The Dilemma of Disempowerment: How Generational Trauma Impacts Alcohol Abuse Rates in the Australian Aboriginal Community

MAHIMA KRISHNAMOORTHI
STANFORD UNIVERSITY

The diverse aboriginal populations within Australia share an unfortunate link – significant health disparities relative to the non-indigenous population. Australian aboriginal communities not only have higher rates of physical illness, but also a high prevalence of mental illness, specifically addiction to drugs and alcohol. This paper will explore the causes behind this health inequality, as well as the current methods of treatment that are being implemented, and their cultural competency. This paper argues the necessity for evidence based biomedical strategies that work alongside indigenous care. The paper further asserts the importance of the comprehensive evaluations of these programs to ensure their longevity and prolonged success. The conclusions of this examination into substance abuse finds a prolonged history of devaluing, dominating and displacing a large group of people, which can push individuals, years later, to abuse alcohol and drugs. Specifically, the connection between personal and structural violence is made within the analysis, demonstrating that a potential connecting force exists between different Aboriginal groups, with important intergenerational ramifications.

Introduction

Anthropologist and physician, Paul Farmer, discussed global health inequity in one of his most significant works, On Suffering and Structural Violence, writing that "it is one thing to make sense of extreme suffering - a universal activity, surely - and quite another to explain it" (Farmer 1996). First coined in 1969 by Johan Gultang, structural violence refers to "violence exerted systematically by everyone who belongs to a certain 'social order' onto those belonging to a different class" (Farmer: 1996). Here, violence is used atypically, including not only physical abuse but also economic, social and emotional violence. According to the principle, attitudes and actions of certain people throughout history, including oppression, disempowerment and displacement contribute to systemic issues within the social infrastructure that continue to impact minority groups, long after the direct actions of disempowerment have been resolved.

This significant theory can be applied to various disenfranchised bodies around the world, especially in Aboriginal populations of Australia. The Aboriginal, or First Nation's, communities experienced mass displacement and disempowerment when European settlement in Australia began in the late 18th century. While the relationship between indigenous and non-indigenous populations has certainly improved, structural inequalities still exist within these groups, such as education access, employment inequity and especially health disparity. Indigenous populations have higher rates than their non-indigenous counterparts of diabetes, cardiovascular disease, chronic respiratory disease, and mental illness including alcohol and drug addiction (Gracey et al. 2009). High rates of drug abuse and alcohol abuse have been noted in the indigenous communities, with some 95% of urban Aboriginal and Torres Strait Islander populations considering alcohol abuse as a serious problem in their community (Ministerial Council on Drug Strategy 2001). This paper will focus on high substance abuse rates among Aboriginal populations, answering two main questions: (1) how are current interventions being implemented to alleviate this health inequality and (2) what are the main causes behind this phenomenon?

Aboriginal populations/communities will be used as an overarching term that describes most indigenous groups in Australia. This, of course, is a major over-simplification as each indigenous group lives on different land, speaks unique languages, and practices distinct cultural activities and ceremonies. However, given that the focus of the study is generational trauma as a potential connecting force between all of these groups, and that there is a dearth in published and peer-reviewed evidence on specific indigenous groups, the paper aims to understand the issues of health inequalities in indigenous populations, with some use of appropriate generalizations.

This paper will discuss structural violence and generational trauma in the aboriginal community, and its impacts on the relatively high rates of substance abuse. First, the paper will assess social determinants and disease patterns of indigenous health, considering the interactions between social and political variables. The paper will then aim to understand the Aboriginal notions of health and healing, and how culturally appropriate (or inappropriate) public health interventions have been used by the government to alleviate these structural health inequalities in alcohol and drug abuse. Specifically, this paper aims to make a distinction between personal and structural violence in indigenous populations, terms that will be further defined later, using substance abuse as a lens for health inequalities. Moreover, the paper will attempt to understand the relationship between these types of violence, and if one type of violence presupposes the manifestation, or latent, presence of the other.

Aboriginal Health Disparities

A clear divide exists in health status between indigenous and non-indigenous groups. Indigenous Australians consist of 3.3% of Australia's population; however and social problems is disproportionately higher than their non-indigenous counterparts. Australian Aboriginal people have a startlingly low life expectancy at birth, about 11 years less than that experienced by other Australians (AIHW). The leading causes of death for Aboriginal Australians demonstrate an interesting divergence between indigenous and non-indigenous populations, specifically within the "external causes" group, which the Australian Institute for Health and Wellness describes as including vehicle accidents, violence, drug abuse, suicides, and essentially all causes of death outside of the biomedical sphere. These external causes often are related to alcohol and drug abuse, illustrating their significance in indigenous communities. In fact, in a comprehensive study on mental illness in Aboriginal communities, 43% of respondents received a diagnosis of at least 1 DSM (Diagnostic Statistics Manual)-III disorder and 18.4% displayed substance use disorders, with alcohol dependence at 9.2%. The 2010 National Drug Strategy Household Survey showed that these rates were higher than the general Australian population, in which Aboriginal people were almost twice as likely to be recent users of illicit drugs as other Australians (Government 2011). Even more so, rates of comorbidity, or the presence of a secondary-linked disease, were very high, with almost one-half of those with behaviour or affective disorders meeting criteria for a substance use disorder (Kirmayer 2000). In 2011, alcohol accounted for an estimated 8.3% of the overall burden of disease among Aboriginal and Torres Strait Islander Australians – a rate 2.3 times higher than among non-Indigenous people (Government 2011).

In addition to harms and health, high levels of alcohol use can cvontribute to a range of social harms. Aboriginal people remain the most frequently arrested and incarcerated group in Australia; a 2016 survey noted that the percentage of Aboriginal prisoners was 27.6%, a number much higher than the total proportion of Aboriginal people in Australia. Sixty five percent of Indigenous homicides involve both the victim and offender having consumed alcohol at the time, which is three times more than the occurrence for others (Georgatos 2013). The aforementioned statistics demonstrate the significance of alcohol on the indigenous community in Australia, contributing to societal and biomedical disadvantages.

The historical context of alcohol and Aboriginal populations is important to understand when discussing how the issue presents itself today. Many social theorists propose that rates of alcohol use in Aboriginal populations began to rise due to European colonization, when the First Fleet arrived and pubs opened on the continent for the first time. Drinking was a prominent part of colonial life, and exposure to the act was likely the most significant influence on Aboriginal life, impacting emerging drinking patterns. In fact, many Aboriginal laborers were actually paid in alcohol or tobacco. However, in the 19th century, under the realization that Aboriginal and Torres Strait Islander population was dying out, colonial and, later, state and territory governments adopted policies "protecting" Aboriginal populations and thus implemented a forced prohibition for Aboriginal people. These assimilation policies rested on the paternalistic assumption that Aboriginal people could not control their own destinies and that the government needed to step in to "aid them". The Licensed Publicans Act of 1838 in New South Wales was the first legislation to forbid the supply of alcohol to Aboriginal populations in Australia, with all mainland colonies subsequently following suit (McCorquodale 1985). This led to increased rates of illegal purchases of alcohol, more Aboriginal people put in jails, and a higher proportion of the community participating in "binge drinking" (Ministerial Council on Drug Strategy 2001). These barriers to alcohol had long been promoted as a method of colonial governments to claim to be "responsible" for the welfare of indigenous peoples. The final prohibition legislation was repealed in 1964, allowing Aboriginal populations access to alcohol, which was considered to be a major civil rights achievement linked to the equality and autonomy of Aboriginal peoples. Unfortunately, the perspective of Aboriginal Australians being unable to control their alcohol intake has persisted throughout time. A field survey of mostly white Australians at Mt Isa, Queensland reported a stereotyped view that Aboriginals "always get drunk" and "drink three times as much as us" (Khan 1990). In fact, the proportion of Aboriginal Australians that drink any alcohol is much lower than that same proportion of non-indigenous groups. However, it is the percentage that does choose to drink that does so at levels harmful to their health, with some studies placing that proportion at 68% of current Aboriginal drinkers.

Fortunately, state governments have been able to repeal most of the discriminatory alcohol legislations that were unfairly targeting Aboriginal peoples. In 2017, the Northern Territory government repealed two policies introduced four years prior: alcohol prevention orders (APOs) and alcohol mandatory treatment orders (AMTs). The former allowed police to "issue an order to a person charged with an offense if they believed that person was affected by alcohol at the time" essentially criminalizing alcoholism with 86% of people issued orders being Indigenous (Davidson 2017). The latter policy allowed police to issue orders to anyone arrested for intoxication three times in two months causing them to be placed in forced three months of treatment while incarcerated (Davidson 2017). It will be certainly interesting to see how legal developments will affect incarceration rates of Aboriginal people, and whether they will decrease the likelihood of an Aboriginal person to be arrested, especially as culturally appropriate interventions continue to be on the rise.

Notions of Health and Healing

Psychiatrist and anthropologist Arthur Kleinman theorized about a patient's "explanatory models", which he described as the perception and understanding of the causes, mechanisms, symptoms and effects of treatment surrounding their disease. In fact, within medical anthropology, disease and illness are considered as two different terms with completely distinct cultural significance. While disease is proposed to be biologically and scientifically determined, illness is considered to be culturally shaped, based on how each person perceives, experiences and copes with the disease. These perceptions influence the explanations of sickness, or Kleinman's explanatory model. For years, the understanding of indigenous health has largely been focused on a Western or European explanatory model. Alternatively, Indigenous peoples define wellbeing and health as being much more than just the absence of disease. For example, the Anishinabek (Ojibway) word mno bmaadis, "which translates into living the good life or being alive well, encapsulates beliefs in the importance of balance. For many other Indigenous peoples, land, food, and health are key components of being alive well (King 2009). Thus the Indigenous definition of health caters to many more concepts than the biomedical definition does. While some might

see this as unnecessary, it is interesting to note that even the WHO adapted their original definition of health, "the absence of disease", to "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Constitution of the WHO). This recognition of multiple components as essential to one's health is important to Indigenous notions of healing, and is necessary for developing culturally appropriate interventions.

Culturally Competent Interventions

It is clear that medical interventions are not "one size fits all", and notions of health and healing are incredibly important in creating culturally appropriate and competent forms of treatment processes. Some interventions have been less successful than others. Most infamously are communities of indigenous populations that have been organized as alcohol-free, dry-camps in the bush. These approaches have oftentimes been undercut by community members secretly bringing alcohol into the camps, or even concocting their own alcoholic beverages. Most researchers agree that these programs largely did more harm than good, pushing people further into the fringes of communities and incarcerating many others (Davey 2015).

In his article Culturally Appropriate Means and Ends of Counseling, Rod McCormick states that "effective healing for First Nations people focuses on interconnectedness rather than autonomy, which is a more common goal for Western therapy" (McCormick 1995). McCormick goes on to note that that aim of healing for many indigenous people is to maintain balance between four dimensions: "physical, mental, emotional, and spiritual" (McCormick 1995). Some might argue that conventional biomedicine weights the physical or biological aspects of health over everything else. This might be a reason why conventional biomedical intervention strategies are typically not successful in the long-term for Australian minority populations, as the "universally accepted notion is that treatment and rehabilitation for native people should be culturally appropriate" (Brady 1995). Most programs at the turn of the 21st century were varying adaptions of the 2 step program of Alcoholics Anonymous, which represents a strictly biomedical and conventional approach to treatment without any room for discrepancies based on the target demographic.

Fortunately, the trajectory of this field has pushed addictions programs towards cultural competence and innovation. For example, the Ngarlu model of mental health counseling for Aboriginal Australians is highly regarded as a culturally appropriate methodology, using the Karajarri word, Ngarlu, for defining the place of the inner spirit (King 2009). This model allows participants to assess how their alcohol and other drug use affects their Inner Spirit and their connections to family, community, and country. The program has recently become particularly important for the Government of Western Australia's Drug and Alcoholic Office. One example of a particularly simple culturally competent awareness campaign was a move towards encouraging Aboriginal women, given that most research indicates that they rarely drink at harmful levels, to play an important role in improving rates of alcohol abuse in their communities (Danieli 2010). Another example of good practice within addiction treatment is creating culturally secure facilities that are staffed by Aboriginal workers. This development has been shown to have positive effects on attracting and retaining Aboriginal people in treatment. Together, these types of programs and developments in the field of addiction treatment for Aboriginal people not only address the alcohol and drug problems of patients but also the underlying the social and historical factors that affect the health and wellbeing of Aboriginal people. The move towards cultural competence has been extremely important to the field and provides hope for much more successful interventions in the future that account for alternative notions of health and healing, like those aforementioned.

One of the most comprehensive programs is the Queensland Indigenous Alcohol Diversion Program (QIADP), which began in June 2007 and is described as "indigenous specific". The program is essentially used as a secondary punishment option for Aboriginal people that have been arrested for an alcohol related offense. The magistrate decides if the defendant can be considered for QIADP and an initial screening assesses the individual's suitability to the program. While the assessment is conducted, some of the defendants are placed on bail, but in many cases, the defendant is incarcerated until a decision is made. Once the magistrate does endorse the treatment plan for the defendant, however, the defendant is bailed into the program and becomes a QIADP participant. The program itself runs for 20 weeks with regular follow-up calls and Progress Reports. Even more so, Aftercare programs that help participants reintegrate better into mainstream society is available to individuals who choose to participate after their treatment has completed. QIADP has been implemented in Cairns, Townsville and Rockhampton, and an extensive post-evaluation survey conducted by the Queensland Government found that overall there was a significant decrease in alcohol-related offenses before the program and after the program was completed. However, analyzing the success of these programs, all of the sites, except Cairns, observed an increase in the frequency of alcohol-related offending from the during-QIADP period to the post-QIADP period. This certainly doesn't take away from the success of this program, but as the evaluation stated "this increase in alcohol-related offenses after the program completes is worthy of further research" (QIADP).

Unfortunately, while QIADP underwent an extensive post-evaluation survey, not many alcohol treatment programs that have been implemented enjoy the same luxury. In a 2010 comprehensive study of alcohol and smoking interventions for Aboriginal people, Clifford et al. discovered that although 18 of the 20 interventions studied utilized indigenous involvement in the planning and implementing of the program, only seven reported any indigenous involvement in the evaluation of the program. As the WHO explains "monitoring and evaluation of any alcohol program or intervention is vital to determine whether it works, to help refine programme delivery and to provide evidence for continuing support of the programme" (WHO 2007). While the trajectory of culturally appropriate alcohol intervention programs has brought much more indigenous involvement in implementation, the lack of Aboriginal voices in the evaluation of these programs is a stark issue that needs to be addressed. Often, it is not always the fault of the program creators that the evaluation process is not as successful as it should be. "Intervention evaluation research is complex, requiring resources, expertise and skills unlikely to be available in local Indigenous communities" (Clifford 2013). Because of this, many programs that exist today do not have any evidence-based protocols, which can often lead to ineffective interventions. Even more so, the fewer programs that have strong evidence supporting their methodologies, the less data that is compiled that can be applied to future interventions. Evaluation research needs to be prioritized in the field of substance abuse treatment programs, not only for the intervention community

itself, but also for state and federal governments. This is the next step in the continued trajectory towards culturally appropriate health programs.

Generational Trauma

Philosopher and social theorist Michel Foucault's wrote in his significant essay Nietzsche, Genealogy, and History, "Humanity does not gradually progress from combat to combat until it arrives at universal reciprocity, where the rule of law finally replaces warfare; humanity installs each of its violence in a system of rules and thus proceeds from domination to domination" (Foucault 1978). Farmer and Galtung would progress this analysis of domination one step further, and emphasize the importance of structural violence, and its compound effect on those being dominated, and the future generations. This concept of generational trauma, passed down throughout the years, has often been described in indigenous populations around the world as a major force that influences structures of inequality. "The high rates of suicide, alcoholism, and violence, and the pervasive demoralization seen in Aboriginal communities, can be readily understood as the direct consequences of a history of dislocations and the disruption of traditional subsistence patterns and connection to the land" (Kirmayer 2000). This theory does not only apply to Aboriginal communities in Australia. It instead makes the claim that the disempowerment and displacement of indigenous populations during European colonization has placed current indigenous groups into a tangled web of institutionalized injustice, unconscious prejudgement and biopolitical disadvantage.

> "Evaluation research must be considered a priority in intervention programs in order to provide effective evidence-based programs for Aboriginal persons"

Contemporary institutions of structural violence can be observed as higher unemployment rates for Aboriginal people and worse access to higher educational opportunities (citation), leading many Aboriginal people to turn to substance abuse, often as a form of a coping with the systemic inequalities they experience. This generational trauma and structural violence connection has been documented as a strong force within tribal communities. For elders, the issues of native title to land and reinforcing cultural practices on country have been, of course, extremely difficult since colonization. Stresses caused by loss of land and loss of culture have led to increased rates of depression in modern tribal Elders, whose role in their communities has been eroded by these factors (Jimenez 2012). These stresses held by elders can cause defragmentation within a tribal community, which of course, can have impacts on the youths within the community. As Kirmayer explains, "Cultural discontinuity has been linked to high rates of depression, alcoholism, suicide, and violence in many communities, with the most profound impact on youth" (Kirmayer 2000). Young Indigenous Australians are more than twice as likely as their non-Indigenous counterparts to die from alcohol-attributable causes (Chikritzhs 2004). This relationship between elders and younger members of the community is incredibly important, but structural violence has been inflicted upon these relationships in the past and present. Hunter (1994) commented on the significance of male figures in young Aboriginal lives, and how this connection has been fragmented by familial separation, along with high incarceration rates. Farmer could see this as a contemporary form of structural violence, a systemic issue that percolates throughout the community and impacts many generations of Aboriginal people. Hunter, without using the term of structural violence, seems to agree with this sentiment, pointing out that "early mortality and excess morbidity from alcohol-related causes, enormous rates of arrest and detention, absence from communities and families in pursuit of alcohol, and the dysfunctionality of intoxication, all disproportionately impact the availability of males as parents" (Hunter 1994).

Traumatized people often use alcohol and other drugs as forms of self-medication and as a means of coping with feelings (Robin et al. 1996). Often times, alcohol and drug abuse lead to increased rates of violence, another potential expression of pent up frustration and despair. An ethnographic study of the transgenerational effects of alcohol, demonstrated that many of the men in the study group expressed rage both in private (e.g. against family members) and public (e.g. street violence) contexts. In all instances of violence, the men were under the influence of alcohol or drugs (Atkinson 2002). This analysis of alcohol abuse rates as a "symptom" of the problem of generational trauma can, unfortunately, be seen in indigenous groups beyond those in Australia. In Maori populations in New Zealand, indigenous groups in Canada, and Native Americans in the United States, high-rates of alcohol-related suicide and alcohol abuse is observed, some with the highest rates out of any ethnic group in their country. These statistics demonstrate a potential connecting force between these groups, and this paper reaches the conclusion that the generational trauma and contemporary structural violence are those connecting forces.

Conclusion

Using substance abuse as a proxy for understanding health inequalities between indigenous and non-indigenous groups in Australia delineates more than just statistics on health. It outlines the importance of culture and societal issues on individual biomedical health. This paper makes the claim that the dislocation and disempowerment of Aboriginal Australians can be understood as structural violence, impacting the systemic issues that have filtered down to have indirect effects on individual Aboriginal peoples. Structural violence could even be seen as the larger "disease", with alcohol abuse as a symptom. This representation of the health issue demonstrates a potential connecting force between Aboriginal peoples, providing reasoning behind this vast gap in health inequality and substance abuse rates between them and their non-indigenous counterparts.

This paper also concludes that the trajectory of intervention programs, while moving towards cultural competence, still has much more to do. Evaluation research must be considered a priority in intervention programs in order to provide effective evidence-based programs for Aboriginal persons. Evaluation strategies that emphasize continuous quality improvement throughout different stages of the intervention have been found to be very important for achieving positive outcomes for the programs (Wandersman et al., 1998, Dusenbury &Falco, 1995; Hansen, 2002). As evaluations are time-consuming and costly, it is absolutely necessary for the state and

federal government to make statements and even policy changes that enforce the requisite of evaluations which can increase opportunity for funding and grants in this field. Moreover, evaluations must include indigenous involvement in order to ensure that the analysis of the success of a program includes the voices of those that actually participated in it. Programs should have a clear outline of goals for their intervention that can be compared to documented results and post-intervention surveys. What seems clear is that any intervention that is implemented should be a blend of evidence-based biomedical and indigenous care strategies. Moreover, enactments of these interventions should be done with cognizance of power dynamics, understanding of alternate notions of healing and health, awareness of the historical contexts of suffering, and a familiarity with the interconnectedness of beliefs.

The reality is that the pursuit of autonomy, and biological, biosocial, and biopolitical healing is "in the end, an ongoing intergenerational struggle to define and redefine and practice what is wellness" (Million 107). There is no set rulebook for how to heal from and reach a healthy status following centuries of dislocation. Recognizing that Aboriginal culture is not just something of the past, but rather an ongoing and adapting collection of ideas and ways of living, is of utmost importance to ensure that programs are culturally cognizant.

References

[1] Alcohol in Australia, Issues and Strategies. (2001). Ministerial Council on Drug Strategy.

[2] Atkinson, J. (2002). Trauma trails: Recreating song lines: The transgenerational effects of trauma in Indigenous Australia. North Melbourne, Vic.: Spinifex Press.

[3] Australian Institute for Health and Wellness. (2018). Deaths in Australia. Australian Institute for Health and Wellness. Web Report.

[4] Brady, M. (1995). Culture in treatment, culture as treatment. A critical appraisal of developments in addictions programs for indigenous North Americans and Australians. Great Britain. Elsevier Science.

[5] Chikritzhs, T., Pascal, R. (2004). Trends in Youth Alcohol Consumption and Related Harms in Australian Jurisdictions, 1990-2002. Bulletin No. 6. National Drug Research Institute, Curtin University

[6] Clifford, A., Pulver, L. J., Richmond, R., Shakeshaft, A., & Ivers, R. (2010). Smoking, nutrition, alcohol and physical activity interventions targeting Indigenous Australians: Rigorous evaluations and new directions needed. Australian and New Zealand Journal of Public Health,35(1), 38-46. doi:10.1111/j.1753-6405.2010.00631.x WHO (2007).

[7] Constitution of the world health organization. Basic Documents, Forty-fifth edition.

[8] Danieli, Y. (2010). International handbook of multigenerational legacies of trauma. New York: Plenum Press.

[9] Davey, M. (2015, February 20). Alcohol abuse behind high rates of early death among Indigenous, study finds. Retrieved from https://www.theguardian.com/australia-news/2015/feb/20/alcohol-abuse-behind-high-rates-of-early-death-among-indigenous-study-find

[10] Davidson, H. (2017, August 18). Northern Territory repeals alcohol laws 'discriminatory' to Indigenous people. Retrieved from https://www.theguardian.com/australia-news/2017/aug/18/northern-territory-repeals-alcohol-laws-discriminatory-to-indigenous-people

[11] Dusenbury, L., & Falco, M. (1995). Eleven components of effective drug abuse prevention curricula. Journal of School Health, 65,420 – 425

[12] Farmer, P. (2009). On Suffering and Structural Violence: A View from Below. Race/Ethnicity: Multidisciplinary Global Contexts, 3(1), 11-28.

[13] Galtung, J. (1969). Violence, Peace, and Peace Research. Journal of Peace Research,6(3), 167-191.doi:10.1177/002234336900600301

[14] Gracey, M., & King, M. (2009). Indigenous health part 1: Determinants and disease patterns. The Lancet,374(9683), 65-75. doi:10.1016/s0140-6736(09)60914-4

[15] Georgatos, G. (2013). Australian Bureau of Statistics on prison rates. Retrieved from http://thestringer.com.au/australian-bureau-of-statistics-on-prison-rates-1928#.XAUrehMzY1h

[16] Government of Western Australia Drug and Alcohol Office (2011). Aboriginal Drug and Alcohol Framework for Western Australia

[17] Hansen, W. B. (2002). Program evaluation strategies for substance abuse prevention. Journal of Primary Prevention, 22,409 – 436

[18] Hunter, E. (1999). Aboriginal health and history: Power and prejudice in remote Australia. Cambridge: Cambridge University Press.

[19] Jimenez, D., Bartels, S., Cardenas V., Daliwal, S., Alegria, M. (2012). Cultural beliefs and mental health treatment preferneces of ethnically diverse older adult consumers in primary care. American Journal of Geriatric Psychiatry

[20] Kahn, M., Hunter, E., Heather, N., & Tebbutt, J. (1991). Australian Aborigines and alcohol: A review. Drug and Alcohol Review,10(4). doi:10.1080/09595239100185411

[21] King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: The underlying causes of the health gap. The Lancet,374(9683). doi:10.1016/s0140-6736(09)60827-8

[22] Kirmayer, L. J., Brass, G. M., & Tait, C. L. (2000). The Mental Health of Aboriginal Peoples: Transformations of Identity and Community. The Canadian Journal of Psychiatry,45(7), 607-616. doi:10.1177/070674370004500702

[23] Kunitz SJ, Gabriel KR, Levy JE, Henderson E, Lampert K, McCloskey J, and others. Alcohol dependence and conduct disorder among Navajo Indians. Journal of Studies on Alcohol 1999;60(2): 159-6 7

[24] Kunitz, SJ, Disease and Social Diversity: The European Impact on the health of Non-Europeans, Oxford
University Press, New York (1994)

[25] McCormick, R. Int J Adv Counselling (1995) 18: 163. https://doi.org/10.1007/BF01407960

[26] McCorquodale, J C., (1985). Aborigines, a history of law and injustice. University of New England.

[27] Million, Dian. (2013). Therapeutic Nations: Healing in an Age of Indigenous Human Rights. University of Arizona Press

[28] Nation, M., Crusto, C., Wandersman, A., Kumpfer, K. L., Seybolt, D., sMorrissey-Kane, E., & Davino, K. (2003). What works in prevention: Principles of effective prevention programs. American Psychologist,58(6-7), 449-456. doi:10.1037/0003-066x.58.6-7.449m

[29] Saggers, S., & Gray, D. (2009). Dealing with alcohol indigenous usage in Australia, New Zealand and Canada. Cambridge: Cambridge University Press.

[30] Queensland Police Service. (2010). Queensland Indigenous Alcohol Diversion Program (QIADP) Recidivism Study. Specialist Courts and Diversion, Legal Services Branch.
[31] Robin, R.W., Chester, B., and Goldman,D. (1996) "Cumulative Trauma and PTSD in American Indian Communities" in Ethnocultural Aspects of Post Traumatic Stress Disorder: Issues, Research and Clinical Applications.
[32] Wandersman, A., Morrissey, E., Davino, K., Seybolt, D., Crusto, C.,Nation, M., et al. (1998). Comprehensive quality programming: Theeight essential steps to effective community-directed prevention pro-grams.Journal of Primary Prevention, 19,3–31.
[33] Weatherburn, D. (2014). Arresting Incarceration: Pathways out of Indigenous imprisonment. Aboriginal Studies Press.
[34] Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. (2014). Canberra: Department of The Prime Minister and Cabinet.