronic or web-based technology, participants should be reminded in the written documentation and in on-line material that this is not a secure medium.

E6. Indicate any relevant **data transcription** issues. *If interview tapes are to be transcribed by persons other than the researcher, an assurance that such persons will be subject to the same requirements to respect and maintain confidentiality and anonymity of the participant should be included in the Letter of Introduction to the participant*.

It is not planned to audio record any of the focus groups/interviews.

E7. Indicate any issues of **participant control of data use** (a) in the immediate reporting, and (b) in future use of the data; eg will participants have an opportunity to view transcripts of their interview and/or the final report for comment/amendment?

Participants will be invited to comment of the draft report. This is outlined in the information letter. A copy of the final Report, which will be reviewed by the Project Management Group, will be made available to participants.

E8. DATA STORAGE AND RETENTION

Note that data should be retained in accordance with the Joint NHMRC/AVCC Statement and Guidelines on Research Practice (available at the website http://www.health.gov.au/nhmrc/research/general/nhmrcavc.htm) which indicates storage of data in the department or research unit where it originated for at least 5 years after publication (15 years may be appropriate for clinical research).

Please tick all boxes that apply to your research.

On completion of the project, data will be stored:

In writing □X On computer disk X□

On audio tape □ On video tape □

Other (please indicate)…….

Data will be stored in a de-identified form Yes x□ No □

If ***No***, explain (a) why and (b) how anonymity and confidentiality of participants will be ensured

Data will be stored in the Department/School of Flinders University Yes X□

Data will be stored for a minimum of 5 years. Yes X□

If you have not answered ***Yes*** to both the above two questions, please clarify …

F. OTHER MATTERS

F1. Indicate any other centres involved in the research and **other Ethics Committee(s)** being approached for approval of this project (if applicable), including the approval status at each. You must forward details of any amendments required by other Ethics Committees and copies of final approval letters received.

This ethics application is being submitted to the SA Aboriginal Health Research Ethics Committee at the Aboriginal Health Council of South Australia.

This application is being submitted concurrently to Yunggorendi.

The application has also been submitted to DECS (Network Learning Communities Unit)

F2. Indicate amounts and sources/potential sources of **funding** for the research. You must also declare any affiliation or financial interest.

This evaluation is being funded by Central Northern Adelaide Health Service. The budget is $41558

F3. Identification Card Requirements for Research Assistants.

Indicate how many accredited interviewer cards will be required for this project (additional to current student or staff identification cards):

Number = 2

Note that enrolled students of the University should use their student identity cards supported by a Letter of Introduction from the responsible staff member/supervisor.

F4. Document Checklist.

Copies of the following supporting documents, if applicable, must be attached to this application. Some sample template documents are included in the application kit. *Please mark the relevant circle*.

	Attached	Not applicable
Letter of Introduction on University letterhead from the staff member (from the Supervisor in the case of undergraduate and postgraduate research projects)	O	
Questionnaire or survey instruments		O
List of interview questions or description of topics/issues to be discussed, as appropriate	O	
Information sheets for participants at any stage of the project	O	
Consent Form(s) for Participation in Research – by Interview	O	
– by Focus Group	O	
– by Experiment		O
– other (please specify)		O
Consent Form for Observation of Professional Activity		O
Advertisement for recruitment of participants		O
Debriefing material		O
Appendix: Privacy legislation matters		O

F5. Research involving or impacting on Indigenous Australians:

	Yes	No
Has a copy of this application been forwarded to the Director of Yunggorendi?	O	

H. CERTIFICATION & SIGNATURES

The Researcher and Supervisor whose signatures appear below certify that they have read *the Ethical Guidelines for Social and Behavioural Research*, and guidelines of any other relevant authority referred to therein, and accept responsibility for the conduct of this research in respect of those guidelines and any other conditions specified by the University's Ethics Committees.

As a condition of subsequent approval of this protocol, I/we, whose signature(s) appear(s) below, undertake to

(i) inform the Social and Behavioural Research Ethics Committee, giving reasons, if the research project is discontinued before the expected date of completion.

(ii) report anything which might warrant review of ethical approval of the protocol, including:
- serious or unexpected adverse effects on participants;
- proposed changes in the protocol; and
- unforeseen events that might affect continued ethical acceptability of the project.

(iii) provide progress reports, annually, and/or a final report on completion of the study outlining
- progress to date, or outcome in the case of completed research;
- maintenance and security of data;
- compliance with approved protocol; and
- compliance with any conditions of approval.

Pro-forma report template may be downloaded from the website

http://www.flinders.edu.au/research/office/ethics/index.html/

Principal Researcher's Signature:		**Date:**
Supervisor's Signature: *(for undergraduate and postgraduate student projects)*		**Date:**

(Attachment C)

CNAHS Family and Community Healing Program
Information letter - Workers

The Family and Community Healing Program has an evaluation team working alongside it, while it rolls out its program. The reason for this is to help us to learn what is working and what is helpful, as well as what could be better, to help Aboriginal families and communities develop their capacity to build safe families and communities.

We would like to introduce you to the evaluation team: Inge Kowanko and Charmaine Power. Inge is the Leader of the Flinders Aboriginal Health Research Unit and Charmaine is an Associate Professor at the School of Nursing and Midwifery at Flinders University, with an interest in the area of family health and wellbeing. The team also includes Cyril Coaby and Joanne Else,
Aboriginal Research Assistants with experience in the Program.

We are asking if you would be willing to participate in a focus group interview or individual interview as part of this evaluation. This is based on:
1) your role as a worker in the Family and Community Healing Program, or
2) your role as a service provider in CNAHS and the relationship between your work and the Family and Community Healing Program, or
3) your role as a service provider or training provider in an external agency and the relationship between your work and the Family and Community Healing Program

If you are willing to participate in this evaluation process, we would greatly appreciate it. Interviews/focus groups will take about 30-60 minutes. You can end your participation at any time and also choose not to share particular information or answer particular questions. Anything you tell us during individual interviews with you will be kept confidential, however we cannot guarantee confidentiality of information shared in focus groups. Information you provide will be used to develop a Report of this evaluation, but you will not be identified in the report. You will be invited to comment on the draft report and we will make sure a copy of the final report is made available for you.

If you are happy to participate, please contact Joanne Else (phone 83348417 or email *Joanne.else@health.sa.gov.au*) to arrange a time. If you have any questions about this research process, you can contact: Inge Kowanko at the Flinders Aboriginal Health Research Unit on: 8201 5898 during office hours Monday-Thursday and you can leave a message on this number.

Thank you very much for your assistance

Dr Inge Kowanko…… Dr Charmaine Power……

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. The Secretary of the Committee can be contacted by telephone on 8201 5962, by fax on 8201 2035 or by email sandy.huxtable@flinders.edu.au.
The project has also received approval from the Aboriginal Health Research Ethics Committee of South Australia and the Department of Education and Children's Services.

Attach c

CNAHS FAMILY AND COMMUNITY HEALING PROGRAM
CONSENT FORM for WORKERS
to participate in FOCUS GROUP or INDIVIDUAL INTERVIEWS

I …..... (name of participant)

being over the age of 18 years hereby consent to participate as requested in

- a focus group interview on …….(date), or
- an individual interview on …….(date).

(c) I have read the information provided.

(d) Details of procedures and any risks have been explained to my satisfaction.
3. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.

4. I understand that:
   - I may not benefit directly from taking part in this evaluation.
   - I am free to withdraw from the study at any time and I am free to decline to answer particular questions. This will not disadvantage me or my employment in any way.
   - I understand that confidentiality of information I share in Focus Group Interviews cannot be guaranteed.
   - I understand that information shared in individual interviews is kept confidential.
   - While the information gained in this study may be published as explained, I will not be identified in reports.

Participant's signature……Date……...

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….…….

Researcher's signature……..Date…….

Attachment C

CNAHS FAMILY AND COMMUNITY HEALING PROGRAM

Indicative questions for semi-structured interviews or focus groups with workers

For program worker and peer educators, questions for Objective 1 and 6, in early 2007:

- How did you get involved in the program?
- Please describe your role in the program. Please provide examples/stories to illustrate.
- What has made it easy/difficult for you to take part in the program?
- What training have you been involved with though the program? (formal and informal training).
- Please give an example/story about what you understand or can do now that you couldn't before being involved in the program?
- What is your understanding of 'building community capacity to support safe families'?
- How has this capacity building been addressed in the program?
- Do you think the program is /will be successful in building this capacity? Why?
- What data is being collected to track and evaluate the program
- How is this data being collected /stored / evaluated and by whom?
- Are you involved in this process? If so, how? Have you received any training to help you do this work?

For workers involved in provision of training, questions for Objective 5, in early 2007:

- What is your understanding of the FCH program?
- What training do you / your organisation provide eg clinical skills, group facilitation, counseling, train the trainer.
- How/where is the training provided?
- Do you feel that the FCH workforce is receiving appropriate training?
- What suggestions do you have for improving/modifying/extending the workforce development

For program workers and other relevant CNAHS workers, questions for Objective 3, in late 2007

- What brief interventions are offered to families in crisis. Who provides these interventions. Do you think they are helpful. Why /why not. What works well? Please provide examples/stories.
- Please describe the care plans and pathways that have been developed within W&CE PHCS to support families in crisis. Please provide examples or stories to illustrate how they operate. Do you think they are helpful? Why /why not. What works well?
- Please describe care pathways for families in crisis that have been developed with key external agencies. Please provide examples or stories to illustrate how they operate. Do you think they are helpful? Why /why not. What works well?
- Has a service agreement with Nunga Minimis been developed? Please outline progress to date. What sort of services are being / will be provided at Nunga Minimis. Any problems or notable successes? Suggestions for progressing this?
- What alternative crisis accommodation options for men have been / will be developed? Any problems or notable successes? Suggestions for progressing this?

For workers in mainstream agencies in CNAHS and external agencies, questions for Objective 4, in late 2007

- What is your understanding of effective and appropriate responses to family violence in Aboriginal communities?
- What is your understanding of CNAHS strategies to address this
- Are you involved in a network of mainstream service providers that respond to Aboriginal family violence? If so, what is your role.
- How do you and your organisation interact with other key agencies. Prompt about care pathways within CNAHS and with external agencies
- Do you think the FCH approach is / will be successful? Why / why not? Please provide an example/story to illustrate.
- Any suggestions for improvement?

(Attachment D)

CNAHS FAMILY AND COMMUNITY HEALING PROGRAM
Information Letter - Youth Participants

The Family and Community Healing Program has an evaluation team working alongside it, while it rolls out its program. The reason for this is to help us to learn what is working and what is helpful, as well as what could be better, to help Aboriginal families and communities develop their capacity to build safe families and communities.

We would like to introduce you to the evaluation team: Inge Kowanko and Charmaine Power. Inge is the Leader of the Flinders Aboriginal Health Research Unit and Charmaine is an Associate Professor at the School of Nursing and Midwifery at Flinders University, with an interest in the area of family health and wellbeing. The team also includes Cyril Coaby and Joanne Else,
Aboriginal Research Assistants with experience in the Program.

We are asking if you would be willing to participate in a focus group or individual interview as part of this evaluation. This is based on your experience of being involved in the

1) Connecting Kids with Community Program, or
2) Leadership and Wellbeing Development Program.

We are interested in your thoughts about what you learned in the Program and how you have been able to use this information since. The information we gather will be used to further develop courses like the one you did.

If you are willing to participate in this evaluation process, we would greatly appreciate it. Interviews/focus groups will take about 30-60 minutes. You can end your participation at any time and also choose not to share particular information or answer particular questions. Anything you tell us during individual interviews with you will be kept confidential, however we cannot guarantee confidentiality of information shared in focus groups. Information you provide will be used to develop a Report of this evaluation, but you will not be identified in the report. You will be invited to comment on the draft report and we will make sure a copy of the final report is made available for you.

If you are interested in participating, please show this letter to your parent or guardian and if they agree to your involvement, please ask them to sign the attached *consent form for parents/guardians*. There is a separate *consent form for youth* for you to sign. Please contact Joanne Else (phone 83348417 or email Joanne.else@health.sa.gov.au) to arrange a time. If you have any questions about this research process, you can contact: Inge Kowanko at the Flinders Aboriginal Health Research Unit on: 8201 5898 during office hours Monday-Thursday and you can leave a message on this number.

Thank you very much for your assistance
Dr Inge Kowanko…… Dr Charmaine Power……

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. The Secretary of the Committee can be contacted by telephone on 8201 5962, by fax on 8201 2035 or by email sandy.huxtable@flinders.edu.au.
The project has also received approval from the Aboriginal Health Research Ethics Committee of South Australia and the Department of Education and Children's Services.

Attach D

CNAHS FAMILY AND COMMUNITY HEALING PROGRAM
CONSENT FORM for YOUTH
to participate in FOCUS GROUP or INDIVIDUAL INTERVIEWS

I …..... (name of participant)

being over the age of 16 years hereby consent to participate as requested in

- a focus group interview on …….(date), or
- an individual interview on …….(date).

(e) I have read the information provided.

(f) Details of procedures and any risks have been explained to my satisfaction.
3. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.

4. I understand that:
   - I may not benefit directly from taking part in this evaluation.
   - I am free to withdraw from the study at any time and I am free to decline to answer particular questions. This will not disadvantage me in any way.
   - I understand that confidentiality of information I share in Focus Group Interviews cannot be guaranteed.
   - I understand that information shared in individual interviews is kept confidential.
   - While the information gained in this study may be published as explained, I will not be identified in reports.

Participant's signature……Date……...

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….…….

Researcher's signature……..Date…….

Attach d

CNAHS FAMILY AND COMMUNITY HEALING PROGRAM
CONSENT FORM for PARENTS/GUARDIANS OF YOUTH PARTICIPANTS to take part in FOCUS GROUP or INDIVIDUAL INTERVIEWS

I …..... (name of parent/guardian)

am the parent/guardian of …… (name of youth participant).

I hereby consent to his/her participation in

- a focus group interview on …….(date), or
- an individual interview on …….(date).

(g) I have read the information provided.

(h) Details of procedures and any risks have been explained to my satisfaction.
3. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.

4. I understand that:
   - He/she may not benefit directly from taking part in this evaluation.
   - He/she is free to withdraw from the study at any time and he/she is free to decline to answer particular questions. This will not disadvantage him/her in any way.
   - I understand that confidentiality of information shared in Focus Group Interviews cannot be guaranteed.
   - I understand that information shared in individual interviews is kept confidential.
   - While the information gained in this study may be published as explained, he/she will not be identified in reports.

Parent/guadian's signature……Date……...

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….…….

Researcher's signature……..Date…….

Attachment D

CNAHS FAMILY AND COMMUNITY HEALING PROGRAM

Indicative questions for semi-structured interviews or focus groups with participants of the men's and women's groups and the leadership program.

For all the above participants, questions for Objective 2, in early 2007

- Can you tell us about your experience of taking part in the group/program.
- What made it hard/easy to participate?
- Did you benefit from the group/program? How? Why/why not? Please provide an example or story to illustrate
- Are there things you understand/can do now that you couldn't before? (prompt for specific issues covered in the men's/women's groups, eg conflict resolution techniques, ….)
- Any suggestions for future groups? (topics, processes, etc)

Additional questions for women's group participants, for objective 2, early 2007:

- Have you been able to make use of the options for counselling, alternative healing therapies, etc?
- What made it hard/easy to make use of these options for counselling, alternative healing therapies, etc ?

For women's group participants willing to share their stories, questions for objective 3, in mid 2007

- What services and supports do you know about that can help Aboriginal families in crisis. (Including care pathways that link to key external agencies)
- Has your family been involved? Can you share your experience of the pathway?
- Do you know which services you can go to for help? Are they helpful, supportive, appropriate, accessible? Have they followed through? What worked well? What didn't work well?
- What made it easy/difficult?
- Any suggestions for improvement.

(Attach E)

CNAHS FAMILY AND COMMUNITY HEALING PROGRAM
Information Letter -Women's Group Participants

The Family and Community Healing Program has an evaluation team working alongside it, while it rolls out its program. The reason for this is to help us to learn what is working and what is helpful, as well as what could be better, to help Aboriginal families and communities develop their capacity to build safe families and communities.

We would like to introduce you to the evaluation team: Inge Kowanko and Charmaine Power. Inge is the Leader of the Flinders Aboriginal Health Research Unit and Charmaine is an Associate Professor at the School of Nursing and Midwifery at Flinders University, with an interest in the area of family health and wellbeing. The team also includesCyril Coaby and Joanne Else,
Aboriginal Research Assistants with experience in the Program.

We are asking if you would be willing to participate in our evaluation process by your experience of being involved in the group healing sessions for women. We are asking you to contribute in two ways. Firstly, a focus group or individual interview about the course itself and secondly, telling us your story about your experiences of using the services available to promote family healing. We are interested in your thoughts about what you learned in the group and how you have been able to use this information since. The information we gather will be used to further develop courses like the one you did and to see how helpful such courses are in developing your skills for better health and well-being.

If you are willing to participate in this evaluation process, we would greatly appreciate it. Interviews/focus groups will take about 30-60 minutes. You can end your participation at any time and also choose not to share particular information or answer particular questions. Anything you tell us during individual interviews with you will be kept confidential, however we cannot guarantee confidentiality of information shared in focus groups. Information you provide will be used to develop a Report of this evaluation, but you will not be identified in the report. You will be invited to comment on the draft report and we will make sure a copy of the final report is made available for you.

If you are happy to participate, please contact Joanne Else (phone 83348417 or email *Joanne.else@health.sa.gov.au*) to arrange a time. If you have any questions about this research process, you can contact: Inge Kowanko at the Flinders Aboriginal Health Research Unit on: 8201 5898 during office hours Monday-Thursday and you can leave a message on this number.

Thank you very much for your assistance

Dr Inge Kowanko…… Dr Charmaine Power……

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. The Secretary of the Committee can be contacted by telephone on 8201 5962, by fax on 8201 2035 or by email sandy.huxtable@flinders.edu.au.
The project has also received approval from the Aboriginal Health Research Ethics Committee of South Australia and the Department of Education and Children's Services.

Attach e

CNAHS FAMILY AND COMMUNITY HEALING PROGRAM
CONSENT FORM for WOMEN"S GROUP PARtICIPANTS
to participate in FOCUS GROUP or INDIVIDUAL INTERVIEWS

I …..... (name of participant)

being over the age of 18 years hereby consent to participate as requested in

- a focus group interview on …….(date), or
- an individual interview on …….(date).

(i) I have read the information provided.

(j) Details of procedures and any risks have been explained to my satisfaction.
3. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.

4. I understand that:
   - I may not benefit directly from taking part in this evaluation.
   - I am free to withdraw from the study at any time and I am free to decline to answer particular questions. This will not disadvantage me in any way.
   - I understand that confidentiality of information I share in Focus Group Interviews cannot be guaranteed.
   - I understand that information shared in individual interviews is kept confidential.
   - While the information gained in this study may be published as explained, I will not be identified in reports.

Participant's signature……Date……...

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….…….

Researcher's signature……..Date…….

(Attachment F)

CNAHS FAMILY AND COMMUNITY HEALING PROGRAM
Information Letter - Men's Group Participants

The Family and Community Healing Program has an evaluation team working alongside it, while it rolls out its program. The reason for this is to help us to learn what is working and what is helpful, as well as what could be better, to help Aboriginal families and communities develop their capacity to build safe families and communities.

We would like to introduce you to the evaluation team: Inge Kowanko and Charmaine Power. Inge is the Leader of the Flinders Aboriginal Health Research Unit and Charmaine is an Associate Professor at the School of Nursing and Midwifery at Flinders University, with an interest in the area of family health and wellbeing. The team also includes Cyril Coaby and Joanne Else, Aboriginal Research Assistants with experience in the Program.

We are asking if you would be willing to participate in our evaluation process by sharing some specific information about your experience of being involved in the men's group sessions. We are interested in your thoughts about what you learned in the group and how you have been able to use this information since. The information we gather will be used to further develop courses like the one you did and to see how helpful such courses are in developing your skills for better health and well-being.

If you are willing to participate in this evaluation process, we would greatly appreciate it. Interviews/focus groups will take about 30-60 minutes. You can end your participation at any time and also choose not to share particular information or answer particular questions. Anything you tell us during individual interviews with you will be kept confidential, however we cannot guarantee confidentiality of information shared in focus groups. Information you provide will be used to develop a Report of this evaluation, but you will not be identified in the report. You will be invited to comment on the draft report and we will make sure a copy of the final report is made available for you.

If you are happy to participate, please contact Joanne Else (phone 83348417 or email *Joanne.else@health.sa.gov.au*) to arrange a time. If you have any questions about this research process, you can contact: Inge Kowanko at the Flinders Aboriginal Health Research Unit on: 8201 5898 during office hours Monday-Thursday and you can leave a message on this number.

Thank you very much for your assistance
Dr Inge Kowanko…… Dr Charmaine Power……

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. The Secretary of the Committee can be contacted by telephone on 8201 5962, by fax on 8201 2035 or by email sandy.huxtable@flinders.edu.au.
The project has also received approval from the Aboriginal Health Research Ethics Committee of South Australia and the Department of Education and Children's Services.

Attach F

CNAHS FAMILY AND COMMUNITY HEALING PROGRAM
CONSENT FORM for MEN'S GROUP PARTICIPANTS
to participate in FOCUS GROUP or INDIVIDUAL INTERVIEWS

I …..... (name of participant)

being over the age of 18 years hereby consent to participate as requested in

- a focus group interview on …….(date), or
- an individual interview on …….(date).

(k) I have read the information provided.

(l) Details of procedures and any risks have been explained to my satisfaction.
3. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.

4. I understand that:
   - I may not benefit directly from taking part in this evaluation.
   - I am free to withdraw from the study at any time and I am free to decline to answer particular questions. This will not disadvantage me in any way.
   - I understand that confidentiality of information I share in Focus Group Interviews cannot be guaranteed.
   - I understand that information shared in individual interviews is kept confidential.
   - While the information gained in this study may be published as explained, I will not be identified in reports.

Participant's signature……Date……...

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….…….

Researcher's signature……..Date…….

ATTACHMENT 4

Regional Service Delivery Approaches

Strategic Area	Communities Priorities	Families Priorities	Individual Priorities
Social and Emotional Wellbeing	▪ Develop social and emotional wellbeing information and education sessions for community, families and individuals	▪ Provide community supported parenting support programs to families and individual parents with children aged 0 – 12 years	▪ Provide activities that connect individuals to community, family, friends and culture. ▪ Implement community supported schooling support programs and activities
Substance Misuse	▪ Provide ongoing community leadership development projects and initiatives, inclusive of community elders	▪ Develop and implement regionally supported family renewal initiatives	▪ Implement community supported early intervention programs and projects ▪ Provide accessible primary health care services for young people
Diabetes	▪ Provide community supported health promotion programs and activities	▪ Provide community involved family support initiatives and programs, inclusive of money matters	▪ Provide community credible, coordinated care and specialist treatment services

- Regional service delivery priorities based on current knowledge, available resources and 'best thinking' towards sustainable health change
- Management prioritised service delivery based on current capacity and resources
- Forms basis for quarterly personnel work-plans and reporting
- Non-prioritised programs noted for future resource allocation, funding proposals, acceptance of grants monies (where recurrent), opportunities for collaborative projects and future service direction if/when increased capacity occurs

Regional Aboriginal Health Service Delivery
January 06 – December 06

Area	Community Programs	Family Programs	Individual Programs
Social and Emotional Wellbeing	▪ Community health education and information activities	▪ Parenting support program ▪ Primary & secondary school 'Start-Up' activities	▪ Annual social activities/events ▪ Nunga IT project and study centre activities
Substance Misuse	▪ Youth leadership activities	▪ Family & Community Wellbeing Project	▪ Annual regional health education sessions ▪ Regional youth 'drop-in' space
Diabetes	▪ Diabetes Health Promotion activities	▪ Family Diabetes Education activities	▪ Coordinated Care Plan program ▪ Diabetes Camps ▪ Weekly Nunga Clinic / Nunga Nutrition lunch