

The central role of Aboriginal families in motivational counselling: family support and family ‘humbug’

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Objective: This mixed methods study aimed to develop and test a brief pictorial motivational intervention for Indigenous people with mental illness, which can be delivered in remote settings. For the purpose of this paper 'Indigenous' refers to Australia's Aboriginal and Torres Strait Islander peoples and acknowledges their rich diversity of culture.

Methods: This study was conducted in remote Indigenous communities in Northern Australia. An ethnographic approach was used to gather remote Aboriginal Mental Health Worker (AMHW) perspectives of wellbeing through key informant interviews and participant observation. The perspectives were integrated into a brief intervention. The intervention was tested in a randomised controlled trial with Indigenous clients and carers and showed improved outcomes. Concurrent qualitative data related to strengths, stressors, goals for change and reasons for change were collected and thematically analysed. This paper reports on the findings of the analysis of the qualitative data. The findings of the randomised controlled trial have been reported in an earlier paper.

Results: Clients rated 'family' as one of the main worries, the main strengths and the main reasons for making lifestyle changes. Dealing with family worry or 'humbug' was a common goal, while seeking support from family to make life style changes was a common step. AMHWs reported high rates of mental illness, domestic violence, self harm behaviour and substance misuse in the client homes.

Conclusions: Family were a source of strength and support as well as stress and worry for Indigenous clients with mental illness. Clients identified a number of goals and steps toward life style change that focused on family support and dealing with family conflict and 'humbug'.

Implications: Client-centred approaches which acknowledge and promote understanding of the role of family in treatment are needed. Family conflict is a key precipitant and perpetuating factor for illness, while family support is a key protective factor. More understanding of successful engagement with families will be pivotal to successful psychological treatment in this setting.

Keywords: Indigenous, brief intervention, motivational interviewing, mental illness, client-centred

Introduction

Indigenous peoples have a high burden of disease from mental illness and co morbid disorders [1, 2]. A recent national survey reported high rates of psychosocial distress among Indigenous people living in remote areas. The most frequently reported stressors in the previous 12 months were death of a family member or close friend (55%), overcrowding at home (42%) and alcohol and drug-related problems (37%) [3].

Co morbid substance use and chronic disease, family disharmony and cultural dislocation in Australian Indigenous peoples are a legacy of colonisation and ineffective and often oppressive political interventions [4, 5]. Conversely, family and culture are integral to wellbeing [6] and acknowledgement of the strength of kinship and cultural identity can promote mental health and strengthen community resilience [7-9].

Expressed emotion (EE) is a well-established construct which refers to the amount of criticism, hostility, and emotional over-involvement of a caregiver with respect to the client with mental illness. Clients living in high-EE environments (high criticism, presence of hostility and/or presence of emotional over-involvement) have higher risk of relapsing than do clients living in low-EE environments [10]. There is evidence that expressed emotion (EE) is a generalised risk factor across a wide range of disorders and that the concept may be applicable in other cultures [11-15]. This has led to development of specific treatment approaches targeting families of clients with mental illness [16]. Further studies to resolve emic bias in the interviewer or the interviewee are needed however, and the validity of the concept of EE in the setting of Indigenous clients with mental illness and implications for treatment has not yet been explored [17].

In terms of treatment for mental illness in non-Indigenous populations there is evidence that education of individuals and families can improve outcomes for people with mental illness and decrease relapse or readmission rates in schizophrenia [18-20]. There is also increasing evidence that joint or integrated treatment for clients with co-occurring disorders improves outcomes [21-24] and that integrated treatment incorporating family interventions has positive results [24].

The high importance of family and kinship in Indigenous cultures combined with high rates of comorbidity would suggest that integrated treatment which includes family interventions and aligns with cultural values may lead to improved outcomes. Finding brief, effective interventions is particularly important for Indigenous people who not only experience poor mental health outcomes but live predominantly in rural and remote settings which are distant from specialist care [25].

This study was undertaken by the Australian Integrated Mental Health Initiative in the Northern Territory (AIMhi) which implemented a program of research in 2003-2008 seeking to improve outcomes in Indigenous mental health [26]. The mixed methods study described in this paper sought to develop and test a brief motivational intervention ('Motivational Care Planning') that focused on goal-setting, psychoeducation and engagement with families. It is the first detailed study of the profile of mental illness and the effectiveness of treatment in a remote Indigenous setting.

Further detail of the design, results and conclusions of the combined data analysis has been published elsewhere [27-30]. Those results suggest that the motivational care planning intervention (MCP) improved client mental health outcomes and that the

improvement was sustained over time. Outcomes were measured from both client and clinician perspectives. The changes noted in client-rated measures of well-being, substance dependence and self-management paralleled the changes in clinician-rated outcome measures.

The results strengthen the evidence that brief interventions, which address co-morbid disorders in an integrated approach, can result in significant change, even in acutely unwell populations. This paper describes some of the relevant findings from the qualitative data analysis, which address the link between motivation and family.

Aim

The present study aimed to explore local Indigenous perspectives of mental health and to integrate these perspectives into a brief motivational intervention which was compared with 'treatment as usual' using a mixed methods design.

Methods

The research team consulted with a range of non-government and government organisations in the 18 months preceding commencement of this study. The three investigators included a non-Indigenous psychiatrist and two Indigenous investigators: a female AMHW of Walpiri-Gurindji heritage from south-west of Katherine and a male Indigenous research officer of Larrakiah (Darwin area) descent. The research team presented the project to both the health centre and the local Land Council or Health Board of a number of communities, and eventually gained consent to work in three remote island communities north east of Darwin.

Design phase 1

The mixed methods study design incorporated sequential and concurrent phases of data collection. The initial qualitative phase of the study (Phase 1) focused on understanding local perspectives of mental health through collaboration with local Aboriginal Mental Health Workers (AMHWs). Qualitative research methods were used to elicit information and data and included key informant interviews, participant observation, story telling, narration and an ethnographic approach [31]. The AMHWs participated in the research process and assisted in development of the tools, and in the delivery of the intervention [32].

The researchers adapted pre-existing urban resources developed by AIMhi to the remote setting by using photographs, music, artwork and language of that community as recommended by the AMHWs [33]. Video and flip chart formats were created using a hand held digital recorder, digital cameras, and laptop computers. This exploratory phase of the study was conducted over twelve months. This allowed time to develop rapport with the AMHWs, and to become familiar with the community. These perspectives were then incorporated into a brief intervention which was compared with 'treatment as usual' using an 18-month repeated measures design (Phase 2).

Design phase 2

Current clients of the health centre with chronic mental illness and their carers were recruited to the randomised controlled trial. Participants were randomised to early and delayed treatment groups. The 2-session motivational care planning intervention was delivered by the research team. Treatment occurred at baseline in the first 'early

treatment' group, and 6 months in the second 'late treatment' group. Client participants were randomly allocated to two groups using a block randomisation random number sequence technique after completion of baseline measures. Further detail of the design of Phases 1 and 2 is described in earlier papers [27, 28].

Collection of quantitative and qualitative data from several sources during the RCT (clients, AMHWs, carers and clinical files) allowed triangulation of the results [34]. Meanwhile the RCT design provided the potential to generalise research findings, and to eliminate confounding influences related to cause-and-effect relationships.

The use of mixed methods enhanced the meaning of the information collected, enhanced the integrity and usefulness of the findings, and allowed the opportunity to understand the 'emic' or insider's viewpoint [35, 36]. Flexible qualitative investigative methods allow sensitivity in 'vulnerable' or 'hard to reach' populations, in which the risk of miscommunication is high [31].

Participants phase 1

Ten local AMHWs and one recovered client in three communities participated in the initial qualitative phase of the study. Their perspectives related to mental health and mental illness were shared in words, images, events and music. These findings were incorporated into the pictorial tools used in Phase 2 [28, 37].

Participants phase 2

Current clients of the health centre with chronic mental illness were referred to the randomised controlled trial by the local mental health workers. Chronic mental illness in this context was defined as duration of symptoms greater than six months or at least one previous episode of relapse. Organic mental illness, intellectual disability, inability to give informed consent, and age less than 18 years were criteria for exclusion. Carers of consenting clients were also recruited to participate in assessment and treatment.

Eighty per cent of clients with mental illness referred to the study by the local mental health service, agreed to participate in the project. Forty nine participants and 37 carers were recruited. Seven carers were caring for two or more clients and four clients identified no carer. No carers declined to participate at baseline and 96% of the clients in the early treatment group attended at least one treatment session. Eighty eight per cent of clients [22] in the late treatment group attended at least one treatment session. Four clients did not receive treatment. One client committed suicide in the first 6 months of the trial and a second client killed himself 12 months later. Fifty seven per cent of the clients were male, and the average age of clients was 33 years. There were no significant differences between the groups at base line in terms of age, diagnosis, overall substance use (Chi square 1.38, $p=0.24$), alcohol use (Chi square 0.23, $p=0.63$) or marijuana use (Chi square 3.64, $p=0.057$).

Diagnosis in this setting of language and cultural difference is challenging. Nevertheless it was possible to group clients into diagnostic categories that were broadly consistent with Diagnostic Statistics Manual (DSMIV) criteria [38]. This grouping took place at the closing stages of the study using multiple sources of information to assist in diagnosis. The sources were: the content of the 6 monthly interviews with client, carer and local AMHW, the observation of that person over the two years of the study, and the notes of other service providers recorded in the clinical file.

Diagnostic categories were as follows: schizophrenia (37%), schizoaffective disorder (2%), major depressive disorder (45%), substance induced psychotic disorder (10%), and bipolar affective disorder (6%). Most clients (82%) were using marijuana and/or alcohol and most of the participants (92%) who used substances were psychologically dependent on that substance as measured by the Severity of Dependence Scale using a cut off score of 3 [27, 39].

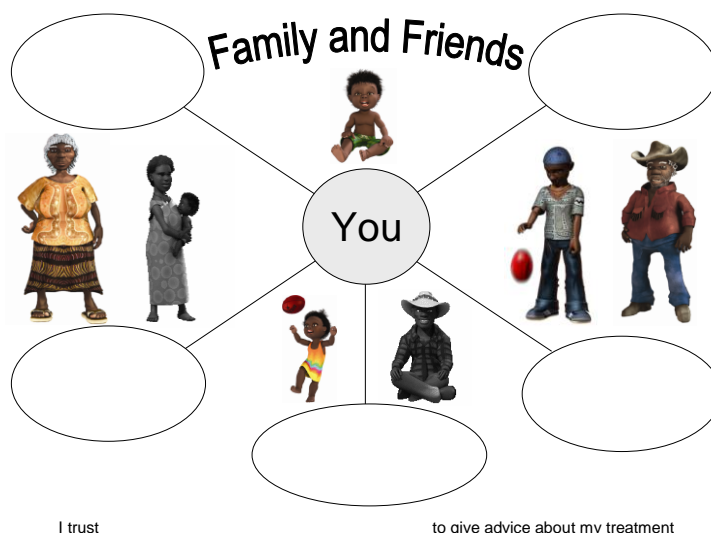
The trial received the required ethics approval of the Menzies School of Health Research and Department of Health and Community Services Joint Ethics Committee and was conducted between November 2005 and August 2006.

Phase 2 intervention

The brief intervention consisted of two one-hour treatment sessions 2 to 6 weeks apart. The key cultural adaptations to motivational counselling were threefold: a focus on family, a 'whole of life' approach to strengths and stressors, and the use of a supporting pictorial tool. Figure 1 shows the first page of the intervention which was used to record the supportive family in the client's life, including children. Supportive family were explored through prompts such as 'Who are the people who help to keep you strong?' 'Who do you care for?' 'Who is watching what you do?'

The use of pictures allowed the intervention to be easily understood despite differences in language and literacy. The first step in the intervention involved discussion about important and supportive family members, and the second and third steps involved review of client strengths and stressors by looking together at the pictorial tools. The final goal-setting phase explored one or two goals and steps to those goals which were immediate, circumscribed, achievable, and relevant to that person. The lead-in to goal setting was as follows: 'Thinking about your family, and thinking about what keeps you strong, and thinking about what is taking your strength away, what would be the most important thing that you would want to change right now, and we can talk together about how you might go about that? A consistent prompt during goal setting was 'Who can help you to make that change?'

Figure 1. Family map used in AIMhi training and resources



The second session, 2-6 weeks later, reviewed the progress to goals, explored barriers to goal achievement, and developed new strategies as appropriate. All participants received 'treatment as usual' from the local health centre throughout the course of the trial.

The brief interventions were conducted with carers present wherever possible. The carers did not receive separate training. They were invited to participate with clients throughout: to receive the education sessions, to observe the goal setting interventions and to add carer perspective of client progress at each data collection point through separately conducted interviews.

Fidelity of treatment

The research team aimed to deliver the same intervention to each individual in each group. In practice there were variations in setting, length of treatment, and content of treatment. The principal investigator delivered all treatment sessions – with assistance from the Indigenous research officers and the local AMHWs in most cases. This was the most consistent component of the protocol. There were otherwise a number of minor variations from the standard process that applied to both treatment and follow up assessments. The variations related to factors in the client, the setting, and the AMHWs. Participants and carers were often very difficult to locate for a range of reasons. Most participants received two treatments, although some were not located in time and only received one.

Some treatment sessions were held in the hot, noisy and dusty setting of the youth workshop, most were held in air-conditioned health centre offices, some were conducted outside under trees, and some in people's homes. The length of treatment varied according to a number of factors such as client concentration, client competing priorities, and flight deadlines for the research team. Treatment time varied from 20 minutes to one and a half hours. The average length of a treatment session was fifty minutes.

Carers, in general, did not attend treatment sessions with participants – despite determined attempts to locate them and to encourage them to come. In these cases the carer was often unaware of the care plan goals. In other cases, however, the carer was engaged with the plan and involved in the process. AMHWs were present for most of the treatment sessions, but there were a number of occasions when they were not available. They were sometimes closely engaged in the treatment, especially when treating their own family members. They were often only engaged from a distance, perhaps assisting in finding the client but then continuing with their own work.

Data collection

Data were collected at baseline, 6, 12 and 18 months. Semi structured interviews and a number of standardised measures were administered at each data collection point. Worries, goals, steps to change and reasons for change were recorded at the time of treatment. Qualitative data were coded and grouped into categories and frequency counts made of each category. Carers and AMHWs were only approached for a follow up interview after the client had been interviewed at each time point. This ensured that client consent to continue to participate and thus for carer and AMHW interviews was confirmed at each data collection point. Thus the number of carer and AMHW interviews sought varied at each time point depending upon how many client interviews were completed.

Results

Phase 1 findings

The Aboriginal Mental Health Workers confirmed that family was a very important element in emotional strength and was central to activities such as hunting, corroboree, treatment and support for illness, and passing on knowledge.

Yeah! My mother and grandmother used to teach everything what they were taught before by their mothers – that how I want to teach my kids, my grandchildren, to do the same ...because back in those times, like to me it was strong, we didn't have this mental health problem... because at that time we had good life ... we've enjoyed everything. (Female Aboriginal Mental Health Worker)

The photos, stories, and music chosen by AMHWs also illustrated connections between family, culture, country and traditional activities. For example, the AMHWs recommended that both traditional and popular music be used to accompany their stories. Both popular songs which were chosen were written by an older family member in response to concern about the behaviour of a younger relative.

*If I could change the world then I would change with you
It's not that easy when you're all alone
Can't you see Murriryar we care for you?
Gunja has got to you*

The intervention incorporated this family oriented perspective. It began with construction of a family map of all the people who supported that participant, those people that the participant supported, and the children for whom the participant was a role model (Figure 1). It then highlighted the strength of family through the psycho education stories and encouraged family engagement in the goals and steps toward life style change.

Phase 2 findings

49 clients and 37 carers were recruited to the study and clients remained well engaged with the research throughout. Seventy-four percent (35) of participants were followed up at the final assessment point eighteen months later (two participants had committed suicide during that time). Carers, on the other hand, became less engaged over time. At commencement of the study all carers who were approached agreed to participate. Thirty (67%) full carer interviews were conducted at baseline out of a possible 49 carer interviews. These percentages take into account that a number of carers were involved with more than one client. At 6 months 24 (53%) carer interviews were conducted, 19 (43%) were completed at 12 months and only 6 (24%) at 18 month follow up.

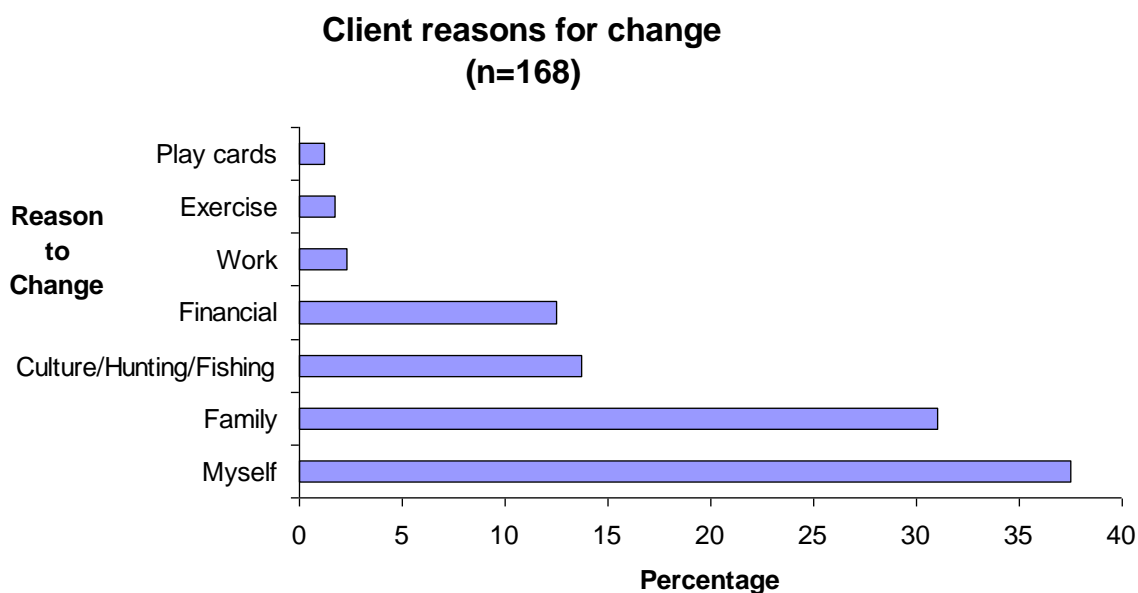
A higher number of brief carer interviews were obtained. These interviews were not complete. The total number of brief and/or full interviews of carers at each data collection point was as follows: 38 (84%) at baseline, 25 (56%) at 6 months, 25 (57%) at 12 months and 11 (44%) at 18 months. Reasons for difficulty interviewing carers or completing full interviews were: employment, engagement elsewhere or travel. No carers formally withdrew from the study.

The study team adopted an opportunistic approach to the follow up interviews and sought opportunities to meet with carers at lunch breaks from work, in airport queues and at the local shop. These opportunities led to arrangements to meet for follow up interviews at a place and time of the carers choosing.

AMHWs were also interviewed and specific inquiry about client homes included whether or not there was domestic violence at home, whether others in the home had mental illness, and whether the AMHWs thought others in the home exhibited self harm behaviour. The AMHWs were interviewed about the clients at each time point. This resulted in 47 (96%) interviews at baseline, 36 (82 %) interviews at 6 months, 42 (100 %) at 12 months and 19 (54%) at eighteen months. All AMHW interviews took place in the confidential setting of the health centre or AMHW office. These interviews explored client mental health as well as domestic violence, mental illness, substance misuse and self harm behaviour in the home.

Despite the decreased availability of carers to the process they were highly important motivators for clients. Clients were asked to identify their strengths and their worries before setting goals and steps to change. They were also asked to identify the reasons that they would choose to make that change (Figure 2). An average of three goals per client was chosen over the course of two treatment sessions (total of 151 goals). An average of four steps was chosen to reach those goals (total of 597 steps).

Figure 2. Client reasons for life style change



In terms of client-identified worries at base line, ‘worry family’ (I do things that worry my family) and ‘family self harm behaviour’ were the top two worries for clients. On the other hand, clients also reported that family were a major source of strength. Dealing with family worry (or ‘humbug’) was the second most frequent goal, and family support was the most frequently chosen step to achieve that goal. Furthermore, family was a key reason identified by clients for making the changes. Reasons for choosing a goal fell into four main categories: ‘for myself’ ‘for family’, ‘for culture’ (including hunting and fishing) and for ‘financial’ reasons (Figure 2). Examples of the ‘for myself’ category were as follows: ‘feel healthier’, ‘stay in control’, ‘you can look (other people) face to face and eye to eye’. ‘For family’ reasons for choosing goals were: ‘makes family happy’, ‘teach children and grandchildren right way’, ‘the young ones can then pass on the stories’.

Examples of the positive reasons for cultural change were: 'don't lose culture', 'the young ones can carry on culture', 'we can't lose our culture'.

It is likely family engagement was an active ingredient in the improved outcomes, but there is also evidence that family members are a source of distress and worry. One type of family worry was 'family humbug' and responses to this particular concern are presented. This term refers to arguments and stress related to sharing and family obligations. Clients described family arguments about money, food, cigarettes, marijuana and alcohol, parental discipline and jealousy. They described causing arguments themselves through their own harassment of their family, and also being the victims of such harassment themselves. The strategies chosen show that although family were part of the problem they were more frequently a part of the solution (Figure 3). The two most frequent strategies for change were to either talk to family or to avoid family (Table 1).

An example of a client experience of humbug is described in Figure 4.

Figure 3. Summary of strategies for dealing with family conflict



Table 1. Client strategies to change ‘family humbug’ and arguments

Strategy	Example
Talk about it with family	‘Ask Auntie to talk to sister’ ‘Talk to (AMHW) and she will talk to skin group’ ‘Tell each family member new rules’ ‘Talk to Dad when feeling angry’ ‘Talk to cool down’ ‘Practice saying ‘no’
Avoid family	‘Move to live with other family’ ‘Put a lock on the gate’ ‘Walk away when angry’ ‘Go to rec (recreation) hall’ ‘Get away from him and go to next community’ ‘Go for a walk and sit down under a tree’
Control spending/lending	‘Only lend one day a week’ ‘Hide my key card’ ‘Save money and leave it at the council office’ ‘Leave money in a safe place’ ‘If they don’t repay you don’t lend’ ‘Not lending money any more – just food’
Stop borrowing	‘Pay off debts’ ‘Stop humbugging family for money for cigarettes’ ‘Don’t humbug family for money’
Think differently	‘Think ‘she can’t help it’ ‘Don’t lose strength on humbug’

Figure 4. Case study

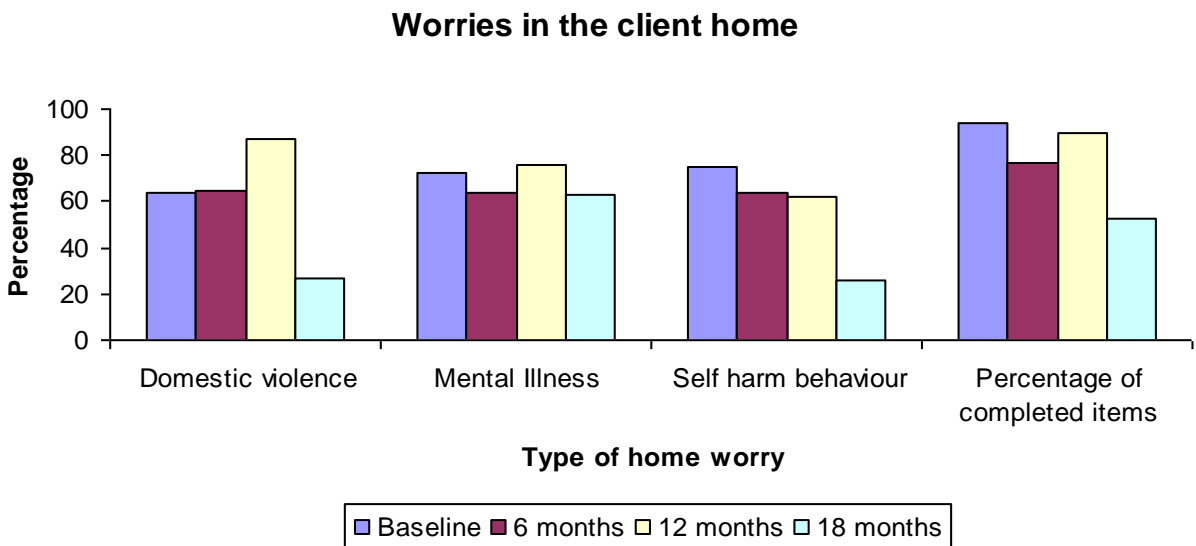
Case study: ‘Jimmy’

Jimmy is a 36 year old single man who was employed at the art centre part time. He described psychotic and depressive symptoms for some years in conjunction with daily use of marijuana. He chose the goal of ‘changing family humbug’ during his first treatment session. Further exploration showed that he was being asked to lend money by a number of family members regularly. He estimated that family members were asking him for money just about every day. He indicated that it was very difficult to say no and that one of the reasons was that he needed to show family that he cared for them, and that giving was one of the ways that he was expected to do that. On the other hand he described this ‘family humbug’ as one of the major stressors in his life. After exploration of possible first steps he decided that he could try to limit the ‘humbug’ in two ways, by only helping once per week rather than every day and by helping in other ways such as sharing food rather than by lending money. He also decided that if he was going to limit the amount that he lent to family then he would need to stop borrowing and pay off his current debts. He planned to talk with his nephew to gain support for these goals and steps.

The client engagement with this brief intervention was highly positive. Clients enthusiastically set goals for life style change and results reported elsewhere show improved wellbeing . These results showed an advantage for the treatment condition in terms of substance misuse, wellbeing, mental health, and life skills which were sustained over time.

One surprising result was the degree to which client wellbeing changed despite the ongoing worries in the home (Figure 5). Domestic violence, mental illness and self harm behavior in client homes (reported at AMHW interview) continued at high rates from baseline to 18 months (Figure 5).

Figure 5. Reported worries in the client home



One of the limitations of the study was the low number of communities recruited and the low numbers of follow up interviews at each data collection point. Fewer interviews were

completed over time for clients, carers and AMHWs. At 18 months only 19 AMHW interviews (54%) and 6 full carer interviews (24%) were completed. In contrast, client engagement remained strong throughout and 36 out of the 47 remaining clients (74%) were assessed 18 months post baseline.

One explanation for the low numbers of recruits to the study is that it was conducted in resource-poor, geographically, climactically and culturally challenging environments. The original target number of communities was five but it took many months to gain full approval from both health centre and land council to approach the community. Once in the community the only mode of approach to clients was through home visits and personal introductions. Communication through letters or telephones is neither an appropriate nor a readily available means of first contact. Power outages and air and land transport limitations were among many of the reasons for delay in study progress and data collection.

Conclusions

This study describes an approach to motivational counselling which is brief (4 steps), requires little training, and which is culturally adapted. It adopts a strengths based approach, an open holistic stance toward worries and goals for change, and emphasises the role of family throughout. It approaches goal setting from a broad perspective rather than beginning with a predetermined 'problem' such as substance use which requires attention. This openness to the client concerns may be particularly helpful when comorbidity and/or social disadvantage render client concerns multiple and complex.

The strongly positive findings of this study suggest that using family as motivator was a key ingredient for change. On the other hand, there is a complex picture behind these findings, and it is likely that some family members are supportive and others are not. The degree of support from the same family members may also vary at different times. The differences may represent generational changes in behaviour (children less supportive than grandparents for example) or behaviours linked with substance use in the family (substance users are more likely to 'humbug' while sober relatives are more likely to provide support).

This study was not designed to measure the extent to which these family changes contributed to the change in outcome for clients, the nature of supportive and stressful family behaviours, and whether or not EE was a predictive factor for that change. Further research, however, might study the response of carers more closely and measure whether family support and engagement, or conversely EE, predicts client outcomes. There is a need for improved understanding of the role of EE in stress and relapse for clients, of whether improved outcomes are linked with low EE environments, and whether EE can be lowered by targeted family interventions. There is a simultaneous need to determine what positive family behaviours and attributes are linked with wellbeing in this setting.

Overall these findings suggest that increased understanding of 'family humbug', and an enhanced focus on the families of clients may be an important component of ongoing treatment and maintenance of improved outcomes. Understanding of the role of family and supportive members is likely to be central to development of motivation for change.

It is possible that this style of brief intervention may be of benefit in other settings where

high rates of comorbid mental illness and social disadvantage are associated with limited access to specialist services. In addition, the pictorial approach may prove helpful in other settings of language difference and/or limited literacy. Further research might thus also explore strategies for the adaptation of this brief pictorial four step approach to other populations such as children, youth and the elderly, and adaptation to in patient and non mental health client populations.

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