# Introduction

Much documentation exists regarding the causes and contemporary circumstances of Aboriginal Australian health and wellbeing; measurements of compromised health and wellbeing are abundant and long-standing. Conversely, little evaluation of what works and what does not work relative to Aboriginal policies and programs is conducted (Hunt, 2010). For too long, erroneous assumptions have informed policy and guided approaches to improve health and achieve social change for Aboriginal people in Australia. Subsequently, little progress has been generated. Aboriginal people continue to experience a high burden of disease and poor quality of life in comparison to other Australians. The scale of capital in terms of economic and material (practical needs) resources required to make changes to the contemporary position of Aboriginal people are vast and need long-term commitment. Deemed critical in any attempt to alleviate the socio-economic conditions experienced by many Aboriginal people, is to address, in unison, identified economic and material needs in addition to the intellectual/human (strategic needs) dimensions of any given circumstances (Bainbridge, 2009, Bainbridge in press; Batliwala, 1994, 1997; Malhotra, Schuler and Boender, 2002; McCalman et al., 2010; Saraswathy Amma, Panicker & Sumi, 2008; Sen, 1999; Tsey, 2008; Tsey et al., 2010; Whiteside, 2009).

For some time, global development efforts have focused on inside-out approaches to promoting social change. In the main, empowerment has been both a means and an end in developmental approaches (Wallerstein, 2006; McCalman et al., in press; Saraswathy Amma, Panicker & Sumi, 2008; Tsey, 2008). Despite advocacy by international development and aid communities over recent decades supporting ecological bottom-up solutions, including both participatory and empowerment strategies to promote health and sustainable social development and change, in reality, the approach represents a major challenge to implement. The means by which participatory and empowerment strategies are implemented as an important determinant of the developmental process for Aboriginal people is complex and diverse. While mounting evidence shows that such approaches are accorded ‘political correctness’ and result in effective and sustainable solutions to local problems (Lennie, 2006), they often “receive insufficient investment of training, time and resources to be done well” (Mayoux & Chambers, 2005, p. 271).

Primarily for these reasons, there is little published evidence-based research that captures the intricacies of the processes involved in promoting initiatives to enhance Aboriginal health and wellbeing. To address the persistent gap in the literature, the purpose of this paper is to consider the innovation arising from the application and utility of community-based participatory research in Aboriginal Australian contexts.The aim of the paper is to present a model of community-based participatory research that works, and has been sustained for over a decade. It showcases an Empowerment Research Program (ERP) from Australia by highlighting the importance of strengths-based participatory approaches for working with Aboriginal people as partners in community development projects. It emphasises how social science research and researchers’ expertise can be relevant to Aboriginal community priorities, people’s daily lives, needs and aspirations by developing research models that build up authentic partnerships; are context-dependent; strengthen local capacity through research; and are based around mutually identified situational ethics (Bainbridge, McCalman & Whiteside, in press; Tsey, 2010). We will provide the context in which the research program has flourished; an overview of the program and its research outcomes; examples of community-level empowerment and the psychosocial processes involved in becoming empowered for Aboriginal women; and provide current empirical examples of our research. The ground question being considered in this paper is: How can social science researchers most effectively move from theory to practice to support improved health and wellbeing for Aboriginal people?

**Historical Context**

Colonisation and its associated disruption to Aboriginal culture and lifestyles meant that Aboriginal people (regional variations excluded) generally experienced erasure from religious, social, economic and political status in early colonial society (Huggins, 1998). This experience profoundly affected the social-economic and health status of Aboriginal people in Australia and restricted their prospects for full participation and social action in such spaces, both within Aboriginal and the dominant societal contexts (Huggins, 1998). The onset of colonisation and its associated genocidal practices, played out through the dispossession of land, massacres and spread of disease, posed serious threats to the daily existence of Aboriginal communities (Huggins, 1998; Kidd, 1997). Acts of genocide were justified under the guise of ‘policies of protection and assimilation’ and continued through enacted legislation, for example, the Aborigines Protection and the Restriction on the Sale of Opium Act 1897 (Huggins, 1998; Kidd, 1997). This legislation meant that state governments commenced the responsibility for Aboriginal welfare and essentially removed their basic human rights. It facilitated the forced removal of Aboriginal people to established reserves, severely restricted movement, denied use of language and cultural practices, and specifically focussed on the forced removal of children, freedom of choice to marry and so forth (Huggins, 1998; Kidd, 1997).

**Contemporary Context**

Contemporaneously, Aboriginal people in Australia continue to inhabit colonised spaces. Comprising just 2.5 percent of Australia’s population, Aboriginal people’s lives are marred by social exclusion and entrenched disadvantage. Colonisation laid the foundations for this situation; misguided policy and programs perpetuated and exacerbated those experiences; continual pledges of change for Aboriginal people made by successive governments have generally not come to fruition; and the personal incapacity of many Aboriginal people themselves now consolidates and sustains those experiences. They experience a burden of disease two-and-a-half times that of other Australians. Cardiovascular disease, cancer, diabetes, chronic kidney disease and chronic respiratory diseases are the major diseases contributing to an unacceptable 9.7 – 11.5 year gap in life expectancy (Australian Bureau of Statistics, 2008) between Aboriginal and non-Aboriginal people (Commonwealth of Australia, 2010). Upstream factors, inclusive of past and present government policies and social, physical, economic and environmental determinants of health continue to influence quality of life. Many communities are located remotely and there is little economic development. Thus high levels of welfare dependency, poverty and unemployment are evident. In addition, there is a lack of infrastructure to support healthy living and as such, health issues, poor educational outcomes and housing problems are prominent. As a result, harmful health-related behaviours and poor psychosocial processes manifest in the population as a lack of control/choice, stress, self-harm and depression, hopelessness, incarceration, alcohol and drug abuse, smoking and a lack of preventative health care (Tsey et al., 2009). Despite these hardships, goals of community control of social and economic institutions are a priority, supported by pockets of strength and resilience throughout communities.

**10 Year Empowerment Research Program**

The Empowerment Research Program takes a longitudinal approach that spans across ten years of research dedicated to supporting Aboriginal community action; contributions of which have created an environment of Aboriginal control at individual, organisational and community levels. It is the first in Australia to undertake extensive work in developing empirical understanding of the potential of empowerment to contribute nationally to improving Aboriginal health and wellbeing.

**What is empowerment?**

Empowerment is a much-used term that is bandied around without much thought to its use. We utilise Minkler and Wallerstein’s (2005) definition of empowerment as “a *social action process* by which *individuals, communities, and organizations* gain *mastery* over their lives in the context of changing their social and political environment *to improve equity and quality of life”* (p. 34).Aboriginal perceptions of empowerment are expressed contextually and are encompassed within their own worldview. They do, nevertheless, support Minkler and Wallerstein’s definition of empowerment. Aboriginal people who have participated in the Empowerment Research Program over the past decade understand empowerment as a social action process in the context of their lived experiences: healing/coming to terms with past and present situation; dealing with the pain; gaining control; becoming strong; finding your voice; participating in change; and working together for a strong community (Haswell-Elkins et al., 2010; McCalman et al., 2009, 2011).

**Why empowerment?**

The evidence-base indicates that developmental approaches which nurture the empowerment of socially excluded populations across psychological, organisational and community levels have achieved improved health outcomes and quality of life (Tsey, Harvey, Gibson & Pearson, 2009; Wallerstein, 2006). Nonetheless, empowerment is only part of the solution for improving the health of Aboriginal people. It is not the panacea for all social ills endured by Aboriginal people; it is the foundational work that is required for individuals to begin to move forward. Consonant with empowerment strategies (human and social capital), are health system level contributions and measures to address the underlying socio-economic disadvantage.

To achieve the reality of social change, however difficult, Sen (1999) espouses that “individual agency is, ultimately, central to addressing deprivations [disadvantaged conditions]” (p. xi). Other change agents also express the significance of agency in overcoming disadvantage (Malhotra, Schuler and Boender, 2002; Kabeer, 1999; Minkler and Wallerstein, 2005; Wallerstein, 2006). They argue, using multiple examples in the literature, that there are numerous cases in which giving women access to resources did not “lead to their greater control over resources” (Malhotra, Schuler and Boender, 2002, p. 9). Thus, resources alone will not necessarily bring about change unless individuals are able to recognise and utilise those resources in their own best interests. Indeed, Sen also argues that when people have knowledge, skills and resources, they will act in their own best interests and shape and contribute to their own well being.

**Philosophical Framework**

The Empowerment Research Team (ERT) takes a research-based approach to addressing issues of Aboriginal health and wellbeing. It works from a resilience model that seeks to work in a culturally safe and respectful manner (Irabinna Rigney, 1999). The ERT

…focuses research on the population’s own resolves in life, attends carefully to the voice of the research population by promoting them as experts in their own lives, positions the researcher and researched as partners with analysis and interpretations of the findings conducted through collaboration and negotiation of meaning and finally, encourages participant engagement in the research. Simultaneously, a concerted effort to strengthen capacity for both parties occurs. The approach invests in phenomenon that already works and which can logically serve as the foundation for realistic growth and change (Bainbridge, McCalman & Whiteside, in press, p. 5).

The ERT’s base assumption is that no matter how dire a situation may appear, looking deeply from the inside, people and communities know what they need and want, and that pockets of strength are actively building toward opportunities for social impact in accord with those identified needs and desires. In partnership with communities, the team assumes a decolonising methodology that seeks to centre Aboriginal values, concerns, perspectives, desires and voices, support capacity building and encourage participation, action and social change (Bainbridge, McCalman & Whiteside, in press; Tsey, 2010). Underpinned by a constructivist epistemology, this methodology, advocates innovative approaches to research, building a coalition of Aboriginal and Western knowledge that has relevance, practical application and vision for Aboriginal people. It aims to develop and nurture authentic partnerships and support and strengthen local capacity (Bainbridge, McCalman & Whiteside, in press; Tsey, 2010). It seeks to problematise both colonial relations and practice and move easily between theory and practice (Flyvbjerg, 2001; Dei, 2005).

Underlying this philosophical approach is the concept of phronetic social science (Flyvberg, 2001). In practice, phronesis is achieved by the analysis of values and power “as a point of departure for action” (Flyvbjerg, 2001, p. 57). To achieve this, the ERT aims for a workable ethical course of action that focuses on localised Indigenous knowledge and responds to the variable or particular, as opposed to the universal and context-independent (Flyvbjerg, 2001; Tsey, 2010). For research conducted with Aboriginal populations, phronetic research approaches enable movement beyond epistemologies that centre the privileges, beliefs and experience of dominant others (Bainbridge, McCalman & Whiteside, in press; Tsey, 2010). The ERT uses the value-rational questions suggested by Flyvbjerg to guide analyses of relations of power. Continuously reflected upon are: Where are we going? Who gains and who loses, by which mechanisms of power? Is this development desirable? What, if anything, should we do about it? (p. 76). Follow-up evaluation prompts for reflection include: how are we going as a community; what is working, what is not working so well; is our community getting its fair share of resources in relation to our need; which people are benefitting from PAR related activities; which people are missing out and what can be done to reach those that are missing out; what can be done to make things better? These questions seek to maximise outcomes of the PAR process by ensuring critical self-learning and awareness is built into the process, inclusion of groups who may otherwise be excluded from the production knowledge and encourage mobilisation over time.

**Operationalising the concept of empowerment: a strengths-based approach**

Enhancing opportunities for empowerment, including choice and control, is critical to health and wellbeing (Bainbridge, 2009, Bainbridge in press; Tsey et al., 2009; Wallerstein, 2006; Whiteside, 2009). The Empowerment Research Team (ERT) has operationalised and rigorously evaluated specific empowerment initiatives to reveal the role and contributions that concepts of empowerment and control can make towards better understanding and addressing the social determinants of health and wellbeing for Aboriginal people. Using a community development perspective and strengths-based approach, the ERT aims to use research to value add to what Aboriginal people are already doing. As such, the ERT uses participatory action research to support and document local initiatives. While the ERT has worked with diverse partners, for instance, community councils and Aboriginal-controlled health services to support a range of issues, two tools of engagement have been most prominent: 1) The Family Wellbeing Program (FWB); and 2) Participatory Action Research (PAR).

**The Family Wellbeing Program**

The Family Wellbeing Program was developed in 1993 by the Aboriginal Education Development Branch of the South Australian Department of Education. It originated as a response to the Aboriginal-identified need for skill training to better cope with conflict, crisis and grief in their everyday lives. In its current form, it is delivered as a participatory empowerment education program that brings individuals, families, communities and organisations together in small groups to gain new understanding about how to deal with the challenges of life; build capacity through skill development (Brown, 2010) and support visionary leadership. It has been delivered in response to a broad range of social and emotional wellbeing issues[[1]](#footnote-1) to more than 3000 people across more than 100 situations across Aboriginal Australia and beyond (McCalman, Tsey, Kitau & McGinty, in press). Groups have comprised primary school students, adult community members and post-graduate students. Figure 1 shows its organic spread in response to grass roots demand from Aboriginal groups in all Australian States and the Northern Territory and it has also been piloted internationally in Papua New Guinea and Ghana (McCalman, Tsey, Kitau & McGinty, in press). The ERT became interested in FWB as a way of operationalising empowerment when the research leader was asked to evaluate the program in 1999. It has drawn on its multidisciplinary networks of practice across Australia to contribute significantly to its spread since 2001.

**Figure 1: Spread of the Family Wellbeing Program**



**Operationalising empowerment in practice: using PAR approaches in community-based research**

The ERT have experienced successful outcomes and collaborated for over 10 years using PAR with Aboriginal communities and others in a variety of settings including schools, men and women’s support groups and to promote organisational change in community-controlled organisations. PAR processes are used to facilitate engagement with, and support the members of Aboriginal communities and organisations to clarify issues that are important to them; plan, implement and evaluate activities based on those needs; and strengthen local and researcher capacity. As a reference point, PAR can be defined as: “a participatory, democratic process…It seeks to bring together action, reflection, theory and practice in participation with others, in pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities” (Reason & Bradbury, 2006). PAR’s purpose is knowledge production that is grounded in, and holds relevance to the lives of people in the everyday, vis-à-vis a tool of inquiry that previously (mis)informed social policies and practices for Aboriginal people in Australia. Thus PAR is a value oriented approach to research that both parallels methodological reform agendas for working with Aboriginal people (National Health and Medical Research Council, 2003) and directly aligns with notions of empowerment and the purpose and aims of the ERP. It is an emergent method, that generates “living knowledge” (Reason & Bradbury, 2006, p. 2) and is only possible with, for and by persons and communities (Reason & Bradbury, 2006). Inherent in community PAR processes is community engagement and collaboration and strengthening of capacity.

PAR is a sustained lived process with practical outcomes emerging from the research. It requires engagement with self, people, community and knowledge, (Reason & Bradbury, 2006). Thus continual reflexive practice, meaningful and productive relationships and questions of sustainability lie at its heart. Without fully explicating process details, typically (variations discarded) the ERT strives toward a mutually informing repertoire of activities (See Table 1) beginning with an ongoing practice of community engagement, collaboration & communication. A group agreement is established at beginning of the research. The research is entered into with a long commitment to partners and sustainability of the process. The creative use of short-term funding for long-term processes is a critical strategy to this vision. Cultural brokers/advisors/researchers are employed to broker community pathways and relationships and ensure cultural sensitivities are upheld. The ERT works toward developing and maintaining authentic partnerships and investing in existing arenas of action & local resources by providing capacity building opportunities such as training and mentoring for community workers; this facilitates engagement with the research in a more meaningful way and thus encourages more participation and control and sustainability of outcomes. Simultaneously, researcher capacity is addressed through mentorship by more experienced researchers and Aboriginal mentorship. The research process itself, such as reviewing relevant literature, data collection, documentation and analysis is primarily conducted by researchers, but still in collaboration with partners; reflective practice, on the part of both community partners & researchers is a critical part of the process. To promote research translation, ongoing knowledge sharing activities that involve researchers, community, policy-makers and leadership of the area that lie beyond the project are co-ordinated.

**Table 1: ERT facilitating strategies of Participatory Action Research**

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The model of research engagement with Aboriginal communities works well. This is evidenced by the fact that three of our current community projects all came as requests directly from the community when, upon the withdrawal of a community employment program by the government, the community council mobilised to address the gap. These projects are a whole-of-community approach engagement into education, the development of a community social and emotional wellbeing action plan, and a health promotion project focussed on alcohol. Significantly, in each case, enhanced capacity and control for community partners has meant that they are now requesting more formalised agreements between the university (ERT) and community to guide and partake in the research processes.

Building on qualitative findings, more recently the ERT has used grounded theory in conjunction with PAR and incorporated quantitative methods and cost-effectiveness into the mix of methods to further contribute to the intellectual and theoretical rigour expected of academic research. The ERT have qualitatively established the benefits of self-empowerment to improving health and wellbeing for Aboriginal people (See Bainbridge, 2009, in press; Tsey et al., 2009; Whiteside, 2009). *Qualitative data* have also been used to develop a *quantitative* screening tool, the Growth and Empowerment Measure, to measure and enhance the analytical understanding of both processes and outcomes of psychological and social empowerment (Haswell-Elkins, 2010). The team is current working on strengthening the research evidence-base by incorporating the cost-effectiveness using quantitative outcome measures.

**Multi-level findings – individual, community and organisational**

A synthesis of the findings of the ERP to date indicate that intricate links exist between empowerment and social, emotional and spiritual health and wellbeing for Aboriginal people. The study findings reveal the role of psychosocial empowerment attributes as important foundational resources in helping people engage and benefit from health and other behaviour modification programs, and take advantage of any reforms made within macro policy environments (Tsey et al., 2009). Evident in narratives of change for participants has been an understanding of self in environment; a heightened sense of Aboriginal and spiritual identity; respect for self and others, enhanced parenting and capacity to deal with life challenges such as substance abuse and violence; personal healing and stability; development of intellectual curiosity, reflective skills, hope and confidence; control of destructive emotions; improved relationships and care/support for family/children; and increased engagement in broader change processes, employment and education (Tsey et al., 2009).

Individual/family, community and organisational outcomes show that concepts of empowerment and control are critical in effective prevention and management of health, education and employment and need to be taken more seriously. Community and organisational change experiences have occurred in social reform, education, health promotion and clinical settings, for instance, welfare reform processes, education, mental health, social health programs, suicide prevention, substance abuse and chronic disease (McCalman et al., 2009; Tsey et al., 2009). Participants specifically expressed increased capacity to work better as a team member by dealing with work issues and conflict and providing support to others. They now look at the bigger picture; have incorporated FWB principles into the work place which affected how the organisation worked; and have come to a consensus about group identity and values (McCalman et al., 2010; Tsey et al., 2009). Structural outcomes have been apparent in advocacy outcomes, for example, housing, early childcare and vacation school care. FWB principles have also been incorporated into state school curricula (Tsey et al., 2005). Other structural outcomes include the development of community controlled health service; cultural activities; sustainability of programs (over 10 years); funding support; and contributions to initiatives in other settings (Tsey et al., 2009).

**Discussion**

Concepts of empowerment and control are critical in effective prevention and management of health, and in influencing the social determinants of health. Multi-level change experiences have manifest in social reform, education, health promotion and clinical settings, welfare reform processes, education, mental health, social health programs, suicide prevention, substance abuse and chronic disease. This finding is supported Wallerstein (2006) in a report to the World Health Organization in which she reviewed the evidence-base on the effectiveness of empowerment to improve health. She found that partnerships promoting empowerment have led to diverse health outcomes. Wallerstein further impressed that empowerment was “an intermediate step to long-term health status and disparity outcomes” (p. 4).

The value of PAR as a critical tool for operationalising notions of empowerment in community-based research with Aboriginal partners was also substantiated. Research on the effectiveness of empowerment strategies has identified two major pathways: the processes by which it is generated and its effects in improving health and reducing health disparities (Wallerstein, 2006). More recently PAR has been recognised for its prospective utility for improving health and reducing health disparities (Tsey et al., 2009; Wallerstein & Duran, 2006, 2010)*.* With the shift toward more collaborative research, PAR has been flagged as an alternate research method that aims to facilitate social, individual and institutional change. PAR processes facilitate engagement of community stakeholders in context and knowledge, create spaces for local theories and broaden discourse to include local realities, contribute to closing the gap in power inequities, sustain programs through integration with existing programs, provide a vehicle for local ownership and capacity building and promote relationships of trust and mutual benefit (Gaventa & Cornwall, 2006; Mayo & Tsey, 2009; Wallerstein & Duran, 2010). Nevertheless, to fulfil the potential of PAR, researchers are increasingly pressed to look outside the square for innovation in what this looks like in practice.

Critical to its accomplishment and often overlooked in the literature, are the innovations of practice that actually contribute to undertaking PAR approaches. Of particular importance are the practical politics of participatory research such as developing an ethics of practice that accounts for tensions arising in how power relations are mediated between researchers and partners; the limitations of participation; achieving a community-driven agenda; the capacity to facilitate PAR processes on the ground; and creatively strengthen the capacity of local experts and researchers alike so that it contributes to the overall aim of sustainable social change (Mayo & Tsey et al., 2009; Minkler, 2004, Wallerstein & Duran, 2010).

The innovations of practice for engaging with Aboriginal research partners require a carefully considered approach that opens the door to respectful relations and culturally-safe practice. A workable ethics of practice must be central to the strategies adopted and take into account context, power relations, difference, empowering ways of communication and engagement with community experts and decision-making processes (Gaventa & Cornwall, 2006; Minkler, 2004; Mayo & Tsey et al., 2009; Wallerstein & Duran, 2006, 2010) (See Table 1 for ERT key strategies). As well as facilitation of knowledge production around the issue at hand, researchers and partners must be prompted to consistently practice reflexivity in relation to all aspects of the research process including their own assumptions and position in the research.

As an emancipatory project, power relations are fundamental to the practice of PAR. In the research context, a broad consideration of power is of primary importance in conceptualising and implementing PAR processes in any context. Power exists both in the research relationship and the broader social and political relationships within which it is situated (Gaventa & Cornwall, 2006). It shapes all fields of possibilities and limitations within that realm and beyond. Most useful when working with Aboriginal partners is a conceptualisation of power as productive and relational. To maximise change possibilities and opportunities, it should have a synergistic element whereby “action by some enables more action by others” (Gaventa & Cornwall, 2006, p. 74). To include the positive aspects through which power enables action, one must focus on context and difference and consider what aspects of the situation enable action and which restrict it (Flyvbjerg, 2001; Gaventa & Cornwall, 2006).

**Conclusion**

Aboriginal health improvement occurs through gradual incremental change generated by the involvement of Aboriginal people in decision making about their own lives as well as the sustained improvement of services and programs. Over the past decade the ERT have achieved the objectives of the Program by through collaborative approaches that start with the concerns of Aboriginal people, and then develop researchable projects that assist Aboriginal partners to strengthen their capacity, build health services and generate policies that will support health improvement. PAR situated within a decolonising framework has provided a valuable approach, while simultaneous rigorous documentation and evaluation of these initiatives has built credibility. The research process also fosters sustainability since by the time a research project is finalised, knowledge transfer to the Aboriginal people who will ultimately be the end users of the research has already been enacted.

After a decade of working in partnership with, and strengthening Aboriginal capacity, authentic and meaningful relationships have developed. As a result, communities now approach the ERT to help them clarify and support their goals and initiatives and we are able to work together toward change as partners for mutual benefit. The research outcomes have also provided professional benefits to researchers, and critical networks or communities of practice have developed across Australia and beyond. However, a key limitation or challenge in the use of psychosocial empowerment programs to achieve this relates to the time and resources required to achieve change at population level.

The findings advocate that greater attention must be given to supporting Aboriginal initiatives that enhance social and emotional wellbeing. This means that concepts of empowerment and control need to be taken more seriously. Understanding the empowerment process informs how people working in an Aboriginal context, such as policy-makers, program developers and those working in the helping professions, can improve their ways of knowing, doing and being in professional practice and importantly consider the role empowerment plays in health and wellbeing and in facilitating the uptake of programs and opportunities. The research findings suggest that maximal outcomes for the health and wellbeing of Aboriginal communities can be achieved by taking a long-term partnership approach to empowerment research that creatively integrates micro community empowerment initiatives with macro policies and programs.

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1. Social and emotional wellbeing is an Australian Indigenous concept derived from the holistic Indigenous view of health and refers to ‘*the emotional and psychological aspects of child and adult development as well as the importance and nature of the social and community relationships supporting good health”* (Zubrick et al., 2005, p. xiv). [↑](#footnote-ref-1)