A trial of a community-based intervention to support the active engagement of Aboriginal and Torres Strait Islander men in parenting, and to improve men's feelings of empowerment, reduce mental distress and reduce drug and alcohol use.

Author:
Reilly, Lyndon

Publication Date:
2021

DOI:
https://doi.org/10.26190/unsworks/2055

Title: A trial of a community-based intervention to support the active engagement of Aboriginal and Torres Strait Islander men in parenting, and to improve men's feelings of empowerment, reduce mental distress and reduce drug and alcohol use.

A thesis in fulfilment of the requirements for the degree of Doctor of Philosophy

School of Psychiatry
Faculty of Medicine and Health
September 2021

Thesis Title

A trial of a community based intervention to support the active engagement of Aboriginal and Torres Strait Islander men in parenting, and to improve men's feelings of empowerment, reduce mental distress and reduce drug and alcohol use.

Thesis Abstract

Objective: This study aims to investigate whether an intervention based on the principles of adult learning and empowerment administered to Aboriginal and Torres Strait I slander men increases knowledge of men's role as parents, improve components of their role as parents, increase feelings of empowerment and decrease mental distress and use of alcohol or drugs. The study will follow the guidelines published by Campbell et al on evaluating complex community based interventions (BMJ, 2000). As such, the study will meet the criteria of an exploratory trial; offering to set the stage for future definitive randomised controlled trials (RCTs) in the field.

Hypothesis: We suggest that men who participate in a structured intervention will have an increased understanding of the role of men as parents and are able to identify b enefits from their engagement in the role of parenting. We also hypothesise that men who learn more about parenting and begin to engage in parenting will have improved feelings of empowerment, lower rates of mental distress and reduced consumption of alcohol and drugs.

Method: Eighty men aged 18 years onwards, will be recruited consecutively into existing men's groups in five separate Aboriginal communities, i.e. 16 participants from ea ch community, three in Far North Queensland, and two in the Lower Gulf of Carpentaria. To be eligible, participants in the study may or may not have attended men's grou p prior to the study, have at least one child and be living in a family unit which includes a female partner and at least one child and other family members if it is an extende d family unit. Nevertheless, single fathers, grandfathers and uncles will not be excluded. Men will be recruited by word of mouth from men who are currently participating in men's groups. Eligible and consenting men will be randomly assigned to a three-phase group intervention, manualised and led by the group leader of the study, the chief i nvestigator, focusing on men's parenting, or to the intervention group-as-usual condition which will contain two structured sessions of stress management only. Structured i nterviews (assessment- Growth and Empowerment Measure (GEM) will be administered pre and post intervention for both groups.

Dissemination of Findings: The intention of this study is to provide continuous feedback of emergent findings to Aboriginal and Torres Strait Islander men and relevant serv ice providers associated with this research, such as Aboriginal Community Control Health Services. The researcher's privileged part-time tenure with RFDS allows access to work within Aboriginal communities on projects that strengthen Aboriginal men's roles as fathers, grandfathers and uncles. Thus, the emergent findings of this research will be continuously disseminated to the relevant community and continue to inform my practice. Study updates, including emergent findings, will be presented to national advisory groups, such as: Andrology Australia; the Aboriginal and Torres Strait Islander Men's Reference group; and the sponsors of this research scholarship – The Men of Malvern, in Melbourne. Additionally, an overview of the study and initial findings will be presented at a National Indigenous Men's Health Conference. Finally, it is intend ed that chapters of the research, including the findings, will be published in a peer reviewed journal.

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Publication Details #1

Full Title:	Fatherhood in Australian Aboriginal and Torres Strait Islander communities: An Examination of Barriers and Opportunities to Strengthen the Male Parenting Role
Authors:	Lyndon Reilly and Susan Rees
Journal or Book Name:	American Journal of Men's Health
Volume/Page Numbers:	Vol.12(2) 420-430
Date Accepted/Published:	September 5, 2017
Status:	published
The Candidate's Contribution to the Work:	The Candidate was the Principal/Corresponding Author
Location of the work in the thesis and/or how the work is incorporated in the thesis:	The article is seen as Chapter 3 in the thesis

Publication Details #2

Full Title:	First Nations Men Experiencing Fatherhood: A Meta-synthesis of Qualitative Literature
Authors:	Lyndon Reilly
Journal or Book Name:	International Journal of Men's Social and Community Health
Volume/Page Numbers:	Vol 4(1):e1-e11
Date Accepted/Published:	8th June 2021
Status:	accepted
The Candidate's Contribution to the Work:	The Candidate's contribution to the work was 100%
Location of the work in the thesis and/or how the work is incorporated in the thesis:	The article is seen as Chapter Two in the thesis

Candidate's Declaration

I confirm that where I have used a publication in lieu of a chapter, the listed publication(s) above meet(s) the requirements to be included in the thesis. I also declare that I have complied with the Thesis Examination Procedure.

Declaration

I declare that this thesis is my own work and has not been submitted in any form for another degree, or diploma at any University or other institution of tertiary education. Information developed from my published articles, and that of others has been acknowledge either as Chapters or text, and a list of references at the end of each chapter is provided

12/07/2021.

Signature ✓ Date

Acknowledgements

To all the men who participated and supported my PhD, especially the following Communities and men in no particular order, **Doomadgee:** George McLean, Beau Walden, Scott O'Keefe, Guy Douglas, and Vernon Ned. **Mossman Gorge:** Joshua Williams, Michael Marriot, Simeon Miglenranza, Jesse Bray and Edward Cooktown. **Mornington Island:** Dwayne Rogers, Sorren Owens, Bradley Wilson, Lloyd (Crow) Chong, Kenneth Adrian (Mad Dog) Jacobs, and Frank Watts. In addition, I would also like to acknowledge the Royal Flying Doctor Service SEWB worker Vincent Tayley and Mental Health Clinician John Riley, for supporting me.

Supporting Service Providers: Apunipima Aboriginal Community Control Health Council, North West Remote Health (NWRH), North West Queensland Catholic Indigenous Social Service (NWQCISS), Junkurlaka Community Justice Group, Save the Children, My Pathways training and employment agency, and RISE training and employment agency.

The Royal Flying Doctor Service, Mental Health, and Child and Family Health Care Units Cairns Base Managers, Colleen Gray and Katherine Neal (Nee Isbister), and the Child & Family Health Nurses I worked with in the Lower Gulf of Carpentaria.

Scared OZ Film Production, thank you Michael Butler and Samantha Martin for filming my personal and professional 'Strong Fathers, Strong Families' Story. And as the copyright owners of my digital story, thank you for your permission to use it in my thesis.

National Indigenous Television (NITV) and SBS OnDemand for broadcasting my story through the Survival Series 2, Episode 10 program.

Andrology Australia/National Men's Health for their generous scholarship award, and the Men of Malvern for their wonderful donation. In addition, to the Chair of the Men of Malvern, Professor Doug Lording, for his genuine support throughout my PhD journey

To my amazing PhD Supervisor Professor Susan Rees, my long-time academic mentor, and for keeping me focussed.

And finally, to my beautiful wife Amanda, children and grandchildren, you are the reason I aim high. Furthermore, to my beautiful wife, for making me realise the potential that I have within to grasp extraordinary accomplishments—thank you my darling.

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List of Abbreviations

ABS	Australian Bureau of Statistics
AH&MRC	Aboriginal Health & Medical Research Council
AUDIT	Alcohol Use Disorder Identification Test
CINAHL	Cumulative Index of Nursing and Allied Health Literature
COAG	Council of Australian Governments – Currently (National Cabinet)
COREQ	A Syllabic abbreviation of the words **CO**nsolidated criteria **RE**porting **Q**ualitative research
DOGIT	Deed of Grant in Trust
DSM	Diagnostic and Statistical Manual
ED	Erectile Dysfunction
EES	Emotional Empowerment Scale
GEM	Growth Empowerment Measure
NHMRC	National Health and Medical Research Council
NITV	National Indigenous Television
HREC	Human Rights Ethical Committee
NWQICSS	North West Queensland Indigenous Catholic Social Service
NWRH	North West Remote Health
PI	Parents Intervention
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PTSD	Post-Traumatic Stress Disorder
QD	Qualitative Description
RCT	Random Control Trail
RFDS	Royal Flying Doctor Service
SEWB	Social and Emotional Well Being
STATA	A Syllabic abbreviation of the words Statistics and Data
UNSW	University of New South Wales
WHO	World Health Organisation

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Introduction Video

The video below provides insight into the Author's role in empowering First Nations men as agents of positive change. This video also represents the broader intent of this Dissertation. Please see link below.

https://youtu.be/kBHB0rQVY5s

Chapter 1

Introduction and Rationale for the PhD

1.1 Introduction:

There were three main factors that motivated me to select this area of study for my PhD. The first involves my own personal journey as an Aboriginal man; father to three daughters, grandfather to four grandsons (with a couple more coming down the track), and uncle to many, allowing me to speak confidently about my rewarding experiences and some of the challenges of being an Aboriginal father. Furthermore, being the second oldest child of ten children, seven sisters and two brothers, I had a head start on how to nurture and care for children via duties given to me by my parents, involving taking care of my younger siblings. Through my personal experience as a father, I have grown as a man. I realised that I needed to take control of my own life to be a good parent. The empowering process brought to my attention that being involved in the early development years of my children's growth created a continuous sense of reciprocal love, respect, integrity, and empathy. Despite my role in nurturing, caring for and building positive relationships with my daughters in the early days, I found that there was not a lot of information about fatherhood available to me.

The second reason for this PhD topic relates to my professional experience over the past 16 years, which has provided me with the opportunity to work at national, state, and local levels with many Aboriginal and Torres Strait Islander men. Over these years, many formal and informal discussions with these men took place to address social issues and provide each other with individual support. I had a particular interest in mental health, and in discussing the significance of self-esteem and empowerment; the interrelationships between men, family and community wellbeing; and the importance of the role of men as nurturing parents (Adams, 2006). In addition, emerging from my experience working with Aboriginal and Torres Strait Islander men, I found that men's groups provided a safe and supportive environment in which to discuss men's business, including issues related to men's health and wellbeing, and how histories of colonisation, racist policies and hardship have impacted and continue to affect how dads parent, their mental health and how they see themselves.

More recently, I worked on a Royal Flying Doctor Service (RFDS) project titled *Strong Fathers Strong Families*. The scope of the project was to promote the roles of Aboriginal and Torres Strait Islander fathers, grandfathers, and uncles within three communities in the Lower Gulf of Carpentaria (Queensland) region. Like my personal experience, I discovered that there was not a lot of literature or resources available to support men in their roles as parents. Therefore, the third reason involved developing a PhD project, which was influenced and inspired by my collaboration with fathers, grandfathers, uncles, and relevant service providers involved with the *Strong Fathers Strong Families* project. In that project we created our own resources, including multi-media narratives that involved men sharing their parental experiences through digital storing telling in remote Aboriginal communities. I realised from that project experience the benefit of men working together for change, and that there was a need for a structured intervention that would address the gaps in knowledge as well as lead to enhanced mental wellbeing and empowerment.

1.2 Objective of the PhD:

The PhD thesis presented here covers three main areas that were considered important to the research aim, which is to provide a holistic understanding of First Nations men's parenting, and to describe, document and test a parenting intervention with men in First Nations communities. The three main parts of the thesis include:

1. A systematic review of the literature with a focus on First Nations men's parenting programs (based on a published paper)
2. An examination of the challenges and barriers to men's parenting from which to inform the intervention (based on a published paper).
3. An intervention, titled 'A trial of a community-based intervention to support the active engagement of Aboriginal and Torres Strait Islander men in parenting, and to improve men's feelings of empowerment, reduce mental distress and reduce drug and alcohol use.

It was assumed that the intervention process would yield only small numbers of participants, given limited funding and time constraints for conducting research in remote Aboriginal communities. The broad aim, however, was to identify and document what the men learned in the intervention, as well as for us to learn from the men's perspectives and experiences. Given that there would be small numbers, it would not have been empirically sound to analyse the measures quantitatively. It was also the case that the intervention aims that related to change in men's knowledge and experiences, as well as the process of the intervention, were suited to a qualitative appraisal. I therefore decided to describe

each intervention item in relation to the outcome measures which had significantly changed from before to after the intervention. I reflect on the intervention findings in the context of the literature, including substantive informing knowledge that is found in the first two chapters.

The PhD in total, including the published papers and description of the intervention, provides a rationale and knowledge base for designing and conducting future rigorous interventions related to parenting for First Nations men. An aim was to describe and document the intervention and wider process that is reflected in the included published papers, so that, if it showed some positive effects, it could be replicated in the future with the requisite level of funding for conducting studies of this kind in remote Aboriginal communities.

Before becoming a PhD student, I worked full-time with the RFDS. The RFDS enabled me to visit and connect with communities, and to work with men's groups, which have become the sites for this PhD study. I was also fortunate to receive funding from Men of Malvern (Andrology Australia) which enabled me to work part-time and focus part-time on the PhD. There were, however, limited funds otherwise with which to conduct the study, and therefore it was not feasible to attempt to involve more than two communities. This thesis focuses on a holistic approach to developing and then trialling an intervention, with an emphasis on qualitatively and descriptively recording the preliminary data-gathering (literature review and exploratory work), the intervention aims, method, process, analysis, findings and future application and benefit for First Nations communities.

1.3 Thesis Layout

The hybrid thesis integrates two published articles (one published and one accepted and in press at the time of writing) and the pilot intervention. Additionally, I refer to the terms *Indigenous, First Nations, Aboriginal* and *Aboriginal and Torres Strait Islander* interchangeably.

1.4 Theory

The reader will note that I have drawn on three broad theoretical constructs, which inform the thesis. The first theoretical framework focuses on rights and justice for First Nations people, and prioritises Indigenous worldview, meaning, and ways of understanding oppressive structures such as colonisation and racism, and how these impact on health, mental health and the perpetuation of violence and trauma (Reilly, 2008; Spry, 2002). In this context, I draw on critical theory throughout,

because critical theory helps to position health inequalities and issues, including relating to men as parents, within the context of oppressive practices. For example, in one section of the thesis (a published article) I discuss the impacts of colonisation, stolen generations and trauma on men's roles as parents (Reilly & Rees, 2018). The seminal work of Franz Fanon and his understanding of racial injustice informs the way I consider and apply empowerment theory (Zimmerman, 2000). Empowerment theory is essentially political, in that its underpinning philosophy is to support the marginalised to understand that they are not the problem, and that historical acts of injustice have undermined their confidence in themselves, including as parents. Fanon said, 'The oppressed will always believe the worst about themselves'. Critical theory also embraces a critique of any system that denies, undermines, or steals Indigenous people's land, their cultures, and their ways of knowing (Bronner, 2009). Empowerment helps people to know the root causes of their oppression, which is an empowering act. According to Fanon, "Imperialism leaves behind germs of rot which we must clinically detect and remove from our land but from our minds as well" (Fairchild, 1994).

I also discuss the use of Qualitative Description (QD) as a theoretical approach to analysing data and describing findings where samples are small (Green & LeBih; Milne & Oberle, 2005).

1.5 Author's Representation:

I am an Aboriginal man and a father of three daughters, grandfather to four grandsons, and uncle to many nieces and nephews. I feel privileged to speak about my rewarding experiences as a father, grandfather, and uncle. In addition, before receiving grant funding from the Million Minds Future Fund and moving to the University of New South Wales (UNSW), I was the Strong Families Project Officer with the RFDS (Qld) Child and Family Health Care Unit, Cairns Base, working to support Aboriginal men and families residing in remote Australian Indigenous communities. I was keenly interested in promoting the importance of Aboriginal and Torres Strait Islander men's groups as a vehicle to empower men as fathers. There is a view held by clinicians and Indigenous male elders that men's groups can provide a culturally appropriate safe space for men to share knowledge and experiences, including sensitive health-related information that could otherwise be challenging to communicate; for example, erectile dysfunction (ED), as Adams and others explain:

> The sensitive nature of reproductive health disorders may be of particular concern for Aboriginal and Torres Strait Islander men, especially in remote communities, where these matters are traditionally seen as taboo, requiring

> culturally appropriate and gender-specific services. (Adams, et al., p. 33, 2013)

My knowledge about the therapeutic dynamics that are generated in Aboriginal and Torres Strait Islander men's groups comes from over 16 years working formally and informally with my Aboriginal and Torres Strait Islander brothers, and the men's groups they are affiliated with. Over the years, formal and informal discussions with Aboriginal and Torres Strait Islander men have involved personal and social issues, many of which resulted in various forms of support. Issues that arose predominantly included fundamental issues related to men's self-esteem and empowerment, and how they impact wellbeing in the context of interrelationships between men, family, and community.

Men's groups are also a place for reflection and recovery, with the traditional framework of men as mentors, and an enduring respect for elders, being keys to success. Men's groups, by their very nature, are universally committed to promoting and re-establishing strong and safe communities as a focus of their activities. In that framework, the men's groups engender feelings of empowerment, and this is part of a nurturing and healing process.

Parenting is a central feature, role, and source of meaning for Aboriginal and Torres Strait Islander men (Reilly & Rees, 2018; Denison et al., 2014; Maslen, 2005). Parenting can be an important mechanism for men's empowerment, and it could impact positively on their health, including empowerment and mental wellbeing as Reilly & Rees suggested that "*Anecdotal and qualitative studies in Australian Aboriginal and Torres Strait Islander communities have reported that the role of men as parents is valued as important to men's general well-being".* (Reilly & Rees, p 4, 2018)

I have noted the need for more educational programs such as male inclusive parenting programs, and these could best be delivered through men's groups. Several Aboriginal and Torres Strait men who I have spoken with believe that to truly could be confident nurturing fathers, they need accessible and meaningful educational programs to assist with knowledge, skill and ultimately their empowerment. Importantly, male parents in Indigenous communities need to feel welcome and equally represented in accessing and management of broader community services related to parenting, including health and child health services.

From a research perspective, men's parenting and its association with their mental wellbeing is a field that requires more empirical knowledge. This largely neglected area of study, and therefore my PhD dissertation involves a holistic process, from an examination of relevant published data to informing the development of an intervention and then testing the intervention to see if it could work.

Note on the use of non-Indigenous parenting and intervention literature

I make special note here of the parenting and intervention literature, particularly that which considers men's roles in parenting (Pfitzner et al., 2020). Non-Indigenous studies, even those that examine men's disadvantage or trauma as factors that may have negatively impacted their parenting, prioritise non-Indigenous notions of disadvantage and trauma (Maxwell, 2018; Giusto et al., 2021). For example, they do not sufficiently recognise collective worldviews, racism in the context of colonisation, systematic forced removal of children, stolen land, spiritual connection with country, and traditional lore. One of the barriers discussed with First Nations men's parenting in Chapter 1 and 2 is the predominance of culturally extraneous non-Indigenous worldview of parenting roles (Caldwell et al., 2019). It would, therefore, be inconsistent with the purpose of this thesis, and the intervention for First Nations men, to give precedence to non-Indigenous academic literature in the thesis. I have therefore, intentionally not prioritised this literature, although I have used it where required to refer to important contributions to knowledge that were necessary to ensure scientific credibility, and robustness. Note that this position, to prioritise the black or Indigenous voice, is fully supported by the theory informing my thesis, including critical theory, and work of academics such as Franz Fanon (Bronner, 2009). Please refer to the Theory section above.

Chapter 2

This paper, which is a meta-synthesis of qualitative literature, is published in the International Journal of Men's Social and Community Health. The paper aims to advance and promote better translation of knowledge concerned with the challenges for First Nations male parents by evaluating the amalgamation of qualitative studies. I further aimed to apply the findings of this meta-synthesis to inform the current thesis, and its main aim which relates to the connection between men's parenting and improved mental wellbeing for men. This published paper was also intended to contribute to future research, policy, and practice. The meta-synthesis examined barriers and facilitators to support First Nations men's parenting, from Indigenous-led or appropriately informed studies. A synthesis of the literature with this focus was intended to provide a useful evidence base to highlight systemic issues. The findings were also planned to inform the development and rationale for appropriate services and programs to support and promote men's parenting. The meta-synthesis aimed to include only peer-reviewed papers. Due to the small number of peer-reviewed journal articles on the topic within the six databases, the search was extended to a web search. From the extended search, the author elected, based on their relevance, to include one higher degree dissertation, and one government report. This fully documented process is found in the published paper below.

This published paper was purposely written prior to finalising, conducting or analysing data from the men's parenting intervention (subject of this thesis, referred to as the intervention). It is presented in the thesis because it was a key mechanism, that was used to inform the intervention, particularly published papers on the barriers and facilitators to support First Nations men to be parents. The paper includes the 9 seminal publications in this field. The plan for my dissertation was to write this paper to inform the main study, and it therefore served as the groundwork to design and analyse data related to First Nations men's parenting interventions. The published articles are located here as the literature review for this thesis. Nevertheless, other relevant literature is cited as required throughout the dissertation. At the time of the study, this was a complete and thorough representation of literature.

The specific contributions drawn from this published paper (Chapter 2) include the barriers and particularly, unchallenged assumptions about parenting roles in First Nations communities. This point, which is discussed in the published paper, is integrated into the parenting intervention that I tested.

The intervention focuses, for example, on discussing the historical importance of the male parenting role and encourages men to consider new ways that they can be fathers. The men also learn about, and how, their roles as fathers can be ignored, or not valued in their communities. For example, to identify the barriers, the intervention includes a component, which encourages participants to consider "what are the barriers or problems that confront men as parents"? And to examine the possibilities for engaging more with children, participants in the intervention group discuss "what do male parents do"? Social adversity is raised in the meta-synthesis, as a factor that can impede men's parenting, and this topic is also considered in the intervention, which focuses on both historical forms of oppression, as well as contemporary forms of disadvantage, and the role both play as barriers to men's parenting. "Keeping Strong" is a centrally important theme that arose in the meta-synthesis. Keeping Strong relates to good mental health, and this is also a centrally relevant component of the intervention, which emphasises the relationship between men's empowerment that evolves from having a better understanding of parenting barriers and, opportunities to having a stronger relationship with their children. As I argue in Chapter 3, to date, at the time of writing this thesis, only anecdotal evidence, and local knowledge indicated that the parenting role would be positively associated with men's psychological wellbeing (Tsey et al., 2002; Tsey et al., 2004; McCalman et al., 2006b; Laliberté et al., 2012; Adams, 2006). In Chapter 3, I discuss the non-Indigenous literature, which shows that amongst that population, the transition, to fatherhood may have varied effects on men's health, from negative, to positive, to neutral (Garfield, 2010).

One contributor that is identified as a barrier to men's parenting is colonisation. Colonisation includes where non-Indigenous worldviews have dominated and shaped the roles and confidence that First Nations men have had with parenting. For example, the published paper described here discusses how the roles and responsibilities of traditionally defined men's business and women business have been undermined. This important message about colonisation, and how it intersects with men as parents from the meta-synthesis directly informed the intervention.

First Nations Men experiencing Fatherhood: A Meta-synthesis of Qualitative Literature'.

2.1 Background

Interrelated social and health issues including contemporary socioeconomic disadvantage, poor health status, racism, colonisation, stolen generations, loss and trauma, impact greatly on First Nations men.[1] All these factors are related to a host of social and emotional problems such as loss of masculinity, self-esteem, self-respect, spirituality, and identity.[2] Undermined emotional wellbeing can severely impact men's roles as fathers. Holistic health from an Indigenous perspective includes the traditional men's parenting role. It is therefore important for male parenting roles to have greater academic attention as a mechanism for promoting men's health and informing parenting policies and practices. It has also been identified that First Nations parents and families need optimal support to overcome structural and historical barriers that reduce opportunities for good parenting and maintain poorer mental health.[3]

There is a dire need to collect and collate existing knowledge of the barriers and facilitators that either undermine or promote the role of First Nations fathers as parents.[3]

Despite evidence demonstrating the important role that male parents play in their children's development and wellbeing, there is evidence of a shortage of knowledge translation from publications to policy and practice.[4] The barriers and facilitators to men's parenting from qualitative studies have been more extensively examined in non-Indigenous populations.[5] It is likely that studies aiming to provide an understanding of the challenges confronting contemporary Indigenous men's experience as parents has been overlooked because of the limited number of peer-reviewed papers, and because they are qualitative.[6] It may be that the current lack of support for First Nations male parenting practices is due to the limited uptake of existing evidence in the field.[3,7] First Nations men are not predominantly represented as parents and in fact they are often written about as neglectful or harmful parents.[8,9] Systemic barriers and facilitators impacting First Nations male involvement in parenting or in child health programs are not highlighted.[10] For example, a scoping review that aimed

to identify and describe Aboriginal and Torres Strait Islander men and parenting programs highlighted the lack of rigorously researched and published literature on the topic.[10]

2.2 Objective

This article aims to advance and promote better translation of knowledge concerned with the challenges for First Nations male parents by evaluating the amalgamation of qualitative studies. The author also to develop an explanatory theory from the findings to inform future research, policy, and practice more effectively. The meta-synthesis examined barriers and facilitators to support First Nations men's parenting. A synthesis of the literature with this focus will provide a useful evidence base to highlight systemic issues. The findings intend to inform the development and rationale for appropriate services and programs to support and promote men's parenting.

2.3 Method

The documentation of challenges and mediators for parenting have commonly applied descriptive, qualitative methods. Given the aim to identify barriers and facilitators to men's parenting, this meta-synthesis, which complies with PRISMA guidelines, a preferred reporting items for systematic reviews and meta-synthesises, focusing on descriptive, fact finding, qualitative studies. The meta-synthesis process also complied with PRISMA guidelines to ensure that a systematic approach to quality and rigor was undertaken.

Our search ensured a comprehensive inclusion of all qualitative studies that concerned First Nations men and parenting across a 10-year period. The 10-year period marked the start of a literature relevant to this field of enquiry. The criteria included studies that identified barriers and facilitators to parenting. Papers were excluded if they were not research based or lacked rigour. The objective was to identify and synthesize novel descriptive data from which to inform and shape future interventions, rather than to examine the interventions themselves.

Meta-Synthesis is a methodological approach, and 'qualitative meta-synthesis' refers to the capacity to build knowledge from the amalgamation of a group of qualitative studies.[11] An aim is to develop an explanatory theory from findings from a group of similar qualitative studies.[12] Meta-synthesis is applied here to examine, provide an explanation, and make sense of knowledge from a sample of qualitative studies related First Nations male parents.[13]

A broad framework guides the process,[14] (refer to Table 1). Table 1 shows the six-step process and gives a basic description of the qualitative meta-synthesis process, and the framework of analysis where rich contextual information about the setting and participants can be comprehensively and rigorously captured.[15] The aim was to discover the essential features and attempt to combine phenomena into a transformed whole.[16] The integrated studies were assessed with the aim of identifying key themes related to First Nations men's parenting.

Table 1: Qualitative Meta-synthesis Process

1. Formulate a Clear Research Problem and Question
2. Conduct a Comprehensive Search of the Literature
3. Conduct Careful Appraisal of Research Studies for Possible Inclusion
4. Select and Conduct Meta-synthesis Techniques to integrate and analyse qualitative research findings
5. Present Synthesis of Findings across studies
6. Reflect on the process

Source: Nelson[17], and Brotherson [15]
Nelson; Adapted Erwin E J, Brotherson et al [15]

Step 1. The research questions:

* How many qualitative studies are there concerning Indigenous men and parenting?
* What are the key topics/questions of these studies?
* What are the methods used in the studies?
* What are the barriers and facilitators that can be identified regarding Indigenous men and parenting?

Step 2. The following = key words were used to search each database *paternal role; men; male; fathers; fatherhood; Indigenous men; Native; Aboriginal; Torres Strait Islander; First Nations; Barriers; Facilitators*.

The databases included: Social Sciences Citation Index, CINAHL, ProQuest, Informit Databases, Expanded Academic, Scopus, and using google scholar for e-journals.

Step 3. Search found (N=789). Step 3: Inclusion of articles that referred to Indigenous men and fatherhood, using key words in the title or Abstract. Search found (N=4). This meta-synthesis aimed to include only peer-reviewed papers. Due to of the small number of peer-reviewed journal articles on the topic within the six databases, the search was extended to a web search. From the extended search, the author elected, based on their relevance, to include one higher degree dissertation and one government report. Web search: individual search in Google Scholar (N=4); Department of Health (N=1). The result of this search revealed publications conducted in Australia and Canada.

Step 4. Initial coding of the collected data was carried out, sorting, and analysing the dominant, less obvious, and contrary issues, whilst keeping in mind the research question/problem. Themes were located, early labels assigned, and mass data condensed into categories, thereby producing an analysis with the strategic intention of providing a rich thematic description of the complete data set, looking for critical terms, key events and/or themes.

Step 5: Present Synthesis of Findings Across Studies

This step presents what had emerged through the process of the combination of 9 of qualitative studies. Further, the findings are presented in a summary table that include the metaphors, concepts or theories identified across the 9 studies.[17]
Next a table of the fathering steps revealed in secondary analysis and categorised themes. The findings are synthesized across the 9 selected articles to reduce categories into major themes.[18]

Step 6: Reflect on the process

It was important from an Indigenous perspective to ensure that the meta-synthesis process was consistent with and would reflect Indigenous ways of knowing, and that broader outcomes related to the promotion of men's parenting strengths.

2.4 Results

The articles for review were studies conducted in Australia and Canada, these include 8 peer-reviewed article and 1 Honours Thesis. The analysis of the 9 studies was carried out using a meta-synthesis methodological approach.

Summary of article aims included in the meta-synthesis

Jia[19] aimed to provide a descriptive analysis of the development of a young Indigenous father's support group. One of the aims of setting up the support group was not only to support young Aboriginal Fathers, but also to change the perceptions and attitudes of young fathers, and particularly to see that raising children is not only women's business. The group targets young fathers from 16 to 25 years of age. The group was initially formed to provide support for the young fathers and to assist them with coping strategies, including how to support their partner, and be positive role models for their children. An addition was a structured culturally appropriate anger and stress program, which aimed to empower the young fathers and to enhance their strengths as young parents.[19]

The Kurti, Holloway & Hudson[20] *Strong Fathers Strong Families* report provided a descriptive analysis of the Strong Fathers Strong Families program across 12 sites in Australia. *Strong Fathers Strong Families* was an Australian Commonwealth Government funded program. The aim of the program was to promote the roles of Aboriginal and Torres Strait Islander fathers, grandfathers, and uncles. The program also encouraged them to be healthy role models and nurturing fathers to children in their care, and be supportive to their partners, pre-, during and post-birth.[20]

Dennison, Smallbone, Stewart, Freiberg, & Teague[21] conducted 41 qualitative interviews with Indigenous males across two North Queensland high-security prisons (Stuart Correctional Centre, Townsville, and Lotus Glen Correctional Centre, Mareeba). The interviews examined how dads felt about their role as parents (paternal identity), and to document the perceived challenges they encountered in maintaining positive relationships with their children.[21]

Ball [22] reflects on an earlier study involving indigenous fathers and their roles in caring for children. The paper describes historical challenges, such as the diminishment of their roles as fathers following

years of colonial interventions, and the paper explores Indigenous fathers' contemporary experiences of fatherhood in that context.[22]

Laws & Bradley [23] focused on the lack of attention and absence of literature involving the transmission of health knowledge from men to boys in Australian society. In addition, the authors draw on the personal experiences working with Indigenous and non-Indigenous Australian men and identified lack of literature in this area with which to inform practice and raise awareness among health professionals supporting male parenting.[23]

Maslen[24] provided a literature review which identified the roles that fathers play in Australian society. In addition, the Maslen thesis aimed to provide clarity around the current situation for Indigenous fathers and the role that they play within contemporary society. Maslen also documented the benefits that fatherhood brings to family and societies in terms of an appraisal of holistic wellbeing. The author, being an Aboriginal father, also draws on his own fatherhood experiences.[24]

Manahan & Ball[25] explored Aboriginal fathers' support groups in British Columbia, Canada. The authors focused on male involvement in parenting, particularly with the factors required to enhance the role of fathers and parenting their children. The article investigated family-centred programs and the father-participant rates in attending those programs. Furthermore, the article is located within a theoretical framework that considers the impact of colonisation and assimilation on parenting, and the importance of holistic healing moving forward for indigenous men.[25]

Reilly & Rees[3] examined 31 interviews with expert First Nations community members to understand the roles of Aboriginal and Torres Strait Islander fathers, grandfathers, and uncles. The paper examined men's business and women business pre- and post-British imperialism. The article explored the reasons why some men were *'shame'* (feeling embarrassed) about parenting, and the need to overcome shame and improve parenting confidence through attending men's groups as a safe space for promoting healthy male role models. The paper discusses yarning and storytelling data and identifies four categories of bias that could inform future policies and practices: Cultural Bias, Institutional Bias and Professional Bias, Content and Resources and Policy Bias.[3]

Hammond[26] provides a narrative description of a father's program within a jail setting. He explores Aboriginal inmates' experiences as fathers, whilst incarcerated. The program is interactive—

allowing men to share and receive information about the fatherhood experience without being judged. In addition, the program provides a space for men to support each other as they discuss the roles as being good dads, in prison and outside prison.[26]

Table 2: Key concepts focusing on barriers and facilitators for male parenting

Authors	Title	Journal	Organisation	Key Concepts
(Ball, 2009).	Fathers in the Shadows: Indigenous Fathers and Canada's Colonial Legacies	A working copy of an article published in *The Annals of the American Academy of Political and Social Science, 624 (*July), 29-48.	University of Victoria, School of Child and Youth Care, Victoria, British Columbia, Canada	The *diminishment* of Indigenous men's roles a father following years of *colonial* interventions, and the impact on Indigenous fathers' experiences of fatherhood.
(Dennison et al., 2014).	'My Life is Separated' *An Examination of the Challenges and Barriers to parenting for Indigenous Fathers in prison*	*British Journal of Criminology.* (2014) 54, 1089-1108, Advance Access publication 22 September 2014.	Griffith University, Mt Gravatt Campus, Queensland	The roles of Indigenous males while in prison, and examining effect on paternal identity, including the challenges in maintaining positive relationships with their children from within prison and outside
(Jia, 2000).	Indigenous Young Fathers' Support Group.	*Aboriginal and Islander Health Worker Journal*. Volume 24 Number 1. Jan/Feb 2000.	CentaCare, Brisbane	Providing support for the young fathers to assist them with coping strategies for daily and life stressors that can impact them and their role as parents. The group includes a focus on how to support their partner and be positive role models for their children. The structured culturally appropriate anger and stress program, which aims were to empower young Indigenous fathers, and enhance their strengths as young parents.

(Kurti, Holloway & Hudson, 2013).	Descriptive Analysis of the Strong Fathers Strong Families Programme Final Report.	Prepared for the Department of Health December (2013)	Urbis	Targets the promotion of the roles of new Aboriginal and Torres Strait Islander fathers, grandfathers and uncles. Furthermore, it encourages them to be healthy role models and nurturing fathers to children in their care, and be supportive to their partners, in particular during and after birth.
(Laws & Bradley, 2003).	Transmission of health knowledge and health practices from men to boys among Aboriginal communities and non-Indigenous Australians: Searching the evidence	Contemporary Nurse (2003) 15: 249-261	University of South Australia, Adelaide, Australia	Targets the absence of literature in this area to inform policy and practice. Aboriginal family members may take on the role of caring for children; however, the father should have a central role in raising his children.
(Maslen, 2005).	Aboriginal Fathers/Fathers Roles Are They Recognised in Australia's Contemporary Society?	University of Sydney, Library Honours Thesis 2005	Yooroang Garang: School of Indigenous Health Studies. University of Sydney	Documents the importance of the roles Indigenous fathers play within a contemporary society, and the benefits fatherhood brings to family and societies holistic wellbeing.
(Manahan & Ball, 2007)	Aboriginal Fathers Support Groups: Bridging the Gap between Displacement and Family Balance*	*First Peoples Child and Family Review*, Volume 3, Number 4, 2007, pp. 42-49	University of Northern British Columbia, Canada.	Aboriginal fathers Support Groups in British Columbia Canada, targeting the involvement and enhancing of roles for fathers and their children, with a holistic health approach using traditional practices.

(Reilly & Rees, 2018)	Fatherhood in Australian and Torres Strait Islander communities: An Examination of Barriers and Opportunities to Strengthen the Male Parenting Role.	*American Journal of Men's Health* 2018, Vol. 12 (2) 420-430	University of New South Wales (UNSW), School of Psychiatry, Sydney	Document's barriers and opportunities to supports the roles of Aboriginal men as parents. Traditional versus contemporary parenting, communities advocating Aboriginal men's roles as parents, and addressing bias and barriers, creating a better way of doing business that will allow confident strong fathers, grandfathers, and uncles
(Hammond, 2011)	Brothers Inside: Fathering workshops with Aboriginal prisoners.	*Australian Journal of Adult Learning,* Vol 5, Number 2, July 2011	Family Action Centre, The University of Newcastle	The fathering workshop with Aboriginal prisons highlights that, although fathers are imprisoned, it does not have to interfere with men being responsible dads. Men learn what that means and to overcome challenges to being in prison and outside prison as Indigenous dads.

2.5 Thematic analysis

All articles were analysed by first considering and grouping data to identify themes. The creation of each theme was informed systematically by the research aims concerning challenges, barriers, and facilitators for male parenting. Themes included were viewed as dominant, unique as well as dissonant. In the tradition of *thematic analysis***,** the predominant themes were first identified as per above, and then coded and analysed.[31] The depth and complexity of the data within each study is refined as the researcher worked towards answering the research questions from across the entire data set. This generalist approach is particularly useful when investigating an under-researched area, and when views on topics are not yet known.[27]

2.6 Key Themes

Complexities of Roles and Relationships

To understand the complexities of the roles and relationships in parenting within an Aboriginal society, there needs to be an understanding of kinship. Without this understanding of policy and practices, Dennison et al, suggest the complexity of the notion of kinship is greater within Indigenous communities when compared with relationship roles within mainstream Western society families. For example, every male within a clan group is either defined first by being a father, grandfather, uncle, or brother, and all have a role in raising children.[21]

Since colonisation, however, the roles and responsibilities of traditionally defined *men's business* and *women's business* have been undermined. Many Aboriginal fathers have identified that the ongoing effects of colonisation and attempts at assimilation into non-Indigenous ways of behaving have changed their traditional roles as fathers in favour of female parenting roles, as in Western society. The undermining of the male parenting role, and the process of achieving it, has caused trauma amongst many men.[19,25] In effect, colonisers privileged women's parenting roles, which served to alienate men from parenting and promote the false belief that Aboriginal and Torres Strait Islander women's business is to raise the child, and that the health of children rests with women.[19] Despite the influence of colonising practices, Law and Bradley[23] argue that fathers still play a central role in the upbringing of their children.

Law and Bradley[23] also suggest that, within Aboriginal and Torres Strait culture, the strong distinctions between the accepted roles of men and women within Aboriginal society around the upbringing of children have persisted despite colonisation.[23] Furthermore, Reilly & Rees[3] identified that roles, relationships and connectedness for men as parents were clear to everyone within tribes and determined the behaviour of individuals.[3] The importance of recognising and celebrating *Lore* to determine men's business and woman business is central for men to regain confidence in the parenting role.[3,24] Malsen[24] saw the role of fathers as complex and specific in the raising of their children, beyond men being the breadwinner as in Western tradition:

> "The importance of fathers extends beyond economics. Their involvement as nurturers, disciplinarians, teachers, coaches, and moral instructors is also critically important to healthy development and maturation of their children" [24, p 52]

Poverty and exclusion

Poverty relates not only to being disadvantaged financially, but also to a psychological destitution related to undermined connectedness between Aboriginal fathers and children due to colonisation. Both forms of poverty are barriers to parenting. It has been claimed that Indigenous fathers are the most socially excluded population around the world in relation to parenting.[22] Ball [22] also claims fathers are systematically excluded from positive fathering because of socioeconomic factors such as poor education, as well as ongoing impacts of colonisation including separation of children from families based on racist policies, Western-imposed mother-focussed parenting programs, and child welfare practices that removed children from families.[22] Colonisation commonly included dislocation of indigenous people from their traditional land by Western colonialists who gained economically from exploiting it for housing, farming or mining. Taking land from First Nations people caused them to experience survival-related and spiritual poverty, and this dislocation has and continues to directly interfere with culture, family, kinship and parenting practices. In fact, the roles of Aboriginal fathers have been displaced, and pathways where Aboriginal and Torres Strait Islander males learn to be men have disintegrated, along with learning how to be a father within a contemporary society. [21,25]

Receiving and Sharing Knowledge

A facilitator for men's parenting is the unique and effective capacity that First Nations men have for sharing and receiving knowledge.

Law and Bradley[23] claim that, regardless of challenges related to where men live (prisons, suburbs, traditional land) or whether they are with a partner, children, stepchildren or alone, First Nations men are uniquely skilled to pass on health knowledge and health practices to their children.[23] These unique skills that men have are deeply embedded traditional verbal skills that combine oral traditions via storytelling, land–based experiences, artistic activities and ceremonial practices.[28] This approach to educational knowledge orientation regarding parenting can be invaluable in improving educational outcomes for Indigenous fathers. Jia[19] makes an important observation: that Aboriginal and Torres Strait Islander fathers' parenting is not only based on theoretical knowledge, but also comes from the heart.[19] In addition, First Nations fathers see themselves as role models, and that it is their responsibility to transfer cultural knowledge, and to provide encouragement for their children to work hard and make good decisions.[21] This traditional motivation for parenting by men needs to be identified in policy and practice and fully supported by governments and society. First Nations men learn from one another as they observe other men parenting and

interacting with children, and this supports the value of men's groups for sharing knowledge of parenting amongst male peers.[22,25] Nonetheless, Malsen[24] reflects on policy and services not adequately reflecting how men share and communicate parenting knowledge, and ultimately how services need to facilitate those cultural exchanges in contemporary times:

> "…if services are not culturally appropriate, then Aboriginal men will not feel comfortable using them." [24 p 50]

Keeping Strong

The Indigenous term commonly used in the literature—*keeping strong* (mentally well)—is enmeshed with sustaining empowerment and confidence in First Nations men, providing them with a sense of belonging in their family and society as parents. In addition, for parenting programs to be culturally inclusive for First Nations fathers, grandfathers and uncles, policy reforms are required to reflect the importance of the parenting role to men's empowerment and wellbeing. The meta-synthesis demonstrates that policy makers need to ensure it has a long-term investment in identifying and reducing structural, personal, and social barriers for First Nations fathers, and to enhance their involvement in parenting. Men's roles as parents may result in creating a stronger sense of empowerment for First Nations fathers.[22]

Reilly and Rees[3] found that men who regularly attended men's groups were more confident to engage with community activities, including parenting programs. Therefore, men who participated in their local men's group seemed more empowered.[3] Manahan and Ball[25] go on to suggest that the establishing of First Nations Men support groups has provided fathers with the opportunity to observe the value and importance of other men's interactions with their children, providing a safe space and a positive environment to strengthen the male identity and increase feelings of empowerment.[25]

> "The need for cultural frameworks around support services for Indigenous fathers, and for positive reflections of Indigenous men in caregiving roles is important in Indigenous fathers keeping strong." [22 p 43]

2.7 Discussion

Nine studies were identified for inclusion in this novel meta-synthesis, which aimed to analyse data concerning barriers and facilitators to First Nations men's parenting. The objective was to translate important findings in qualitative studies that have been largely overlooked in policy and practices related to men's parenting in the indigenous context. Elements across studies were identified as a barrier, facilitator, or both to male parenting. The dominant themes found in the meta-synthesis were Complexity of Roles and Relationships as a possible barrier if the indigenous understanding of men as parents is ignored in current policy and practice; Poverty and Exclusion, identify the need to ensure that men are not denied economic and spiritual means to be good parents in the indigenous context; Sharing and Receiving knowledge demonstrates the intrinsic skill and capacity that indigenous men have for communicating parenting knowledge both to each other and to their children. The last them, Keeping Strong, emphasises the critically important role that parenting can play in strengthening First Nations men's identity and empowerment. In a context where indigenous men have faced widespread forms of discrimination, marginalisation and trauma, the importance of strengthening mental wellbeing by way of empowerment and the parenting role is very important for future policy and practice.

Importantly, the qualitative meta-synthesis aimed to identify First Nations men's strengths more broadly. The paper and key themes form an empirical guide to ensure that men can actively embrace their rightful roles as positive, engaged fathers, uncles, and grandfathers within a contemporary Indigenous society. Although the primary focus on this paper is on men and their wellbeing as parents, the meta-synthesis also revealed the significance of the parenting role to children's health and wellbeing. The evidence suggests that child development and functioning can be positively impacted by healthy male role models, particularly from fathers. As Canuto and others suggest, *"…the value and importance male parents can add to the lives of their children should not be underestimated."* [29 p 7]

2.8 Policy Implications

The findings in this meta-synthesis, need to be recognised and supported by governments as a strategy for policy and procedure leading to 'constructive change' towards the betterment of men as parents and for First Nations children and communities. In addition, the significant role of men as parents may provide, self-esteem and empowerment to fathers, and give them the capacity to strengthen the interrelationships between family and community. Empowering fathers, uncles and

grandfathers to acquire the skills necessary to take greater control and responsibility for family, work and community life creates a ripple effect for positive change.[30] First Nations men can and should advocate the importance of the development and continuation of successful male inclusive parenting programs within their communities. Having strong fathers, uncles and grandfathers acquiring the skills necessary to take greater control and responsibility for individuals, family, and community life creates sustainable empowerment, enabling First Nations men to address all challenges in front of them.

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Chapter 3

This Chapter reports a peer-reviewed article that was published in the American Journal of Men's Health American Journal of Men's Health 2018, Vol. 12 (2) 420-430, I was the lead author, and it was intended to form part of my PhD Dissertation. The article already has 9 scholarly citations, and it describes the findings from a Royal Flying Doctor Service program known as Strong Fathers, Strong Families, which I was involved with in my role as a Strong Families Project Officer. That program and my experience with it was critically important to designing the intervention described in this thesis. It is important for research in Indigenous communities to be founded on a thorough consideration of theory, need and empirical evidence. The article is presented here as Chapter 3 of the dissertation.

The study has highlighted the need for awareness in communities, and health and welfare services for men's parenting role, which may be impacted by traditional understanding of men's business, and women's business, and additional difficulties in undertaking contemporary parenting practices. The study demonstrated that men's engagement with parenting, could strengthen his identity, and improve his mental wellbeing. These findings supported the need for more information, and therefore provided a rationale for the parenting intervention, which is the main subject of the PhD project.

This paper describes, shame, predominantly experienced as embarrassment, and a lack of confidence around parenting. The parenting intervention was directly informed by this finding, that is, that men experienced shame about parenting because of its lack of acceptability, and because they lacked confidence to be dads. I consider, from this knowledge, that men would feel empowered, and that this would have a mental health benefit, if they were playing a more direct, and meaningful role as dads. Empowerment theory, I considered, would better inform the development of programs to include male parents (Wallerstein & Bernstein, 1994). The findings published in this paper, also identified many barriers to Indigenous male parenting that we

subsequently included in our component of the parenting intervention. These barriers that I subsequently included in the parenting intervention, included structural factors that serve to undermine men's confidence in parenting, such as colonisation and its effects on men, racial disadvantage, and marginalisation and negative stereotypes about men and their use of alcohol and drugs, Empowerment approaches, such as those I used to design the parenting intervention manual, have been reported to support men, to establish positive thoughts, behaviour and emotions, to sustain positive change, and have the power to help others (Laliberté et al., 2012; Rees et al., 2004).

Like the findings from this article, the aim of my parenting intervention was to highlight the importance of men's groups, in providing a supportive male space and championing male parental role models in Indigenous communities.

This is a published article:

Fatherhood in Australian Aboriginal and Torres Strait Islander communities: an examination of barriers and opportunities to strengthen the male parenting role.

3.1 Introduction

Evidence suggests that Aboriginal and Torres Strait Islander men's health and wellbeing may benefit from strengthening their role as parents (Adams, 2006; Tsey et al., 2004). Further, men's parenting can improve child development and family harmony in low-income and indigenous societies (Panter-Brick et al., 2014; Bornstein, 2012; Opondo, 2016). The Strong Fathers Strong Families (SFSF) program, conducted in a men's group format, incorporates the broad aim of promoting men's wellbeing by emphasising the value of their role as proud Aboriginal and Torres Strait Islander fathers, grandfathers, and uncles (McCalman et al., 2006b; McCalman et al., 2006a). Participating men are encouraged to see themselves as healthy role models for their children, and to provide positive support to their partners, particularly in the antenatal and postnatal periods (Strong Fathers, Strong Families Funding Guideline, 2011).

To strengthen the Aboriginal and Torres Strait Islander male parenting role it is vital to examine current barriers and opportunities for their engagement with the relevant health and welfare services in remote Aboriginal communities. This paper is informed by data from yarning sessions, which are an Aboriginal and Torres Strait Islander method for sharing experiences and knowledge (Geia et al., 2013). Yarning sessions were conducted systematically with Aboriginal community

stakeholders (Bessarab & Ng'andu, 2010; Geia et al., 2013) to gather knowledge about the opportunities and barriers to men's parenting in the context of service delivery. The aim was to inform the SFSF program, Aboriginal health policy and practice related to child and maternal health, and the Aboriginal men's health field.

3.2 Strong Fathers, Strong Families

The Strong Fathers, Strong Families (SFSF) program is funded by the Australian Federal Government Department of Health and Ageing. The funding was distributed to 13 organisations nationally, with the Royal Flying Doctor Service (RFDS) Queensland Section being one of the funded organisations. The SFSF program broadly aims to build genuine, sensitive, trusting, and culturally appropriate relationships with Aboriginal and Torres Strait Islander males and the wider community. For brevity, the endorsed term Aboriginal and Torres Strait Islander is interchangeably referred to as Aboriginal or Indigenous in this paper. The broad objective of SFSF is to recognize and support the important influence that fathers, uncles, and grandfathers have in the lives of children, mothers, and families. Specific objectives of SFSF are to engage Aboriginal and Torres Strait Islander men using a men's group method to increase knowledge and access to culturally-appropriate antenatal, early childhood development, and parenting services (McCalman et al., 2006b). The men's groups also function as a referral site to other health providers in the communities. The SFSF program was implemented by RFDS in three remote area Lower Gulf Communities, Normanton, Mornington Island and Doomadgee.

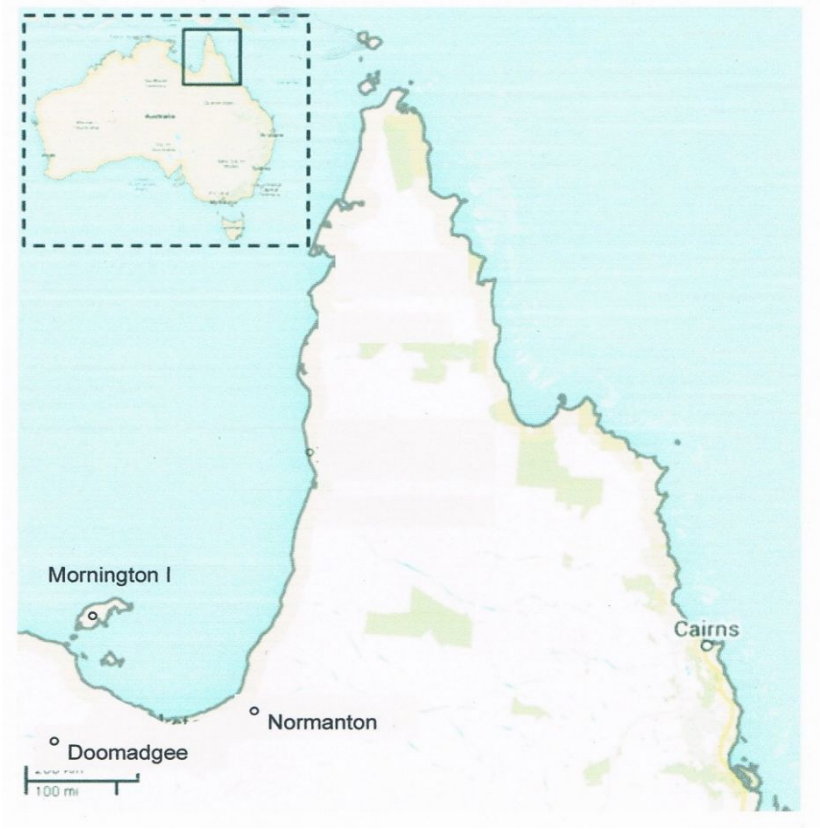

Figure 1 – Locations of the SFSF participating Lower Gulf of Carpentaria Communities (Adapted from: https://maps.google.com.au/)

3.3 Historical parenting roles among Aboriginal and Torres Strait Islander men

Aboriginal and Torres Strait Islander men's parenting requires an understanding of contextual factors including colonisation, discrimination, and bias in government policy. Compromised health including mental health and increased risk of suicide have been associated with an undermined male role in Indigenous society (Adams & Danks, 2007). The denial of the male role and responsibility has been connected with living less meaningful and healthy lifestyles, and with poor psychological and physical health status relative to that of non-Indigenous men (Marmot, 2011). Aboriginal and Torres Strait Islander men have a life expectancy of approximately 59 years, which is 17 years less than non-Indigenous men. The mortality rate for Aboriginal and Torres Strait Islander men is in fact three to seven times higher than non-Indigenous men in the same age group, with the main causes being cardiovascular diseases, injury, respiratory diseases, and diabetes (Hayman, 2010).

To understand the historical and contemporary role that men play within Aboriginal and Torres Strait Islander families it is necessary to reflect on Australian history. Before British settlement in 1788 – or from a critical perspective, before the conquest – Aboriginal and Torres Strait Islanders lived in a complex democratic society with a diversity of roles and relationships (Rowe, 2017).

These roles and relationships defined connectedness to every other person in the group, and determined the behavior of an individual to each person (Purdie et al., 2010). Aboriginal and Torres Strait Islander kinship determined particular rules of commitment, obligation and entitlement in the family and in the wider community (Furber-Gillick, 2011). The intricate kinship system placed importance on relationships and the family unit, including the rearing of young children by the women. An important component of kinship was the initiation of young males, who were understood to have reached adolescence following their ritual removal from the family unit by senior male leaders so that they could participate in ceremonies. These initiation ceremonies, which have also been known as the *Bora Ring*, symbolise the shift from being a boy to becoming an adult male (McIntyre-Tamwoy, 2008).

Traditional Aboriginal kinship systems had clearly defined responsibilities and obligations for women and for men, which include parenting, ceremonies, and accessing food (Hamilton, 1980). Traditional gendered roles, relationships and responsibilities have however been threatened and undermined by contemporary Australian society. In particular, modernisation has challenged Aboriginal and Torres Strait Islander male roles, authority and status (Bulman, 2009). Since colonisation, Aboriginal and Torres Strait Islander people have experienced systemic racism and discrimination. This has included unfair and damaging legislation, acts of murder, denial of essential foods, removal from traditional lands, inhumane treatment, rape, and other acts of physical violence. Aboriginal children who were considered 'part white' or 'half caste' were taken from their families so that they could be 'civilised' under a devastating policy of racial assimilation. As many as one in ten Indigenous children were forcibly removed from their families and communities in the first half of the 20th century (Dudgeon et al., 2010).

The historical and in some cases contemporary removal of Aboriginal children from their families has significantly undermined the confidence of parents, including the male fatherhood role. Aboriginal and Torres Strait Islander children raised in non-Indigenous homes lacked culturally appropriate role models, and therefore raised their own children without the benefit of cultural continuity in knowledge. In traditional Aboriginal and Torres Strait Islander societies, young men had a clear passage to manhood. However, racial oppression and the dislocation and dispossession of Aboriginal people has disrupted these traditional practices, denying young males the pathway and rituals to signify their development into men (Reilly, 2008). In addition, the forced relocation of Aboriginal and Torres Strait Islander people to missions and settlements restricted men from performing their traditional roles as landowners, educators, father figures, providers, and decision

makers. The historical treatment of Aboriginal people has been described as a process of breaking their spirit and connection to the land and the family (Lowe and Spry, 2002).

3.4 Fatherhood research

Health research and policy on fatherhood is almost non-existent when compared with the wealth of studies concerning maternal health (Bartlett, 2004). A global review of literature reported that men are marginal to the bulk of parenting interventions (Panter-Brick et al., 2014). Most research concerning men as parents focuses on health and development outcomes for children (Opondo, 2016) or their female partners (Bond, 2010). Research on fatherhood in Indigenous cultures, including Australian Indigenous communities, is underexplored when compared with research conducted with men from white, married, well-educated, and middle-to-high socioeconomic backgrounds (Garfield et al., 2006; Astone, 2014). One important study amongst African American men identified the benefits of parenting for men. The study reported that fathers valued learning about child rearing, child health and development (Smith et al., 2015). Because of the general lack of research, the health benefits or risks of parenting for Aboriginal and Torres Strait Islander men are empirically unknown. Anecdotal evidence and local knowledge, however, strongly suggests that the parenting role is positively associated with men's psychological wellbeing (Tsey et al., 2002; Tsey et al., 2004; McCalman et al., 2006b; Laliberté et al., 2012; Adams, 2006). Previous research with non-indigenous men indicates the transition to fatherhood may have varied effects on men's health, from negative, to positive, to neutral (Garfield, 2010).

Emotional consequences related to the prospect of parenting for the father-to-be shows that he can feel unprepared, anxious, and experience role strain (Bartlett, 2004). The significance of the major change in life for a male first-time parent has been identified as a dominant stressor (Fägerskiöld, 2008). An Australian prospective study identified increased levels of stress during pregnancy and the first year of the child's life for first-time fathers (Condon et al., 2004). A large longitudinal study in the US of depressive symptoms amongst young men during the transition to fatherhood found that fathers experienced a decrease in depressive symptoms in the period before fatherhood, and then experienced a 68% increase in depressive symptoms through the child's first 5 years of life (Garfield et al., 2014). A study examining physical health and parenting identified that the time spent with children, the degree of worry about children, and satisfaction with the parental role had no influence on men's subsequent risk of death or diagnosis of heart disease, stroke, or cancer (Hibbard and Pope, 1993).

Anecdotal and qualitative studies in Australian Aboriginal and Torres Strait Islander communities have shown that the role of men as parents is valued as important to men's general wellbeing (Adams, 2006; Tsey et al., 2002). The positive health effect of parenting on men has also been documented in literature relating to African American men (Smith et al., 2015). The association between Aboriginal and Torres Strait Islander men's wellbeing and parenting may be explained by the intrinsic value of the male historical role and its relationship to child development, particularly in the initiation of older boys into traditional manhood (Walker, 1977). The importance placed on Aboriginal and Torres Strait Islander men to be strong role models for their sons and other children may be associated with this specific proclivity to embrace the parenting role (Read, 2000). It appears likely that the influence of western gender roles have altered the expectation of fathers and their partners regarding men as parents (Cabrera et al., 2000). Through exposure to western models of maternal and child health care, Aboriginal and Torres Strait Islander women may, for example, expect that their partners will now play a more significant role in assisting with the care of children, including babies and young infants. These assumptions currently have not been tested empirically in the Aboriginal and Torres Strait Islander context.

The objective of this study was to qualitatively analyse data gathered from stakeholders in communities where the SFSF program was being offered. The findings were intended to be used directly in the SFSF men's group intervention to promote male parenting, as well as to inform community health and welfare services related to male parenting and the care of babies, infants and children. Another aim is to enhance the limited literature on Aboriginal and Torres Strait Islander men's parenting. Participants in the study included the SFSF men's group facilitators and health and welfare workers from local Indigenous communities. Participants examined the challenges faced by fathers and the factors that enable men to engage in parenting roles. An additional study is currently investigating the relationship between parenting and Aboriginal and Torres Strait Islander men's mental health and wellbeing.

3.5 Method

Sample

To examine the challenges and barriers to parenting for men, 31 key stakeholders from across three Lower Gulf of Carpentaria communities were interviewed by the first author, an Aboriginal male project officer (See communities in Figure 1). The study was conducted in 2011 and all sites at that time offered the SFSF program. A qualitative method was selected because this was a hitherto unexplored area of knowledge and there were not many participants with the specialised knowledge required available to inform the study. The qualitative study complied with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007). Participants were from either men's groups or community health and welfare agencies with an interest in supporting men's parenting. They were recruited from a qualitative, non-probabilistic expert sampling approach, which included a snowballing recruitment process (Tashakkori and Teddle, 2003). Expert sampling enabled researchers to recruit natural experts with knowledge about men's parenting as participants (Gentles et al., 2015). A male facilitator from each men's group offering the SFSF program in the 3 participating communities was specifically recruited. In addition to the three male men's group participants, we prioritized the inclusion of expert knowledge and support for men as parents over the gender of selected participants. Participants were employed in Aboriginal health care and related programs servicing Indigenous families, such as maternal and child health, child safety, and social services. We located and invited participants with expert knowledge using a snowballing method. This method valued the knowledge of each participant and their capacity to identify other suitably informed participants.

For example, discussion about the project with one participant led to a discussion with another participant, who suggested the project officer speak with another participant, and so on (Salganik and Heckathorn, 2004). Two program sites are identified as Aboriginal communities, and one community had a high proportion (almost half) of Aboriginal people.

Participants in the study included 25 Aboriginal and Torres Strait Islander people, 16 males and 9 females with ages ranging from 25 to75 years, as well as 6 Non-Aboriginal and Torres Strait people, 2 males and 4 females with ages ranging from 40-60.

Table 1: Participant Profile

Communities	Participant	M/F	Aboriginal and Torres Strait Islander non-Aboriginal and Torres Strait Islander
Doomadgee	8	M= 4 F= 4	8 = Aboriginal and Torres Strait Islander
Mornington Island	11	M=9 F=2	9 = Aboriginal and Torres Strait Islander 2 = non-Aboriginal and Torres Strait Islander (Female- Child and Family Health Nurses)
Normanton	12	M=5 F=7	8=Aboriginal and Torres Strait Islander (5 female – 3male) 4= non- Aboriginal and Torres Strait Islander (2 female – 2 male)

This article is a secondary analysis of the SFSF program data and the primary report document, which has been published online by the program funders, the RFDS.

Process

Yarning refers to an Aboriginal and Torres Strait Islander way of verbally sharing knowledge (Geia et al., 2013). Yarning can include storytelling or discussions in groups, and is an important cultural method for sharing values, expectations, mores, and beliefs to younger generations (Geia et al., 2013; Nagel et al., 2011). Yarning has also become a recognised method for Indigenous research (Bessarab and Ng'andu, 2010).

In this study, yarning incorporated accepted principles of Aboriginal and Torres Strait Islander research practice, including respect for Aboriginal ways of knowledge sharing within the context of a standardised qualitative focus group approach (Wilson, 2003; Gwynn et al., 2015). The yarning session method enabled the application of rigorous qualitative research standards of a focus group, which involves a systematic approach to sharing ideas and knowledge concerning key areas of inquiry. Discussion was driven by a thematic focus on each of the research questions (Tong et al., 2007). This process is in keeping with reciprocal knowledge-building that is embodied

in yarning (Bessarab and Ng'andu, 2010). The facilitator encouraged exploration of ideas and questions around each theme. Emerging ideas and contributions could be refined or clarified, and new areas of inquiry could also be pursued within the group (Geia et al., 2013).

The key research questions applied in the yarning groups mirrored those applied in the SFSF program. Those areas of knowledge were originally derived from preliminary discussions with communities, and a piloted study with men's group participants. Research questions included: What are culturally appropriate family roles for men and women within their community? What are culturally appropriate processes to support men's engagement in antenatal, early childhood and family health care services? What are the barriers for men participating in antenatal, early childhood and family health care, and how can men overcome these barriers? How can men better access resources to allow them to increase their knowledge and understanding of participating in their children's and families' lives?

3.6 Ethics and consent

Data applied in this paper were collected as part of a program evaluation of SFSF that was funded and implemented by the Royal Flying Doctor Service (RFDS). The primary data from the evaluation is available online at www.flyingdoctor.org.au/what-we-do/research/. The RFDS requires strict adherence to its organizational research policy and research procedures, which are available to request at FederationOfficeEnquiries@rfds.org.au. All participants provided verbal agreement to participate after being fully informed about the reasons for their participation and the aims of the evaluation. The collection and secondary analysis of data from the RFDS described in this article was undertaken in adherence with its ethical procedures and standards. Ethical conduct during this study also adhered to the National Aboriginal and Torres Strait Islander Research Council and National Health and Medical Council guidelines, which are available at https://www.nhmrc.gov.au/guidelines-publications/e52.

3.7 Data collection and analysis

Data were recorded using an audio recorder with permission from participants. The groups were small, and the researcher kept notes on who was contributing comments throughout the discussion. Data were de-identified, except for the participant's role in the community. Data were transferred into text in preparation for analysis. De-identified data was kept in a locked computer in a locked office for the requisite time required by the Aboriginal Health & Medical Research Council

(AH&MRC). A thematic analysis of the dataset was conducted and resulted in rich descriptions of the dominant themes**.** Data was read line by line within the broad domains of the research questions as they were applied during the yarning groups. The dominant themes were identified according to the most common and the most strongly articulated issues. Views and perspectives relevant to themes were both contradictory and confirmatory. Data that was aligned with the themes were colour coded and further analysis of each comment was undertaken to fully understand and interrogate its meaning and relevance within the broader dataset. Two raters independently examined and coded the data and minor differences were reconciled by consultation. With only one source of data from the SFSF project, triangulation was undertaken by separately examining data from each of the three communities to confirm or challenge trends and conclusions (Tong et al., 2007). Findings from the three communities was confirmatory.

Using this method, knowledge was transferred from the 31 participants into thematic categories that could be applied to answer the primary research questions (Ward et al., 2009). A preliminary report on the data was crossed-checked with the participants before being revised and finalised (Lincoln and Guba, 1988; Tong et al., 2007).

3.8 Results

Men's business and women's business

It was identified that in the past family roles were determined strictly by lore, that is, men's business and women's business. This lore has now changed according to new ways of thinking and living post-colonisation.

An Aboriginal female participant declared: "in the old days, childbearing … and the raising of the children was only women's business" and that "…in the old days it was taboo for men to get involved in the upbringing of child – even childbirth – that was women's business". An Aboriginal male went on to state, "this was the period when men participated in the upbringing of only the male child, and not until the boy turned a certain age did, he become part of men's business through initiation". Here the male participant is referring to the initiation of male boys into men, known in this region as the *Bora Ring* Ceremony. It was lamented that these traditional practices seem to be less commonly practised within many contemporary Aboriginal communities, and that new expectations to help with babies and young children were now placed on men, often by health

authorities that influence new mothers' own expectations of men. In turn, men felt unprepared for these new expected roles and perceived a loss of their traditional role in passing on knowledge.

One Aboriginal male participant stated: "…the old ways for fathers was to pass their knowledge on … but that has stopped a long time ago." Nonetheless, it was also stated by several other Aboriginal male participants that they still undertake cultural practices such as traditional hunting, and through these practices men are still involved in sharing traditional knowledge, and therefore the upbringing of the children. Another Aboriginal male participant explained that the process still involves: "…taking them (children) fishing and going on country (traditional land) to camp and go back to the old ways" (SFSF report, 2016, p 3). Participants explored how western culture had changed the parenting roles of men and women. It was identified that only the men worked in the old days after colonisation, and the women's role was to stay at home and look after and raise the children. The men would only get involved if it had to do with disciplining the children (SFSF report, 2016, p 3).

An Aboriginal female participant's view was: "Once upon a time men were the breadwinners and women stayed at home [to] look after the kids". In contemporary society, this way of thinking is shifting, with more women being employed, creating an expectation of equal shared parental responsibility. In the modern context, it was viewed that the changed times had to be acknowledged and that young men now require support to take on the important role of parenting their young children and helping their partners more equally in the shared parental role. A non-Aboriginal female participant (Child and Family Health Nurse) explained that from her vantage point there are already many examples of young men successfully taking on this challenge: "Young fathers do stand out as playing a fatherly role towards their children." It was agreed that these young men should be promoted as role models and that these new approaches to parenting should be better understood and valued by all young indigenous parents.

Shame

The SFSF yarning sessions identified the importance of working in this way to shift the mindset of certain people in the community about the traditional parenting roles expected of men and women. This is a challenge because the value of men's business and women's business is seen to be needed to be upheld for traditional and cultural reasons. It was however stated that many men are merely acting on what they saw when they were growing up. Therefore, a newer approach to parenting may be better understood as a matter of transgenerational change, rather than as being

in opposition to tradition. It was suggested by several Aboriginal female participants that one of the reasons preventing men from taking on the role of parents is that they do not see enough role models or "good male leaders" as parents. Several male participants said that men feel 'shame' about their role as parents, an indigenous term used to describe an individual being embarrassed, and that through peer pressure to be "a real man", men feel reluctant to engage in parenting. Contextual factors related to colonisation, such as transgenerational trauma, gambling, alcohol, drug, and substance abuse were identified as factors that created stigma about the responsibility and capacity of male carers. These barriers to men engaging with their children and partners need to be acknowledged, and this stigma challenged in order to empower men to be confident fathers.

Overcoming shame

It was identified through yarns that men prefer culturally appropriate services that are run by Aboriginal and Torres Strait Islander men. An example included the Mornington Island Men's Group program, which provides spiritual, emotional, and social wellbeing related health information sessions. These sessions allow health educators to talk to men about their health and wellbeing in a culturally sensitive way where men do not feel shame. The spiritual, emotional, and social wellbeing component of the program encourages men to attend community centres that provide appropriate services for men, such as individual, family and community health programs. A non-Aboriginal female participant noted that participating men were either more confident to engage with a group, or that they became more empowered since their involvement in the group: "it looks like that men who attend the men's group are more engaged in the community than the other men who don't attend men's groups". It was also recognised that a culturally appropriate solution was to have service providers and community organisations employ local male leaders. These men act as role models within the community and provide culturally appropriate and informed advice for men who attend those services. An Aboriginal male participant said:

> "You know why men don't go along to community health… because they're all women. If we are going to be serious about getting men along to these services, they need to start employing local fellas; fellas who are seen as leaders within this community."

Leaders such as Aboriginal and/or Torres Strait Islander male health workers were seen to be the key to provide a culturally appropriate way for men to attend health services. One Aboriginal male participant stated: "We need to see more male black faces at the frontline of our Community Health Service here in Mornington Island". Furthermore, it was considered important for service providers to engage with and support male health workers to encourage and promote men's roles

as fathers, grandfathers, and uncles. As suggested by one Aboriginal male participant: "the male health workers there at Community Health should be supported by their boss to come along to men's groups and let the men know what services are being delivered up there" (SFSF report, 2016, pp. 4,5).

Using men's groups to promote male role models

It was said that the overall responsibility for men to be active in their children's lives should be determined by men themselves. For this reason, using a Men's Group as a place that promotes and respects male autonomy is a good mechanism for men to learn more about antenatal and early childhood practices and programs, and men's possible role in parenting. Men's groups were commonly suggested by participants as a way of harnessing men's self-sufficiency in a familiar setting to learn more about parenting. One Aboriginal male participant said:

> "Men groups are an ideal place for men to get some knowledge about parenting… Having men's shed (gathering place) and coordinated by someone who lives in the community… to advocate the roles of father involvement in their children's life…"

Another participant explained:

> "Men's groups are places where men [through support and education] can be confident when they may need to attend or actively participate in health services"

Men's group meetings were also considered to be possible safe places for fathers to take their children, where they could parent without concern related to shame or judgement by others. It was further articulated that men's groups have emerged in a diversity of ways, including men's gathering groups related to rugby league football. It was suggested by several participants that the ruby league players could be role models with regards to health screening, including for issues related to sexual health and the role of men in caring for children during early childhood. One Aboriginal female participant stated: "It's not only about playing footy, the players on sign up day also sign to agree to get regular health checks" (SFSF report, 2016, pp. 5,6).

Improving men's educational status

An overwhelming response by Aboriginal and non-Aboriginal participants about the challenges for participation by men in their children's upbringing was the lack of local and accessible information sharing processes related to men's roles as fathers, uncles and grandfathers within their communities. Lack of accessible information resulted in men distancing themselves from attending community-run parenting programs, including antenatal and early childhood development programs. It was also identified that the low numeracy and literacy levels of many men within communities creates low-self-esteem, and that this contributes to their alienation from health services that attempt to provide parenting knowledge. These issues are associated with the aforementioned feelings of 'shame' experienced by Aboriginal men. One non-Aboriginal female participant said: "more than likely, some men in this community don't attend training workshops because they can hardly read" (SFSF report, 2016, pp. 6, 7). Whilst improving educational status generally at a community level may take time, one non-Aboriginal female participant (Child and Family Health Nurse) suggested that at least "education" could just focus on the service that is being offered: "Through education and shifting the mindset of men [they can] understand that it is OK to attend health service[s] and participate in antenatal and early child development programs" (SFSF report, 2016, p 9).

Improving Service Delivery

Programs that focus on caring for babies and children should target both men and women. It was suggested that some government and non-government service providers lacked community engagement skills. There was a need to "get out and talk to community people." Participants also expressed the need for service providers to improve delivery by providing a culturally appropriate service for men. This reflects the need for more Aboriginal and Torres Strait Islander men to be trained and employed in these roles. One Aboriginal male participant stated that the services did not offer a "father friendly environment' and that "there should also be men working in that field… in parental programs."

The group, particularly the male participants, identified that programs such as antenatal care were too female focused and, in this way, they excluded men from participating. The yarning sessions identified that men felt isolated from parenting programs when the gendered name of a program automatically excluded men from having an active parenting role. For example, one of the dominant community programs is called "Mums and Bubs."

The group noted that the lack of funding generally meant that men may be resented for trying to get involved in programs that have been established for women.

Sharing knowledge through Men's Groups

Culturally appropriate avenues for knowledge sharing such as men's groups and men's gathering places are important sites to share educational resources about antenatal and early childhood issues. It was noted that there is a need to provide men with good opportunities to make informed decisions with regards to understanding and attending these programs. An Aboriginal male participant (Men's Group Coordinator) suggested that parenting can be incorporated into health sharing nights in the men's group: "we do leather work Tuesday nights, on Wednesday nights we have health talk where we invite health workers up to have a yarn about certain health issues." It was also suggested that local media such as radio, the local paper, and newsletters may be useful in promoting the parenting role and responsibilities of fathers, uncles and grandfathers. An Aboriginal female participant said: "we have a radio station here, [the] men's group should go there and talk about men's [responsibility to be] good dads". The group called on the support of local government and inter-agency collaboration to engage in a strategy to invite health service providers to attend men's meetings and provide educational workshops and support related to men's parenting (SFSF report, 2016, pp. 10, 11).

3.9 Discussion

This study has, for the first time, systematically identified barriers and opportunities to support Australian Aboriginal and Torres Strait Islander men's role as parents (Table 1 here). The study was undertaken by stakeholders working with parents and with men in remote Aboriginal and Torres Strait Islander communities. The study has highlighted the need for an awareness in services for men's parenting role, which may be impacted by traditional understanding of men's business and women's business, and additional difficulties in undertaking contemporary parenting practices.

Challenges for male parents included a low level of cultural sensitivity in maternal and child health services, which reflect a bias toward mothers being conceptualised as the primary parent, and a general absence of male Aboriginal health workers in the frontline of service delivery. Shame, predominantly experienced as embarrassment, and a lack of confidence around parenting were additional challenges. The lack of confidence in men as parents was associated with the absence

of support and encouragement for male parents in services. A general sense of disempowerment was associated with low levels of literacy amongst men. These findings highlight the importance of men's groups in providing a supportive male space and championing male parental role models in Indigenous communities.

The strengths and limitations of the study need to be considered. The inclusion of 25 Australian Aboriginal and Torres Strait Islander and 6 non-indigenous community stakeholders from 3 remote communities is rare in a systematic study of this hitherto unexplored field. The qualitative method proved to be invaluable in providing a detailed and rich account of this area of inquiry. The study findings were however exploratory and cannot be generalized to other communities. The findings were nevertheless instructive and clearly replication with representative populations of stakeholders is necessary. Whilst we included female participants because of their expertise and knowledge as community stakeholders, the male voice and perspective in relation to this topic could have been attenuated or influenced by their inclusion. Although we included 6 non-Indigenous Aboriginal community participants, we separately examined their data and intentionally prioritized the Aboriginal and Torres Strait Islander voice. The results offer guidance in developing policy and practice in the men's parenting and maternal health field, especially because there is a dearth of research focusing specifically on men in these contexts. Our findings of men's shame and disempowerment that associated with parenting, and the compelling non-Indigenous literature on male parenting and depressive symptoms, supports the need for research into Aboriginal and Torres Strait Islander men's mental health in the context of male parenting (Garfield et al., 2014).

The yarning data is able to be categorised according to biases identified in a global study that examined the relative exclusion of men from parenting interventions (Panter-Brick et al., 2014). Four categories of bias warrant consideration as a method for informing future policy and practice.

Cultural biases

Conflicting expectations of traditional and contemporary ways of parenting are not adequately understood or incorporated into current policy and practice. This study shows that cultural parenting practices such as fishing and hunting with older boys, as well as contemporary male parenting behaviours such as changing nappies and caring for infants, are both being practised. Whilst cultural parenting practices are considered at risk of being undermined by modern life and

expectations, contemporary parenting of babies and young children is culturally unfamiliar for many men. The cultural complexity of male parenting roles needs to be understood and valued. The styles and practices of male parents should be documented, and staff working in communities should be formally acquainted with this knowledge. Staff also need to be aware that Aboriginal and Torres Strait Islander men may not have sufficient confidence or knowledge to engage fully in the contemporary parenting role, and that support, and encouragement is required.

Institutional biases and Professional biases

Parenting and child-related services should explicitly reflect and promote the importance of male parenting, including having Aboriginal men at the forefront of service delivery. Services should not have gendered names such as "maternal and child health" and "Mums and Bubs." These gendered terms alienate men and exclude them from participating in parenting programs. Services should generally be strategically informed and culturally sensitive to the factors that may prevent, as well as encourage, men from engaging with them.

Content and Resources biases

Many any of the resources available to men were not culturally sensitive, and they were often not designed or delivered by Aboriginal and Torres Strait Islander men. Low literacy is associated with low self-esteem and 'shame' and together these factors prevent men from attending programs that offer parenting education. It is vital for parenting services to offer programs designed for men with very low literacy. From a broader policy perspective, governments need to prioritise improving Aboriginal and Torres Strait Islander men's literacy and numeracy, as this can have profound impacts on their psychological wellbeing and capacity to engage in health programs.

Policy bias

Policy is biased in favour of those motivated to engage with services. The level of disempowerment amongst marginalised groups, including Indigenous men, needs to be incorporated into policy. Empowerment theory would better inform the development of programs to include male parents (Wallerstein and Bernstein, 1994). Empowerment approaches focus on facilitating a structural analysis of factors that serve to undermine men's confidence in parenting, such as colonisation and its effects on men, racial disadvantage and marginalisation, and negative stereotypes about men and their use of alcohol and drugs. Empowerment approaches have been

reported to support men to establish positive thoughts, behaviour and emotions, to sustain positive change, and have the power to help others (Laliberté et al., 2012; Rees et al., 2004.). Ultimately, empowerment approaches need to foster community action to promote men's roles and family and community inclusion. Aboriginal and Torres Strait Islander men's groups, as well as other male support groups interested in strengthening the parenting role for men, should consider the issues that were identified in the yarns. It was aptly said that the parenting role strengthens father's identity; if you have strong fathers, you will have strong families, and if you have strong families, you will have strong communities.

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Chapter 4

The Parenting Intervention

4.1 The Aim of the Intervention:

The intervention 'A trial of a community-based intervention to support the active engagement of Aboriginal and Torres Strait Islander men in parenting, and to improve men's feelings of empowerment, reduce mental distress and reduce drug and alcohol use' aimed to increase knowledge of men's role as parents, increase feelings of empowerment and decrease mental distress, family conflict and reduce the use of alcohol or drugs. The study followed the guidelines published by Campbell et al., (2000) on conducting and evaluating complex community-based interventions. As such, the study assumed only small numbers of participants given the time required and the low level of funding available to the candidate. The intervention aimed however to meet the criteria of an exploratory trial, apply a pragmatic community-based design, and it aimed to ensure feasibility, cultural acceptability, and the potential to sustain the initiative. Finally, the intervention offered to set the stage for future definitive Random Control Trials (RCTs) in the field.

4.2 Research Questions

The intervention aimed to answer two questions.

1. Do men who attend a structured intervention program on parenting have improved knowledge and understanding of the male parental role?
2. Are men who engaged in the program more empowered, have lower rates of mental distress, reduced family conflict, and reduced (or are less likely to participate in) consumption of alcohol and drugs?

I hypothesised that men who participate in a structured parenting intervention will have an increased understanding of the role of men as parents and be able to identify benefits from their engagement in the role of parenting. I also hypothesised that men who learn more about parenting and begin to engage in parenting will have improved feelings of empowerment, lower rates of mental distress, reduced family conflict and reduced consumption of alcohol and drugs.

4.4 Theoretical Framework:

Personal ethics of practise

As an Aboriginal person, I will bring an Aboriginal lens to the research; I am committed to upholding strong ethical standards in research, including maintaining the dignity and respect of all the participants in this study. Therefore, being and knowing who I am, a strong *Badtjala (*Butchulla) man from *K'gari* (Fraser Island) and the Hervey Bay region, I aimed to bring to the study an Indigenous methodological approach. This approach embraces reciprocal relationships, culturally appropriate consultations, negotiations, networking, respect, recognition, involvement, benefits, outcomes and agreement with the fathers, grandfathers, uncles, and relevant service providers involved in the study (NHMRC, 2003). This study aimed to ensure an Indigenous perspective, informing both Indigenous and western traditions with an interpretation through the lenses of Aboriginal and Torres Strait Islander men and myself: *ways of knowing, ways of doing* and *ways of being* fathers, grandfathers and uncles; an Indigenous methodological approach (Martin & Mirraboopa, 2003).

4.5 Methodology

The study was informed by Campbell et al., (2000) who described a 'Framework for design and evaluation of complex interventions to improve health'. The Campbell et al, proposed model reflects the importance of different stages, or components of a trial as useful contributions, and that each plays a role in the evolution of a process towards the ultimate randomised control trial. This model supports the view that an exploratory trial is seen as an important component in its own right, and importantly where lessons can be learnt from the process in developing, and implementing the trial, rather than merely establishing whether or not the controlled trial showed positive results (Campbell et al., 2000). This rationale set the scene for me to conduct my study, as an exploratory trial, with the knowledge that each step in the process, from a literature review, scoping and rationale, community engagement in the study and onward, had the potential to inform a future randomised controlled trial of the intervention for Indigenous communities. And, that each stage of the intervention process, could stand alone as a contribution to this thesis.

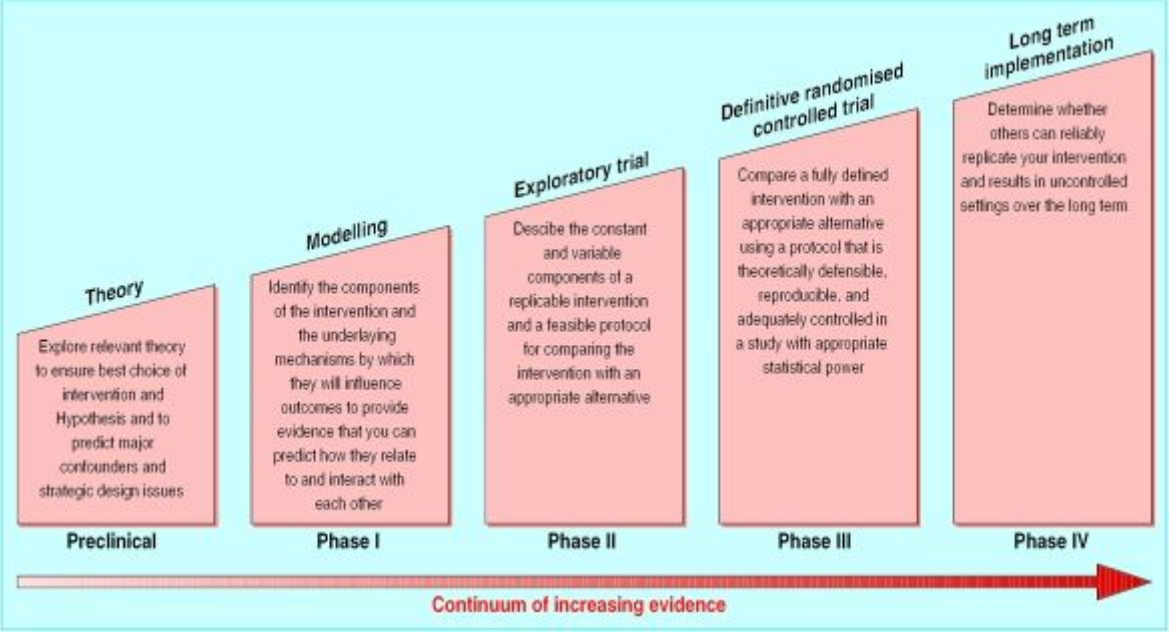


Figure 1 Sequential phased of developing randomised controlled trials of complex interventions (Campbell et al., 2000)

I aimed for my intervention to be guided systematically to the stage of Campbell's identified Exploratory Trial. In this thesis, I have detailed the key stages including the theory building in Chapter 1; the literature review in Chapter 2; the guiding research questions, and rationale for a men's parenting and mental health intervention, including an examination of key areas that may influence outcomes for an Intervention in Chapter 3; the method and detail of the intervention, and the control group program in Chapter 4; and the findings of the exploratory trial in Chapter 5. Chapter 6 is centrally important because it reflects, as an exploratory trial should, on what worked, and what didn't in terms of answering the research questions related to the efficacy of the parenting intervention.

I also note that my study is a pragmatic community-based intervention, and not a laboratory-based trial. Whilst, the science is equally important in both, the factors that can impact a community-based intervention are less be anticipated and controlled (Sushames, 2018). Therefore, a flexible approach is required to adjust and account for changed variables during the trial process (Jolley, 2014). This indeed, occurred when I was able to only recruit small numbers of participants in the timeframe available to be for this PhD study. The results were positive however, the aim was for it to set the groundwork for a more definitive randomised controlled trial of a larger intervention program building in a longer follow-up period to test any positive changes over time. I took a systematic approach to this study because it had never been done before, and because I wanted to

modify the non-Indigenous approach to a randomised controlled trial by ensuring that intervention included a holistic approach with three areas of focus, which all form part of this PhD thesis:

1. A systematic review of the literature with a focus on First Nations men's parenting programs
2. An examination of the challenges and barriers to men's parenting from which to inform the intervention.

3. The intervention: 'A trial of a community-based intervention to support the active engagement of Aboriginal and Torres Strait Islander men in parenting, and to improve men's feelings of empowerment, reduce mental distress and reduce drug and alcohol use.'

I applied a qualitative descriptive (QD) approach for the analysis (described in the analysis section below), knowing that I may feasibly only have the time to recruit small numbers into the intervention, and that, along with answering the research questions, it was also important to describe the research process, the acceptability, and the feasibility in the Indigenous setting.

Theoretical frameworks

This study is informed by a genuine collaboration among First Nations community members, and me as a researcher, in each of the research or intervention stages. These stages included identifying the goals, research questions, methods, interventions, data analyses, interpretation and dissemination of results (Farwell & Cole, 2001; Goodkind et al., 2017; Wallerstein & Duran, 2008). This process is critical to good practice research in Indigenous communities, and it is paramount in ensuring that the intervention intends to improve the lives of the targeted persons, and their communities without doing any harm (Goodkind et al., 2017; Wallerstein & Duran, 2008).

The ***critical*** theory also informs this study was applied from an Aboriginal perspective, providing a critique that acknowledges the disadvantages of Aboriginal and Torres Strait Islander fathers, grandfathers, and uncles, with a commitment to bring about social and political change. The critical methodology enables me, as the researcher, to temporarily disengage from impartiality as a researcher. Candy (1989) states that the critical approach vacates every pretence of neutrality, and acknowledges that ethics, morality, and politics are enmeshed with personal knowledge, allowing individuals (researchers) to position themselves to what is right and just in each situation. This approach, therefore, allowed me to apply the research findings to my work with men's groups and

relevant health and wellbeing service providers to address culturally appropriate paternal service delivery.

A ***critical*** approach challenges structural inequity and reveals the socially constructed foundations of disadvantage (Green & LeBihan, 1996). This method therefore offers the opportunity for politicised awareness, and therefore empowerment to occur as an outcome of the research. Aboriginal and Torres Strait Islanders understand empowerment as a healing journey, providing them with the evidence and therefore the power to control past and current situations influencing their lives. Being empowered also facilitates the capacity to voice injustices and solutions, and therefore to critically bring about social and political developments to achieve true change (Tsey et al., 2007). From my experience working with Aboriginal and Torres Strait Islander men over the years, it is evident they believe that to truly have the opportunity to be nurturing fathers, they need to access realistic educational programs (Reilly, 2008).

They believe that accessing educational programs will empower them and provide them with the knowledge to enhance their roles as loving, caring and supportive fathers, grandfathers, and uncles. A Critical approach will, therefore, allow me to focus on structural inequalities and to collaboratively work with fathers, grandfathers, and uncles within an empowerment context. An outcome will be to facilitate paternal strategies that will assist men to participate in shaping and accessing relevant community services, including parental child and family health programs.

4.6 General Points of Relevance

There is a gap in the literature, with very limited detailed systematic research to provide an understanding of the roles and responsibilities of contemporary Aboriginal and Torres Strait Islander experience as parents (Tsey et al., 2002). Nonetheless, it has been noted that, in the Indigenous context, nurturing environments and the specific role that fathers, grandfathers and uncles play may contribute to improved wellbeing of men (Adams & Danks, 2007; Tsey et al., 2004). Men's roles as parents can also provide them with responsibility and value as they nurture and protect their children. This may have been disrupted as a result of colonisation and the removal of children from their parents (stolen generations). Wellbeing is applied in this context to mean a general state of psychological strength and capacity, and the absence of mental disorder. There is also evidence that fathers can play an important role in the early development phase of their children (Maslen, 2005). In the non-Indigenous context only marginally, more is known about how men learn to be fathers, either from their own parents, from parenting classes, or their own

experience (Cowan et al., 2009; Daud et al., 2005; Sack et al., 1995) (Daly, 1993; Tanfer & Mott, 1998). It has been noted that cultural and social changes have weakened the connection between masculinity and the expectation of responsible fatherhood (Marsiglio,1998). Certainly, experiences of colonisation, westernisation and modernisation may well also have impacted significantly on the notion and experience of parenting for Aboriginal and Torres Strait Islander men. The analysis of nine identified studies (see data analysis) was carried out using a meta-synthesis approach, forming the study's Literature Review.

Setting:

The two participating Aboriginal communities were: Doomadgee in the Lower Gulf of Carpentaria region, and Mossman Gorge in the Far North Queensland region. Aboriginal people are not homogenous, and there are many tribes with different cultural beliefs and traditions. Communities in North Queensland are often home to people who were forcibly removed from their traditional lands, as well as traditional owners. The two communities in this study are historically typical of the evolution of contemporary communities today, including that they were originally established as Missions. It was the aim of the invading Europeans to control the Indigenous people of Australia. Loos argues that the Missions were fully intended as a mechanism of control, because the belief was that Christianity was essential and that Aboriginal people needed to convert – including their beliefs and how they acted (Loos, 1991; Loos, 1975).

Community Profiles:

Doomadgee

Old Doomadgee was settled as a Christian mission in 1933, on the coast of the Lower Gulf of Carpentaria at Point Parker, known to the Traditional Owners as Dumji. In 1936 the Old Doomadgee mission was flattened by a tropical cyclone, and a more suitable site was established inland, at the current location on the banks of the Nicholson River. There are two main peoples (tribes) coexisting on this land: Waanyi and Ganggalidda. The Doomadgee mission ceased operation in the early 1980s and was handed over to the Queensland Government, becoming a Deed of Grant in Trust (DOGIT) community. Since 2005, the Doomadgee community has become a Shire Council, with local people (Waanyi and Ganggalidda) becoming councillors leading policies and practices for a current population of 1405. Doomadgee is located 992 km west of Cairns in Far North Queensland (Akehurst, 2006; ABS Doomadgee Census, 2016; Wikipedia.org/Doomadgee, Queensland, 2021).

Mossman Gorge

Mossman Gorge Mission was established around 1916, with the lands belonging to the Eastern Kuku Yalanji people. The mission was governed by several different religious dominations, including Assemblies of God, Australian Inland Mission, and the Brethren Church. In 1995, the missionaries walked off the Mossman Gorge mission leaving it as itinerant, meaning the people travelled in and out of the near township of Mossman. In addition, unlike Doomadgee, Mossman Gorge was never placed under the DOGIT Act, and is not a shire. The community is governed by the Port Douglas Shire Council, with a population of 246. Mossman Gorge/Mossman is located 78 km north of Cairns in Far North Queensland (ABS, Mossman Gorge Census, 2016; Wikipedia.org/Mossman Gorge, Queensland 2021).

Sample size:

The outcome measures for this study are both continuous and dichotomous (categorical), so that power estimations and sample size estimates would, if the sample size allowed, need to be based on these and other considerations, such as size of the populations in each site and prior relevant research findings (Gao et al., 2015).

For this pragmatic intervention, sampling was not randomised and given the small size of the communities, all men interested in the program who met the criteria participated. I decided to recruit as many men from each community who met the criteria as I could, within a certain timeframe a qualitatively pragmatic method for recruiting. The final number from each community was 31, with dropouts due to transitory behaviour (moving from community to community), incarceration, sorry business (deaths and funerals), seasonal reasons (i.e., due to wet season, men were stranded in other communities and could not get home). The number was sufficient to achieve the aims for a feasible, pragmatic intervention pilot that would be qualitatively described and replicated by community-based workers or researchers (Conn et al., 2010). The sample size was suitable for qualitative thematic analysis of the measures, which is described below (QD).

Qualitative Description

Qualitative Description (QD) is a distinct method of naturalistic inquiry that uses low inference interpretation to present the facts using everyday language (Sandelowski, 2000). The goal of QD is not thick description (ethnography), theory development (grounded theory) or interpretative

meaning of an experience (phenomenology), but a description of the findings, in this case the intervention findings, depicted in easily understood language.

The main aspects of QD applied to this intervention analysis were to assess trends in the findings; that is, compare qualitatively the findings from the intervention measures to establish if it appeared that the intervention group improved on the measures.

Data was entered into NVivo, and descriptive analysis conducted to examine responses according to the level at which they were endorsed and compare whether changes had occurred pre- and post-intervention, as well as compare any changes in the control group with the same measures (see analysis section above. Consistent with the QD approach, I used a 'quasi-statistical' analysis method, using numbers and my observations to summarise the descriptive statistics (Sullivan-Bolyai et al., 2005).

Method

Eligible men were adults over the age of 18 years, with at least one child in the age range of 3 to 18 years. Noting that probabilistic, community recruitment based on epidemiological principles is not feasible in this setting, men were recruited by word-of-mouth; a process initiated by community health workers and existing men's group coordinators, leading to a snowballing effect throughout the communities. Exclusion criteria for men included overt severe mental illness, and those not included will be referred to appropriate agencies.

Information provided to all local personnel, participants and to the wider community avoided creating the impression that one group condition is superior to the other, emphasising that the intervention focus concerns learning from others about how to respond to problems in everyday life. This veiled approach was intended to ensure, as far as possible, that there is reduced bias in perceptions of the value or expected efficacy of each of the two group conditions. In future interventions where randomisation is applied to sampling, it is recommended that a block design conducted by an independent statistician using Stata software should be used. Data was collected by the independent assessment team blind to the intervention condition at the three time points (refer to the timeline below); males interviewing fathers. Training, reliability checks, and fidelity of data gathering, and data entry were extensive and ongoing. The importance of privacy and confidentiality was repeatedly emphasised in the men's parenting groups.

Men were reassured that they were not being judged as parents and that all data from those interviews would be de-identified. Being the PhD student, I trained the recruited male facilitators to deliver the group intervention, which was manualised (see Appendix 1, and see the description below).

Training of the facilitators and research assistants

Facilitators were trusted men from each community who were already facilitating men's groups in each site. I trained each one individual, to conduct the study, and use the intervention manual. The following process was followed:

1. Facilitators committed to a full week of training to understand the study, and the use of the manual. The training process included the following areas: a). The rationale and intention of this study. This included the importance of men's parenting, and the aim of the intervention. b). Why scientific rigour is important to seeing if the intervention works, and why we follow the process that we do. c). Research ethics, confidentially and safety. d). How to identify if men need support or help during the study.

2. In addition, the Research Assistants had training in using the mental health and wellbeing measures. This was also over one week, and involved extensive practice with the PhD student

3. As the PhD student (and supported by RFDS- Qld Section) I was able to play a hands-on role in each site to oversee, and support all the facilitators, Research Assistants and participants.

The measures (described below) were applied by face-to-face interviews with trained local research assistants under the supervision of myself as the PhD student. The measures were used before and up to three weeks after the intervention of each participant to identify if the manualised intervention had changed any of the outcomes that were anticipated, including knowledge of parenting, empowerment, mental wellbeing, alcohol use and family violence. All standards described below, with respect to cultural practices in research (including confidentiality, privacy and safety) were adhered to. *[see in more detail the importance and detail of cultural research practices below, Ethical Consideration sections]*

The description here of the content and process for the Parenting Intervention (PI), and the control intervention (Yarning Relaxation) details the intervention process. This is to be read along with the intervention manual which is attached as an Appendix.

Content and process of the parenting intervention (PI)

The manualised intervention is ideally intended to be used by fully trained, locally recruited facilitators. The manualised intervention runs over five sessions. The locally recruited facilitators in this case were supervised by me as the PhD student, with the direct support and involvement from my mentor Uncle Mick Adams (expertise in Indigenous men's health) and my PhD Supervisor Professor Susan Rees. Extensive qualitative work with Indigenous men on parenting and men's mental health informed the iterative process of refining the content and format. The manualised intervention sessions target the barriers and enablers to parenting that have been identified in the qualitative research, including historical and contemporary social factors. These factors include discussing positive images of fathers in society; connecting at an emotional level with children; the negative impact of stolen generations and related dislocations; lack of role models; intergenerational trauma; alcohol use and unemployment). The emphasis is on 'Dad's Strengths' and their intrinsic capacities and resources (personal, familial, communal, traditional) to overcome obstacles to their being caring and sensitive parents to their adolescents.

Using the group dynamic, the men discuss and share their skills and strengths as parents. The facilitator takes notes (mental or written), summarising and reflecting on key points of learning and consensus, with an emphasis on being positive, affirming, and empowering. Included in the discussion are immediate living issues facing the men, shared strategies to address them, and the general principles of addressing obstacles, providing learning for all participants. A substantial focus is on contemporary parenting expectations in a context of cultural transformations, and how to integrate the positive aspects of traditional approaches with changing expectations and mores within an evolving society.

Consideration is given to the array of services in the community, experiences (negative and positive) in engaging with these agencies, the problem of bias against male parents, and ways (collective and individual) of addressing these misconceptions and encouraging an approach that is inclusive of fathers. The strengthening of the parent-child relationship is considered one of the keys to advancing social and emotional wellbeing. Exploring these more enduring relational

qualities is emphasised in the process of sharing cultural experience and knowledge. The deeper transformation achieved in increasing men's confidence and sensitivity to the emotional needs of their children and partners was frequently referred to as a turning point by men in the pilot Strong Fathers program detailed in Chapters 2 and 3 in this thesis. This achievement is regarded as a point of substantial empowerment by men, in that regaining the capacity to parent effectively acts as a protective change which allows them to begin to feel in control of other areas of concern in their lives; for example, their reactions to past trauma and, for some, the use of alcohol to deal with stress, and a greater respect for their partners. This rationale supports the selection of the measures used in the intervention, detailed below (The World Health Measure for Domestic Violence). The coherence that the process brings to their lives restores a sense of meaning and purpose which renews feelings of empowerment. Homework sessions in intervention group relate directly to engaging the child. This focus is not only on implementing specific parenting techniques but also on men being consciously aware of becoming attentive, sensitive, caring and helpful to their children. In subsequent sessions, men discuss and share the successes and setbacks they have experienced in these efforts, supporting each other in taking the next steps to consolidate the knowledge gained.

Content of comparison Yarning-Relaxation group (YR):

As a PhD student in my Strong Families Project Officer role with the RFDS, I designed and implemented a primary health care program based on a men's group format, which aimed to build genuine, sensitive, trusting, and culturally appropriate relationships amongst Indigenous men, and to use that forum to share health-related knowledge. This was used for the comparison condition because it was tested and culturally accepted. It is based on the tradition of ‘yarning’ coupled with a component of relaxation training. Men meet for the same number and duration of sessions as the Intervention group, in a safe, social setting where they are supported in yarning (discussing) issues that affect all aspects of their lives.

The facilitator uses general counselling and group dynamic skills by encouraging mutual respect, listening, positive interactions, support, and the opportunity to express feelings and concerns without being judged or censored. Two structured and tested sessions of stress management are administered to the YR group. There is not a special focus on parenting, although spontaneous discussion of the topic will not be discouraged. If a parenting related matter arises, it will be documented and discussed generically without the empowerment focus on enablers and barriers.

Ethics and cultural advisors:

At the same time as adopting a pragmatic intervention approach, the design ensures that the content of the program is embedded in, and highlights, an understanding of the consequences of trauma and social marginalisation experienced by Indigenous communities (Kwaymullina, 2016). In that sense, I have reconciled the need for scientific rigour with a commitment to social justice and a culturally sensitive framework of intervention, ensuring strict adherence to the Indigenous protocols governing research practice and community engagement (for example, respecting Sorry Days) (Sabag & Schmitt, 2016). Conducting research within an Indigenous setting risks diminishing respect for Indigenous world views and culturally valid sources of knowledge generation that do not conform to mainstream society epistemologies (Smith, 2006). Strict intervention designs without accompanying community development and inclusion activities risk producing rarefied findings that do not consider local skills or the wider historical and structural factors that influence mental health (Smith, 2006). My engagement with the two communities, in which there has been extensive knowledge sharing (bidirectional), has, on the contrary, demonstrated a rich, Indigenous-led awareness and keenness to pursue rigorous research that can validate effect.

Measures:

Measures are used to test whether the intervention has been effective. If the sample size is large enough, comparisons can be made with changes in the measures, applied before and after the intervention, between the intervention group and the control group. Within each group, changes can also be examined to see if the same men who took part in the intervention changed after it.

The measures in this pilot intervention were used before the intervention and within three weeks after it. The following measures were selected based specifically on their centrality to answering the research questions; previous validation in Indigenous populations or across cultures; assessment of their cultural sensitivity; relevance and ease of use by local Indigenous workers (rather than clinicians); and suitability for use in routine health services for the future. Measures are selected to answer the research questions most effectively.

Men's Parenting Knowledge, Attitudes and Beliefs (Answers Research Question 1)

As the author, I designed this measure based on knowledge gained from running men's groups on topics such as parenting for many years and following a thorough appraisal of the literature and the theory (contained in the previous chapters herein). The measure examines men's parenting

knowledge, including barriers and enablers. This measure is closely aligned with the content of the SFSF intervention as detailed in the manual and from early data from our ongoing study. It demonstrates sensitivity to the manual's learning outcomes. Testing has demonstrated a high level of comprehension and acceptance.

Growth and Empowerment Measure (GEM) (Haswell et al., 2010) Psychometric validation of the GEM applied with Indigenous Australians (**Answers Research Question 2**): The GEM measures empowerment and mental health. Quantitative Measures: *Pre- and Post- Measures.* All measures have been tested in similar settings and are considered culturally appropriate for Aboriginal and Torres Strait Islander men.

Growth and Empowerment Measure (GEM) (Haswell et al., 2010; Berry et al., 2013)
K6 (in the GEM), AUDIT Drug and Alcohol measure. Personal assessment of actual engagement in parenting since the beginning of the program using a Knowledge, Attitudes and Beliefs interview about Aboriginal and Torres Strait Islander parenting. This interview includes questions related to men's roles; the potential benefits of men's parenting for men, their partners, and their children; barriers to being active parents and a standardised and culturally tested measure for family conflict.

The GEM is an instrument developed with Aboriginal and Torres Strait Islander communities. The GEM assists people in identifying where they feel they are in relation to fundamental aspects of empowerment. The outcome measure used in the GEM is the Kessler 6 Distress Scale (K6), with scores with and without two additional items added through the development of the GEM, to include how often people feel 'happy in yourself' and 'angry at yourself or others' (K6 plus 2). The usage of the psychometric validated GEM, an empowerment-measuring tool, will also be used as a guide to analyse mental health, including the social and emotional wellbeing and empowerment level of participants.

The Alcohol Use Disorders Identification Test (AUDIT) (Answers Research Question 2)
The AUDIT is a 10-item alcohol screener that has been recommended for use in Aboriginal primary health care settings (Calabria et al., 2014. Identifying Aboriginal-specific AUDIT-C and AUDIT-3 cut off scores for at-risk, high-risk, dependent drinkers using measures of agreement with the 10-item Alcohol Use Disorders Identification Test).

The World Health Measure for Domestic Violence (Answers Research Question 2)

The World Health Organization (WHO) measure includes items inquiring into physical, psychological, and sexual violence perpetrated by a current or past intimate partner. We used these items to inquire if men had perpetrated them. One item asks if the men had been victim of family violence, when and by whom (Garcia-Moreno et al., 2006; García-Moreno et al., 2013).

Risk Management Plan

Ethical approval for the intervention was gained from Aboriginal Health and Medical Research Council (AH&MRC) NSW, HREC REF number 1207/16. It was not anticipated that this study would invoke any negative consequences to past Aboriginal paternity roles. Preliminary work focusing on men's parenting in a men's group setting has in fact shown to be a positive and empowering experience for men. The participants were asked to talk about experiences of parenting, the roles men's groups played, and the ways in which men's groups can support men to be nurturing fathers. The participants were not asked about any negative personal experiences of their children's upbringing, or if they had experienced a negative upbringing themselves.

The local community facilitators were trained to identify and respond to personal disclosures to the group, or outside the group, that may require psychological or emotional support or intervention. Any evidence of the need for urgent mental health care was responded to by way of a standardised and tested safety procedure. Although trained to identify distress, our facilitators are not mental health professionals and are not intended to act as mental health professionals. The key steps in the procedure that facilitators were trained to follow include: 1. Identify evidence of psychological distress, depression, suicidal ideation, or other need for intervention. 2. Provide information about services and supports, and support the person to access these, or to take steps to access them. 3. Refer to supervisors and discuss the process with supervisors. 4. Follow up with the participant to ensure that he is OK and that he is engaged with a professional mental health service. 5. Support the person to connect with at least one key support person in his family or community. 6. Ensure that the participant or his support person has emergency contact numbers available to them.

Ethical Considerations

The intervention acknowledges and abides by the three Principles of Ethical Research in Aboriginal and Torres Strait Islander studies: consultation, negotiation, and mutual understanding;

respect, recognition, and involvement; benefits, outcomes, and agreement. As an Aboriginal person, I am committed to upholding strong ethical standards in research, and in maintaining the dignity and respect of Aboriginal and Torres Strait Islander peoples.

This study aligns with the following strategies.

- NHMRC Road Map 11 (2010) 'A Strategic framework for improving the health of Aboriginal and Torres Strait Islander people through research' research principles.

- Council of Australian Governments (COAG) Closing the Gap targeted measures; Indigenous life expectancy, health, housing, education, and employment, will be supported under seven strategic platforms, as a means of meeting these targets.

1. Early childhood
2. Schooling
3. Health
4. Economic participation
5. Healthy homes
6. Safe communities, and
7. Governance and leadership

(Closing the Gap on Indigenous Disadvantage, 2009)

My study particularly relates to points 3 and 5 above, although it is also relevant to points 6 and 7, as the study also focuses on family violence and alcohol reduction, as well as building First Nations leadership in conducting health and mental wellbeing interventions.

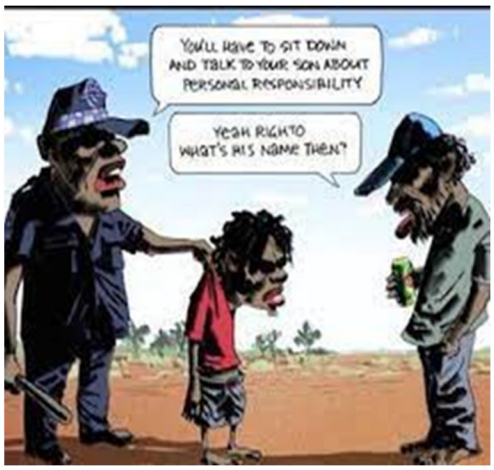
Safety issues are paramount for the researcher (PhD student), the community and participants. The following principles were adhered to.

As a PhD student, I always carried a mobile phone and, in the unlikely event that a participant became upset about the issues of parenting experiences (or any other identified distress), the participant was able to use it to call an appropriate and previously identified support person. I organised, in advance, an Aboriginal Health Worker and/or Indigenous counsellor to be available by telephone throughout interview sessions and for future referral if appropriate.

If for any reason distress was caused or arose, I immediately contacted an Aboriginal Health Worker and/or Indigenous counsellors, or culturally appropriate counsellors from Community Health Centres (including local Wellbeing Centres). The purpose for citing these organisations is that counsellors (either voluntary or employee) are accredited counsellors. I also consulted my supervisor, Professor Susan Rees, who has extensive experience working in Indigenous communities in the health field.

The following is a statement addressing the five AH&MRC criteria in relation to net benefits for Aboriginal people and communities.

The research aims to benefit individuals and communities by identifying strategic points of action that are evidence-based to influence policy and practice related to men's social and emotional wellbeing. Most importantly, this is a unique area of study in an area that has received little attention or acknowledgement. In fact, recent representations of Aboriginal and Torres Strait Islander men as parents in the media has been negative and racist, as depicted in Bill Leaks cartoon in the Daily Mail below.



Bill Leak cartoon in Daily Mail, 2016.

There is a vital need to support interventions or activities that aim to redress and challenge this negative portrayal and improve the image of Aboriginal and Torres Strait Islander fathers. The very process of this study aims to validate men's roles as parents, elucidate the challenges, and support men to be involved with their families in ways that are positive for their mental health and wellbeing, and the wellbeing of their children, families, and communities.

The study also aims to promote mental health-enhancing strategies in the context of men's parenting, and it embodies strategies to transfer knowledge back to communities, and to learn from participant and community feedback during the process of an intervention. Positive feedback can bring communities together to apply for future support in implementing it more widely.

The research applies a pragmatic systematic method that is used in community-based trials, which is the first of its kind applied in this setting.

Based on existing qualitative research and testing with Aboriginal and Torres Strait Islander groups, the intervention applies culturally appropriate practices, and it acknowledges impacts of colonisation and marginalisation on men's roles as parents.

The intervention study also acknowledges men's strengths, existing knowledge, and capacity, and it aims to engender and measure changes in feelings of empowerment (Tsey et al., 2007). An empowerment measure (GEM) tested in similar settings was used (Haswell et al., 2010). In addition, through an exchange process with the participating men's groups and communities, the research process is intended to champion and draw attention to the meaning and importance of Aboriginal and Torres Strait Islanders men engaging in the upbringing of children in their care, and to provide a deeper understanding of the roles and responsibilities of Aboriginal and Torres Strait Islander men as parents within a contemporary society.

Aboriginal Community Control of Research

This intervention is developed and designed by me as an Aboriginal PhD student having worked extensively in the target communities developing and supporting men's groups for over six years. During my employment with the RFDS Queensland since 2012, I had been working on projects related to a program known as 'Strong Fathers Strong Families' in the Lower Gulf region of Queensland. The sites wrote letters of support to trial this intervention in each community. A priority when conducting the intervention is to provide the participants with an information sheet explaining the aims of the research, as well as to ensure that all participants in the research have signed consent forms. Full understanding of the study is checked by way of verbal discussion with each person prior to asking for their consent to participate. Prior to the intervention, the participants were informed that they have the right to say no to being interviewed, or withdraw from the research at any time without giving a reason or feeling judged about saying no. In addition, the participants were asked for their approval that all collected data is true and correct before it is placed into any reports or publications. No identifying information was or will be reported in any form, and all participants were assured of confidentiality. In addition, as the PhD candidate, I provided continuous feedback of emergent findings to Aboriginal and Torres Strait Islander men and relevant service providers associated with this research. The study offers an opportunity for the Aboriginal and Torres Strait Islander male parents, relevant health and wellbeing service

providers, and the PhD student as the primary researcher, to produce change by working together in an equal and mutually respectful relationship.

Cultural Sensitivity

As an Aboriginal man, I am acutely aware of and honour Aboriginal and Torres Strait Islander people as custodians of their cultural knowledge, and have the right to be involved with research, protection, and distribution of their knowledge. Therefore, being and knowing who I am, a strong Badtjala man from K'gari and the Hervey Bay region, I bring to the study an Indigenous methodological approach. This approach embraces reciprocal relationships, culturally appropriate consultations, negotiations, networking, respect, recognition, involvement, benefits, outcomes and agreement with the fathers, grandfathers, uncles and relevant service providers involved in the study. This study provides an Indigenous perspective, informing western traditions with an interpretation through the lenses of Aboriginal and Torres Strait Islander participants and my own lenses: *ways of knowing, ways of doing* and *ways of being* – an Indigenous methodological approach (Hart, 2010; Martin, & Mirraboopa, 2003).

Reimbursement of costs

The men employed as facilitators and as participants were paid for their time. Facilitators were paid to engage in training, conducting the intervention and for conducting pre- and post-interviews. (Refer to the section on training of facilitators' section – pages 60-62)

Data Management

A priority is to ensure that all individuals participating in the research have signed consent forms. In addition, as the PhD student, I informed participants that no identifying information would be written on any of the interview materials, and nothing that identifies individual participants will be used in any reports or disseminations. Throughout the life of the project, interview materials have been kept in locked cabinets on secure premises of the University of New South Wales. Only the PhD student has access to the interview materials, and after final dissemination, the interview materials will remain in locked storage on University of New South Wales premises for a period of five years.

Dissemination of Findings

In addition to contributing to the literature in this field, my study will also provide the groundwork for future Indigenous researchers to replicate this study with larger samples. The aim of the PhD at a more micro level is to provide continuous feedback of the emergent, as well as the final, findings to Aboriginal and Torres Strait Islander men and relevant service providers associated with this research, such as the RFDS Cairns-based managers, and Child and Family Health nurses. The researcher's privileged tenure as a health worker with RFDS at the time of the study allowed access to work within Aboriginal communities on projects that strengthen Aboriginal men's roles as fathers, grandfathers, and uncles. Thus, the findings of this research will also be disseminated through this service to the relevant communities and continue to inform my practice. In addition, findings have already been presented to national advisory groups, such as: Andrology Australia and Men of Malvern (who provided funding for the PhD); and the Aboriginal and Torres Strait Islander Men's mentors, especially Uncle Mick Adams. Additionally, an overview of the study and initial findings will be presented at National Indigenous Men's Health Conferences.

Summary of the Final Recruited Cohort

The Intervention trial commenced late November 2016, in Mossman Gorge Aboriginal community at the RFDS Mossman Gorge Wellbeing Centre. In early 2017 the trial started in the Lower Gulf of Carpentaria Aboriginal community of Doomadgee in the Men's Shed. In total there were nine intervention group members, (five Doomadgee – four Mossman Gorge), and five control group participants (three Doomadgee – two Mossman Gorge) (see below for cohort demographics). All men successfully participated in the pilot study, including completing all four data collection surveys: GEM, Parenting Knowledge and Attitudes, Domestic Violence and Alcohol and Drug Audit.

Table 1: Cohort Demographics

Participant ID	Community	Age	Number of Children	Ethnicity	Group	Completed
DMG	Doomadgee	59	Approx. 4	Aboriginal	Control	NO
DMG-2	Doomadgee	48	6	Aboriginal	Intervention	Yes
DMG-C1	Doomadgee	45	Approx. 3	Aboriginal	Control	Yes
DMG-1	Doomadgee	29	3	Aboriginal	Intervention	Yes
DMG	Doomadgee	30	2	Aboriginal	Control	No
DMG	Doomadgee	22	1	Aboriginal	Control	No
DMG-5	Doomadgee	25	1	Aboriginal	Intervention	Yes
DMG	Doomadgee	24	Approx. 2	Aboriginal	Control	No
DMG	Doomadgee	24	Approx. 1	Aboriginal	Control	No
DMG-3	Doomadgee	28	2	Aboriginal	Intervention	Yes
DMG	Doomadgee	44	Approx.4	Aboriginal	Control	No
DMG-C2	Doomadgee	20	1	Aboriginal	Control	Yes
DMG	Doomadgee	24	2	Aboriginal	Intervention	No
DMG-C3	Doomadgee	18		Aboriginal	Control	Yes
DMG	Doomadgee	51	Approx. 4	Aboriginal	Control	No
DMG-4	Doomadgee	18	1	Aboriginal	Intervention	Yes
DMG	Doomadgee	18		Aboriginal	Control	No
MG-2	**Mossman Gorge**	35	1	Aboriginal	Intervention	Yes
MG-3	**Mossman Gorge**	48	Approx. 2	Aboriginal	Intervention	Yes
MG-C2	**Mossman Gorge**	51	3	Aboriginal	Control	Yes
MG-1	**Mossman Gorge**	27	1	Aboriginal	Intervention	Yes
MG	**Mossman Gorge**	28		Aboriginal	Intervention	No
MG	**Mossman Gorge**	53	Approx. 4	Aboriginal	Control	No
MG-C1	**Mossman Gorge**	52	5	Aboriginal	Control	Yes
MG-4	**Mossman Gorge**	51	7	Aboriginal	Intervention	Yes
MG	**Mossman Gorge**	34		Aboriginal	Control	No
MG	**Mossman Gorge**	Approx. 30		Aboriginal	Control	No
MG	**Mossman Gorge**	Approx. 30		Aboriginal	Control	No
MG	**Mossman Gorge**	Approx. 50-60		Aboriginal	Intervention	No
MG	**Mossman Gorge**	Approx. 40		Aboriginal	Intervention	No
MG	**Mossman Gorge**	34	2	Aboriginal	Control	No

Table 2: Reasons for Drop Out

Refusal or Drop Out	Reason
Refusal (did not want to participate)	There was no refusal as to say, although some participants who stated they would participate, however, did renege.
Drop out (started but did not finish)	Several participants stated that drop out of the project was due to acquiring full-time jobs. In addition, a number of these jobs were out of the relevant communities. Therefore, could not commit to finishing the project either in the intervention or control group.

	Other reasons for dropouts were issues around transit in the wet season (November-February) to other communities, hence not being able to get back to relevant community and complete program. Some men dropped out due to being incarcerated. And some participants were described in communities as 'chasing the grog' or too intoxicated to continue with the program.

The Aboriginal Communities of Aurukun, and Hope Vale fall under the Welfare Reform scheme, and under this plan was the establishment of Social and Emotional/Mental Health Clinical Wellbeing Centres. At the time of this study, these centres were under the management of the RFDS. Being the PhD student, I had an affiliation with RFDS, and an agreement was undertaken that RFDS would support me in implementing the intervention in these relevant communities. Nonetheless, after some time, these centres were transitioned over to a community controlled Aboriginal Health Service. Therefore, I lost the support, which included logistics, interrupting the planning schedule to implement the intervention trial.

The implementation of the intervention trial in the Lower Gulf of Carpentaria Aboriginal Community, Mornington Island, did initially commence. The initial process witnessed twelve participants completing pre-intervention surveys. Nonetheless, due to unforeseen circumstances—incarceration, community transit behaviour, high distribution of alcohol (home brew) and high level of sorry business (deaths of community persons/funerals)—corrupted the planning schedule, hence the ongoing recruitment, implementation of intervention program and post-intervention surveys did not occur.

Chapter 5

Findings

5.1 The analytic approach

The findings are based on a Qualitative Description (QD) related to each of the measures in the Parenting Intervention (PI). This is described in detail in the methodology section above. The sample size for the control was substantially smaller than anticipated. Given the small sample, it was not empirically sound to compare changes pre- and post- parenting intervention with pre- and post-control (Yarning/Relaxation), even descriptively. In the case of having sufficient power, I would recommend using a standardised approach to measuring effects by comparison between the control and intervention group. Where changes are significant with respect to a comparison, I describe them; however, although they provide great insight, they cannot be given empirical significance given the small numbers of men in the control. A general observation is that across the four surveys, the men who participated in the intervention program predominately scored better (from observation of each of the item responses in each measure) than the men who participated in the control group (men's group activities). Although the sample size was small, it can be argued that there was evidence that the intervention program 'Strengthen Dad's Identity' observationally showed a positive result.

Based on the absence of data available to empirically compare the two arms of the study I elected to examine more closely the changes pre- and post-interviews with the men who participated in the intervention. My analytic plan would serve as a mechanism to identify what the men learned, as well as for us to learn from the men's perspectives and experiences associated with each measure, and more broadly the Parenting Intervention (PI). This is consistent with the community participatory approach that prioritises what can be learnt from the intervention to benefit the community, rather than adhering to an analysis that may have rendered the study unfeasible, because of the low number of participants (Wallerstein et al., 2008). I decided to phenomenological describe the items related to each outcome measure which had significantly changed from before to after the Parenting Intervention (PI). This is consistent with the application of QD design features and techniques, which have been described in the literature (Kim, et al 2017). First, researchers can generally draw from a naturalistic perspective, and examine a phenomenon in its natural state. It is appropriate to design a method for analysis which systematically utilises what is available after the data collection to qualitatively answer the research question (Kim et al., 2017;

Sandelowski, 2000). In fact, QD encourages and facilitates flexibility in commitment to a theory or framework when designing and conducting a study (Sandelowski. 2000,2010). For example, researchers may or may not decide to stay with a particular methodological analysis, but instead elect for an alternative approach to ensure the research questions are answered (Kim et al., 2017). To bolster the descriptive method for examining the data, I have also included descriptions of relevant or insightful responses from male participants.

The reasons for withdrawal or dropout are described in the thesis, and there was no demographic of other differences in men who dropped out or remained in the study.

The insight and knowledge gathered from this study offers great learning and evidence for the field, and the communities that support, or might in the future support, men's groups and men's parenting.

5.2 Findings associated with each of the outcome measures

Measure 1: Men's Parenting Knowledge, Attitudes and Beliefs.

With this measure, questions were asked with several key options which served as prompts for respondents. The options were selected by me based on my and other Indigenous men's prior work on men's parenting, the scoping interviews, yarns with men in communities, and from the existing published literature, including the published papers herein. There was equally an opportunity for participants to write down novel thoughts and reflexibility, a method which ensured flexibility with respect to gathering and building the knowledge base in this field.

Importance of Parenting: Intervention Group.

Pre-intervention, six participants responded by stating that parenting was very important, two suggested that it was somewhat important, and one participant claimed they perceived parenting as not very important. Post-intervention, the rating improved for this question. Eight participants claimed that parenting was very important, and one suggested somewhat important. It was notable that the participant who suggested not very important pre-intervention changed to very important after the intervention.

Knowledge of Barriers to Parenting: Intervention and Control Groups.

This item revealed that men in both groups had a good awareness of the barriers that men encounter with parenting. Barriers that the men identified in both groups included alcohol use and smoking drugs, not knowing what to do or say to the kids, lack of trust from partners in their parenting ability, and lack of confidence.

What Do Good Male Parents Do? Intervention Group.

Participants endorsed that good male parents get involved with their children's activities, teach kids to be healthy, love their kids, and talk to Elders. Post-intervention, it was of note that most participants had also added that good male parents also offer to help their partners with the children.

Who Should Not Parent Kids?

It was insightful and important to note that the participants enjoyed this discussion topic, and the enthusiastically engaged with it. In the Intervention Group pre-intervention ratings, three men identified that anybody who is drunk or taking drugs should not parent, and after the intervention all the participants identified that item. The other most commonly endorsed response was 'anyone that is going to harm, hurt or frighten the child should not parent

How Can Men's Parenting Benefit Children?

The Intervention Group improved on identifying areas that they felt male parents could benefit children. The items that were more strongly endorsed after the intervention included comments that it is good for children to see men as role models, children can learn different things from their fathers, and it is good for children to be able to rely on their fathers.

Men's Parenting Benefiting Intimate Partners:

The intervention group improved on endorsing the benefits for intimate partners related to men being good parents. Pre-intervention, five participants endorsed that their partners will be happier because they have more help with the children. One stated that the relationship will be stronger with his partner. Post-intervention, more items were endorsed. Four participants endorsed that their partners will be happier because they have more help, three said their relationship will be stronger

with their partner, and one endorsed that his parenting more would help him understand more about what it takes to look after the kids.

Who to Speak with if Your Child is Sick or Hurt?

The intervention identified a significant change in knowledge amongst the intervention group. **Pre-intervention,** four participants suggested that if their child was sick or hurt, they would speak with other family members, two stated a doctor, nurse or other medical worker, and one stated other (and gave the example of a Traditional Healer). Post-intervention saw a significant shift, with eight participants identifying that they would talk to a doctor, nurse, or other medical worker if they were worried about their child being sick or hurt. The other six participants suggested they would talk to other family members first.

Measure 2: Growth and Empowerment Measure (GEM) – The Kessler 6

The GEM measures empowerment and mental health. This project applied two GEM: a 14-item Emotional Empowerment Scale (EES14) and the Kessler 6 Psychological Distress Scale (K6), supplemented by two questions assessing frequency of happy and angry feelings. For validation, the measure has been applied with 184 Indigenous Australian participants involved in personal and/or organisational social health activities (Haswell et al., 2010).

Given the small numbers, and consistent with the QD approach, I report only the K6 items (measured before and then after the intervention) that improved across the intervention group when no improvement was shown in the control group. How is the Kesseler Six plus 2 scored? the intervention group had nine participants; multiply this by the question's scales, for example, *how often did you feel happy in yourself*? The strongest score: 9 x 1 = 9 The weakest score: 9 x 5 = 45

Scoring Scale: Note: *the lower the score, the better the result.*

How often did you feel **happy in yourself**? (1 = best score = all the time), (3 = OK = some of the time), (5= poor = none of the time)
How often did you feel **nervous**? (1= best score = none of the time), (3 = OK = some of the time),(5= poor= all of the time).
How often did you feel **without hope**? 1= best score – none of the time, 3 = OK = some of the time, 5= poor= all of the time.
How often did you feel **restless or jumpy**? 1= best score – none of the time, 3 = OK = some of the time, 5= poor= all of the time.
How often did you feel **everything was an effort/struggle**? 1= best score – none of the time, 3 = OK = some of the time, 5= poor= all of the time.
How often did you feel **so sad that nothing could cheer you up**? 1= best score – none of the time, 3 = OK = some of the time, 5= poor= all of the time.
How often did you feel **worthless**? 1= best score – none of the time, 3 = OK = some of the time, 5= poor= all of the time.
How often did you feel **angry with yourself or others**? 1= best score – none of the time, 3 = OK = some of the time, 5= poor= all of the time.

Kessler 6 plus questions related to being Happy and being Angry (Haswell et al., 2010).
Data is reported here from the Intervention Group, comprising 9 participants with interviews conducted pre-& post-intervention. Collective scores from participants across all items are reported to demonstrate the improvement across the whole measure of psychological wellbeing.

Happy:

Most participants, except one, either remained the same or improved. Two participants remained on *All of the time*, three remained on *Most of the time*, one going from *Most of the time* to *All of the time*, one participant from *Some of the time* to *Most of the time*, and one participant going from *None of the time* to, *Most of the time*. This is seen as a significant improvement. One participant showed a deficit**,** however not a significant deficit, going from *All the time* to *Most of the time*. (Collective score pre- and post-: pre-= 19, post-= 15)

Feeling Nervous:

The *Feeling nervous* measure showed that four participants' scores remained the same, three stating *A little of the time,* and one *Some of the time*. Most of the other participants scored improved, one from *Some of the time* to *None of the time*, one from *Some of the time* to *A little of the time*, and two going from *All of the time* to *None of the time*, this is seen as a significant shift. In addition, one participant did go from *None of the time* to *A little of the time*. (Collective scores pre- and post-: pre-= 26, post-= 16)

Feeling without hope:

Four participants scores remained the same, with two participants *A little of the time*, one participant *Some of the time*, and one stating *None of the time*. Most of the other participants scored did improve, with two participants from *Some of the time* to *None of the time*, one from *Some of the time* to *A little of the time*, and one from *All of the time* to *Some of the time*. Although, one participant did not remain the same or improve, going from *None of the time* to *Some of the time*. (Collective scores pre- and post-: pre-= 23, post-= 18)

Feeling restless or jumpy:

The *Feeling restless or jumpy* measure showed four participants scores remaining the same, two stated *A little of the time*, one *Some of the time*, and one claiming *None of the time.* The other participant scores did improve; two from *A little of the time* to *None of the time*, one from *Most of the time* to *Some of the time*, and two participants going from *All of the time* to *A little of the time*. (Collective scores pre- and post-: pre-= 29, post-= 18)

Everything an effort or struggle:

Most participants improved, and some remained the same. Two participants remained on *A little of the time*, and one remained on *None of the time*. From the other participants, it was noticed, three participants went from *Some of the time* to *None of the time*, one participant going from *Some of the time* to *A little of the time*, one going from *Most of the time* to *A little of the time*, and one going form *All the time* to *Some of the time.* (Collective scores pre- and post-: pre-= 26, post-= 14)

So, Sad:

The *So sad nothing could cheer you up* measure showed one participant remaining the same, A little of the time. Most of the other participant did improve, three going from Some of the time to A little of the time, one from Most of the time to A little of the time, one Most of the time to None of the time, one Most of the time to Some of the time, and one from All the time to Some of the time. Although, one participant went from None of the time to A little of the time, this was not a significant shift. (Collective scores pre- and post-: pre-= 29, post-= 18)

Feeling Worthless:

The *Feeling worthless* measure indicated all participants either remained the same or did improve. Therefore, two participants scores remained the same, None of the time.

The participants score showed four going from Some of the time to None of the time, two from Some of the time to A little of the time, and one from A little of the time to None of the time. (Collective scores pre- and post-: pre-= 22, post-= 11)

Feeling Angry:

Most participants' scores did improve, with one remaining the same, stating Some of the time. The other participants showed four going from Some of the time to A little of the time, one going from A little of the time to None of the time, one from Most of the time to A little of the time, one from Most of the time to None of the time, and one from All the time to A little of the time (Collective scores pre- and post-: pre-= 30, post-= 17)

Overall, there was an improvement post-intervention, therefore suggesting the trial of the intervention program accomplishing a positive result.

Emotional Empowerment Scale (EES) Measure: Intervention Group Pre-& Post-intervention.

NB: Improvement is based on scores being highest. Scale Scores: 1= Very Poor, 2= Poor, 3= OK, 4 = Good, 5= Very Good

I am knowledgeable about things that are important to me.

Eight of the nine participants scored better or remained the same. Therefore, four participants, remained the same, one staying on Good, with three remaining on OK, with one participant improving from OK to Good. (Collective scores pre- and post-: pre-= 31, post-= 36)

I am strong and full of energy to do what is needed.

Seven of the nine participants scored better post-intervention, with one remaining the same. One participant went from Good to Very Good, one from OK to Good, one from OK to Very Good, one from Poor to Very Good, one from Good to Very Good, one from OK to Very Good, and one that was very significant, going from Very Poor to Very Good. The one participant staying same was OK. (Collective scores pre- and post-: pre-= 27, post-= 39)

I feel very happy in myself & with my life.

One participant remained the same on Good, with seven participants improving. Scores ranging from: Good to Very Good, OK to Good, Good to Very Good, OK to Very Good, OK to Good, **Poor to Very Good**, and OK to Good. (Collective scores pre- and post-: pre-= 30, post-= 39)

I feel that other people admire me and value me.

Three participants remained the same, one staying on Good, and two participants remaining on OK. In addition, five other participants' scores did improve, ranging from: OK to Good, OK to Good, Good to Very Good, Poor to Good, and OK to Good (collective scores pre- and post-: pre-= 29, post-= 34)

I can speak out and explain my views, people listen.

Three participants remained the same, one remaining on Good, and two remaining on OK. In addition, five other participants improved, with two ratings from OK to Good, two ratings from Good to Very Good. With one participant going from Poor to Very Good, this is seen as a significant improvement. (Collective scores pre- and post-: pre-= 30, post-= 36)

EES 6: I belong in community, I feel connected.

All participants either stayed the same or improved. Two participants remained the same, with one scoring Good, and the other OK. Four participants went from OK to Good, one from Good to Very Good, one from Poor to Good, and one from Poor to Very Good, these are significant improvements. (Collective scores pre- and post-: pre-= 27, post-= 37)

I have confidence in myself.

All participants either stayed the same or improved. Five participants remained the same, three scoring Good, and two scoring OK. The other participants that did improve scores, three from Good to Very Good, one from Poor to Good. (Collective scores pre- and post-: pre-= 32, post-= 37)

I am centered and focused on meeting the needs of myself and my family.

Four participants scores remained the same, three scoring Good, and one scoring OK. In addition, four participants improved, three going from OK to Good, and one going from Ok to Very Good. (Collective scores pre- and post-: pre-= 32, post-= 36)

I feel safe and secure, I can face whatever is ahead.

Two participant scores remained the same, one scoring Good, and one scoring OK. The participants that improved where two scoring, Good to Very Good, two scoring, OK to Good, one from OK to Very Good, and one scoring Poor to Very Good; this is seen as a significant improvement. (Collective scores pre- and post-: pre-= 30, post-= 38)

I don't hold anger inside of me about bad things in my life.

One participant score remained the same, Good. Other participants scores showed, three participants going from OK to Good, one participant going from OK to Very Good, two participants from Poor to Good, and one participant from Poor to Very Good, this is seen as a significant improvement. (Collective scores pre- and post-: pre-= 26, post-37)

Measure 3: The World Health Organisation Measure for Domestic Violence

The WHO measure includes items inquiring into physical, psychological, and sexual violence perpetrated by a current or past intimate partner (Garcia-Moreno et al., 2006; García-Moreno et al., 2013).

Consistent with the analysis of the other measures, I describe here any positive changes that were seen when comparing before and after the intervention, when there was also no change or a worsening of the issue in the control group.

Spent More Time With their Partners

Men spent more time with their Partners after the intervention, although it was just a slight change in endorsement.

Respecting their Partner's Wishes:

Intervention Group Pre-intervention, four participants indicated they frequently respected their partners wishes, two suggesting sometimes and one stating never, with two not responding. Post-intervention showed an improvement with four participants indicating frequently, and five now suggesting sometimes.

Being Jealous or Angry Toward their Partners

Pre-intervention, five participants stated no to being jealous or angry towards their partners talking to other men, while two said yes, while two participants did not respond. Post-intervention, all nine participants stated no, indicating a significant improvement.

Accusing Partner of Being Unfaithful

Pre-intervention, four men stated yes to accusing their partners of being unfaithful, while five said no to accusing their partners of being unfaithful. Post-intervention, all nine participants declared no, indicating a vast improvement.

Not Allowing their Partner to Go Out with Friends

Pre-intervention, seven participants said no to **Not Allowing their Partner to Go Out with Friends while** two said yes, they do not allow their partner to go out with friends.

Post-intervention demonstrated an improvement with all nine participants saying they do allow their partners to go out with friends.
[spacing]

Limiting Contract with Family and Friends.

Pre-intervention**,** six participants suggested no, while three stated yes to limiting their partners' contact with family and friends. Post-intervention, all nine-participant stated no, demonstrating a considerable improvement.

Insisting on Knowing Where your Partner.

Pre-intervention, seven participants stated no to insisting on knowing where their partners were all the time, while two said yes. Post-intervention, all nine participants said no, indicating improvement.

Physical Abuse

Of note was the item inquiring if the participant had been hurt by someone in their lifetime**.** This question asked, 'Has anyone ever hit, slapped, kicked, or done anything else to hurt you physically?' This item response did not change pre-or post-intervention or control group, as would be expected. Of particular concern was the number of men who had been physically abused, and worth reporting. Out of twelve men, four said yes to this question. Although this is a small sample, one third of the men had been hurt by someone in their lifetime. Some had been repeatedly abused by multiple people. One participant said that, as a young teenager, he was hurt by a male friend, a teacher, and a stranger. Another participant stated that he was six years old when hurt by his stepfather. Another participant stated also that he was hurt as a young fella by his stepfather. The fourth participant said that, at around 15 years of age, he was physically hurt by his brother and by an employer.

A review of the other domestic violence items showed that the four men who were abused as children or teenagers were also more likely to endorse items that suggested controlling behaviours in their intimate relationships. For example, they were more likely to endorse not permitting their partners to go out with their friends, limiting their contact with family and friends, insisting on knowing where their partners were all the time and not trusting them with money. One revealed that he had humiliated his partner in front of other, as well as threatened her with harm, and had hit, pushed, or thrown something at her.

Measure 4: The Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT is a 10-item alcohol screener that has been recommended for use in Aboriginal primary health care settings (Calabria et al., 2014. Identifying Aboriginal-specific AUDIT-C and AUDIT-3 cut-off scores for at-risk, high-risk, dependent drinkers using measures of agreement with the 10-item Alcohol Use Disorders Identification Test). Reported here are the items where change was positive for the intervention group after the intervention.

Standard Drinks in a typical day

How many standard drinks do you have on a typical day when you are drinking? Ratings: 1= 1or 2, 2 = 3 or 4, 3 = 5 or 6, 4 = 7 to 9, 5 = 10 or more.
Pre-intervention, three participants consumed *1 or 2* drinks in a typical drinking session. The other five participants indicated drinking *5 or 6* standard drinks, one drinking *7 to 9*, and one drinking *10 or more st*andard drinks in a typical day. Post-Intervention, four participants' ratings remained the same. Of the other five participants, one went from drinking *10 or more* standards drinks in a typical day, to *7 to 9*; one went from *5 or 6* to *3 or 4*; one went from *7 or 9* to *3 or 4*; and the other went from *5 or 6* to *3 or 4*.

Six or more standard drinks on one occasion

How often do you have six or more standard drinks on one occasion? Ratings: 1= Never, 2= Less than monthly, 3= Monthly, 4= Weekly, 5= Daily or almost daily.

Intervention Group indicated that seven participant ratings stayed the same from pre-to post-intervention. Where there was change, one participant indicated going from monthly to less than monthly, and the other participant claimed going from weekly to less than monthly.

Not able to stop drinking once started

How often during the last year have you found that you were not able to stop drinking once you had started? Ratings: 1= Never, 2= Less than monthly, 3= Monthly, 4= Weekly, 5= Daily or almost daily.

Pre- and post-intervention measures revealed that five participants responses remained the same, four participants stated never, and one said less than monthly). The other four participant responses changed, with one going from less than monthly to never, one going from monthly to less than monthly, one from daily or almost daily to less than monthly, and one going from never to less than monthly. Although the last participant rating went up marginally, collectively the ratings improved.

Fail to do what was normally expected

How often during the last year have you failed to do what was normally expected of you because of drinking? Ratings: 1= Never, 2= Less than monthly, 3= Monthly, 4= Weekly, 5= Daily or almost daily.

The Intervention Group pre- and post-intervention ratings indicated six participants responses remained the same (three claimed less than monthly, the other three indicated never). Of the other participants, one stated going from less than monthly to never, one stated going from weekly to less than monthly and the last participant claimed they had gone from never to less than monthly. Nonetheless, collectively the intervention ratings had dropped.

Needing a drink in the morning

How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? Ratings: 1= Never, 2= Less than monthly, 3= Monthly, 4= Weekly 5= Daily or almost daily.

The Intervention Group pre- and post-intervention ratings indicated five participants claiming, pre- and post-, never wanting in the last year to have a first drink in the morning. The other ratings included one going from weekly to monthly, one going from weekly to less than monthly (this

is significant) and one going from less than monthly to never, therefore, collectively there was an improvement.

Guilt and remorse after drinking

How often during the last year have you had a feeling of guilt or remorse after drinking? Ratings: 1= Never, 2= Less than monthly, 3= Monthly, 4= Weekly 5= Daily or almost daily.

Generally, continuous feelings of guilt or remorse can lead to mental health problems i.e., clinical depression and anxiety. Therefore, it can be suggested that, if participant indicates they are feeling guilty or remorseful weekly, daily, or almost daily from drinking, this is seen as a deficit.

Intervention Group pre- and post-intervention ratings indicated five participants' scores remained the same, rating never. The other participants' scores showed that one went from less than monthly to never, one from daily or almost daily to monthly, one from weekly to less than a month, and one remaining feeling guilty or remorseful less than monthly. Pre-Score: 18, Post-Score: 13, suggesting the group improved post-intervention.

Unable to remember

How often during the last year have you been unable to remember what happened the night before because you had been drinking? Ratings: 1= Never, 2= Less than monthly, 3=Monthly, 4=Weekly, 5= Daily or almost daily.

Intervention Group pre- and post-intervention ratings indicated that six participants' scores remained the same (never been unable to remember what happened). The other participants scores revealed that one went from less than a month to never, one from weekly to less than monthly, and one remained on less than monthly. Post-intervention, the group has clearly improved on this item.

Injured because of drinking

Have you or someone else been injured because of your drinking? Ratings:

1. No
2. Yes, but not in the last year
3. Yes, during the last year

Intervention Group pre- and post-intervention ratings indicated seven participants' scores remained the same – No. The other participants' ratings showed that one participant went from Yes, but not in the last year to No, while one participant pre-intervention was Yes, but not in the last year, but they did not respond post-intervention. Pre-Score: 11, Post-Score: 8, post-intervention scores dropped, however mindful that ID MG-3 post-score is missing.

People concerned about your drinking

Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? Ratings:

1. No
2. Yes, but not in the last year
3. Yes, during the last year

Intervention Group pre- and post-intervention ratings indicated six participants' scores remained the same, four claiming No, one claiming Yes, but not in the last year, and one suggesting Yes, during the last year. The other participants' scores showed one participant going from Yes, but not in the last year to No, one Yes, but not in the last year (did not respond post-intervention), and one stated Yes, during the last year (also did not respond post-intervention). Pre-Score: 16, Post-Score: 10, Post-Intervention scores dropped/improved, however mindful that MG-1 & MG-3 post-scores were missing.

Supplementary Question 1- Presently having a drinking problem

Intervention Group pre- and post-intervention ratings indicated that five participants' scores remained the same, with four claiming No they do not think they presently have a drinking problem, the other participant claiming Unsure. The other scores revealed one participant going from Unsure to No (improvement) one going from Unsure to Probably not, one going from Possible to Probably not (improvement). One participant stated No pre-intervention, however post-intervention score is missing.

Supplementary Question 2- The difficulties in reducing or stop drinking in the next 3 months

Intervention Group pre- and post-intervention ratings indicated that six participants' scores remained the same, five claiming Very easy to in the next 3 months to the question: how difficult would you find it to cut down or stop drinking? One participant claimed it would be Fairly easy. The other participants revealed one going from Neither difficult nor easy to Very easy (improvement), one going from Neither difficult nor easy to Fairly easy (improvement). The other participant stated Very easy, however did not respond post-intervention. Overall, post-intervention scores improved, suggesting the intervention program succeeded. It is with little surprise that the score post-intervention to a GEM question, how satisfied are you with the place you live? showed that participants were far more positive about the place where they lived following the intervention program. Pre-Intervention Score = 27 points, Post-Intervention Score = 35 points.

5.3 Discussion

This discussion of the intervention is informed by my professional insights as an Indigenous mental health promotional worker, an academic and an Aboriginal father, grandfather, and uncle. I use the lens of the knowledge that precedes this chapter to frame my thoughts and reflections, from the published meta-synthesis to the article on the barriers to Indigenous men's parenting.

The evidence from this intervention suggests that men who participated in the intervention program became more aware and empowered as fathers. The intervention demonstrated improvements in their social and emotional wellbeing and empowerment. Further, the men embraced fatherhood and felt more confident in the role. It appeared to me that the intervention was designed appropriately for the target group, and that it challenged the negative stereotype that many men internalise. Further, the intervention demystified First Nations men as fathers, grandfathers, and uncles, making this record of the findings a piece of historical evidence of the capabilities, knowledge, and skills of First Nations men collectively.

Parents Knowledge and Understanding

The intervention group participants' knowledge, attitudes and beliefs encompassing men's parenting improved significantly. I observed that the men enjoyed the process and felt comfortable in doing the program. It was important to the success of the program that the intervention was delivered in a familiar setting in their community, and in a men's group format. The intervention group overtly demonstrated what they thought parents should be and do, such as their important role in nurturing and caring for their children. They shared a belief in the privilege of being a father, rather than taking it for granted. One of the changes that was highly significant was that the men, following and during the intervention, started to offer their partners more help with the children. This is a positive change that cannot be underestimated in terms of the potential for greater collaboration and support, rather than conflict, between parents.

Another significant finding relates to men's roles in child protection. The change centred around the participants' views about who should not parent children. I noticed that the men commonly and strongly endorsed that is not good for men to harm their child, and it is also not good to be around your children while intoxicated.
These views and the men's articulation of them suggest a future benefit to younger men that they will mentor to be protective and nurturing fathers. The findings also suggest that after the intervention, men were more significantly aware of seeking assistance if their child was sick or hurt, and importantly they felt more empowered and motivated to contact a doctor or medical person rather than only family or friends.

The Growth and Empowerment Measure (GEM)

I observed that, after the intervention, men felt less anxious and, more importantly, they felt more hopeful and optimistic. This observation was reflected in the GEM findings. The men felt confident and felt that parenting was a great opportunity for them to engage with something meaningful and important. This had the effect of reducing feelings of anxiety about parenting. In addition, they felt more hopeful for the future about being a great role model to other men, as well as their own children around parenting.

The EES showed a significant change, and it can be argued that the improvement was reflected in the item related to increased satisfaction with the place where they lived. This allowed the men to think more positively about the world around them, and the place they lived became more

meaningful and important to them after the intervention. They considered, after the intervention, that the place where they lived was not that bad after all.

The intervention led to all participants becoming more knowledgeable and confident in the upbringing of their children. In addition, my observation was that by attending the intervention program, participants felt valued and admired by their families. This provided the participants with a sense of belonging, and an important part of family and community. I also noted that intervention participants felt fuller of energy and vitality, working towards creating positive outcomes for themselves, family, and community. This made the participants happy, knowing they have the confidence and capacity to be good parents. It was therefore no surprise that the participants scored high post-intervention on the Kessler 6 plus 2 score for mental wellbeing.

The Kessler 6 plus Happy and Angry

The intervention participants, post-intervention, had more hope, and felt more worthy as a human being, partner, and father. This self-worth was very important to the nexus of the family's wellbeing, in the Indigenous sense, because of the interconnections between the father, his children and his family. Post-intervention, the participants personally suggested that having parenting knowledge made them feel less angry, and this is based on having the tools to positively engage with their children and support their partners. Anger is strongly associated with trauma and injustice, as well as with parenting and interpersonal violence (Atkins, 2002; Day et al., 2008). This was therefore a very positive indicator of change, where men said that, without feeling angry and nervous, they could feel more worthy and no longer that everything is a struggle. It was of significance to the reduction in anger, that the domestic violence score improved as well.

Domestic and Family Violence

The intervention led to me gaining an understanding of their roles as parents and men who spent more time with their children and partners and, more importantly, their time spent with their partners, and respecting their partners wishes. The men discussed how this contributed to a healthy relationship with their partner. This also adjusted the mindset of the participants who felt more confident in their role as a partner and less need to control their partner. They felt less jealous of their partner when talking to other people, especially males, and the measures reflected the men's views that they were no longer accusing their partners of being unfaithful or insisting on knowing where their partners were all of the time.

The findings were ambiguous with regard to the use of physical violence or the reduction of it. Nonetheless, with the intervention workshop creating a culturally safe space, the participants opened up and talked about their use of violence. Some of the participants who had indicated that they abused their partners, whether verbally, physically, or emotionally, also disclosed that they had suffered their own traumas of being abused as a child. After the intervention, these participants learnt to understand the effect of childhood trauma on them emotionally, and how not to use their trauma as an excuse to perpetrate violence on their partners. They learned, instead, to seek support and talk to the appropriate health experts around treatment and recovery of their post-traumas. It is important for practitioners and policy makers to note that the participants who were abused as children, and those who used violence themselves, also tended to consume more alcohol than the other participants.

The Consumption of Alcohol

The intervention program allowed the participants to think about their consumption of alcohol. Not all participants consumed alcohol. Most participants stated that people who are intoxicated or high on drugs should not be caring for children. Therefore, the intervention provoked thought around what the consumption of alcohol meant to them, and their role-modelling for their children. Post-intervention, the participants who did consume alcohol significantly changed their drinking habits, reducing the number of standard drinks a day, and were more likely to be able to stop drinking once started. They showed they had more mastery, control, and insight into the consumption of alcohol. In addition, it can be confidently argued that participants saw themselves as being healthy role models for their children after the intervention, and that they also ended up not wanting to have a drinking problem. Clearly, they saw that these two factors were linked, which is a profoundly important finding. With the consumption of alcohol being a trigger for domestic and family violence, the reduction of violence was also potentially a positive change for the future.

5.4 Conclusion

This study has investigated the worthiness of a program titled ‘Strengthening Dads Identity’ through applying an Adult Learning and Empowerment manualised intervention. The value of the intervention workshops revealed that the participants improved across all measured aspects. It was demonstrated qualitatively and descriptively that fathers enjoyed the opportunity to be involved in an educational program that enhanced their strength and brought about positive changes. A limitation of the study was that the numbers were too small to make a quantitative comparison of

the two groups (the intervention and the control group). Further, any positive effect that was measured may not be sustained over time. More research needs to be done to establish if the benefits from this Intervention are sustained, and if so, which ones. The thesis as a whole integrates two academic papers that have been peer reviewed.

Both papers contributed to the informing knowledge base, which identified gaps in literature and areas of historical and contemporary biases and injustice that can and do undermine the roles of fathers in Indigenous communities (Reilly, 2021; Reilly & Rees, 2018).

More needs to be done, as shown in this study, to support men to not only build personal and community capacity to acknowledge injustices but also to take opportunities to demonstrate their own strengths and skills. This intervention 'Strengthening Dads Identity' demonstrated that an intervention can and does work to systematically support men to do what they do best, that is, be strong fathers and build strong communities (Lyndon Reilly Story, '*Strong Fathers, Strong Families'*, NITV, 2014). Finally, there needs to be a push towards positive change by community organisations and lobbyists, including local men's group facilitators, to engage with policy makers at local, state, and federal government levels to advocate for the implementation of educational programs like the 'Strengthen Dads Identity' intervention across all communities.

Chapter 6

Concluding Remarks

6.1 Summing-Up

Grounded in the history of dislocation, dispossession, oppression, current discrimination and racism, many Aboriginal and Torres Strait Islander men have been denied pathways to becoming men. The past 16 years of working with Aboriginal and Torres Strait Islander men has underscored evidence that Aboriginal and Torres Strait Islander men are the most disadvantaged group within the Australian population. Aboriginal and Torres Strait Islander men have the poorest health and wellbeing, poorest education and employment levels, and highest representation within the correctional centres throughout Australia, (Adams 2006; Tsey et al., 20022004; Hayman, 2010). Nonetheless, I have also witnessed a breath of leadership, wisdom, and empowerment in national Aboriginal and Torres Strait Islander men's groups.

There is a growing momentum within First Nations men's discussions about empowerment, parenting and creating safe spaces. Key Australian First Nations men associated with health promotion, health and wellbeing, social justice and community development, are actively seeking to engage in a knowledge sharing experience with current men's groups. Leadership and empowerment including men taking responsibility for the health and wellbeing of the future generations, is seen as paramount to the health and wellbeing of First Nations societies. Furthermore, it can be said that men who are empowered become the men they need to be, and have the characteristics to bring about positive individual, family and community change (Guyula, 1998). Knowledge sharing, including from this study of men's parenting, is a process in which individuals and groups manage critical understanding and improvement of their situations through participatory plans, practices, observation/reflection and/or evaluation of the results of the action encompassing leadership and parenting. Ongoing action is required to enhance good practice that generates knowledge and skills around men's responsibilities, including roles in fatherhood, relationships and health and wellbeing. Furthermore, the knowledge sharing process and men's group activity exchange events that have been offered so far, have engendered a ripple effect for positive change – a sense of worth and empowerment through strengthening the knowledge of men's individual, family and community obligations.

In addition, the intervention program which is the centerpiece of this dissertation can be seen as a mechanism to identify and document what the men learned, as well as for us to learn from the men's perspectives and experiences.

6.2 The Intervention Process

The need for a men's parenting group, and my quest to conduct a systematic trial of an intervention, was informed primarily by interviews conducted with health and wellbeing stakeholders, including men's group coordinators within three Lower Gulf of Carpentaria communities. Since those interviews were conducted and drawing on the information that came out of the interviews, a Strong Fathers, Strong Families (SFSF) report for the Royal Flying Doctors Service established what was being strongly suggested, that there were no culturally appropriate men's programs for parenting. During this time, a film was produced to broadcast a SFSF Empowerment of Change forum. This film aimed to create, through documenting forum sessions and rich individual narratives, a culturally appropriate SFSF information DVD, and for it to be utilised by all health services aiming to promote positive healthy Aboriginal and Torres Strait Islander male positions within their respective communities. In addition, the SFSF DVD was intended to be utilised as an introduction to SFSF workshops for Wellbeing Centres and Community Health Services in the Lower Gulf, Western Queensland Corridor and Cape York district.

As part of this SFSF Empowerment Forum, I also talked to men in community, trying to imagine what an Aboriginal male parenting program would look like. From those discussions, with guidance from participating community members, local stakeholders and my PhD Supervisor Professor Susan Rees, I developed this existing program. Once they have that knowledge—you know knowledge is powerful and it empowers men, they can embrace their roles as fathers. This process allows them to be proud of being strong, healthy role models for their children. Furthermore, it is all about giving them the opportunity to receive educational tools encompassing fatherhood, because a lot of men in community, rightly or wrongly, father the way they were brought up. In addition, to have that understanding and knowledge around fathering in a cultural sense is critically important. Being in community and observing these men—those participants of the program—grow was really rewarding. Therefore, learning in First Nations men's gatherings is the essence of learning from one another.

It was not about men's group facilitators acting as paternalistic educationalists, (including myself) sitting at the front and teaching the participants. It's about being inclusive, with all the men within

a yarning circle – sitting down and sharing and receiving knowledge. Moreover, it had to be from the bottom up, at a grassroots level; if it is done that way, and community-driven, the participants take ownership. As the PhD student, I steered the study in the direction that allowed participating men and communities be the mechanisms to drive the study. We will train them up and support them; they are the men on the ground (grassroots) and, along with participating community-based organisations, will be much more likely to take ownership of the men's culturally appropriate parenting program.

6.3 To What Extent Do the Findings Support the Hypothesis and Answer the Two Research Questions? What reflections are important from the analysis of these intervention findings?

The research findings suggest that men who attended the structured intervention program on parenting demonstrated improved knowledge and understanding of the male parental role. They appeared to be more informed and confident about the parenting role, and this had a positive effect on the relationship with their partners. The study findings support the need to examine these issues in greater detail, and to study whether more informed and engaged fathers have a positive impact on the relationship and wellbeing of their children. This is the topic of my current research focus, and the project is funded by the Million Minds Research Fund.

The intervention data also suggests that men who engaged in the program felt more empowered and had lower rates of mental distress. Men also seemed to have better self-reported findings in relation to violence against their partners, particularly those that relate to psychological violence, coercion, and control. Men who participated in the study reported drinking less alcohol and had lower levels of higher risk drinking behaviours. Given the strong association between alcohol use and domestic violence, it makes sense that a reduction in drinking might have also impacted the domestic violence outcomes (Mcmurran, & Gilchrist, 2008).

The findings also support the hypothesis that men who participate in a structured parenting intervention will have an increased understanding of the role of men as parents and be able to identify benefits from their engagement in the role of parenting. The second hypothesis, that men who learn more about parenting and begin to engage in parenting, will have improved feelings of empowerment, lower rates of mental distress (measured by the K6 plus 2 and the GEM), reduced family conflict including emotional abuse items, poor disclosure on physical abuse perpetration, and reduced consumption of alcohol was also supported. In addition, the structured intervention

title ‘Strengthen Dad’s Identity’ manual that was delivered within the two communities intervention group workshops can be seen as Appendix 1.

The data collected for this study are informed by the meta-synthesis of the existing literature, and by the analysis of the Strong Fathers program (Reilly & Rees, 2018) – Fatherhood in Australian Aboriginal and Torres Strait Islander communities: An Examination of Barriers and Opportunities to Strengthen the Male Parenting Role. American Journal of Men’s Health 2018, Vol. 12(2) 420–430. Chapters 2 and 3 respectively. I use the same format as the American Journal of Men’s Health article in Chapter 5 to expand on the application of the findings from the intervention: ‘A trial of a community-based intervention to support the active engagement of Aboriginal and Torres Strait Islander men in parenting, and to improve men’s feelings of empowerment, reduce mental distress and reduce drug and alcohol use’ (Chapter 4).

Note: It was of note that most participants in the intervention had added that good male parents also offer to help their partners with the children – this may be associated with improving relationships with the intimate partner, respecting her role, understanding at an emotional level the importance of nurturing and care in the family.

Cultural biases

Conflicting expectations of traditional and contemporary ways of parenting are not adequately understood or incorporated into current policy and practice. This study shows that cultural parenting practices, such as fishing and hunting with older boys, as well as contemporary male parenting behaviours, such as changing nappies and caring for infants, are both being practised.

Whilst cultural parenting practices are considered at risk of being undermined by modern life and expectations, contemporary parenting of babies and young children is culturally unfamiliar for many men. The cultural complexity of male parenting roles needs to be understood and valued. The styles and practices of male parents should be documented, and staff working in communities should be formally acquainted with this knowledge. Staff also need to be aware that Aboriginal and Torres Strait Islander men may not have sufficient confidence or knowledge to engage fully in the contemporary parenting role, and that support and encouragement is required.

Institutional biases and Professional biases

Parenting and child-related services should explicitly reflect and promote the importance of male parenting, including having Aboriginal men at the forefront of service delivery. Services should not have gendered names such as 'maternal and child health' and 'Mums and Bubs'. These gendered terms alienate men and exclude them from participating in parenting programs.

Services should generally be strategically informed and culturally sensitive to the factors that may prevent, as well as encourage, men from engaging with them.

Content and Resources biases

Many any of the resources available to men were not culturally sensitive, and they were often not designed or delivered by Aboriginal and Torres Strait Islander men. Low literacy is associated with low self-esteem and 'shame' and together these factors prevent men from attending programs that offer parenting education. It is vital for parenting services to offer programs designed for men with very low literacy. From a broader policy perspective, governments need to prioritise improving Aboriginal and Torres Strait Islander men's literacy and numeracy, as this can have profound impacts on their psychological wellbeing and capacity to engage in health programs.

Policy bias

Policy is biased in favour of those motivated to engage with services. The level of disempowerment amongst marginalised groups, including Indigenous men, needs to be incorporated into policy. Empowerment theory would better inform the development of programs to include male parents (Wallerstein & Bernstein, 1994). Empowerment approaches focus on facilitating a structural analysis of factors that serve to undermine men's confidence in parenting, such as colonisation and its effects on men, racial disadvantage and marginalisation, and negative stereotypes about men and their use of alcohol and drugs. Empowerment approaches have been reported to support men in establishing positive thoughts, behaviour and emotions, to sustain positive change, and have the power to help others (Laliberté et al., 2012; Rees et al., 2004). Ultimately, empowerment approaches need to foster community action to promote men's roles and family and community inclusion.

6.4 Synthesis of the Study

Table One: Synthesis of Chapters

Chapter and what it aimed to contribute to the whole thesis	Importance of this chapter to the thesis	Limitations of this chapter	What this section offers the field
Chapter 1 This chapter provided the reader with an understanding of the author's position as an Indigenous male academic and health worker and his commitment to addressing inequitable psychosocial outcomes for First Nations Male parents. The chapter provided the rationale, objectives, thesis layout and the informing theoretical frameworks.	To inform the rationale for the entire thesis. The chapter establishes the academic work as a contribution to non-Indigenous, First Nations, men's mental health and wellbeing. The first person account, the theoretical frameworks, and the emphasis on the collective and Indigenous worldview is centrally important to how this work should be read and valued.	No limitations	The chapter emphasises the importance of supporting Indigenous ways of knowing and supporting First Nations health. The PhD student articulated the unique knowledge that will come from the study, for the benefit of other First Nations men, their partners, communities and of course their children. The chapter demonstrates to other practitioners in Indigenous communities the importance of a systematic Intervention process that is both rigorous and culturally aware and led. It details the benefit of the Intervention aims for Indigenous mental health research and to inform practice in Indigenous communities, particularly

			men's groups that are promoting male parenting practices.
Chapter 2 Chapter 2 is a published Meta-synthesis of studies examining the barriers and facilitators to First Nations men's parenting from qualitative studies. Qualitative studies were selected because they describe and detail the barriers, to provide the best opportunities for insight. The Chapter served to establish an awareness of the dearth of First Nations Fathers parenting programs. The author applied this groundwork to develop an explanatory theory to inform future policy,	Advances and promotes better knowledge concerning the challenges for First Nations male parents by evaluating the amalgamation of qualitative studies on this topic. The findings directly informed the parenting intervention, as described in the thesis.	The dearth of literature in this field.	The key themes from this chapter form a guide for programs and interventions, to ensure that men can actively embrace their rightful roles as positive, engaged fathers, uncles, and grandfathers within a contemporary Indigenous society. In addition, the chapter emphasises the role that parenting can play in supporting men's self-esteem and empowerment, giving them the capacity to strengthen the interrelationships between family and community. This rationale and each of the core areas found in the meta-synthesis informed the Parenting Intervention. The findings of the chapter are intended to inform the development and rationale for appropriate services and programs to support and promote men's parenting.

practice, and the content of the PhD parenting intervention.			
Chapter 3 Describes the work titled 'Strong Fathers, Strong Families' project, undertaken by the PhD student in his role with the Royal Flying Doctor Service. The chapter was a type of pilot for the parenting intervention, particularly around the focus on the importance of dads and on promoting and supporting dads	The site for this study was in the same location as the PhD students' study, including the same remote Queensland First Nations communities, and it applies a men's group format and focuses on parenting. It informed the PhD study. It contributed a thorough review of the literature and a theoretical approach to developing the content of the parenting intervention.		This published paper has, for the first time, systematically identified barriers and opportunities to support Australian Aboriginal and Torres Strait Islander men's role as parents. The identified barriers directly informed the development of the parenting intervention. The study highlighted the need for an awareness in communities and health and welfare services for men's parenting role, which may be impacted by traditional understanding of men's business and women's business, and additional difficulties in undertaking contemporary parenting practices. The study demonstrated that men's engagement with

in this role through the mechanism of a men's group format.			parenting, could strengthen his identity and improve his mental wellbeing. These findings supported the need for more information and therefore provided a sound rationale for the parenting intervention, which is the main subject of this PhD project. This paper describes shame, predominantly experienced as embarrassment, and a lack of confidence around parenting. The parenting intervention was directly informed by this finding, that is, that men experienced shame about parenting because of its lack of acceptability and because they lacked confidence to be dads. The PhD student considered, from this knowledge, that men would feel empowered and that this would have a mental health benefit, if they were playing a more direct and meaningful role as dads. The findings published in this paper also identified many barriers to Indigenous male parenting that were

			subsequently included in the components of the parenting intervention. These barriers that we subsequently included in the parenting intervention included structural factors that serve to undermine men's confidence in parenting, such as colonisation and its effects on men, racial disadvantage and marginalisation, and negative stereotypes about men and their use of alcohol and drugs. Empowerment approaches, such as those the PhD student used to design the parenting intervention manual, have been reported to support men to establish positive thoughts, behaviour and emotions, to sustain positive change, and have the power to help others. Like the findings from this article in Chapter 3, the aim of the parenting intervention was to highlight the importance of men's groups in providing a supportive male space and championing male parental role models in Indigenous communities.

Chapter 4 The intervention '**A trial of a community-based intervention to support the active engagement of Aboriginal and Torres Strait Islander men in parenting, and to improve men's feelings of empowerment, reduce mental distress and reduce drug and alcohol use'** aimed to increase knowledge of men's role as parents, increase feelings of empowerment and decrease mental distress, family conflict and reduce the use of alcohol or drugs.	This Chapter brings to the study an Indigenous methodological approach, and it emphasises the importance of ethical research standards, and opportunities for learning at every stage of the thesis process.	Smaller participants numbers than expected limited the capacity to compare the intervention with the control group. This did not undermine the feasibility of the study for the future, because the main reason for low recruitment numbers was constraints related to time available to the PhD student given his fieldwork was largely unfunded.	The intervention is informed by research into what exists in this field, what the barriers and facilitators for Indigenous men's parenting are, and the informing work from the PhD student work with the Royal Flying Doctor Service. It is also informed by the PhD students' professional insights as an Indigenous mental health promotional worker, an academic and an Aboriginal father, grandfather, and uncle. Therefore, an Aboriginal lens was applied to the research. This is the first time an empirically designed parenting intervention with a manual, and an intervention process suited to this setting and population has been developed and tested. There is much to learn from this process for Indigenous researchers and health workers.

Chapters 5 and 6 This is the findings chapter. It provides a rationale for the selected method for analysis, which was to derive observations from the intervention regarding positive findings, particularly focusing on those identified from each of the outcome measures that assessed the parenting intervention group. Chapter 6 is a summary of the findings and a section that considers to what extent the findings were able to answer the research questions.	The findings and discussion of the intervention is informed by my professional insights as an Indigenous mental health promotional worker, an academic and an Aboriginal father, grandfather, and uncle. The PhD student use the lens of the knowledge that precedes this chapter, from the whole dissertation, to frame my thoughts and reflections on the parenting intervention. The evidence from this intervention suggests that men who participated in the intervention program became more aware and empowered as fathers. The intervention demonstrated improvements in their social and emotional wellbeing and empowerment. Further, the men embraced fatherhood and felt more confident in the role. It appeared to the PhD student, that the intervention was designed appropriately for the target group, and that it challenged the negative stereotype that many men internalise. Further, the intervention demystified First Nations men as	No limitations	Evidence demonstrates that First Nations men's educational programs can be rigorous, can be replicated by using a tested intervention manual, and most importantly can be owned and led by the men and their communities. The thesis and material in it offer policy and practitioners the opportunity to replicate this parenting intervention, and to adapt it for their own settings. It also suggests a framework, and measures, to assess the effectiveness of the parenting intervention. This is a valuable resource for First Nations communities, and one which has addressed a neglected area in the field of parenting and men's mental health.

	fathers, grandfathers, and uncles, making this record of the findings a piece of historical evidence of the capabilities, knowledge, and skills of First Nations men collectively. The key domains which showed observationally derived evidence of positive change included: Parents Knowledge and Understanding of Parenting; Mental Health and Empowerment; Domestic and Family Violence; and Alcohol use.		

6.5 Exiting Comment

The evidence from my thesis contributes to knowledge regarding men's culturally appropriate parenting programs, and it suggests that they are effective, then these programs should be financially supported, and be scaled up and shared across other communities. My thesis demonstrated that interventions, even in remote communities impacted by historical trauma, dispossession, loss and contemporary social and economic adversity, can be rigorous and culturally acceptable and useful. The PhD study has also provided a means for the intervention to be replicated in the future by using a tested intervention manual. Most importantly this intervention has cultural salience because it can be owned and led by the men and their communities. Men's groups offer a space where fathers, grandfathers and uncles can provide other men with a sense of hope that things can change, as well as the knowledge, skills and confidence to sustain better relationships with their children, partners and communities (Reilly & Rees, 2018). After all, and as stated in Chapter 3, if you have strong fathers, you will have strong families, and if you have strong families, you will have strong communities.

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Appendix 1

Strengthen Dad's Identity Manual

Contents

PROGRAM OVERVIEW:

ACKNOWLEDGEMENT:

WEEK ONE:

SESSION ONE - START UP SESSION:

SESSION TWO - STARTING FROM DAD'S STRENGHTS:

SESSION THREE – UNDERSTANDING MEN'S PARENTING:

Week TWO:

HOMEWORK - DOING MEN'S PARENTING:

Week THREE:

SESSION ONE – SHARING HOMEWORK

SESSION TWO - BENEFITS OF PARENTING TO YOU AND YOUR FAMILY:

SESSION THREE - GROUP ACTIVITY:

1. PARENTING KNOWLEDGE AND AWARENESS
2. PARENTING CARE-SEEKING BEHAVIOUR

PROGRAM OVERVIEW:

Title: *The Strengthen Dad's Identity manual forms part of a PhD study titled "A trial of a community based intervention to support the active engagement of Aboriginal and Torres Strait Islander men in parenting, to improve men's feelings of empowerment, reduce mental distress, family conflict, and reduce drug and alcohol use."*

Objective: The manual forms part of an intervention to see whether principles of adult learning and empowerment administered to Aboriginal and Torres Strait Islander men increases knowledge of men's role as parents, improves components of their role as parents, increases feelings of empowerment, reduces family conflict, and decreases mental distress and use of alcohol or drugs.

What we think: We consider that men who participate in a structured intervention will have an increased understanding of the role of men as parents and are able to identify benefits from their engagement in the role of parenting. We also hypothesise that men who learn more about parenting and begin to engage in parenting will have improved feelings of empowerment, lower rates of mental distress, less family conflict and reduced consumption of alcohol and drugs.

Method: Eighty men aged 18 years and over, will be recruited consecutively into men's groups in five separate Aboriginal communities, four in Far North Queensland, and one in the Lower Gulf of Carpentaria. To be eligible, participants will have at least one child under the age of 18 and be living in a family unit which includes a female partner and at least one child and other family members if it is an extended family unit. Nevertheless, single fathers, grandfathers, and uncles will not be excluded. Men will be recruited by word of mouth and the use of fliers. Men who are currently participating in men's groups, men's group facilitators and community health workers will assist with recruitment. Eligible and consenting men will be randomly assigned to a two-session, three week, and group intervention, manualised and led by a trained facilitator for each group in a men's group format. The intervention focuses on men's parenting (with stress management and men's group activity), and the intervention group-as-usual condition will contain two structured sessions of stress management only.

Structured interviews assessing knowledge, attitudes and beliefs about men's parenting, empowerment, mental distress, alcohol and drug use and family relationships will be administered pre and post intervention (twice) for both groups.

Dissemination of Findings: The intention of this study is to provide formal and informal feedback of preliminary findings to Aboriginal and Torres Strait Islander men associated with this research, men's groups, health services and community leaders. Final findings will be presented in report form and presentations to each community and all publications will be made available to communities. All opportunities for translation of research findings into practice and policy will be sought by the PhD candidate.

ACKNOWLEDGEMENT:

Week 1, Session 2 has been adapted from the Family Well Being empowerment program

WEEK ONE:

SESSION ONE - START UP SESSION:

Learning Outcomes

This introductory session provides a practical way to commence the workshop. This is only one option, as with all sessions, the session can be adapted to suit the group.

WELCOME AND HOUSEKEEPING

Preparation

Prepare a copy on the handouts for this session to give each person in this group. On butchers' paper, whiteboard or coloured cardboard write up a list of all of the Session topics for Stage 2. Have an exercise book and a pen ready to give to each participant to use as their journal if they need it (they might like to continue with the same book they used for Stage 1).

Lesson Plan

Provide an overview of men identity as dad's, explaining that the program aims "to strengthen and deepen the knowledge and skills learned from men about being parents" in particular

understanding of the skills and barriers to being fathers and the benefits of men as fathers to their partner and children.

Hand out exercise books as required and tell participants these will be used for reflection through-out the sessions.

Group Agreement

The group agreement creates an environment that is both productive and safe for the men to discuss freely knowing that it will remain confidential.

WEEK ONE:

SESSION TWO - STARTING FROM DAD'S STRENGHTS:

Duration: 10 minutes

Learning Outcome:

To provide awareness, that we all have strengths; the things that keep us strong, as well as the people that make us feel stronger. This session also aims to provide discussions about our history and the role of being dads in the past and now.

Lesson Plan:

- Ask the participants to write down anything about being fathers, in history and now.
- Brainstorm words (what the participants had written down) about parenting in the past and now. Think about the similarities and the differences.
- Ask the participants - What are the things (activities) that make you happy
- Who are the people that help you feel strong? Get the men to write their responses in the root section of the tree. (see attachment)

Week One:

SESSION THREE – UNDERSTANDING MEN'S PARENTING:

Duration: 50 minutes

Learning Outcomes:

- To discuss and learn the barriers or problems for men as parents.
- To discuss and learn what a man can do to be a good parent
- Discuss why men's parenting is good for kids

Lesson Plan

Brainstorm barriers for men as parents. Talk about each point and then see if the men can remember these issues, and talk over them again.
[TALK ABOUT WHICH POINTS BELOW ARE MOST IMPORTANT]

What are the barriers or problems that confront men as parents?

1. You don't have time to spend with the kids
2. Lack of trust from partners that I can be a good parent
3. Lack of trust from others that I can be a good parent
4. Not feeling confident
5. Feeling Shame or ridicule
6. Not knowing what to do or say to kids
7. Others: ……Please list them

Brainstorm what dads can do as parents. Talk about each point and then see if they can remember these and talk over them again.
[TALK ABOUT WHICH POINTS BELOW ARE MOST IMPORTANT]

What do men do when they are parents?

[REMEMBER THESE ARE NOT THE ONLY THINGS THAT MEN CAN DO. PARTICIPANTS MIGHT HAVE OTHER IDEAS. PLEASE WRITE THESE DOWN.]

1. Spend time/more time with the children
2. Play sport or with toy or games with them
3. Get involved with the children's activities
4. Offer to help out the partner with the children
5. Take them to school or picking them up from school
6. Help with homework
7. Taking kids fishing or hunting
8. Others: ……

Who should not be involved with parenting kids?

The last two are not true, but they might be mistaken beliefs

1. Anybody that is drunk or taking drugs (true, but OK when sober)
2. Anyone that is going to harm, hurt or frighten the child
3. Anyone that is told by elders or people with authority to keep away from children
4. People living with HIV/AIDS (not true)
5. People who have been in prison (not true unless it was because they did something illegal to kids)

How can a man's parenting benefit his children?

1. Children can learn things from their fathers
2. It is good for children to see men as role models
3. It is good for children to be able to rely on their fathers or to ask their fathers' help
4. Fathers can share their own knowledge and experiences of life with their children (now or when they grow up)
5. Fathers can teach their children culture and tradition
6. Children will feel more secure and happy
7. Children will grow up to feel more confident parents themselves
8. Other: ……

Week TWO:

HOMEWORK - DOING MEN'S PARENTING:

Explain that there is no group next week but during the week the participant should be aware of being a good parent and do all he can to get involved. As him to think about the challenges and what was good about what he did. Ask him to think about these things so that he can share it with the group the week after.

PLEASE REMEMBER IF YOU HAVE ANY WORRIES OR CONCERNS AFTER THESE SESSIONS, PLEASE LET US KNOW SO THAT WE CAN HELP YOU AND TALK ABOUT IT WITH YOU. YOU CAN CONTACT a Doctor, Nurse, Aboriginal/Health Worker, Social Worker etc At YOUR LOCAL COMMUNITY HEALTH CENTRE.

Week THREE:

SESSION ONE – SHARING HOMEWORK

Review Participants Home Work:

What were the highlights?

What were the challenges/barriers?

Where to from here?

SESSION TWO - BENEFITS OF PARENTING TO YOU AND YOUR FAMILY:

Brainstorm following questions

How can a man's parenting benefit his partner?

1. Partners will be happier because they have more help

2. Relationship may be stronger with my partner
3. Our whole family may be closer
4. I will understand more about what it takes to look after the kids
5. Others……..……

How can a man's parenting benefit his own wellbeing?

1. Feel more confident
2. Self-esteem improved and feeling empowered
3. Feel loved by your children
4. Feel appreciated by children
5. Feel appreciated by partner
6. Feel like you have an important role in family and society
7. Be a good role model for other men and boys

SESSION THREE - GROUP ACTIVITY:

Sometimes things can affect our strength as dads. Think about the day-to-day activities that you may need to do to stay a strong person and dad

Write or draw your answer here:

Think about how as a man, you can make sure that your children and partner health and wellbeing is being met.
Ask yourself; what steps do I need to take as a man, to ensure your home is safe and secure for your children and partner?

Remember family, friends or important people can also help you to **meet those immediate Needs.**

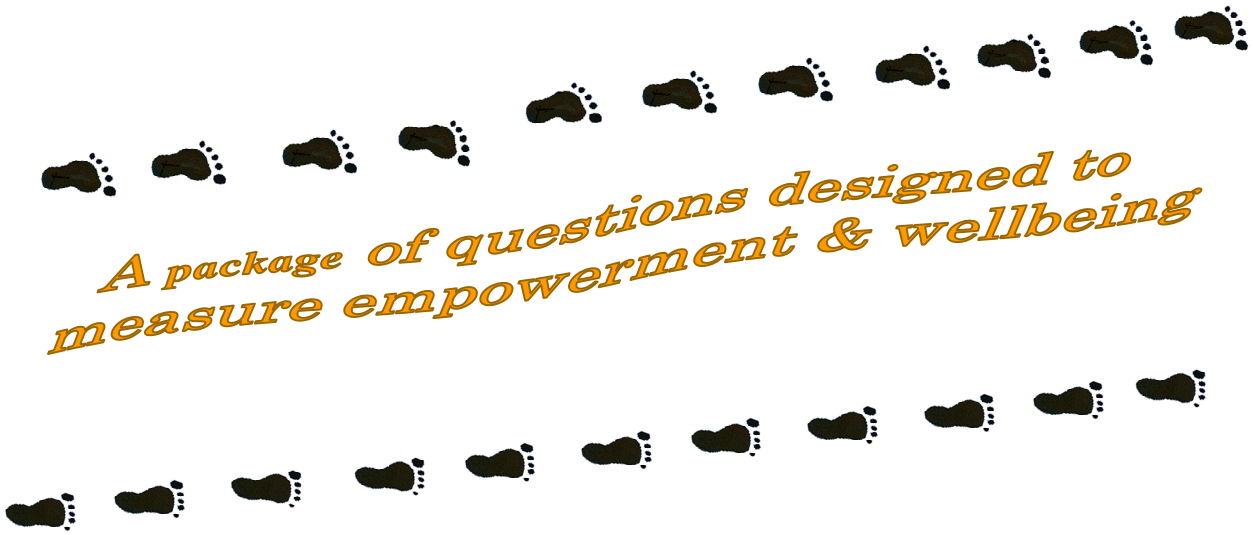
Write or draw your answer here:

What health Care and Support are available to you, your partner and children?

Write or draw your answer here:

The GEM

Growth and Empowerment Measure



The Kauri Pine is one of the oldest, strongest living trees in the world, and its presence in Australia can be traced back 30 million years. This measurement tool incorporates the Kauri Pine Tree as a symbol of empowerment and the reclaiming of Aboriginal culture and strength. While many other Australian trees have significant meaning for different Aboriginal groups, the choice of the Kauri Pine in our work aims to represent the collective strengths of Aboriginal culture as one of the oldest surviving cultures in the world.

The GEM was developed by staff of the Muru Marri Indigenous Health Unit, UNSW and Collaborative Research on Empowerment and Wellbeing Team (CREW) Empowerment Research Program (ERP), James Cook University/University of Qld

INFORMATION SHEET
The Growth and Empowerment Measure

The word "Empowerment" has been adopted by Aboriginal people to mean healing from past wounds, developing strength and skills to live life in a positive way, to have good relationships with others and to work together to make communities a better place. As one young Aboriginal woman commented,

"… Empowerment… its like a tree – there is a foundation (seeds, roots), then the energy and self-esteem to look after yourself (trunk), so you can grow – the more you grow the bigger it gets… on the branches (of the tree) are education, job opportunities, housing".

We have talked to lots of people about "empowerment" and heard many stories about changes people made in their lives that allowed them to grow.
Sometimes they were helped by services and programs, such as the Family Well Being Program. In today's world, getting funding to keep programs going depends on how well we can 'measure' change through time and show whether a program has made a difference for people or not. If we can measure a positive change and show that a program is making a difference, we are more likely to get funding and support to bring it to more people.

The GEM was developed to measure empowerment and growth within yourself, your family and your community. The questions have come from lots of listening and consultation about what people think is important about empowerment in workshops in Alice Springs, Yarrabah, Hopevale and Cairns. Aboriginal people have given their ideas about what we should be asking and how the form should look. People who complete the form also help us improve the questions.

We would like to invite you to answer the questions on the pages that follow. It will take about 30 minutes. Please be aware that it is completely your choice if you participate or not. You are free to stop at any time or not answer any of the questions that you don't want to. We ask you to write a nickname on this form – if you use the same nickname in the future; we can tell you what changes

you have made over time. We will write reports about what we find, but the report won't have anybody's name next to any of the information provided. We welcome your involvement and hope that you are happy to be part of this.

One thing we would like you to keep in mind when you answer these questions is to be careful that you are really thinking about where you are now, not where you'd like to be. In order to say things have gotten better, we have to know exactly where we started from – try to be as true about this as you can.

Thank you for your time and contribution!

SECTION 1: - GETTING TO KNOW YOU

These questions ask about your age, education and training, the place you live and if you are currently working.
Please tick the correct boxes and write your answers in the lines.

Your Name or Nickname _____ **Today's Date** _____

Your Sex: □ **Female** □ **Male** **Your Age** _____

Are you: ☐ **Aboriginal** ☐ **Torres Strait Islander**

☐ **Both Aboriginal & Torres Strait Islander** ☐ **Non-Indigenous Australian**

☐ **Other** _____

Have you completed this survey before? □ **No** □ **Yes**

If yes, where? _____ **When (approx month & year)?** _____

What Community do you live in now? _____

Have you always lived here? □ **No** □ **Yes**

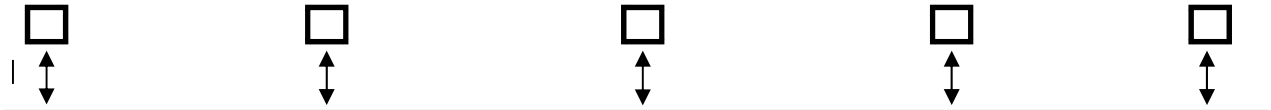
If no, where else have you lived? _____

Do you have a partner? □ **No** □ **Yes**

Do you have children? □ **No** □ **Yes** **If yes, how many?** _____

How many other people do you live with (count both adults & children): _____

How would you describe the place where you live?



Very Bad	*Mostly Bad*	*OK*	*Mostly Good*	*Very Good*
Doesn't meet our needs at all	*some good but mostly problems*	*half n half*	*Some problems but not serious*	*Meets all our needs*

Are you currently employed? □ **No** □ **Yes, part time** □ **Yes, full time**

What work do you do? _____

Do you volunteer your time helping people or groups in your community?

□ **Not much time** □ **Yes, some of my time** □ **Yes, a lot of my time**

How far did you go in school? (Highest school grade completed) _____

Have you done any University study? □ **No** □ **Yes**

Have you done any Technical training, like TAFE? □ **No** □ **Yes**

Have you done any of the Family Well Being program? □ **No** □ **Yes** □ **Just started**

If yes, what parts have you done? (Please tick appropriate boxes below)

□	□	□	□	□	□
Some Stage 1	**All Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Facilitator Stage**

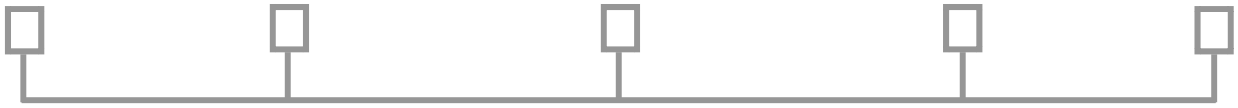
Have you ever been involved in any other healing, personal development or leadership programs? If yes, which ones: _____

SECTION 2: - HOW I FEEL ABOUT MYSELF

Please tick the appropriate box that matches:
The way you usually feel about yourself most of the time

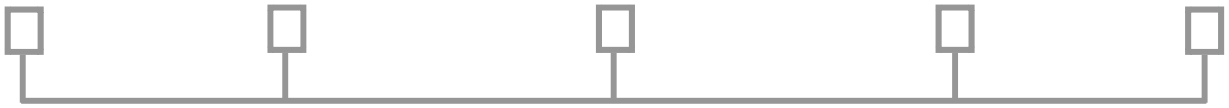
1.

I feel like I don't know anything. ← half 'n' half → I am knowledgeable about things that are important to me.



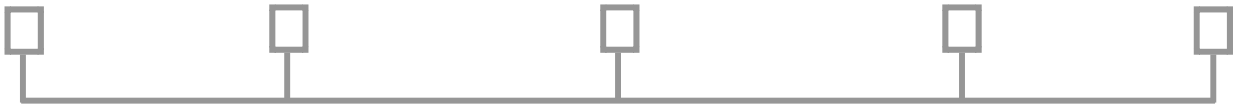
2.

I feel slack, like I can't be bothered to do things even when I want to. ← half 'n' half → I am strong and full of energy to do what is needed.



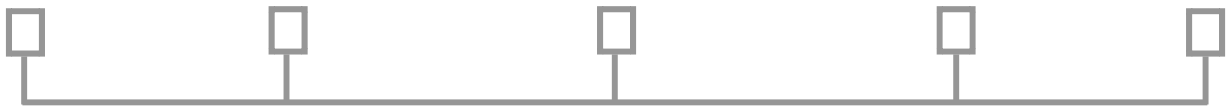
3.

I feel very unhappy with myself and my life. ← half 'n' half → I feel very happy in myself & with my life.



4.

I feel that other people don't admire or value me. ← half 'n' half → I feel that other people admire me and value me.

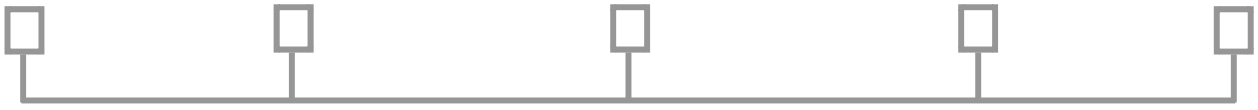


5.

I have no voice. I can't express myself. Nobody listens to me.

half 'n' half

I can speak out and explain my views. People listen.

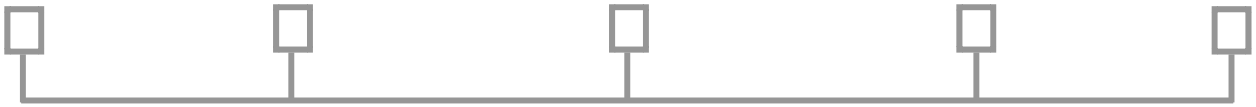


6.

I feel isolated and alone, like I don't belong.

half 'n' half

I belong in community, I feel connected.

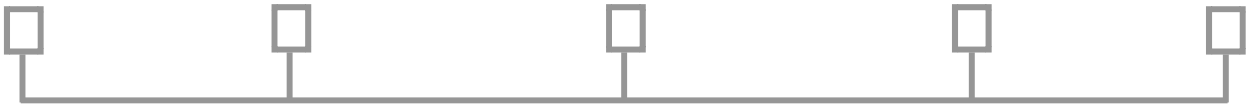


7.

Mostly I feel shame or embarrassed.

half 'n' half

I have confidence in myself.

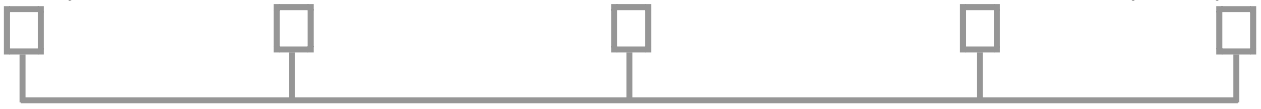


8.

I do things for other people all the time. I'm not looking after myself or my family well.

half 'n' half

I am centred and focussed on meeting the needs of myself and my family.

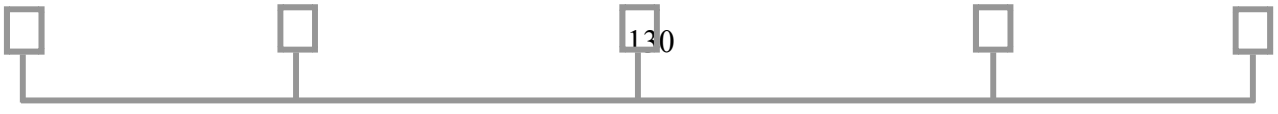


9.

I live in fear of what's ahead.

half 'n' half

I feel safe and secure, I can face whatever is ahead.

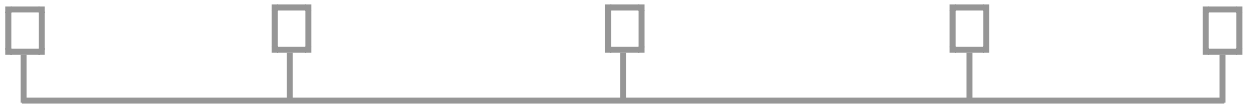


10.

I feel a lot of anger about the way my life is.

half 'n' half

I don't hold anger inside of me about bad things in my life.



SECTION 3: YOUR FEELINGS IN THE LAST MONTH

Please tick the appropriate box that matches:
How much of the time did you have these feelings In the last month?
*** Questions 1 through 6 are the Kessler 6 Psychological Distress Scale developed by Professors Ron Kessler and Dan Mroczek in 1992**

	In the last one month,	None of the time	A little of the time	Some of the time	Most of the time	All of the time
0	How often did you feel **happy in yourself**?	**O**	**O**	**O**	**O**	**O**
1	How often did you feel **nervous**?	**O**	**O**	**O**	**O**	**O**
2	How often did you feel **without hope**?	**O**	**O**	**O**	**O**	**O**
3	How often did you feel **restless or jumpy**?	**O**	**O**	**O**	**O**	**O**
4	How often did you feel **everything was an effort/struggle**?	**O**	**O**	**O**	**O**	**O**
5	How often did you feel **so sad that nothing could cheer you up**?	**O**	**O**	**O**	**O**	**O**
6	How often did you feel **worthless**?	**O**	**O**	**O**	**O**	**O**
7	How often did you feel **angry with yourself or others**?	**O**	**O**	**O**	**O**	**O**

Appendix 3

Parenting KAP measure- Facilitators Guide

Contents

1. SOCIO-DEMOGRAPHIC DATA 132
2. PARENTING KNOWLEDGE AND AWARENESS 133
3. PARENTING CARE-SEEKING BEHAVIOUR 134

Interviewer: Place an X in the box of the selected answer(s). Do not read responses unless the directions indicate.		
SOCIO-DEMOGRAPHIC DATA		
1. 1	Participant ID:	
1. 2	Location interview:	
1. 3	Participant category :	1. Intervention group 2. Normal group
1. 4	Interview date:	____/_____/_____
1. 5	Interviewer:	1. IPad 1 2. IPad 2 3. IPad 3 4. IPad 4
1. 6	Participant Full name:	
1. 7	Age Group	1. Under 20 2. 21-30 3. 31–40 4. 41–50 5. Over 50
1. 8	Gender	1. Male 2. Female
1. 9	What is the highest level of education you have completed?	1. No school 2. Primary school 3. High school 4. Higher education (professional or post-graduate)
1. 10	Do you currently have paid employment?	0. No 1. Yes
1. 11	How far do you live from the nearest service or organisation that supports parents, including fathers?	1. 0–10 kilometres 2. 11–20 kilometres 3. 21–30 kilometres 4. More than 30 kilometres

PARENTING KNOWLEDGE AND AWARENESS	
2. 1 Where did you learn most about parenting for fathers? *[Check all that are mentioned.]*	1. Newspapers, radio, TV and magazines 2. From my own father 3. Brochures, posters and other printed materials 4. Health workers 5. Family, friends, neighbours and colleagues 6. Teachers 7. Men's Group 8. Other
2. 2 In your opinion, how important is parenting by fathers? *[Select one.]*	Not very important Somewhat important Very important
2. 3 In your opinion is it unusual for men to be involved in parenting their children?	No, it is common Somewhat unusual Very unusual
2. 4 What are the barriers or problems that confront men as parents? (check all that are mentioned. Answers do not have to be in the exact words. Don't prompt)	1. Don't have enough time with the kids 2. Lack of trust from partners that I can be a good parent 3. Lack of trust from others that I can be a good parent 4. Not feeling confident 5. Feeling Shame or ridicule 6. Not knowing what to do or say to them 7. Other (please explain):
2. 5 What do good men parents do? (check all that are mentioned. Answers do not have to be in the exact words. Don't prompt)	1. Spend more time with the children/get involved with their activities 2. Offer to help out the partner with the children 3. Taking them to school or picking them up from school 4. Helping with homework 5. Do not know 6. Other (please explain):
2. 6 In your opinion, who should not be involved with parenting kids? *The last two are not true, but they might be mistaken beliefs]*	1. Anybody that is drunk or taking drugs 2. Anyone that is going to harm, hurt or frighten the child 3. Anyone that is told to keep away from children 4. People living with HIV/AIDS 5. People who have been in prison 6. Other (please explain):
2. 7 Can men's parenting be good for children?	0. No 1. Yes
2. 8 How can men's parenting benefit children? *[Check all that are mentioned.]*	1. Children can learn different things from their fathers 2. It is good for children to see men as role models 3. It is food for children to be able to rely on their fathers or to ask their fathers help 4. Fathers can share their own knowledge and experiences of life with their children (now or when they grow up)

	5. Fathers can teach their children culture and tradition 6. Children will feel more secure and happy 7. Children will grow up to feel more confident parents themselves 8. Do not know 9. Other:
2. 9 How can men's parenting benefit their partners? *[Check all that are mentioned.]*	1. Partners will be happier because they have more help 2. My relationship will be stronger with my partner 3. Our whole family will be closer 4. I will understand more about what it takes to look after the kids 5. Do not know 6. Other:
2. 10 How can men's parenting benefit men themselves?	1. Feel more confident 2. Self-esteem 3. Feel loved by your children 4. Feel appreciated by children 5. Feel appreciate by partner 6. Feel like you have an important role in family and society 7. Be a good role model for others

PARENTING CARE-SEEKING BEHAVIOUR	
Who would you talk to if you were worried about your child being sick or hurt? [Check all that are mentioned.]	1. Doctor, nurse, or another medical worker 2. Partner 3. Other family member 4. Close friend 5. No one 6. Other:

Appendix 4

SECTION 4: DOMESTIC AND FAMILY VIOLENCE

You might or might not experience these problems, but we would really like to ask you some questions about it because it is so common, and we need to know more about it. Remember this is totally confidential and we don't even keep you name on what you tell us about it.

`[DV1] [CHECK FOR PRESENCE OF OTHER PEOPLE:]
[DO NOT CONTINUE UNTIL EFFECTIVE [ONLY SELECT ONE]

1. PRIVACY OBTAINED	**NO [0]**	**YES [1]**
2. PRIVACY NOT POSSIBLE	**NO [0]**	**YES [1]**

[READ TO ALL RESPONDENTS:] Now I will ask you questions about some other important aspects home life. I know that some of these questions are very personal however they are really important to the research and possibly good outcomes for Aboriginal and Torres Strait Islander men. Let me assure you again that your answers are completely confidential and will not be told to anyone

[DV2] [MARRIAGE STATUS:] 1 currently married or in a relationship [ ] 2 separated/ divorced [ ]	

When two people marry or live together, they share both good and bad moments. In your relationship with your wife/partner do (did) the following happen frequently, only sometimes, or never?

[DV3] I usually (spend/spent) my free time with her?	Frequently [1]	Sometimes [2]	Never [3]
[DV4] I (consult/consulted) her on different household matters?	Frequently [1]	Sometimes [2]	Never [3]
[DV5] I (is/was) affectionate with her?	Frequently [1]	Sometimes [2]	Never [3]
[DV6] I (respect/respected) her and her wishes?	Frequently [1]	Sometimes [2]	Never [3]

[READ TO ALL RESPONDENTS:] Now I am going to ask you about some situations which happen in some relationships. Please tell me if these apply to your relationship with your (last) wife/partner?

[DV7] I (am/was) jealous or angry if she (talk/talked) to other men?	**YES [1]**	**NO [0]**	DK[888]
[DV8] I frequently (accuse/accused) her of being unfaithful?	**YES [1]**	**NO [0]**	DK[888]
[DV9] I (do/did) not permit her to go out with her friends? <Note: negatively worded Q; be careful with your scoring>.	**YES [1]**	**NO [0]**	DK[888]
[DV10] I (try/tried) to limit her contact with friends or family?	**YES [1]**	**NO [0]**	DK[888]
[DV11] I (insist/insisted) on knowing where she (is/was) at all times?	**YES [1]**	**NO [0]**	DK[888]
[DV12] I (do/did) not trust her with money? <Note: negatively worded Q; be careful with your scoring>.	**YES [1]**	**NO [0]**	DK[888]

READ TO ALL RESPONDENTS:] Now if you will permit me, I need to ask some more questions about your relationship with your (last) wife/partner. Does/did you ever do the following to your current or last wife/partner:			How many times did this happen during the LAST 12 months?
[DV13] Say or do something to humiliate her in front of others?	**YES [1]**	**NO [0]**	
[DV14] Threaten her or someone close to her with harm?	**YES [1]**	**NO [0]**	
[DV15] Hit her, push her, shake her, or throw something at her?	**YES [1]**	**NO [0]**	
[DV16] Slap her or twist her arm?	**YES [1]**	**NO [0]**	
[DV22]Are there any other ways in which you might have hurt her that I have not asked about?	**YES [1]**	**NO [0]**	No comment[999]

[**DV32**] *Has anyone ever hit, slapped, kicked or done anything else to hurt your physically? [IF NO, STOP THIS SECTION AND MOVE ONTO NEXT]*	**YES [1]**	**NO [0]**	No Answer [999]
[DV 33] *How old where you when you were first hurt by someone?*			

[**DV33**] Who has physically hurt you in this way? Anyone else? [RECORD ALL MENTIONED] *[IF ONLY ONE PERSON MENTIONED SKIP NEXT Q AND GO TO DV35]* *[IF MORE THAN ONE, CONTINUE TO DV34]*	1. Mother 2. Father 3. Stepmother 4. Stepfather 5. Sister 6. Brother 7. Daughter 8. Son 9. Late/ex-wife/ex-partner 10. Current girlfriend 11. Former girlfriend 12. Mother-in-law 13. Father-in-law 14. Mother female relative/in-law 15. Other male relative/ in-law 16. Female friend /acquaintance 17. Male friend /acquaintance 18. Teacher 19. Employer 20. Stranger Other (specify)_____

Appendix 5

Alcohol Screen Audit

Australian Government
Department of Veterans' Affairs

Alcohol Screen (AUDIT)

AT EASE THE RIGHT MIX

Full Strength Beer 285ml 4.8% Alcohol	Low Strength Beer 425ml 2.7% Alcohol	Pre-mix Spirits 275ml 5% Alcohol	Wine 100ml 13.5% Alcohol	Spirits 30ml 40% Alcohol	Full Strength Beer Can or Stubbie 375ml 4.8% Alcohol
					

*This guide contains examples of **one standard drink**.*

A full strength can or stubbie contains ***one and a half standard drinks***.

Introduction

Because alcohol use can affect health and interfere with certain medications and treatments, it is important that we ask you some questions about your use of alcohol. Your answers will remain confidential, so please be as accurate as possible. Try to answer the questions in terms of **'standard drinks'**. Please ask for clarification if required.

AUDIT Questions Please tick the response that best fits your drinking.

						Score	Sub totals
	Never	*Monthly or less*	*2 - 4 times a month*	*2 - 3 times a week*	*4 or more times a week*		
1. How often do you have a drink containing alcohol?	☐ Go to Qs 9 & 10	☐	☐	☐	☐		
	1 or 2	*3 or 4*	*5 or 6*	*7 to 9*	*10 or more*		
2. How many standard drinks do you have on a typical day when you are drinking?	☐	☐	☐	☐	☐		
	Never	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*		
3. How often do you have six or more standard drinks on one occasion ?	☐	☐	☐	☐	☐		
4. How often during the last year have you found that you were not able to stop drinking once you had started?	☐	☐	☐	☐	☐		
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	☐	☐	☐	☐	☐		
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	☐	☐	☐	☐	☐		
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	☐	☐	☐	☐	☐		
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	☐	☐	☐	☐	☐		
	No		*Yes, but not in the last year*		*Yes, during the last year*		
9. Have you or someone else been injured because of your drinking?	☐		☐		☐		
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	☐		☐		☐		
						TOTAL	

Supplementary Questions	*No*	*Probably Not*	*Unsure*	*Possibly*	*Definitely*
Do you think you presently have a problem with drinking?	☐	☐	☐	☐	☐
	Very easy	*Fairly easy*	*Neither difficult nor easy*	*Fairly difficult*	*Very difficult*
In the next 3 months, how difficult would you find it to cut down or stop drinking?	☐	☐	☐	☐	☐

D0718 - 8/09 - P1 of 2

Appendix 6

HREC Approval No: 1207/16

THE UNIVERSITY OF NEW SOUTH WALES

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM

Research Title:

Chief Investigator: My name is Lyndon Reilly, and I am a Badtjala man from K'gari (Fraser Island and Hervey Bay Region). For many years now I have been working with Aboriginal and Torres Strait Islander men. This work involved strengthening men's sense of identity and improving wellbeing through guiding leadership and empowerment workshops.

Introduction

Recently, I had worked on a project titled *Strong Fathers Strong Families*. The scope of this project was to promote the roles of Aboriginal and Torres Strait Islander fathers, grandfathers, and uncles within three communities in the Lower Gulf of Carpentaria (Queensland) region. During this time, and based on my personal experience being a father, grandfather, and uncle, I discovered that there was not a lot written or resources available in this area. Discovering this clear lack of information and resources available to supports the roles of Aboriginal and Torres Strait Islander fathers, grandfathers, and uncles as parents, I felt that it was my duty an Aboriginal man to explore and improve knowledge of parenting and men's participation in the family, with aim that it would improve health and wellbeing outcomes for men, families and communities. This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

What is the purpose of this research?

The purpose of this yarn is to test a men's group-based intervention (a special program) about the experiences of Aboriginal and Torres Strait Islander men in their parenting roles, and what is needed to support men in their parenting roles. To do this I would like to yarn with fathers who are caring for children, and to ask them about what they know, what the problems with parenting are and what the things that help to be good parents are. The yarns will concern parenting knowledge and awareness, as well as parenting care-seeking behaviours.

Why have I been invited to participate in this research?

I would like to invite you to join a group of men and share your story and yarn about being a parent. I am interested to share information about how Aboriginal and Torres Strait Islander men experience parenting roles. We want to yarn about what can better support men in their roles as parents. This all happens over 3 weeks with men's groups (with the intervention) at week 1 and week 3. During week 2 you just practice more about parenting and keep being a good dad. We will also interview you before the yarning session and after it and then about 3 months later (so 3 times). We are not looking to see who is right or wrong; we just want to learn about what you learnt from the yarning groups, and we also want to know how you are feeling and if the groups helped you in any way. The interview will ask you about what you know about parenting, how strong and in control of your life you feel, about your current mental health and wellbeing, your family relationships, as well as alcohol and drug use. The interviews will be carried out within men's group's gatherings, or a place that is comfortable for the group. The information you provide in the interviews is totally confidential and we are bound to ensure that your name is never reported and nothing about you is able to be identified. The men in the men's group (the intervention) will all agree not to talk outside the group about what is said inside the group. Most men respect this agreement; however, we can never guarantee that some men might say something. Remember in any reports or articles you will not be identified in anyway, unless you give permission.

Description of study procedures and risks:

If you decide to participate, it is not expected that this yarn will cause you any harm however due to the type of questions. If you do experience some sadness or bad feelings, or if you recall some negative experiences from the past, then as the principal researcher, I will carry a mobile phone and organise for you to talk to an appropriate support person. You can always contact me after the group as well, if you feel you would like to talk with someone.

Counselling Contacts:

Community and Counselling Service	Contact details
Aurukun: Apunipima Wellbeing Centre	(07) 42206200
Mossman Gorge: Apunipima Wellbeing Centre	(07) 40844800
Hope Vale: Apunipima Wellbeing Centre	(07) 42128200
Doomadgee**:** North West Remote Health Wellbeing Centre	(07) 47429406
Mornington Island: Junkurlaka Community Justice Group	(07) 47457278

What are the possible benefits of taking part?

One of the aims of the yarns is to find ways that will benefit individuals and communities. What we find could be used to identify and plan programs that can assist men to be confident parents, and to improve their wellbeing as a result of being more engaged with parenting. Other aims are to promote health improvement plans to funding bodies and governments; identify ways to handover knowledge back to communities; and establish future action and teamwork. The yarns can also bring us together as men to recognise shared areas of concern around the roles and responsibilities of men in the community; examine the importance of these concerns for the men, and the extent to which they are concerned about culturally appropriate practices; and identify issues related to these concerns. The yarns through a mutual process will help us to share and promote the meaning and importance of men engaging in the upbringing of children in their care; and understanding the role and responsibilities of men as fathers, grandfathers, and uncles within today's society.

What are the alternatives to participation?

Participation in this research is voluntary. If you don't wish to take part, you don't have to. Your decision not to participate will not affect your future relations with the University of New South Wales. You can also drop out of the study at any time without anyone getting upset about it. All you tell us is confidential and everything you say will be analysed without your name or any information that can identify you on it.

Confidentiality and disclosure of information

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission, except as required by law. If you give us your permission by signing this document, we plan to *discuss/publish* the results. I will provide an academic report for the university and a community report which will be available locally to participants, men's groups, community organisations and health care services. Findings may be used in publications in journals and at conferences and forums. You will not be identified in reports or publications of the results and findings of the project, unless you approve.

Complaints

If you have any concerns about the nature/ ethical conduct of the research project, complaints may be directed to the Ethics Secretariat, The University of New South Wales, SYDNEY 2052 AUSTRALIA (phone (02) 9385 4234, fax (02) 9385 6222, email humanethics@unsw.edu.au. In addition, you can contact the Aboriginal Health & Medical Research Councils Ethics Committee, (phone (02) 9212 4777, fax (02) 9212 7211, email ethics@ahmrc.org.au. Any complaint you make will be investigated promptly and you will be informed out the outcome.

Feedback to participants

The intention of this study is to provide feedback of findings to Aboriginal and Torres Strait Islander men and relevant service providers associated with this research, such as the participants, the men's groups, and the project partners; Junkurlaka Community Justice Group: Mornington Island, North West Remote Health: Doomadgee, and Apunipima Cape York Aboriginal Health Council: Aurukun, Hope Vale and Mossman Gorge. The researchers aim use findings related to a useful intervention within programs and services in the Aboriginal communities. The aim of this study is always to strengthen Aboriginal men's roles as fathers, grandfathers and uncles. Thus, the findings of this research will be shared with community members and their feedback will be valued and applied to inform analysis, reporting and translational activities.

Your consent

Your decision whether or not to participate will not prejudice your future relations with the University of New South Wales. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice.

If you have any questions, please feel free to ask us. For more information about this yarn or study please feel free to contact my research supervisors, or myself anytime, and we will be happy to answer them.

PhD Student: Lyndon Reilly
Email: Lyndon.reilly@yahoo.com.au
Mobile: 0419715468

Primary Advisor: Professor Susan Rees
Email: s.j.ree@unsw.edu.au
Phone: 02 96164311

You will be given a copy of this form to keep.

THE UNIVERSITY OF NEW SOUTH WALES

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM (continued)

Declaration by Participant

Research Title: A trial of a community-based intervention to support the active engagement of Aboriginal and Torres Strait Islander men in parenting, and to improve men's feelings of empowerment, reduce mental distress and reduce drug and alcohol use

PhD Student: Lyndon Reilly

□ I have read the Participant Information Sheet, or someone has read it to me in a language that I understand.

□ I understand the purposes, procedures and risks of the research described in the project.

□ I have had an opportunity to ask questions and I am satisfied with the answers I have received.

□ I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future care.

□ I understand that I will be given a signed copy of this document to keep.

……
……
Signature of Research Participant Signature of Witness

……
……
(Please PRINT name) (Please PRINT name)

……
……
Date Nature of Witness

Message from PhD Student

Sincere thanks to you for agreeing to participate in this study, the information you provide will help to create a better understanding of the parental experiences of Aboriginal and Torres Strait Islander fathers, grandfathers, and uncles. In addition, your information will be valuable in understanding ways to improve support for rural and remote Queensland Aboriginal and Torres Strait Islander men in their parenting roles.

REVOCATION OF CONSENT

Research Title: A trial of a community-based intervention to support the active engagement of Aboriginal and Torres Strait Islander men in parenting, and to improve men's feelings of empowerment, reduce mental distress and reduce drug and alcohol use

PhD Student: Lyndon Reilly

I hereby wish to **WITHDRAW** my consent to participate in the research proposal described above and understand that such withdrawal **WILL NOT** jeopardise any treatment or my relationship with The University of New South Wales and Monash University Melbourne

……

……

Signature Date

……

Please PRINT Name

The section for Revocation of Consent should be forwarded to:

PhD Student: Lyndon Reilly
Email: Lyndon.reilly@yahoo.com.au
Mobile: 0419715468