ORIGINAL RESEARCH

There should be more help out here! A qualitative study of the needs of Aboriginal adolescents in rural Australia

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A B S T R A C T

Introduction: Aboriginal adolescents living in or near rural towns have different social and cultural needs than Aboriginal adolescents living in large cities or remote areas. Identification of health needs by the community is an established principle of health promotion for improving community health. The objective of this study was to identify the views of rural Aboriginal adolescents regarding health promotion topics, the most important health problems they faced, their support networks and their beliefs about who should help them meet their health needs.

Methods: Ninety-nine adolescents aged between 12 and 18 years were involved in in-depth interviews or focus group discussions using a tested and trialled questionnaire. Data collection took place at three sites in rural Australia from 2006 to 2008: two Aboriginal-controlled communities and one rural town. All locations were de-identified at the request of participants because confidentiality and anonymity were concerns of the adolescents, who felt that identifying their own community would result in stereotyping. After preliminary interviews with parents, teachers, youth and health workers, snowball sampling was used to identify 'vulnerable' adolescents with low school attendance. The mean age of respondents was 13 years. There were 40 male participants and 59 female participants, representing 6 language groups. Informed consent was obtained from both participants and their guardians. Data were analysed using thematic matrices and cross-checked in subsequent interactions with participants.

Results: Alcohol, drugs and violence were identified as the biggest problems facing Aboriginal adolescents in rural areas and the topic they would most like to know about. The youth from a smaller Aboriginal community near a town with a population of 1500 stated that boredom was an equally important problem. Racism and bullying were noted as reasons for poor school attendance. Family members were the most important supports, and the people they felt would help solve their health problems. They strongly identified with sports and were proud to be Aboriginal although there were many adolescents who had no future plans or ambitions. Most participants wanted a 'safe and fun' place to go to in the evenings.

Conclusions: The importance of engaging the community and being sensitive to social and cultural contexts in research and programming was confirmed. Policy-makers, health providers and agencies working with youth need to focus on inclusion of families in youth health promotion and drug and alcohol prevention for Aboriginal adolescents in rural areas. Mentorship and peer-support programs are more effective than health professionals and agencies in working with youth. The expertise of those traditionally working with youth could be channelled into coordinating a mentorship program. Personal wellbeing and safety is an important issue and multipurpose youth centres may provide a secure place for adolescents to learn, interact and develop a vision for their futures.

Key words: Aboriginal, adolescent health, Australia.

Introduction

Australian Aboriginal youth in rural Australia

Health inequities, social breakdown and abuse or neglect of young people in Aboriginal communities in Australia have received national and international attention[1-4]. Studies from around the country show that Aboriginal and Torres Strait Islanders are becoming parents in their adolescence more often than non-Aboriginal Australians, and that they have poorer socio-economic status than other Australians[5-7]. School engagement is low: in 2006, 22% of Aboriginal males and 24% of Aboriginal females had completed year 12, compared with 49% of non-Aboriginal Australians, leading to higher unemployment levels[6]. Aboriginal youth are over-represented in the criminal justice system, despite changes to the law intended to divert first offenders to cautioning, community service or conferencing[8]. A larger proportion of Aboriginal adolescents live in rural areas, compared with non-Aboriginal adolescents, where they are additionally disadvantaged by fewer educational and health resources[9]. Substance abuse is of primary concern to both Aboriginal communities in rural towns, as well as agencies operating in these towns, particularly alcohol and petrol inhalation, which are affecting increasing numbers of young people[10,11].

Youth programs for Aboriginal adolescents

Health programs targeting Aboriginal youth have a long history of short-term solutions, due to limited funding, high turnover of staff and/or staff shortages. Often health promotion programs target the symptom or the unhealthy behaviour without looking at the underlying contextual and social causes. For example, a study in northern Australia over 5 years found that restricting alcohol and petrol availability led to an increase in marijuana use[12]. Unemployment and boredom play an important role in the use of alcohol in rural areas, particularly among Aboriginal youth. This realisation has led to many successful Australian projects engaging Aboriginal adolescents in sports programs[13], regular festivals[14], magazines targeting literacy and health[15], participatory projects[16], and cultural tours and camps[17].

Finding an effective solution: ethical and participatory research

International research provides insights into what could make a youth program work. An evaluation of a US outreach program over several years reported that the most successful program in Indigenous communities employed an Indigenous worker and extended beyond the usual one year time frame in order to show results. Program organisers emphasised the importance of connecting with the community[18] and developing good relationships to achieving successful outcomes. Experiences with traumatised youth in Canada also confirm the value of community-based interventions in assisting adolescents rebuild their lives[19].

To discover an effective solution it is necessary and vital to connect with Aboriginal communities. Cheng criticises past research in Australian Aboriginal communities and highlights the necessity of involving Aboriginal people in finding solutions for their own communities[20]. Likewise, the Australian National Health and Medical Research Council guidelines for ethical Aboriginal and Torres Strait Islander research suggest that a number of participatory models could be used in research, as long as reciprocity, respect, equality, responsibility, cultural survival and spirit or integrity are maintained[21]. Models of health promotion for Australian Aboriginal communities consistently stress the importance of community consultation, participation and identification of needs by the community[22-25].

The research question: understanding the needs of rural Aboriginal adolescents

Aboriginal adolescents living in or around small country towns often share the same schools, youth services, mental health services and drug and alcohol services as non-Aboriginal youth. Some adolescents come from very traditional families, while other young people are from families with strong ties to those in cities. In common with all rural adolescents they lack the facilities that urban adolescents enjoy. Most health promotion materials for Aboriginal youth are either targeted at urban youth and an urban culture, or intended for remote and isolated youth in more traditional Aboriginal communities. In order to design a health promotion program for Aboriginal adolescents living in rural areas with both Aboriginal and 'mainstream' health services available, it was necessary to understand the social and cultural context of this population of Aboriginal youth, in order to help them identify their own needs and discover their vision for the future.

Objectives

The overarching objective of this study was to inform the design of a health program for Aboriginal adolescents living in or near rural towns in Australia. The sub-objectives were to:

- develop an understanding of the perceptions, interests and goals of Aboriginal adolescents in and around rural towns
- encourage Aboriginal adolescents taking part in the survey to express their views of the needs of youth in their community, and identify who they believed should help them fulfil those needs.
- allow young people to choose which health program topics they would like to learn about.

Methods

Sample and location

This study formed part of a cross-cultural exploratory study undertaken in India and Australia, investigating empowerment programs for vulnerable adolescents. A qualitative study was undertaken over 3 years in two-month blocks with Aboriginal adolescents living in rural Australia. A total of 99 Aboriginal adolescents took part in in-depth interviews (IDI) and/or focus group discussions (FGD).

Participants came from three sites that were de-identified at their request. One site was an Aboriginal community of less

than 100 people near a rural town with a population of approximately 1500, known as Town A. The second site was a rural town with a total population of 15 000, including at least 2000 Aboriginal people, known as Town B. The third site was an Aboriginal community of approximately 300 near Town B. All participating adolescents were enrolled in town schools.

Each of the three sites had an Aboriginal-controlled health service, and every participant had access to Aboriginal health workers as well as mainstream/non-Aboriginal youth and health services. The adolescent participants were from six different language groups, with English as a common language. Many of their families included members from more than one language group, approximately half the group were living in their family's traditional land, and half the group lived in other areas, often because their grandparents had been sent to missions that are now Aboriginal-controlled communities.

Selection process and process of data collection

Snowball sampling was predominantly used for the study[26]. The selection criteria were that participants should be between the ages of 12 and 18 years, have low school attendance, and give informed consent. Aboriginal health workers, Aboriginal youth workers and Aboriginal staff of schools identified possible participants. Parents or guardians were informed about the research and gave verbal consent to the youth's participation. The timeline and details of data collection are described (Table 1).

The aims of the FGD were to cross-check and enlarge on themes that had emerged from the initial data collection in 2007. This article presents emerging themes concerning the perceptions of Aboriginal youth living in and around rural towns of the factors impacting on their lives.

Ethical engagement and relationship building

The research had ethical clearance from the Human Research Ethics Committee of Curtin University of Technology and the state level Aboriginal Health Council. Participants were given an information sheet about the purpose of the research. Because most participants had a low level of literacy, the consent form and guarantee of anonymity were explained orally. Participants were concerned about confidentiality and anonymity issues due to their small communities. If they wished, they were able to 'sign' the consent form with a cross rather than their name. In the initial stages of the research an agreement was negotiated that the location of the research and participants' language groups would be de-identified, in order to protect against stereotyping and to allow full and frank discussion of the issues.

The first 2 months of the study was devoted to relationship building and cultural immersion. The primary researcher and first author interviewed Aboriginal health workers, parents and teachers about their concerns and experiences to build a background about the current situation. The researcher also attended youth centres and health activities involving Aboriginal youth in the two areas where the study took place, and attempted to start a dialogue with young Aboriginal residents. These interviews were not included in data analysis but were used to inform the adaptation of the questionnaire.

The instrument and data collection method

In the initial interviews with Aboriginal adults, Aboriginal adolescents were described as having feelings of hopelessness and being difficult to engage with. Parents explained that they were dealing with their own multiple traumas and grief and often did not know how to deal with their children's grief. Other terms used were that the young people 'had no future' and that they were 'caught between two worlds'; being neither accepted by the 'mainstream'/non-Aboriginal community, nor having the same cultural connections as their older relatives.

Table 1: Process of data collection

Year	No. participants	Location	Method of Data Collection	Gender
2007	33	Aboriginal community near town A	IDI	15 male, 31 female
	13	Aboriginal community near town B	IDI	
2008	17	Town B	FGD	Female
	19	Town B	FGD	Male
	15	Town B	FGD	6 Male, 9 female
	2	Aboriginal community near town B	IDI	Female
Totals	99	33 Near town A 66 In or near town B	48 IDIs 51 Participants in FGD	–

FGD, Focus group discussion; IDI, in-depth interview.

Based on similar (unpublished) studies with out-of-school adolescents in India, a questionnaire was trialled with 10 Aboriginal adolescents in the sample area, including questions about self-perception, their vision for the future, the person they turned to for advice, and the needs of youth in their community. The feedback was similar to feedback received in India; the questionnaire was shortened and simplified. The final questionnaire included the following questions, which were asked after approximately 15 minutes' discussion about general topics and demographic questions. The same questionnaire was used in both IDI and FGD, with the use of open-ended questions:

1. What are the most important problems facing young people now? (If no response, prompt: Which topics should be in health programs for youth like yourself?)
2. Where do you go to get help for general problems?
3. Where do you go to get help for personal problems?
4. Describe yourself in three words.
5. What will you be doing in 10 years time?
6. What is the most important thing for young people to know about so they can be happy and healthy?
7. Who should be helping young people?

In the FGD the question about health topics was asked in two stages. First the participants brainstormed the health problems that faced young people in their communities. A list was made on a board. The youth then voted by secret ballot for each topic according to its importance. While the rest of the group was engaged in another activity and unable to see the board, participants took turns to mark the problem they felt most important with a cross. The researcher and research assistants recorded all responses.

Data analysis and verification

The principal researcher (first author) was able to meet the participants several times during the research to discuss the data collected and to clarify responses. When English was a second language, research assistants who spoke the participant's first language were present during interviews. Data were transcribed in English and subjected to thematic content analysis using matrices[26]. There were six distinct phases of data collection (Table 1). Themes were generated for each separate phase and then data were merged and themes again generated from the entire data set. The two final IDIs with female participants were used to confirm the themes that were generated from analysis by comparing their responses with the main themes identified. No new themes emerged in these IDI and saturation (the point when theme generation was exhausted) was reached[26].

Results

Demographic data

Most of the youth who participated in the research were identified as 'vulnerable' or 'at risk' by Aboriginal health workers, youth workers and teachers, based on their knowledge of the community or concerns raised by parents. The main criteria for vulnerability were non-attendance at school, substance abuse and/or a known unstable family situation. The youth faced many challenges in their lives, including family illness, violence, substance abuse and a lack of meaningful ways to spend their time. Their main motivation to take part in the research was the knowledge that their responses would be published and would let others know what they thought. The youth were given freedom to choose which questions they wished to answer. Demographic questions were regarded with suspicion because participants wanted to be completely de-identified.

Sixty-three of the 99 respondents reported their ages. The mean age was 13 years (SD 1.365) with a range of 11 to 17 years. There were 40 male and 59 female participants. Sixty-one youths reported their year of schooling (61.6%); the majority were in grades 6–8 ($n = 40$).

Themes

After the initial interviews with Aboriginal adults portraying Aboriginal adolescents as having feelings of hopelessness, the most surprising finding was that most of the respondents were quite positive about their lives, their friends and families, and their community.

The selection process and consent process meant that some highly vulnerable youth were not included in the study. These youth were involved in petrol sniffing or had mental health issues and declined to be interviewed. They represent a significant and important population but to involve them in the research process when they were so vulnerable would

have been unethical. It is hoped they will benefit from any programs resulting from this study.

Bullying and racism: There were many respondents who mentioned bullying and racism at school, but did not want to focus on these issues. They asked the researcher to write about what could be done to help their communities. Only one respondent asked for her comments to be recorded:

> *I learnt about drinking by doing it and having a hangover. I was bullied at school; boys were very nasty at school. Alcohol makes people mental and violent. I'd like to change being bullied at school, being abused and health. The most important things for me are education, health and money. I like to go out with friends, go to movies and party. I am dull, lifeless and angry. In 10 years I will be a mother. Teach young people to stay at school. There should be more help out here. Government should come out here themselves and look.* (Female, 16, Town B)

Boredom, alcohol and drugs: Young people living in an Aboriginal community near the smaller town stated that the biggest problem they faced was boredom, followed by alcohol and drugs, problems with school and getting a job. The other respondents, all of whom lived in or near a larger rural town, stated that drugs, alcohol, sex, fights and peer pressure were the most important problems faced.

> *When someone sniffs petrol they act crazy. We should help them when they are like that to stop them getting hurt. If someone offered me drugs I'd say no because you don't know what the drugs are and what they would do to you.* (Female, 14, Town B)

> *Young girls get pregnant because of drinking.* (Female, 15, Aboriginal community near Town B)

Sport: Without a doubt, sport is a passion for most Aboriginal youth. When asked what is the most important thing for young people to know about, apart from the negative responses (alcohol, drugs, fights), the positive

responses were: sports, be active or be healthy. More than 20 different sports, including football, basketball, bike-riding and motorcycling, were mentioned and both males and females enjoyed all sport.

Who should help young people? There were also differences between those living near the smaller town and the rest of the participants in their response to the question about who should help young people. The adolescents near the smaller town felt that teachers had a role in helping young people. These participants also had better records of school attendance than the other respondents. Almost all the participants in both locations felt that parents, grandparents or aunties (depending on who the youth was living with) should be helping young people. In other words, Aboriginal adolescents want help from their immediate family. The next most common response was that 'everyone should help young people' or 'everyone who cares' should help. A few respondents mentioned friends, doctors or the police. A small number of youth said they did not know what their health problems were, and that people from outside should help them find out and solve them. The following comments are typical of the majority of responses:

> *The biggest problems are drugs and alcohol and boredom. Nanna helps me at home but I need more help with schoolwork.* (Male, 13, Aboriginal community near Town A)

> *I don't know what people need to do. Drugs is the biggest problem and parents should help.* (Female, 16, Town B)

> *Youth should know: don't drink, smoke or do drugs. Biggest problems are fights. Parents should try to help young people.* (Female, 13, Aboriginal community near Town B)

> *My family has most effect on me. Sex and drugs and alcohol are important problems.* (Male, 16, Town B)

Support from the family: When asked who they turned to for general advice, all participants stated that they went to

family members; most frequently parents (37%), followed by siblings and then aunts or uncles. This reflects the number of participants who were living with siblings or aunts and uncles. Most youth would discuss their problems with the family member they lived with, rather than a friend, teacher or health worker. When it came to personal problems, there were a greater variety of responses. The three most common responses were parents, followed by friends and then grandparents (these were young people who did not live with parents). Five respondents stated that they did not have anyone to turn to. Other infrequent responses were aunts or uncles and brothers or sisters.

Self-image and visions of the future: Most young people described themselves as being happy, funny or 'deadly', and being sporty. They described episodes of racism but these were just explained as 'part of life' in a rural town. There was a strong sense of pride in being part of an Aboriginal community. The majority of Aboriginal adolescents who took part in the study did not know what they would be doing in 10 years time and, thus, did not have a clear vision of their future. Those who did have some plans stated that in 10 years they would have left home or left their community. A few males said when prompted that they would be working, and a few prompted female participants thought they would have a family in 10 years time.

A safe place to learn and have fun: All participants spontaneously mentioned the need for 'a place' to meet or to get information. They were not comfortable using Aboriginal-controlled health services because of concerns about confidentiality and 'shame jobs' if it was a personal problem. They rarely used 'mainstream' services because of fear, language or literacy difficulties, or the racist attitudes of the first contact staff. The discussions revealed that Aboriginal adolescents needed a place that was safe, would support their studies, give them the health information they needed, could teach them something useful and where they could 'play games'. They did not feel that schools or health centres could fulfil this need because in the evenings the streets, and sometimes their homes, became unsafe because of 'drinking and fights'.

We need a youth centre in town where we can go. They should not let drunks in. It should have games. (Female, 14, Town B)

This theme was explored further in the mixed FGD and led to a lively interaction:

It should have after school help with homework… we'd like a holiday program…and classes like typing… I want to learn cooking… Computer! ..I think, umm, mechanics… There should be painting…what about glass blowing…we had a dance group…that was good!

There were youth centres in the larger town, Town B. The youth workers there felt that they were not supported by government agencies working with adolescents because youth centres only opened after normal working hours. As one youth worker put it:

They only want to work with young people from nine to five. We get heaps of young people here on a Saturday night because there is nothing else for them to do and then all we can do is just manage the crowd. We don't have any agency support to teach them anything. Then the agencies say young people are hard to engage. (Anonymous youth worker, 2008)

Discussion

Research with Aboriginal adolescents

This article describes an approach to research with Aboriginal communities and vulnerable adolescents that is highly sensitive to ethical and confidentiality issues, and the need for anonymity of the participants. The information gathered during the initial 2 months' interviews with Aboriginal adults painted a negative and hopeless picture of Aboriginal adolescents that did not match the perceptions of the 99 young people who participated. This is important information for future studies with 'communities'. The

emphasis on community consultation and allowing communities to set their own priorities should not suggest that a community is a homogenous group of people. Consultations should reflect the needs of those who will be affected by the programs, particularly in Aboriginal communities that span a wide range of language groups, age groups and social backgrounds.

Addressing alcohol, drugs and violence: an urgent need

One of the objectives of the study was to allow young people to choose which health topics they would like to learn about in a health program. 'Alcohol', 'drugs' and 'violence' were identified as the most important topics affecting the lives and safety of young Aboriginal Australians in rural areas, and this should not be ignored. The need to look at new ways of addressing alcohol use in rural Aboriginal communities is well documented[11,27]. International research has demonstrated beyond a doubt that information-based programs do not influence behaviour. Young people who participated in this project had poor literacy skills and wanted to hear health information from their families, making it unlikely that drug and alcohol awareness programs based on information dissemination would be effective. There is also doubt about whether making alcohol unavailable would solve the problem[27].

Family mentors

One possible solution can be found in the results of another objective of this study: identifying who young people felt should fulfil their needs. Aboriginal adolescents trust their family members as supports, and sources of information and guidance for both general and personal problems. Even though teachers, Aboriginal health workers and non-Aboriginal youth and health workers were available, the family was the first point of contact for each participant. This raises the possibility of training family members as mentors. Mentoring programs have been used in Canada among Aboriginal youth[28] and throughout Australia for young offenders[29]. Mentors act as role models, are often

family members or accepted by the family as culturally appropriate, and can play an important role by encouraging and spending time with adolescents.

The most disturbing finding of the study was that most young people did not have a vision of their future. They lacked successful Aboriginal adults as role models. Mentorship and peer support may be one method of addressing this need, as well assisting communication between parents and children. The importance of including and supporting the whole family is confirmed by the observation made at the beginning of the project that some Aboriginal adults felt overwhelmed by traumatic events in their own lives and were not aware of the perceptions and views of their children.

A role for agencies as coordinators of community efforts

In Western Australia, mentors working with young offenders were trained and reported to an agency coordinator[29]. In a presentation about an Aboriginal community-based program for adolescents in the state of New South Wales, the role of mentors was also recommended[30]. It was suggested that in each area, one agency position should be devoted to a person who would support the authority of community members to mentor adolescents, rather than transferring that authority to agencies[30].

The fact that Aboriginal adolescents are less likely to engage with health professionals or agency staff for support should not be a cause of despair or lead to disinterest and a lack of effort. Rather, it should awaken policy-makers, health professionals and youth workers to the fact that Aboriginal adolescents are concerned about confidentiality and are strongly influenced by family and cultural ties. A new mindset for health promotion, including the use of youth centres, the training of family mentors and opportunistic brief health promotion regarding alcohol with Aboriginal clients[31] are all realistic avenues of sustainable behavioural change.

The bigger picture

From the perspective of the primary researcher, there were two other prominent issues observed while conducting the research which, if not acted upon at a national level, will thwart attempts to improve the health of Aboriginal adolescents. The most obvious was racism; the participants were almost apologetic when mentioning the role that racism has played in discouraging their engagement in school or health services. The other was the lack of drug and alcohol services in rural areas. For those who wanted support to 'give up' alcohol, drugs or petrol sniffing, there were no Aboriginal health workers involved in drug and alcohol programs in the entire sample area, and no nearby residential facilities for those who wanted to 'dry out' (detoxify). As one of the participants discovered when her family tried to obtain support to address her petrol sniffing, the only place to go was the local hospital, whose staff were inexperienced and unwilling to deal with adolescent inhalant withdrawal.

Conclusion

The study demonstrates that Aboriginal adolescents in and around rural towns have distinct social, cultural and educational challenges that should be addressed through culturally appropriate and contextually relevant health promotion programs. Alcohol, drugs and violence are important health risks that need to be addressed in an evidence-based manner. Having meaningful ways to pass their time, involvement in sports or after-hours schooling, and respecting their acute sense of the need for confidentiality should all be part of a program designed to improve the health outcomes of this vulnerable adolescent population. These findings are consistent with Australian research on the challenges facing rural Aboriginal youth from a decade ago[32], and more recent international research[33] that emphasises the importance of including cultural and family values in Indigenous health programs. By including Aboriginal adolescents in identification of their needs and the implementation of solutions, and by involving family and

peer mentors, a more holistic method of addressing health inequities is possible.

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