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WIC-K
Wellbeing Informed Care - Kimberley

WELLBEING INFORMED CARE KIMBERLEY

Community Consultation Report - 2024



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Executive Summary

Context

The Wellbeing Informed Care- Kimberley (WIC-K) project is a partnership between University of Western Australia (Rural Clinical School and School of Indigenous Studies), Kimberley Aboriginal Medical Service (KAMS) and their member services.

The project aims to strengthen the Kimberley Aboriginal Community Controlled Health Services (ACCHS) ability to deliver on their Model of Care by enhancing the delivery of integrated and holistic approaches to mental health and social and emotional wellbeing (SEWB) care.

Purpose

The objectives of the consultation were to:

1. Investigate how Aboriginal people want their mental health and SEWB to be explored when attending a Kimberley ACCHS.
2. Identify enablers and challenges in providing and receiving mental health and SEWB care.

Methodology

Consultation with Aboriginal ACCHS employees and Aboriginal community members occurred at Kimberley Aboriginal Medical Services clinics (KAMS), Broome Regional Medical Service (BRAMS), Yuri Yungi Medical Service (YYMS), Derby Aboriginal Health Service (DAHS), and Ord Valley Aboriginal Health Service (OVAHS).

A yarning based qualitative methodology was used and data was collected by Aboriginal and non-Aboriginal team members and Investigators from the WIC-K project.

A total of 103 Aboriginal people across the Kimberley region were involved in the consultation. Of these, 50 participants were interviewed individually, and 53 participants contributed via 9 focus groups.

Data analysis and the development of the report was a collaboration by all report authors.

Findings

The consultation results reveal significant mental health SEWB challenges among Aboriginal people in the Kimberley. These findings offer a qualitative perspective on the complex and cumulative impact of stressful life events, extending beyond statistical data. The insights gained contribute to the understanding of factors that promote wellbeing in the region. Key protective factors identified in the project include self-efficacy, family support, and SEWB programs delivered by the ACCHS.

The consultation found the term 'mental health' still carries significant stigma in the Kimberley Aboriginal population and is often associated with extreme behaviors or severe mental health conditions. Aboriginal Health Workers (AHW) are recognised for their essential role in responding to mental health and other crisis based SEWB incidents within their communities.

The findings revealed a diversity of viewpoints on the acceptability of mental health and SEWB enquiry during routine clinical consultations, the approach to these discussions, and who should lead them. Despite divergence in responses there was a consensus that talking about mental health and SEWB was important. Principles for enhancing clinical enquiry were identified throughout the consultations.

Many participants identified SEWB services as the most suitable approach for improving community wellbeing. These services were identified as accessible, and meaningful. The desire for the continuation of current SEWB service delivery along with SEWB service delivery expansion has been identified throughout the data.

Recommendations

1. Empower Aboriginal Health Workers (AHW) to deliver mental health and SEWB care through skill development, confidence building, and access to confidential spaces.
2. Promote routine clinical enquiry of mental health and SEWB by AHW, commencing with the annual 715 Aboriginal Health Check. Adhere to a screening procedure that emphasises confidentiality and offers patients the choice of talking to another healthcare provider if required.
3. Improve 715 Adult Health Check approach to SEWB and mental health screening:
 - a. Reintroduce broader SEWB yarning questions into the 715 Adult Health Check.
 - b. Consider alternatives to scaled response questions.
 - c. Where appropriate translate mental health and SEWB terms and screening tools into local Aboriginal languages.
 - d. Ensure patient facing resources on SEWB and mental health enquiry are available.
4. Strengthen perceptions of confidentiality regarding mental health and SEWB enquiry for patients of Kimberley ACCHS. Engage community leaders in this effort.
5. Retain current SEWB services and expand by:
 - a. Strategically planning and seeking funding to deliver place based SEWB services the communities of Balgo (servicing Mulan and Bililuna), Beagle Bay, and Bidyadanga.
 - b. Assessing the viability and priority of progressing opportunities to develop location specific healing centers.
6. Support the needs of 'priority' SEWB populations across the region by:
 - a. Assessing support groups and services available Aboriginal carers within their region and where appropriate develop programs or activities responsive to place-based need.
 - b. Continuing to progress responses to ongoing community violence in identified communities by engaging key stakeholders and community leaders in discussions relating to conflict resolution and violence prevention approaches.

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Abbreviations

ACCHS - Aboriginal Community Controlled Health Services

AHCWA - Aboriginal Health Council Western Australia

AHW- Aboriginal Health Worker

AOD- Alcohol and other drugs

BRAMS- Broome Regional Aboriginal Medical Service

DAHS - Derby Aboriginal Health Service

EMR- Electronic Medical Record

KAMS – Kimberley Aboriginal Medical Service

OVAHS – Ord Valley Aboriginal Health Service

NDIS – National Disability Insurance Scheme

SEWB – Social and Emotional Wellbeing

WIC-K- Wellbeing Informed Care- Kimberley

YYMS – Yura Yungi Medical Service

Terminology

The term social and emotional wellbeing (SEWB) is used in conjunction with mental health throughout this report to situate conversations about wellbeing outside a bio-medical model of mental health. Use of the term SEWB refers to the Gee et al SEWB model (fig 1). This is an Aboriginal developed framework that recognises that Aboriginal wellbeing is impacted by historical, social, and political determinants, individual life experiences, and the interconnectedness of the 'self' across the domains of Body, Mind, Family, Community, Culture, Country, and Spirit. The SEWB model is a strengths-based approach that promotes culture as an Indigenous knowledge system.

This report uses the term Aboriginal, as all Kimberley participants identified as Aboriginal, and the report is to advance the work of Aboriginal Community Controlled Health Services across the region. The term is inclusive of Torres Strait islander people and no disrespect is intended to those participants who have Torres Strait Islander heritage.

Figure 1: Social and Emotional Wellbeing Model



SEWB Diagram adapted from Gee et al., (2014)

Note. Reprinted from Aboriginal and Torres Strait Islander Social and Emotional Wellbeing (p.57), by Gee, G., Dudgeon, P., Schultz, C., Hart, A., & Kelly, K. (2014). In P. Dudgeon, Milroy, H, Walker, R. (Ed), Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. Perth, WA Australia: Department of the Prime Minister and Cabinet.

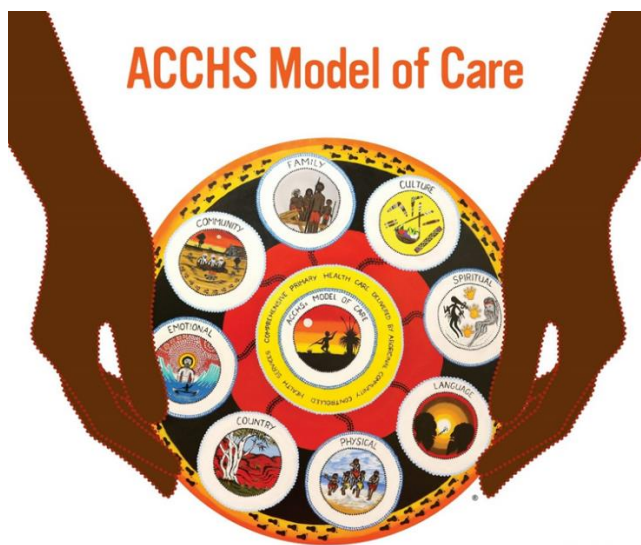
Introduction

The Wellbeing Informed Care- Kimberley (WIC-K) project is a partnership between University of Western Australia (Rural Clinical School and School of Indigenous Studies) and Kimberley Aboriginal Medical Service (KAMS) and its member services.

The project aims to strengthen the Kimberley Aboriginal Community Controlled Health Services (ACCHS) ability to deliver on their Model of Care (fig 2) enhancing the delivery of integrated and holistic approaches to mental health and social and emotional wellbeing (SEWB) care.

This report provides an overview of the consultation undertaken with Aboriginal community members to progress WIC-K Priority Area 2: enhanced mental health and SEWB enquiry (table 1).

Figure 2: Aboriginal Community Controlled Health Service Model of Care



Source: Aboriginal Health Council of Western Australia. Reprinted under a CC BY license, with permission, original copyright 2021. Available at www.ahcwa.org.au/about-us/

Background

The WIC-K project is framed by an understanding of the historical and contemporary factors that shape the lives of Aboriginal people across the Kimberley. These include the impacts of colonisation, the systemic erosion of cultural, kin and family systems and enduring policies of racism and exclusion. Many Aboriginal people across the Kimberley experience adverse health outcomes including a high burden of disease (1), over representation of mental health disorders (2), over representation in suicide and self-harming statistics (3), and experience high rates of violence, incarceration, and child removals (4,5). There is limited availability of health and wellbeing services across the Kimberley, particularly psycho-social or therapeutic services (2,6). Consistent with the broader Northern Australia experience, the region has significant challenges with health workforce retention (7-9).

The Western Australia Primary Health Alliance 'Kimberley Needs Assessment 2022-2024' (10) identified the critical status of mental health in the lives and health profiles of Kimberley residents:

- Mental health was the second leading cause of disease burden in the Kimberley contributing 15% to the total disease burden for the region.
- Suicide and self-inflicted injuries were the leading cause of burden of disease (contributed to mortality and morbidity rates) for males in the Kimberley contributing to 10% of the disease burden.
- Mental health presentations to hospital Emergency Departments were the highest in the state.
- Less than 1% of the Kimberley population accessed psychological services through MBS in 2020.

Improving mental health and SEWB care at the primary health level is a complex but necessary undertaking. Primary healthcare (as delivered by the Kimberley ACCHS) is the most accessible form of health care available and used by Aboriginal people in the Kimberley. ACCHS provide 'whole of life', ongoing, care with a strong preventative health focus. ACCHS are governed by Aboriginal boards, are committed to employing Aboriginal staff, and deliver health care that is culturally safe. These conditions are known enablers in reducing health care hesitancy (11). As ACCHS are not associated with any specific health condition the fear of being stigmatised for seeking or receiving help for a mental health concern or SEWB challenge is greatly reduced (12). Further, ACCHS are a constant fixture in Aboriginal people's communities and care is proximate to peoples' homes. These factors further enhance accessibility for mental health and SEWB care by reducing the challenges associated with 'one off' or visiting service based care (12).

Previous Kimberley mental health and SEWB research has found that mental health and SEWB care is core business of Kimberley ACCHS but one that requires support and development at the systems level. Currently most documented episodes of mental health care are linked to crisis, acuity, or the management of patient's schizophrenic affective disorders (2). Clinical documentation of screening for high prevalence disorders such as depression, anxiety, and stress is understood to be low (2). Additionally, SEWB case notes are not often linked to the ACCHS Electronic Medical Record system (EMR) fragmenting continuity and integration of care (6). Qualitative research with Kimberley health care providers they are often overwhelmed with 'primary health' conditions and/or are hesitant in talking about mental health and SEWB. Hesitancy is associated with a lack of training and/or a belief that enquiry is futile given the complexity of patient's lives and the limited treatment and support options available to Kimberley residents (13).

Kimberley ACCHS are committed to further improving the health and wellbeing of their communities and understand that good mental health and SEWB is essential in achieving this outcome. Kimberley ACCHS leaders and Boards also understand they are uniquely positioned to provide the most acceptable and accessible mental health and SEWB care to Aboriginal people. It is understood that principles of Aboriginal self-empowerment, control, and voice are essential in creating and sustaining improvements to Aboriginal health and wellbeing (14,15). To this effect, project partners have looked towards decolonising Trauma (and violence) Informed Care (16-20) and Health Equity literature (21,22) to help guide the project's approach to progressing it's aims. This resulted in the identification of six priority areas for the WIC-K project which were endorsed by project partners (table 1).

Table 1: Summary of WIC-K Action Plan Priority Areas

PRIORITY AREA	DETAILS	OUTCOME
1. Stakeholder engagement	Quarterly communication from WIC-K to project partners and extended networks	ACCHS are engaged in conversations about Trauma and Wellbeing Informed Care and Health Equity
2. Enhanced SEWB/ mental health enquiry	Regional community and clinical consultation to identify acceptable and achievable approaches to improving SEWB enquiry	SEWB and mental health enquiry model and/or principles developed and actioned across ACCHS
3. Workforce training and development	Priority areas include trauma training, de-escalation training, reflective practice resources, and psycho-social brief intervention tool kit	Workforce skills and resources are developed, implemented, evaluated, and available to ACCHS staff
4. Workforce wellbeing support	Collate and where appropriate develop staff wellbeing and self-care resources.	Workforce wellbeing resources that are culturally secure and relevant to the ACCHS workforce are collated and included in staff induction packs
5. Trauma informed systems	Enhance/ establish pathways for patients/clients to receive SEWB, mental health, alcohol, and other drug (AOD) support and care	Select ACCHS achieve certification against the AOD Human Service standard
6. Trauma informed use of Electronic Medical Record System (EMR)	Improved clinical coding of patients' mental health and SEWB Increased availability of culturally secure screening tools within EMR	EMR systems are responsive to and used by health care providers in ways that optimise patients' mental health and SEWB

Community consultation scope and methodology

This report provides an overview of the consultation undertaken with Aboriginal community members to progress WIC-K Priority Area 2: enhanced mental health and SEWB enquiry (table 1).

The objectives of the consultation were to:

1. Investigate how Aboriginal people would like their mental health and SEWB to be explored when attending a Kimberley ACCHS.
2. Identify enablers and challenges in delivering and receiving SEWB care.

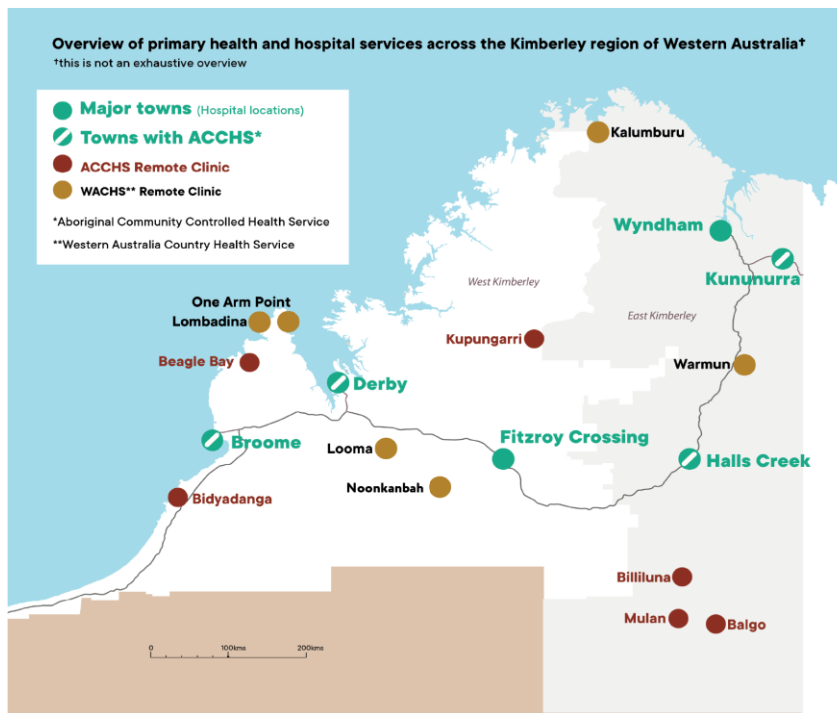
Data collection was undertaken by the WIC-K project team (EC, SF, JL) and WIC-K investigator (ZC) between June and December 2023. All data was collected in person, via site visits that were undertaken by one Aboriginal team member (SF or ZC) and/or one non-Aboriginal team (EC or JL).

Data collection occurred at Kimberley Aboriginal Medical Services (KAMS) clinics located in Beagle Bay, Bidadanga and in the Kutjungka (Balgo, Mulan, Billiluna); Broome Regional Medical Service (BRAMS); Yuri Yungi Medical Service (YYMS); Derby Aboriginal Health Service (DAHS) and Ord Valley Aboriginal Health Service (OVAHS) (fig 3).

All ACCHS where data collection took place deliver on site SEWB services through a designated program team. The exception to this is the KAMS remote clinics where SEWB services are provided

by the KAMS SEWB team who are based in Broome and service the communities on a drive in/ drive out basis.

Figure 3: Overview of primary healthcare and hospital services in the Kimberley region of Western Australia



Source: Kimberley Aboriginal Medical Services. Reprinted under a CC BY license, with permission, original copyright 2021. Available at www.kamsc.org.au.

ACCHS staff helped identify appropriate timing of consultation visits and supported the project through the recruitment of participants and access to spaces within the clinics where opportunistic recruitment could take place. At many sites Aboriginal staff from the ACCHS also supported the project team in collecting data by co-facilitating focus groups.

The community consultation used the principles of yarning (23,24) to inform the qualitative methodology. The project team guided participants through a social yarn (relationship setting); research yarn (see interview/ focus group guides Appendix A); therapeutic yarn (25) (truth telling, experience and participant-research context setting); and collaborative yarn (listening, synthesising responses, recommendation formulation).

Data collection involved face to face individual yarns and focus groups with:

1. Aboriginal patients of the ACCHS, including SEWB clients.
2. Aboriginal ACCHS staff including clinic drivers, receptionists, SEWB workers, National Disability Insurance Scheme (NDIS) Support workers, Aboriginal Health Workers (AHW) and other Aboriginal professionals including Managers and Doctors. Several ACCHS Board members are also included in this group of participants.

During the process of obtaining informed consent (Appendix B) individual participants were asked if the yarns could be audio recorded and if the project team could also take notes. Audio recordings were transcribed as fully as possible by the project team but due to many of the interviews taking

place outside, audio quality was suboptimal, and notes were used to supplement the transcriptions. For the focus groups, the project team sought consent to take notes. All data were coded thematically using qualitative software NVivo. Analysis was primarily undertaken by EC with substantial input from Aboriginal WIC-K investigators (ZC, LA) and team member (SF). The thematic approach to data analysis limited the rich narrative responses that the participants graciously provided, however it was the most pragmatic approach to efficiently addressing the objectives of the consultation.

Participants who were not employed by the ACCHS were provided with a \$40 pre-paid visa card as a gesture of appreciation for their time and participation in the consultation. All participants will receive a plain language summary of this report (Appendix C).

The project has endorsement from the Kimberley Aboriginal Health Planning Forum and approval from the Western Australian Aboriginal Health Ethics Committee (HREC 1201). The project is aligned and responsive to the National Health and Medical Council's Principles for ethical conduct in research with Aboriginal and Torres Strait Islander peoples (26).

Findings

Participants

A total of 103 Aboriginal people across the Kimberley region were involved in the consultation, of these 50 participants were interviewed individually, and 53 participants contributed via 9 focus groups.

A total of 31 participants were employed by Kimberley ACCHS. Within the sample of participants 49 participants identified as male (47%) and 54 identified as women (53%). All participants were aged over 18 years of age. Other than being asked to confirm they were over 18 years of age; participants were not asked their age.

Given the potential identifying nature of the responses in this report, a decision was made to use two participant-type categories, 1: ACCHS employee and 2: Community member. We note that this is a crude classification system as all the ACCHS employee participants are community members, it was however chosen as it represented the best approach to protecting the anonymity of responses.

Table 2: Demographic and location overview of community consultation participants

Data collection Site	Total n. Individual interviews	Total n. of focus groups	Total n. of ppl in focus groups	Total n. male participants	Total n. Female participants	Total n. ACCHS staff	Total n. Community participants	Total n. ppl engaged
Balgo/Kutjungka	12	2	8	7	13	3	17	20
Kununurra	8	2	10	6	12	6	12	18
Halls Creek	6	2	23	22	7	8	21	29
Beagle Bay	8	1	3	2	9	4	7	11
Bidyadanga	6	0	0	1	5	3	3	6
Derby	7	0	0	4	3	4	3	7
Broome	3	2	9	7	5	3	9	12
Total	50	9	53	49	54	31	72	103

Themes

Theme 1: Trauma, distress and adverse SEWB is prevalent, complex, and often recurrent for Aboriginal community members across the Kimberley.

Experiences of mental distress, stress, trauma, and other challenging life experiences were prevalent amongst the participants. Whilst the consultation did not specifically ask participants to share their experiences of trauma or distress, the sharing of personal stories provided the context for participants to engage in the consultation, and the framework for their responses. Each participant spoke to their own and/or their families experiences of trauma, stress, or distress.

For Aboriginal people in the Kimberley, mental health and SEWB were adversely impacted by high levels of intimate partner violence, community and family fighting, overcrowding and/or insecure housing, and problematic use of drugs and/or alcohol. Many participants identified that these challenges to wellbeing were part of a 'cycle of trauma'.

The coping mechanism is the alcohol or the drugs, then the alcohol becomes the fighting. It's a never-ending story. Now it is just everywhere, every family, and it's all a cycle of trauma and dispossession, and racism, and now people seem trapped in it. ACCHS employee

Depression, anxiety, stress, trauma, psychosis, this town has it all. Worryingly we are seeing self-harming on Facebook and Snapchat. Our young people posting pictures of them cutting themselves or making threats of suicide. ACCHS employee

Grief and loss were spoken about as profound challenges to people's sense of wellbeing. Participants spoke about how they, or other community members, would 'mask' the pain of a loved one's death with alcohol and/or other drugs. Several participants however spoke about grief and loss as a time of clarity and change.

When I lost my mother, I was on methamphetamines and all of that. I needed to stop and snap out of it. This is in my early 20s. I'm in my 30s now.... I think I'm just strong. I mean, I'm a survivor of suicide. I've harmed myself before. I promised myself I'll never do that again. My family has lost so much to suicide. I was like, I can't do this. I can't put my family through this for the fourth time. ACCHS employee

Almost all participants spoke of their personal experience of a close family member's death by suicide and the impacts on their own mental health and wellbeing. Caring for family, particularly their own children, was a commonly spoken about protective factor in 'keeping going' after the devastating impact that a loved one's death by suicide had caused.

*That happened [suicide] for my girl... I've been struggling. I don't want to see parents getting hurt like me. I want to see the parents just happy and bringing their kids up happy and seeing them [the parent] being a grandfather or grandmother. But I am still surviving today. My wife too, sometimes [it feels] we are you know, but still going, looking after our kids. All our families have lost [loved ones] like this. In this little place. It's no good.
Community member*

Several participants believed that suicides spiked in times of grief or loss and spoke of clusters of suicides that 'rocked' their families and communities.

Like a bomb has gone off, an accident and young people die, then suicides. One after the other. What can we do? How can we have hope? My children give me hope, but I worry for them. I talk to them about suicide. I tell them that's not the way. It's a big worry for us.

Community member

The stresses and challenges associated with responding to a family member who has mental ill health or is affected by substances was a common theme. Several participants talked about their feelings of worry and uncertainty in how to respond to their family member's behaviour.

My son, now he is using self-harm to force me to do things for him. On the weekend now I get very anxious, waiting for them to start drinking and for him to put these demands and threats on me. ACCHS employee

Carers and legal guardians were identified by ACCHS employees as a group at risk of experiencing multiple stressors and challenges to their own SEWB. Carers and guardians were acknowledged as dealing with some very difficult behaviours in an environment of low practical or therapeutic support. A desire for respite was raised by all participants who identified as guardians (n.19).

At home there are [an]other three kids in my care. My daughter is 15, another kid there 16, my nephew's 17, and my son is 17. And then I have guardianship of my niece, that is really hard. I need help as she can get real mad at times. The little kids tease her and then she gets wild. I can't get her to go to Centrelink to get her back on a payment, so I am paying for her, for everything. I just need a break, somewhere to send her to get her proper help. Her mother has been away for two years. I am stressing about my niece; I am not sure what to do.

ACCHS employee

We see them [patients with a severe mental health condition], they come in and we give them medication for their mental health, but it is hard for their carers, their families. Sometimes they are dangerous. 'Come in and get your medication', that all we can say. 'Come in and sit with me a bit, have a smoke'. Then they go back, walk around, sometimes make trouble. I worry for their families, those old people who care for them are tired. ACCHS employee

Community or family-based fighting was reported to be a major stressor for Aboriginal people. This was particularly evident in one community where all participants discussed the fighting between community members. These participants described the community fighting as a long and multifaceted dispute between different families within the community which at times it brought the community to a standstill and caused services to temporarily close. Participants shared stories of children witnessing large scale community violence and shared their own experiences of the impact of the violence.

You can't escape it, it's all the families, all my families. I worry all the time. I don't know if it will ever stop. I want peace for my families. Community member

"It stresses me out, I feel nervous. Especially for the young ones, watching this, growing up like this, it never used to be this way. Growing up in the mission it was never this way.

Community member

It changes everything the fighting, makes it so much harder for people to see their own hurt, people are blinded by this fight, lashing out. Destroying each other. ACCHS employee

Theme 2: Aboriginal people in the Kimberley have diverse approaches to supporting good mental health and SEWB

Participants spoke about painting, collecting bush foods, spending time with family, talking to friends, religion, keeping healthy, and being on Country (camping, hunting, fishing) as important in supporting their own wellbeing and building their resilience.

My children stress me out, so I do things to get me out of that stress. I go fishing a lot, I love fishing! And I've got Elders around me that I can, speak to, especially I speak to my mum, or my sister to take my feelings out of me, or even talk to my daughter. Community member

Going back to country is a big eye-opener. Teaching people. Listening to people. Telling a story, lighting a fire, and having a cook up on-Country. That gives us people a sense of meaning and purpose. ACCHS employee

Attending groups, such as SEWB yarning groups, NDIS support groups, or playgroups was highly valued as an approach to 'staying strong' and feeling 'connected'. These groups were identified as a safe space for Aboriginal people to come together to yarn and be with other people who might be experiencing similar experiences or feelings. The groups were facilitated by Aboriginal workers and only included Aboriginal community members. This was viewed as important, with participants noting that non-Indigenous guest speakers were 'helpful' and 'ok', but the sense of connection and safety came from having a designated space for Aboriginal people.

Our play group is amazing. We're just Aboriginal mum's talking about everyday life, but slowly talking about other things too. Community member

This group of men, led by our brother here. A strong thing for us fellas. Community member

Since SEWB is coming out here every two weeks, we feel good. We have somewhere to send the men to and it's the proper way. The worker, [name of SEWB worker], he is respected. The men respect him, we see them all going. I ask them about it, and they tell me they feel more free from their troubles. ACCHS employee

I love coming with the ladies, yarning, learning things. It's a real good thing we have. I wish there were groups like this for the younger ones too. Community member

Self-efficacy, or a person's confidence and belief in their ability to exert control over their motivation, behaviour, and social environment, was a prominent protective factor amongst almost all participants in managing their SEWB and mental health. Self-efficacy was associated with an insight into one's feelings, the ability to reach out to either family and/or attend a group, and a belief in one's own self.

For years I've been dealing with my own demons. Domestic violence. My kids. All that kind of stuff. It's the state of mind. If you've got a strong mind and a strong heart and you've got support and you've got family, you can conquer anything. Community member

I have to be strong, strong in myself because I go through those things, but I got to work myself out, and get out there, and do what's best for me to keep my stress away. You know

what I do to keep my mind off things, I just do gardening. Yeah, that's what I do. Community member

Self-efficacy was prominent amongst the nine female participants from the individual interviews who shared their experience of attending the clinic to talk to a health care professional about their mental health and SEWB. These participants spoke about the decision to attend clinic as intentional, and self-directed.

I was feeling rubbish, no good. It's an ugly feeling you know. I trusted no one at first and then I went to the clinic, and I trusted a nurse and I made the call, I am going to tell her... She found someone for me to talk to. Community member

I went to see the Dr to say I need someone to talk to, it was everything, work, the families hating each other, fighting, just everything... So, I went to the doctor and they prepared me for that lady now, for talking. A counsellor lady, she was visiting from somewhere... I talked to her and after a few days I felt much better. Community member

Getting that referral to SEWB...Oh it was hard, but I knew I was there at that point, and I almost had to, for me you know. And I reckon that working with [name of SEWB worker], maybe it has saved me from going right down...I am getting back to a better place in myself, letting that shame go. Every month, I get closer... I see her here every week or two. Community member

Theme 3: Challenges to accessing mental health and SEWB support

There was much discussion amongst participants about how challenging it can be for many Aboriginal people to access their own protective factors or seek help from the ACCHSs or other services. Participants identified the impacts of the social determinants of health (education, poverty, discrimination, conflict, housing, etc), Stolen Generations, substance misuse, and intergenerational trauma as contextual factors underpinning the challenges to help seeking behaviours.

Many people don't know how to open up, they keep it all bottled up all of the time. They have to find trust first and they need to go through all of the emotions to identify where they are at, where their next steps might be, but the problem is they don't know how to get help. So, they are self-medicating with gunja and alcohol. ACCHS employee

Our people are focused on getting through today, they are not able to plan and get the help. Stress, trauma, overcrowding, violence. It boils down to surviving day to day living. ACCHS employee

Hard for our people, some people don't know how to express themselves, and they know that. Some people they get drunk, and it goes round in their head, but they just want to go to sleep and not always talk about it. But lots of stuff comes out when you're drunk, people destroy things and then they feel shame. I have done that, it took me a while to see that problem and I had to go away from here and my family to get help. Community member

Participants noted that concepts of 'shame', fear of the stigma associated with the term 'mental health', and a lack of awareness of mental health conditions were all additional barrier to seeking support.

There are times when we can identify mental health episodes, but when we approach the person, they deny. Sometimes it is shame, people don't want to know, but other times people really don't know. ACCHS employee

I tell them you guys need to speak to someone speak to mental health, to speak to the SEWB workers. They're like, 'why am I are gonna see mental health for? Because I'm not hearing things. I don't see things. I'm not mental. I'm not crazy'. But it's like, no, you have something that's worrying you, you have a traumatic event, or you have something that's making you stress and that could build up and lead towards, you know, suicide... ACCHS employee

While participants identified challenges in community members seeking support for their wellbeing, ACCHS were seen to have a strong role in acute or crisis situations involving community members mental health.

And here most of the time people come up with things like that [talking about mental health/ SEWB] when they drunk, when we have a family gathering, sitting down having a barbecue and they just walk up to you, charged up and just say, 'I'm feeling no good in the head, like, I'm mad'. As far as them coming into the clinic for help, it's a different thing. Only coming in for a crisis, or medication. ACCHS employee

People feel comfortable to go to the clinic and know clinic will respond if there is someone talking silly or getting ready to hurt themselves. Clinic will work with police. But they right, we feel safe. Community member

There is a lot of shame, people won't talk. Maybe if you ask them, they won't answer, maybe they will. But when they are at that point of suicide or been beaten, they will talk then. You will hear it all then. ACCHS employee

Participants from Balgo and Beagle Bay indicated they did not have access to SEWB support groups and programs regularly through the ACCHS and expressed a desire for place based SEWB workers and programs.

Historically the SEWB service supporting these communities has not operated in close partnership with clinics on community, with service delivery focussing crisis responses and postvention support and/or the delivery of SEWB training. It was noted that in 2023 the service delivery focus expanded to include a more regular schedule of SEWB programs to these communities.

Understanding the importance of SEWB and what needs to happen to deliver SEWB programs is through establishing and maintaining place-based activities, responsive to what community tell us. This is about developing those strong relationships with clinic and community. We are on that journey with these communities now, building relationships with community leaders, clinics, and other stakeholders and promoting community engagement with SEWB services. ACCHS employee

Theme 4: Routine clinical enquiry

Is routine clinical enquiry happening?

ACCHS employees (n.31) were asked if they thought that ACCHS clinical staff were routinely asking patients about their feelings, stressors, mental health or SEWB. These participants expressed the belief that patients were not routinely being asked by the majority of clinical staff. The annual

Aboriginal and Torres Strait Islander Peoples Health Assessment (715) was identified as a time when questions relating to mood, mental health, drug and alcohol use, and housing were more consistently asked.

I always ask how they are and how they're travelling, are they okay. That's my first question, I mean on top of introducing myself. It's a conversation that rolls and I give them the chance to tell me what's happening. I might say, "Well, why aren't you happy? Why are you talking like that?" and then the story rolls out slowly on their own steam. I've had a consult for nearly an hour with some patients; we're not supposed to, but in some cases you have to sit and you have to listen, and you can't just say, "Look, come on, hurry up. I have to do this in 20 minutes." It's giving your time, or your ears to them to listen to what they've got to say, and then maybe see if they want a referral to SEWB or someone, sometimes they just want to talk, that's enough for them, others might want that referral. ACCHS employee

We all see our community acting out, but we [in the clinic] see the fighting and don't ask about the pain, I was talking about this [consultation] to a doctor, she has been here a while, I was saying everyone has a trauma story and needs support, she said, 'oh I reckon it's more like 1 in 10'. We see the same people, maybe it's just we [Aboriginal people] all only tell them [non-Aboriginal clinic staff] when it gets unbearable. ACCHS employee

I think the 715 is really the only time clinic staff are asking. And even then, I don't drag them into it, if they don't open up I respect that, but maybe with some people we should, we should ask more. ACCHS employee

Community member participants had varied responses, some felt that clinic staff asked 'how they were going' but did not always ask more questions. Other participants identified that clinical staff have a very good knowledge of what was happening in their lives and that regular check in, and support was happening. This was occurring through yarns with the driver, AHW, or via a conversation with the Nurse or Doctor.

Should routine enquiry happen?

Participants indicated that routinely asking open ended, yarning-based questions as part of the clinical consult could help patients know they could talk about their mood, feelings or worries with their health care provider. Responses indicated it was 'hard' but 'important' for clinics to ask these types of questions.

Most of us are nervous with the fighting. It's good to ask our people about this. People need to know they can talk. Community member

Before they use to ask me about that thing now [mental health, SEWB], cause we can hide what is inside and that was good, but now they just ask me about my diabetes. I would talk to a nurse or a doctor about those things again. It felt good. But, too hard with the Health Workers they are from the other families. Community member

I don't think a lot of people realise that it hurts them until you are asked the question. Asking the question that could send that, light bulb moment off. 'That actually does affect me, I didn't know until somebody had asked me. ACCHS employee

Other participants suggested it was very challenging to ask, or be asked, about SEWB and mental health at a routine clinical visit. Responses suggested that clinic staff could seem 'nosy', 'bossy' or 'off-putting'.

For some people, Countrymen, this is very private, it's not always right to talk about these things. You have to give the options, in a careful way. I mean you can ask the questions, but you gotta approach it right way. Explain it gently 'this is for everyone; we are not just picking on you'. ACCHS employee

I don't really go to the clinics and express my feelings. I go to the clinic for medication, or when I get sick or my child gets sick for, Panadol. I'd rather just keep it keep it to myself and tell the ones that I trust more you know, then going to the clinic and talking about myself to them because you know, they might be chit-chat behind your back. Community member

Asking about suicide and self-harm straight up as an Aboriginal person to me, well it feels culturally insensitive. All our training says this is what we can and should do but the worry is that we are putting that thought in a person's head. That is my worry, all the time, so I don't ask. I might say 'how you going bub?' but never, 'do you feel like you are going to harm, proper hurt yourself? ACCHS employee

When should routine enquiry occur?

Participants gave differing responses to when clinic staff should ask about mental health and SEWB. Participants endorsed clinics asking these questions because it was 'important for clinic to know'. However, participants stressed that they wanted the approach to be considered, for relationships and trust to be established prior to asking, and for support to be made available to those disclosing concerns.

I think it's alright to ask but that will automatically trigger 'oh you're just thinking something going on in my house', this person asking me all these questions. 'I'm not here for that, I'm only here to pick up a Webster-Pak or I'm only here to get looked at'. You need to find somebody who's good at cracking the shell, you know, 'oh yeah you're here, oh are you alright brother, oh how's your kids brother'? Or 'how's things your husband?'. You have to have the relationship. ACCHS employee

You should only ask if you're going to keep asking, and help me. Give me ways to feel better, that support like. Not just 'Oh I [Clinic staff member] did this thing cause I had too'. Community member

I want that stuff to be asked but it should be on the computer so not asking me every time, maybe every six months something. But not too much, some people have no patience for those questions. Community member

Other participants suggested that consistent routine enquiry was essential in looking after the health of Aboriginal people and implementing the theory behind the ACCHS model of care.

I don't see how you can't enquire about a patient's wellbeing. I think is negligent not to, because it feeds into every aspect of physical health. I am very excited about trying to get people to engage with making better health decisions, but the reality is, if they're not in a good headspace, then those things won't happen. In fact, they can't do it, so it should be a

conversation that's had, it is a conversation I have. Outside of the health checks [715] we should be having this conversation, inside of the health checks, we should be having this conversation. ACCHS employee

Yeah well clinics should ask at every visit. They don't, but that is the holistic health approach, right? It needs to start with the AHW. That's how you get the cultural safety and the trust, and they can refer onto the doctor for follow up or if that person doesn't feel right talking to that AHW. ACCHS employee

What about routine enquiry through the 715?

The consultation team showed 20 community member participants involved in individual interviews print outs of the current 715 mental health questions (Appendix C) and asked if they remembered doing these questions. Many participants stated they could not remember completing these questions.

I don't ever recall that. Being asked those questions. My daughters have gone and done the 715. My husband has done it. And my one daughter has been in a violent relationship that's never been raised at a 715. Community member

All participants in the individual interviews (ACCHS employees and community members) were shown the old (circa 2022) and new (circa 2023) mental health screening questions from the 715 (Appendix C). Participants were asked if they had a preference in how the mental health questions should be approached. Almost all participants stated they preferred the old questions, that were more open-ended and yarning based. Other participants indicated they would like the old and new questions to be asked together.

I think those old questions [from the 715 Adult health check] are good. So that other one is ok [referring to the new 715 questions] but those first ones, the questions are good. Community member

Some people don't know how to answer those ones, then they feel like they have to choose one of those instead of saying, 'Look, I just don't know, it's not like a simple answer, 'little time, some of the time most of the time'. So you feel like you're being told you have to choose one of those instead of just saying, I don't know, sometimes I'm right, sometimes I'm not. Community member

Yeah the old questions are really good, especially for the carers, they have a lot going on. Doing it, the 715 with people, they open up. I break down the questions, I might ask 'everything all right, you feeling no good'. Sometimes I use Kriol, sometimes a bit of language.... We write the notes up, but the Dr might then do more. ACCHS employee

Location matters for SEWB enquiry

Participants from remote communities and those participating in consultation through a focus group overwhelmingly suggested that the clinic was not the right environment to talk about their SEWB. These participants suggested that conversations about SEWB that are non-crisis-based, are better suited to a non-clinical environment. There was a perception that clinics were a place for treating 'sickness' and getting 'medication'.

We all want to talk, maybe to an Aboriginal person and a nurse but not at the clinic, we gotta have somewhere outside of clinic to talk, cause this is not about sickness you know.

Community member

I would like to talk to a male nurse and an Aboriginal person, that would be palya [good].

Maybe go for a cruise, drive to the look out, talk a bit. Yeah I like that. Community member

Most of these participants stated that conversations about their SEWB should happen 'on-Country', in community, or in a special 'healing centre' that promoted and provided western therapeutic, medical, and cultural SEWB services.

Cultural leaders, Aboriginal workers, social workers, visiting psychologists, coming together in an inviting space working both-ways, that's what a healing centre means to me. ACCHS employee

Delivery of language programs, life skills (cooking, cleaning, budgeting) and intensive child and family support, in addition to current SEWB activities were highlighted. Having gender matched staff was seen as important as was having a 'two-way' team consisting of Aboriginal and non-Aboriginal staff.

Many participants stated that talking about SEWB should happen in group environments that had a focus on yarning, culture, and education/skills development. Having trusted relationships with the persons facilitating the group was seen as essential and participants identified trust and security was enhanced when an Aboriginal staff member led the conversation.

You know, so psycho-education, creating awareness, there's a lot of stigma and shame around coming in for counselling. That's one of the reasons we had our SEWB building separate, so that nobody sees where they're going kind of thing. ACCHS employee

There needs to be a lot more outreach work because a lot of people won't go to us, they won't go to the hospital, they won't go to services because they're, whatever it maybe. They're probably scared. ACCHS employee

Last year we did the bush medicines with the pharmacist, she came out here and all the ladies gathered around. We had such a good time. Such a good time talking, being on our Country, making the bush medicines for the clinic. Made us feel really good. Community member

Theme 5: Role of the Aboriginal workforce

The role of the Aboriginal workforce in responding to patients' mental health and SEWB was found to be important and multilayered. As members of the community Aboriginal staff were mostly privy to the complexity of patients' lives and would often proactively ask about a patient's wellbeing. These conversations were often in the clinic car, out the front of the shop, at social gatherings, or at people's houses. Participants suggested that the details of these conversations did not often make their way onto the EMR system. Aboriginal staff stated they were considered about what information would be handed over to other health care professionals, noting that disclosures of self-harm, suicidal ideation, and threats to self-harm or harm another person were always handed over to the clinic manager or a doctor.

Aboriginal employees spoke about being the 'eyes and ears' of their community. They reported being involved in responses to suicide attempts, episodes of psychosis, and other crisis situations such as those involving family or intimate partner violence.

We will be out driving, and they will say, 'they have taken rope and gone to the tree', we are the response. We know the families; we know the places. We just go. ACCHS employee

I have people call me after hours, drop in and see me. They will see me when there is a problem. That's the same for every AHW on a remote community, every Aboriginal staff member. You can't escape that, community come to us, and we respond. ACCHS employee

Aboriginal staff leading community-based education, case management, group work, and on-country trips were highly valued. Aboriginal staff were viewed as essential in engaging Aboriginal people about their SEWB in a culturally safe way.

The doctor will refer to us [SEWB]. And we always check in, cause sometimes local people that might say 'yeah', to the doctor, they don't really want to talk to us because we are local, you know. They don't want us to know their business. So, we check in and the doctor always says, 'I have asked them and they are quite happy for you to contact them'. And they are happy to see us, they feel safe to see a Countryman most of the time for this type of work, yarning, case management, fishing. Men's groups. So if the referral is male, I'll send the male SEWB worker. And if it's a female then the female SEWB worker. ACCHS employee

There was a more nuanced set of responses to the role of AHW in routine enquiry about a patient's mental health or SEWB or undertaking the 715 mental health screening. Both ACCHS employees and community participants noted that family tensions, enduring relationships outside the clinic, and other community dynamics could complicate AHW-led enquiry.

With some clinic staff we know them too well so it's uncomfortable to go to them to talk. Me I'd prefer to go to [name of non-Aboriginal nurse] and [name of non-Aboriginal GP]. ACCHS employee

Lot of community just come in when things are hard or call up, they know we are here and that is our job but sometimes, they wanna wait and see a nurse. Because they probably think because we were from here, don't want to be judged by other people that's from the community, because I could be related to them. And it's a choice who they want to see. We respect that. ACCHS employee

ACCHS employees explained when a mental health or SEWB crisis (including a suicide attempt) occurred these events impacted lots of people in the community and could be thought of as occurring in the public (or community) sphere. Having Aboriginal ACCHS staff support in a time of crisis enhanced the cultural security of the response (and subsequent follow up) for the patient and the family involved. At the other end of the spectrum, Participants explained that Aboriginal clients who chose to engage with SEWB services appreciated working with Aboriginal staff. Aboriginal SEWB staff were respected for being non-judgemental, supportive, and having similar lived experiences. However, for patients who were not having an acute crisis, or were not at the point of wanting to engage with SEWB services, having an AHW ask questions about mental health or SEWB could be considered inappropriate.

The existence of shame and stigma is highly prevalent amongst Aboriginal people, and Aboriginal clinicians, which contributes to the complexities around asking about a person's wellbeing or mental health. There is still shame when people know each other or are connected. ACCHS employee

What are those solutions to the fears patients have about mental health confidentiality breaches? What are the tangible things we can really do for community. It's about our policy, staff training, letting patients know what the rules are, and support clients to report breaches. It's complicated and I am not sure how many 'breaches' there are but it's not just confidentiality with outside people, we hear concerns, and I have experienced it, of people sharing information with others in the clinic, things I don't need to know. Information for the person treating them, not for me. ACCHS employee

Other clinic level-barriers such role clarity, training, and a lack of access to private consultation rooms were noted as additional barriers to AHW enquiring about a patient's mental health or SEWB.

Well, when I've done that training, trauma informed care in town, that was a real eye opening for me, you know. I'm not the type of person that asks a lot of questions. And I'm sort of quiet myself. But that gave me a lot of confidence to be stepping into those questions, asking them in like a support way. ACCHS employee

The health workers here don't have a room. They're seeing people in the bay. So, I think it's very difficult for them to do, if nigh impossible, to do a proper STI screen or to really ask people 'how you're doing?'. Some do when they can and that's fantastic, but that's really where the conversation could formally start. It could start sooner, and you occasionally get those bits of information from the drivers if they end up having a conversation just one-on-one in the car, and occasionally the driver will say 'hey, I've been yarning with such and such and feel this', which I love. I think it's great. It's the model of care we'd like to promote, but not enough coming through the health workers and that's partly because they're not really being empowered, but partly because they haven't got the facility to do it. ACCHS employee

I am not sure if the mental health stuff in the 715, that stuff, if that's my role, no one talked me through that stuff and maybe should be confidential. Like it should be done by a professional, trained more than us as AHW. I stick to the other things I have been trained in obs [observations], bloods, getting them ready for the doctor. ACCHS employee

Discussion

The findings from the consultation highlight the high levels of mental health and SEWB challenges for Aboriginal people across Kimberley. Participant responses provided extensive insight into the complex and cumulative burden of stressful life events beyond statistical snapshots. These insights advance the understanding of what enables and promotes wellbeing across the region. Consistent with other Kimberley mental health research findings (27,28) self-efficacy (the belief in one's own capabilities to carry out an action and affect positive change) (29) and family support were commonly identified protective factors.

SEWB teams were also described by community members as critical enablers of wellbeing across the region. SEWB teams were reported to be delivering community-based psycho-social education and awareness training that destigmatised mental health and promoted health seeking behaviors. SEWB

programs provided an opportunity to acquire new knowledge and skills and strengthen pro-social and kinship bonds. Aboriginal SEWB staff were highly valued and viewed as integral to the success of SEWB programs. Participating in cultural practices/activities on-Country (hunting, fishing, bush foods/medicine collecting) were very highly regarded component of SEWB programs. These findings are consistent with the broader Australian literature on what Aboriginal people consider important in SEWB service delivery (30-33).

In keeping with other Aboriginal Australian mental health literature (34) this consultation found that that the term 'mental health' retains high levels of stigma and shame across the Kimberley Aboriginal population. It is associated with extreme and adverse behaviors, people experiencing psychosis, or mental health conditions such as schizophrenia. AHW's were acknowledged for having an essential and valued role in responding to 'mental health' and other crisis based SEWB incidents within their communities.

Routine clinical enquiry of mental health and SEWB is an evidence-based response to normalising mental health and SEWB conversations. Scheduled enquiries are associated with increased health care provider compliance with mental health screening and higher rates of patient acceptability (13,35,36). The consultation did not identify a unified and consistent approach to enhancing clinical mental health and SEWB enquiry across the Kimberley ACCHS. Aboriginal community members and ACCHS staff had different opinions about whether mental health and SEWB should be discussed during routine clinical consultations, how to approach these discussions, and who should lead them. General principles for optimising enquiry however were identified during the consultation and are presented below.

Limited SEWB and mental health promotion materials were observed by the WIC-K team in the waiting rooms of ACCHS clinics across the region. The development of resources for ACCHS patients could provide critical knowledge for community about SEWB and mental health and help contextualise how and why these enquiries take place. This recommendation is further discussed below.

Many participants expressed a preference for enhanced mental health and SEWB care to focus on the continued and expanded delivery of SEWB services. This was seen as the most appropriate approach to improving community wellbeing, acknowledging the barriers and challenges associated with clinic-level responses. These recommendations along with the identification of certain SEWB priority groups are also presented below.

Approaches to optimising mental health and SEWB enquiry

1. Empowering Aboriginal Health Workers to engage with patients about their mental health and SEWB

The role of AHW's and other Aboriginal staff within ACCHS was identified as essential to ACCHS being accessible and culturally safe for Aboriginal people. Aboriginal staff were identified as central in responding to crisis based mental health and SEWB presentations and valued for their knowledge of community. AHW's could be further empowered to undertake SEWB and mental health enquiry through skill development, confidence building, access to confidential spaces, and by including enquiry into routine care/core business. Routinising AHW-led enquiry could commence with a commitment by the ACCHS for AHW's to administer relevant 715 mental health and SEWB questions in accordance with an AHW screening procedure which:

- Emphasised the universality of questions for all ACCHS patients.

- Positioned mental health and SEWB enquiry as a commitment to delivering holistic health through the ACCHS Model of Care.
- Acknowledged the sensitivities of mental health and SEWB screening.
- Asserted the confidential nature of discussion.
- Provided choice- patients are informed that they have a choice to talk to another healthcare provider if that is more comfortable.

2. Enhancing the enquiry approach

Based on established practices and the consultation findings, the enquiry approach should be based on the following principles:

- Commence with broad open-ended questions. Examples include: is there anything else you would like to talk about today, how are you feeling in yourself, last time you were here we talked about XX, how are you feeling about that today?
- Move to specific questions if concerns become apparent or if administering questions through the 715 Adult Health Check.
- Conversations should take place in accordance with patient preference. This may include a gender-matched health care professional or an Aboriginal or non-Aboriginal health care provider.
- Use yarning-based questions in addition to, or instead of, scaled response questions in screening .
- Address language barriers particularly when non-Aboriginal health care providers are involved in mental health or SEWB enquiry. Strategies include mental health and SEWB terms and screening tools being translated into the major languages spoken across the region or use of an interpreter.

3. Engaging community members in approaches to strengthen perceptions of ACCHS and AHWs as keepers of confidentiality

A fear of confidentiality breaches was noted as a barrier in patients engaging with AHW's around their SEWB and mental health. Remote community participants were more forthcoming in expressing these concerns. Concerns with AHW's and confidentiality are not unique to the Kimberley (37,38) and reflect the multiple roles and connections that AHW's and patients have within the community and the deep stigma and shame associated with some health conditions. It was noted that community members did not express the same confidentiality concerns in talking to Aboriginal doctors or Aboriginal SEWB workers.

Given perceptions and fears expressed in the consultation findings it is recommended ACCHS' consider approaches to strengthening confidentiality and perceptions of confidentiality within their communities in partnership with community.

Enhanced mental health and SEWB care to focus on retaining and expanding SEWB services.

The consultation findings found SEWB teams and service delivery across the region are highly valued and participants wanted SEWB services to continue across their communities.

While all town based ACCHS reported having an SEWB program, the KAMS remote clinics receive SEWB support from a team that travels from Broome. During 2023 this service has broadened from a training/ and or crisis response service to include regular, scheduled SEWB yarning circles, and cultural activity-based program delivery. While this service delivery expansion has been positively

viewed, participants from remote communities stated they ultimately wanted a SEWB service that was place based and could provide case management and psychosocial support for community members and more frequent SEWB program delivery.

The desire for communities to expand SEWB services through the establishment of SEWB healing centers was a common finding. Participants spoke of the need to have a designated, inviting space that could expand on therapeutic and cultural SEWB service delivery.

Priority groups for SEWB and mental health care

Aboriginal Carers

Aboriginal carers, particularly those caring for a family member with a chronic and severe mental health issue were identified as priority group for enhanced mental health and SEWB care. The lack of appropriate services, competing family and community demands, and the challenging behaviors of those they cared for were all identified as adversely impacting on carers' physical and mental health. The consultation identified that ACCHS across the region are frequently engaging with carers, this positions ACCHS as well placed to formally assess and respond to the unmet SEWB and mental health needs of carers. These findings are consistent with a recent study focusing on carers of older Aboriginal people located in four remote Kimberley communities which suggested that carers' require SEWB support that is 'empowering' and 'holistic' (39).

Communities experiencing protracted community-level conflict

Responses from participants in one community shared the adverse impacts of community fighting on individual and collective SEWB. All participants stated they wanted the fighting to stop and for families to heal. Many participants suggested that they would like Doctors and visiting Aboriginal SEWB workers to yarn with them about the implications of the fighting on their physical health and wellbeing. Participants shared feelings of helplessness around opportunities to effect change and restore peace in their community. It is noted that in addition to the routine and emergency healthcare provided to residents affected by violence, additional initiatives to support the wellbeing and safety of residents have been developed:

- Key stakeholders and KAMS are involved in regular conversations about violence de-escalation and community safety.
- In the last quarter of 2023 Executive staff from KAMS were involved in mapping some initial responses to promoting community safety and violence recovery. This has been circulated to key stakeholders to review.
- KAMS are recruiting for a mental health nurse, and a community SEWB liaison officer to assist in providing support to the high number of people requiring mental health and SEWB care.

KAMS are well positioned to continue to support the development of a conflict reduction response (40). It is suggested that looking to national and international examples of conflict resolution may help frame ongoing engagement with stakeholders.

Recommendations

1. Empower Aboriginal Health Workers to deliver mental health and SEWB care through skill development, confidence building, and access to confidential spaces.
2. Promote routine clinical enquiry of mental health and SEWB by AHW's, commencing with the annual 715 Aboriginal Health Check. Adhere to a screening procedure that emphasises confidentiality and offers patients the choice of talking to another healthcare provider if required.
3. Improve 715 Adult Health Check approach to SEWB and mental health screening:
 - a. Reintroduce broader SEWB yarning questions into the 715 Adult Health Check.
 - b. Consider alternatives to scaled response questions.
 - c. Where appropriate translate mental health and SEWB terms and screening tools into local Aboriginal languages.
 - d. Ensure culturally appropriate patient resources addressing SEWB and mental health are available in clinic waiting rooms.
4. Strengthen perceptions of confidentiality for ACCHS patients regarding mental health and SEWB enquiry. Engage community leaders in this effort.
5. Retain current SEWB services and expand by:
 - a. Strategically planning and seeking funding to deliver place based SEWB services the communities of Balgo (servicing Mulan and Bililuna), Beagle Bay, and Bidadanga.
 - b. Assessing the viability and priority of progressing opportunities to develop location specific healing centers.
6. Support the needs of 'priority' SEWB populations across the region by:
 - a. Assessing support groups and services available Aboriginal carers within their region and where appropriate develop programs or activities responsive to place-based need.
 - b. Continuing to progress responses to ongoing community violence in identified communities by engaging key stakeholders and community leaders in discussions relating to conflict resolution and violence prevention approaches.

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Appendix

- A. Interview and focus group guide
- B. Participant Information Forms and Consent forms
- C. Plain Language Report for Community Participants
- D. Aboriginal and Torres Strait Islander Peoples Health Assessment (715) Mental Health and Wellbeing Screening questions

APPENDIX A

Interview Guide

Wellbeing Informed Care- Kimberley

Interview and focus group guide by theme and participant type

Theme	Questions/prompts for Kimberley community members	Questions/prompts for Kimberley ACCHS staff
Contextualizing trauma and wellbeing informed care	<p>Do you feel the clinic is aware of what your life looks like (good and bad) at home and in community?</p> <p>Do you feel like when things get hard or stressful it is hard to look after your health and wellbeing?</p>	<p>Do many of your patients/clients experience stress, crisis, trauma or SEWB challenges?</p> <p>Do you think this impacts on their health – how? Do you think it impacts on their ability to come into the clinic/ other health services?</p> <p>How does this impact on your workplace practices and wellbeing?</p>
Access and provision of wellbeing informed care	<p>Have you sometimes felt worried or stress out or not good in yourself?</p> <p>Have you ever gone to the clinic for support with you have those feelings? Why, Why not</p> <p>When you go to the clinic for something like a cough or a sore foot do clinic staff ever ask you about how you are feeling (mood/ lyian)?</p> <p>Do you think it would be helpful for clinics to ask these questions when someone goes to the clinic? Why, why not?</p> <p>What type of questions should they ask?</p> <p>When do you think they should ask – each time, once a year, something else?</p> <p>Who at the clinic would be best to ask you about your mood/ feelings (AHW, midwife, GP)?</p>	<p>How should clinics best respond to the stress, trauma or SEWB needs of patients?</p> <p>What is happening now and what needs to change?</p> <p>Many trauma approaches rely on universal screening of patients for mood at each visit or at certain time points, would this be helpful in your clinic – why/ why not</p>

<p>Capacity building</p>	<p>What would help you to talk to clinics about the stress and other things that are going on in your life?</p> <p>What type of support could the clinic help you with (information, training, Aboriginal support worker, counsellor/ psychologist GP)?</p>	<p>Do you feel comfortable supporting patients with SEWB/mental health concerns?</p> <p>Have you done any workplace training to explore the structural and interpersonal impacts of trauma and violence and their impacts on peoples' lives and behaviors; do you think this would be helpful?</p> <p>How much training would you be willing to receive, in person/online?</p> <p>Have you received any cultural safety training? Please tell us about your experience</p> <p>How is cultural safety training or trauma training reflected on in your team?</p>
<p>Workplace practices and wellbeing informed care</p>	<p>Is the clinic some where that you feel safe – physically, emotionally and culturally? Please tell me about your answer.</p> <p>Outside of clinic what brings you healing?</p> <p>What can clinic do more of to create healing space?</p>	<p>Do you feel the clinic is an emotionally, culturally, and physically safe spaces for service users? Please tell me about your answer.</p> <p>Is it safe in these ways for you as a staff member?</p> <p>What could be done to improve your sense of safety and patients' safety?</p> <p>Do you feel the clinic offers patients the opportunities for choice, collaboration, and connection in their healthcare; what can be done to improve this?</p> <p>What would you like to see this project achieve over the next three years?</p>

Appendix B

Wellbeing Informed Care- Kimberley

Participant Information Form: Community

About the Project: This project is about understanding ways that Aboriginal Controlled Health Services (ACCHS) in the Kimberley can support the wellbeing and mental health of their patients, clients, and their own health workforce. Lots of research shows us that when people are well in themselves (have good mental health and social and emotional wellbeing) they have better physical health outcomes. This is the holistic and connected nature of health that Aboriginal people have known for a long time. Western science is just catching up.

This research project is a partnership between the University of Western Australia, Kimberley Aboriginal Medical Services and Broome Regional Aboriginal Medical Services to work with patients and the health workforce to find out how we can best include wellbeing care into the clinics.

To undertake this research first we need to yarn, consult, and have workshops with patients, clients, and the health workforce to understand what types of wellbeing care patients, clients and staff would want, who would provide the wellbeing care, and how would we know if this type of care was improving outcomes for everyone. This is called co-designing the wellbeing care project for the Kimberley.

Today, we would like to interview you for around 30 minutes to 1 hour. There are no right or wrong answers, this is about you sharing your experiences and knowledge. We would like to use our audio recorder to record your answers to the questions we ask.

All the information that you provide us today will be stored in a safe place. Your information will be treated as strictly confidential and will not be given to anyone else in any form that could identify you. If the interview causes you distress, please let the interviewer know. We can stop the interview at any time and refer you to a counsellor or someone to talk to if you would like.

The study team will write reports about this project, but we will not say your name in the report. The results from this study may be published in academic journals but your name or any information that may identify you will not be included in any publication.

What next? If you would like to participate in this study, then you will need to sign a consent form.

Voluntary participation and withdrawal: Your participation in the Wellbeing Informed Care - Kimberley project is voluntary. You do not have to be involved in this research unless you want to, and none of your information will be used without your full consent. You can pull out of the research at any time until the report is prepared for publication. If you pull out of the research, you do not need to give a reason, and there will be no negative consequences. If you pull out of the research, any data or information provided by you in the one-on-one interview will be destroyed unless you tell us you want us to keep it. You can also decline to answer any questions asked or participate in group discussions, with no negative consequences.

Contact: If you would like more information, to withdraw, or to stay informed, please contact: Emma Carlin, Research Fellow, University of Western Australia, 08 9194 3234 or emma.carlin@rcswa.edu.au

If you wish to speak with someone from outside the study, please contact: Western Australian Aboriginal Health Ethics Committee, Aboriginal Health Council of Western Australia on (08) 9227 1631 or by emailing ethics@ahcwa.org. All research participants are entitled to retain a copy of any Participant Information Form relating to this research project.



Wellbeing Informed Care- Kimberley Participant Information Form: Workforce

About the Project : This project is about understanding ways that Aboriginal Controlled Health Services (ACCHS) in the Kimberley can support the wellbeing and mental health of their patients, clients, and their own health workforce. Lots of research shows us that when people are well in themselves (have good mental health and social and emotional wellbeing) they have better physical health outcomes. Emerging research says that when wellbeing or trauma informed approaches are applied to workplaces, the workforce experiences improved work satisfaction and less turnover.

This research project is a partnership between the University of Western Australia, Kimberley Aboriginal Medical Services and Broome Regional Aboriginal Medical Services to work with patients and the health workforce to find out how we can best include wellbeing care into the clinics.

To undertake this research first we need to yarn, consult, and have workshops with patients, clients, and the health workforce to understand what types of wellbeing care patients, clients and staff would want, how could this be implemented into the workplace, and how would we know if this type of care was improving outcomes for everyone. This is called co-designing the wellbeing care project for the Kimberley.

Today, we would like to interview you for around 30 minutes to 1 hour. There are no right or wrong answers, this is about you sharing your experiences and knowledge. We would like to use our audio recorder to record your answers to the questions we ask.

All the information that you provide us today will be stored in a safe place. Your information will be treated as strictly confidential and will not be given to anyone else in any form that could identify you. If the interview causes you distress, please let the interviewer know. We can stop the interview at any time and refer you to a counsellor or someone to talk to if you would like.

The study team will write reports about this project, but we will not say your name in the report. The results from this study may be published in academic journals but your name or any information that may identify you will not be included in any publication.

What next?: If you would like to participate in this study, then you will need to sign a consent form.

Voluntary participation and withdrawal: Your participation in the Wellbeing Informed Care - Kimberley project is voluntary. You do not have to be involved in this research unless you want to, and none of your information will be used without your full consent. You can pull out of the research at any time until the report is prepared for publication. If you pull out of the research, you do not need to give a reason, and there will be no negative consequences. If you pull out of the research, any data or information provided by you in the one-on-one interview will be destroyed unless you tell us you want us to keep it. You can also decline to answer any questions asked or participate in group discussions, with no negative consequences.

Contact: If you would like more information, to withdraw, or to stay informed, please contact: Emma Carlin, Research Fellow, University of Western Australia, 08 9194 3234 or emma.carlin@rcswa.edu.au

If you wish to speak with someone from outside the study, please contact: Western Australian Aboriginal Health Ethics Committee, Aboriginal Health Council of Western Australia on (08) 9227 1631 or by emailing ethics@ahcwa.org. All research participants are entitled to retain a copy of any Participant Information Form relating to this research project.



PARTICIPANT CONSENT FORM
Wellbeing Informed Care – Kimberley

- I agree to participate in this research project.
- I have been given a Participant Information Sheet. The study has been explained to me and any questions I have asked have been answered to my satisfaction.
- I know that I can stop participating at any time without reason and this will not change the relationship I have with the researchers and their associated organisations or affect my health care and/or employment.
- I understand that all information that I provide is treated as strictly confidential and will not be released by the researchers in any form that may identify me. The only exception to this principle of confidentiality is if documents are required by law.
- I agree that research data gathered for the study may be published, provided my name or other identifying information is not used.

	YES	NO
I consent to be interviewed		
I consent for the interview to be audio taped		

Name: <i>(printed)</i>	
Signature:	Date:

This study has been supported by the Kimberley Aboriginal Health Planning Forum Research Subcommittee and approval to conduct this research has been provided by the Western Australian Aboriginal Health Ethics Committee, in accordance with their ethics review and approval procedures. Any person considering participation in this research project, or agreeing to participate, may raise any questions or issues with the researchers at any time. All research participants are entitled to retain a copy of any Participant Information Form and/or Participant Consent Form relating to this research project.

In addition, any person not satisfied with the response of researchers may raise ethics issues or concerns, and may make any complaints about this research project by contacting: Western Australian Aboriginal Health Ethics Committee, Aboriginal Health Council of Western Australia on (08) 9227 1631 or by emailing ethics@ahcwa.org. Alternatively, please contact the University of Western Australia Human Ethics Office on (08) 6488 3703 or by emailing humanethics@uwa.edu.au.



Wellbeing Informed Care - Kimberley Community Consultation Report - 2024

Why was this study done?

The project wants to make sure that Kimberley Aboriginal Community Controlled Health Services (ACCHS) can give better care for mental health and social and emotional wellbeing (SEWB). We are trying to improve how clinics approach these issues.

In our talks, we aimed to find out how Aboriginal people prefer to deal with their SEWB and mental health when they go to a Kimberley ACCHS. We also wanted to understand what makes it easier or harder to give and get care for SEWB and mental health.

How was this study done?

We used a yarning approach to gather information from Aboriginal clinic staff and community members across seven (7) ACCHS located in Broome, Derby, Halls Creek, Kununurra, Kutjungka, Bidyadanga and Beagle Bay.

In total, 103 Aboriginal people across the Kimberley took part in the discussion. We individually interviewed 50 participants, and 53 participants joined via groups sessions.

What did we find out?

In the Kimberley, the phrase 'mental health' still makes some people feel uncomfortable, often linked with extreme behaviours and serious conditions. Aboriginal Health Workers (AHW's) were recognized for their important role in dealing with mental health and other tough SEWB situations in their communities.

The conversations showed us that many Aboriginal people in the Kimberley face tough challenges with SEWB and mental health. This helps us understand how hard experiences affect them, not just by looking at numbers. We learnt that family support, confidence in looking after yourself and SEWB programs really make people feel better.

People have different opinions on whether it's okay to talk about mental health and SEWB during regular check ups, how these talks should happen, and who should lead them. However, there was an agreement that discussing mental health and SEWB is important. The interviews helped identify principles to make these discussions better.

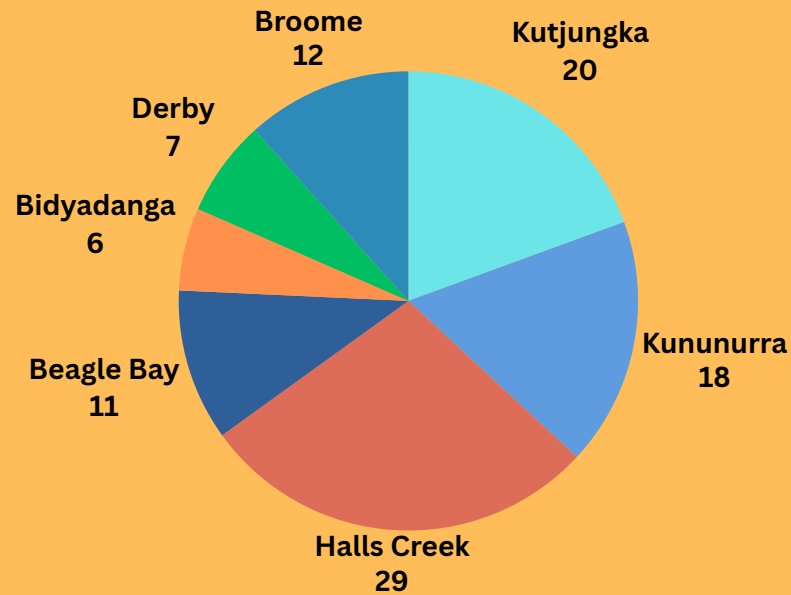
A lot of participants suggested that SEWB services are the best way to improve community wellbeing. They found these programs easy to access and meaningful. People want the current SEWB services to continue, and there's also a wish for these services to expand.



Transforming Indigenous
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Interviews completed in each region



What did this study contributed?

During our study we learnt that we need to empower our AHW's with more skills and confidence to support people who need mental health and SEWB care. We should also encourage regular discussions about mental health and SEWB during the yearly 715 Aboriginal Health Check. It is important to keep these talks private, and patients should feel free to choose who they would like to speak to.

To make things better, we should ask broader questions and try new ways of talking about SEWB and mental health during the 715 Adult Health Check. It would be helpful to use local languages and provide resources for patients.

Trust is important when talking about mental health and SEWB, so involving community leaders is key. We also learnt that keeping and expanding SEWB services was important to the communities. ACCHS's should plan new services in specific areas and continue to work on stopping ongoing community violence by talking to key people and leaders about resolving conflicts and preventing violence.



Next steps

We plan to keep collaborating with Kimberley ACCHS and communities to put into action what we have learned from this study. Our goal is to make mental health and SEWB support more effective. We want to remove the stigma around seeking help and ensure that communities receive continuous, relevant care for their mental health and SEWB.

If you have any questions or would like more information about the Wellbeing Informed Care-Kimberley (WIC-K) project, or to obtain a full copy of the report, please contact the WIC-K team:



Shannon Fong
shannon.fong@kamsc.org.au



Mental Health - Current 715 Questions

The maximum score is 12 indicating severe distress. The minimum score is 0 indicating no distress.

Score

0

Normal

Over the last 2 weeks, how often have you been bothered by the following problems?

Feeling nervous, anxious or on edge

- None of the time A little of the time Some of the time Most of the time

Not being able to stop or control worrying

- None of the time A little of the time Some of the time Most of the time

Little interest or pleasure in doing things

- None of the time A little of the time Some of the time Most of the time

Feeling down, depressed, or hopeless

- None of the time A little of the time Some of the time Most of the time

Other Mental Health Concerns



Have there been any stressful life events recently to cause you to be upset (eg death, illness, financial)?

- Yes No

Details



Do past events in your family still affect your wellbeing today (such as being taken away from family)?

- Never/Hardly Ever Sometimes Most Days/Every Day

Score: -

Would you like some support or to yarn psychologist/counsellor

- Yes No

Details



Do you feel safe in the home?

- Yes No

Details



Are you exposed to violence?

Violence can include verbal abuse, financial restrictions, physical harm, social isolation and withholding basic necessities

- Yes No

Details

