

# Qualitative exploration of an Aboriginal and Torres Strait Islander adolescent community-controlled social and emotional wellbeing program

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## Abstract

**Objective:** Wellbeing in adolescence is an important opportunity to shape healthy futures. However, psychosocial distress is high amongst adolescents, and rural Aboriginal and Torres Strait Islander adolescents are at an increased risk. Situated within a rural Queensland community-controlled health service, this research explored community perceptions of an adolescent social and emotional wellbeing program.

**Methods:** Through yarning circles, adolescents, parents/guardians, community leaders, Elders and health service staff shared their perceptions of the program. Participants were purposively sampled through their existing community-controlled engagement forums. Data were audio-recorded, transcribed, and thematically analysed using NVivo 11.

**Results:** Thirty people (n=30) participated in the research, of whom, 83% identified as Aboriginal. Four themes suggest the program is highly valued. Participants perceived the program as improving adolescent confidence and empowerment, preparing adolescents for adulthood and providing positive role models. Participants felt the program should be upscaled and sustained.

**Conclusions:** The program was perceived as achieving its target outcomes, and several success factors were identified that are consistent with the literature.

**Implications for Public Health:** The program is an example of how adolescent social and emotional wellbeing can be done well in the community-controlled setting. Exploring program expansion and further evaluation is encouraged.

**Key words:** health equity, wellbeing, indigenous, adolescent, qualitative, rural health

## Background

Supporting Aboriginal and Torres Strait Islander wellbeing through the National Agreement on Closing the Gap is a whole-of-government priority in Australia.<sup>1</sup> Aboriginal and Torres Strait Islander social and emotional wellbeing is holistic, deeply connected to culture, health and spirituality and includes elements of connection to Country, family and community, cultural expression and self-determination.<sup>2,3</sup> Amongst others, cultural identity, traditional practices, and spirituality protect Aboriginal and Torres Strait Islander wellbeing.<sup>2,3</sup> These, however, continue to be

disrupted by colonial structures that perpetuate inequity across the life course,<sup>4</sup> including in adolescence.<sup>5</sup>

It is widely accepted that adolescence (11–17 years) is a period of rapid physical, emotional, social and cognitive development.<sup>6,7</sup> Behaviours, attitudes and beliefs established in adolescence can influence life outcomes that impact across generations.<sup>8,9</sup> Evidence suggests that social, emotional and mental wellbeing in adolescence impacts health and wellbeing in adulthood, including the risk of overweight and obesity.<sup>10–12</sup> Hence, adolescence is a critical timepoint to shape healthy futures and stimulate intergenerational change.<sup>6,8</sup>

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Figure 1: Program principles.<sup>16</sup>

Almost one-quarter (24%) of Australian adolescents experience emotional, peer and/or social problems.<sup>7</sup> Twenty percent experience high or very high levels of psychological distress.<sup>7</sup> In comparison to regional and urban Australia, rural adolescents experience poorer social and emotional wellbeing and are at a higher risk of alcohol and substance abuse.<sup>7</sup> Ten per cent of the health gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians has been linked to mental health conditions.<sup>13</sup> Hence, appropriate policy, programs and practices that support rural Aboriginal and Torres Strait Islander adolescents are needed to reduce inequity.

The Aboriginal and Torres Strait Islander Community-Controlled (hereafter, community-controlled) health sector is an important element of Australia's health system. It delivers culturally responsive, multi-disciplinary and accessible services that foster wellbeing, self-determination and empowerment.<sup>14</sup> In many cases, these services support communities across the life course and are well placed to respond to local community needs.<sup>13,15</sup>

This study aimed to qualitatively explore community perceptions of an adolescent social and emotional wellbeing program (hereafter, the program) within a community-controlled health service in rural Queensland, Australia. The program, delivered after-school, targets youth (12–17 years) to drive social and emotional wellbeing through four principles: social inclusion, mentorship, life skills and education (Figure 1).<sup>16</sup> Led by a local co-ordinator, in partnership with community, the program aims to foster a consolidated positive reinforcement environment across adolescent life domains.<sup>16</sup> Program activities include sporting competitions, team games, homework help, outdoor education, employment and organisational skills as well as group participation in community and cultural events. Previous evaluation of the program suggests that target outcomes related to improved self-esteem, healthy relationships, education, employment, sense of pride, purpose and worth are being realised.<sup>16</sup> However, to date, the program has not been formally evaluated in the peer-reviewed context.

## Methods

### Positionality

It is acknowledged that the authors' positionality plays an active role in influencing the research process. As such, it is appropriate that we, the authors, position ourselves relative to this research.

The lead author (RE) is a non-Indigenous woman who was living and working within the community in which this research was conducted. This research was undertaken as part of her PhD Candidature. The authorship team consisted of a combination of Aboriginal (FL), non-Indigenous Australian (RE, JW and RL) and Fijian Australian (SN) researchers. FL is a Wakka Wakka man and leader of the community-controlled health service within which this research is situated. He, and the team, has extensive experience working with communities to design and evaluate public health and prevention initiatives. As outsiders to the community, RE, JW, RL and SN approached this research with a deep sense of responsibility, respect and humility, acknowledging the historical and ongoing impacts of colonisation, dispossession and systemic inequities that Aboriginal and Torres Strait Islander communities continue to face. We reflect on the power dynamics inherent in academic research and are conscious of enabling a collaborative and ethical space that prioritises the agency and autonomy of Aboriginal and Torres Strait Islander participants and colleagues.

Through her experiences living in the community, RE has established trust and meaningful partnership with the local community. Consciousness of being non-Indigenous and the potential biases this may bring, RE proactively used multiple strategies to ensure the research was conducted in a culturally safe manner and in balance with an Aboriginal and Torres Strait Islander lens. For example, she sought cultural mentorship in an Aboriginal Elder with ancestral ties to the community who supported reflexivity particularly through data analysis processes, met with local Elders to seek permission to conduct the research, actively consulted Aboriginal colleagues on all elements of how the research should be conducted (and with whom),

responded directly to community suggestions about how the research was being conducted as they arose and conducted data collection in partnership with a local Aboriginal colleague. The team has actively sought to platform the voices of Aboriginal and Torres Strait Islander participants and be guided by their epistemological and axiological knowledges and worldviews. Partnering with the community before, during and after this research has generated new knowledge that is the product of both Euro-centric and Aboriginal and Torres Strait Islander epistemologies. The purpose of this manuscript is to share some of the knowledge generated through this partnership with the academic community. Separate appropriate communications have been developed and disseminated to the community to disseminate findings.

### Research setting

Situated in a rural Queensland community, this research was undertaken in partnership between Health and Wellbeing Queensland, the University of Queensland and the local community-controlled health service. This co-leadership is formally recognised by a collaborative research agreement amongst all partners.

The community in which this research is situated is made up of 3,000 residents, 22% of whom identify as Aboriginal and/or Torres Strait Islander.<sup>17</sup> The research was situated within a community-controlled health service which operates in alignment with the Queensland Aboriginal and Islander Health Council values and goals. Queensland's community-controlled sector strives to drive improved Aboriginal and Torres Strait Islander health outcomes through cultural safety, strong Aboriginal and Torres Strait Islander leadership, governance and self-determination.<sup>18</sup> In this research, governance, decision-making and processes were conducted on the advice and permission of the local community-controlled health service, who shared leadership over the project. The program under investigation was developed and delivered by the community-controlled health service in alignment with a nationally accepted definition of community control—a process allowing for the local Aboriginal and Torres Strait Islander community to be involved in its affairs in accordance with protocols or procedures determined by the community.<sup>19</sup> Being situated in this context, this research was heavily influenced by processes of community control. Through this influence, and with the authors remaining conscious of their biases, the research was undertaken in alignment the Principles of Ethical Research Conduct with Aboriginal and Torres Strait Islander peoples.<sup>20</sup>

Research questions for this study were developed iteratively through community engagement undertaken as part of the lead author's PhD. This study responds directly to community aspirations to share their experiences with the program.

### Framework and methodology

De-colonial and Indigenous Standpoint theories were used to guide the researchers' process and reflexivity.<sup>21–24</sup> These theories, with re-Indigenising research frameworks, have guided considerations of positionality, methodology and knowledge dissemination. It is acknowledged that to undertake a re-Indigenising research process, it is critically important for the (predominately non-Indigenous) authorship team to uphold principles of ethical research conduct<sup>20</sup> and a high degree of integrity and transparency.<sup>21</sup>

In alignment with de-colonial theory, the methodological design sought to utilise Aboriginal and Torres Strait Islander qualitative methods, amplify community voices and partner in alignment with local priorities. As such, the Aboriginal and Torres Strait Islander methodology of yarning was utilised to conduct this research in a culturally appropriate manner. A yarning circle is a dialogue process used to share information, learn and build respect and trust.<sup>24–26</sup>

### Participants

Yarning-circle participants included adolescents participating in the program, their parents/guardians, community leaders, Elders and health service staff. Participants were recruited purposively through existing community engagement mechanisms established by the community-controlled health service. This included face-to-face recruitment through program sessions, health service staff meetings, Elders and community leader groups and community events. The lead researcher was invited to these forums, explained the research and, with the permission of the group, conducted yarning circles within these forums. Furthermore, online and written communications about the research were distributed throughout community inviting participants to yarning circles. All participants provided voluntary, informed written consent and parent/guardian consent if the participant was less than 18 years of age. Participants were asked to agree to maintaining the confidentiality of matters discussed within the yarning circle through a written form, prior to participation.

### Data collection

The research was conducted in community settings that were familiar to participants and undertaken during May–June 2021. Data were collected by the lead author and a local Aboriginal colleague who shared control over the data collection process. In groups of 5–10 participants, yarning circles explored participant perceptions of the program. Researchers made efforts to ensure all participants had equal opportunity to contribute to the research. This was facilitated by ensuring each yarning circle was made up of one participant group. To achieve this, yarning circles were situated within naturally separated forums such as at the program (for adolescents), at staff meetings (for health-service staff) and at Elders groups (for Elders). Furthermore, participants were provided the option to respond via written survey or in one-on-one discussions (if they were unable or unwilling to participate in group yarning).

Yarning sessions explored topics related to health, empowerment, rural living and wellbeing in relation to the program. The yarning circles were guided by open-ended questions developed by the research team in partnership with a local Aboriginal colleague. Questions included, but were not limited to, empowerment in adolescence, the role of the program in adolescent social and emotional wellbeing, barriers and enablers of adolescent/family health and wellbeing and the influence of the environment/rural town on adolescent wellbeing. For example, "What sort of impacts is the program having in this community?" While questioning was utilised to focus the discussion, participants were free to direct the yarn towards topics of importance to them. Prompts were utilised to encourage discussion that would deepen and confirm the researchers' understanding of participant perceptions (for example "How do you think that impacts adolescent wellbeing?", or "Why do you think that element of the program is working well/not well?").

Table 1: Participant characteristics (n=30)

Participant group	n	Mean age (years)	Sex (% female) <sup>b</sup>	Aboriginal (n) <sup>c</sup>
Adolescent	10	14	50%	10
Parent/guardian	2	36	50%	2
Health service staff	8	39	50%	5
Elder	4	a	75%	4
Community leader	6	39	50%	1

<sup>a</sup>n=1 Elder reported their age, which has not been reported in the interest of participant confidentiality.

<sup>b</sup>all other participants identified as male. No participants identified as non-binary or gender diverse.

<sup>c</sup>all other participants identified as non-Indigenous. No participants identified as Torres Strait Islander or Aboriginal and Torres Strait Islander.

Where it was not explicitly obvious that a comment was generally supported by the group, prompts were used to, respectfully, determine the level of agreeance from other members (for example, “have others had a similar experience?”).

### Data analysis

With the knowledge and permission of all participants, yarning circles were audio-recorded. Data were transcribed verbatim by hand and thematically analysed utilising NVivo 11.<sup>27</sup> Thematic analysis provides flexibility for effective analysis of complex data.<sup>28</sup> Systematically, each transcript was analysed for meaningful text and coded to a relevant theme by the lead author and later confirmed by the wider authorship team. The emergent themes were analysed in the context of participant groups/yarning circles.

This research was approved by The University of Queensland Human Research Ethics Committee B (2020/HE002894) and conducted with the permission of the local community-controlled health service.

### Results

Thirty people participated in the research. Of which, 83% (n=25) identified as Aboriginal. All yarning circles took place within existing community engagement forums established by the community-controlled health service. All parents/guardians opted to participate via written survey, rather than yarning circle. Ten adolescents participated in this research, representing 33% of total program participants. All adolescent participants were active participants of the program. See Table 1 for participant characteristics.

Health service staff members were from a range of professions (for example, management, administration, clinical services and counselling). Community leaders included local leaders and education and other service providers. All community leaders and Elders had knowledge of the program, but their level of involvement varied. For example, some were broadly aware of the program through indirect involvement, while others had intimate knowledge of it through personal, direct involvement.

Four broad, overarching themes emerged from the data, each representing a cluster of ideas, which is representative of the nature of yarning between participants. As expected, yarning circles were unstructured and covered many interrelated topics and ideas.<sup>24,26</sup> The program was discussed holistically with several ideas threaded into one response or conversation. The findings of this research are therefore presented accordingly. This tendency to view “the whole” rather than its individual parts is consistent with Aboriginal and

Torres Strait Islander world views.<sup>2</sup> The authors have deliberately chosen to present the findings in ways that best represent the voice of research participants in alignment with Indigenous Standpoint theory. As such, themes and accompanying participant quotes are presented in the following and in Table 2 verbatim (with minor edits for clarity and to protect participant anonymity).

The themes collectively speak to the general perception that the program is highly valued by participants. The positive impact of the program was observed by adult participants and, mostly, verified by adolescents. Generally, there were high levels of agreeance within yarning circles, reflecting similar perceptions within participant groups. Across groups, participants indicated that the program had contributed to improved adolescent self-confidence, self-esteem, social connectedness and general wellbeing. However, differences emerged between adult and adolescent participants in their perception of the program, and some groups held stronger views across the four themes. Despite these differences, consistency across themes emerged (see Table 2).

### Theme 1: Improved adolescent confidence and empowerment

All participant groups identified empowerment and confidence as important elements of the program that contributed to overall health and wellbeing. Adult participants described the experience of witnessing adolescent self-improvement journeys. They described adolescents entering the program as shy, unsure and generally of low self-confidence and gave examples of how adolescent behaviour had changed over the course of program to reflect improved self-esteem. This was seen as a process that occurred over time, increasing with exposure to the program. For example, “*Seeing you guys (adolescents) go from really shy and medium to low self-esteem, to really high self-esteem and really confident in yourself*”—health service staff.

Adult participants noted that their observations were from an “outsider” perspective. As such, they were cautious to confidently attest to a changed state of mind within adolescents. For example, “*But, this is only for me as an observer. I can't say what you (adolescents) feel inside, but from my observer, looking at you guys, I think you've gained confidence in yourselves*”—health service staff.

Adolescents, themselves, generally agreed that the program had improved their confidence and empowerment. While they supported the idea that they had experienced positive changes in their self-esteem, all except one adolescent were reluctant to share with the yarning circle their inner thoughts and mental processes related to empowerment.

Adult participants suggested that the mechanism for building adolescent confidence and empowerment within the program was through the opportunity to try new activities that would otherwise not be available to participants. For example, cooking, sports, art, and hospitality skills. Having the freedom to test and trial these new activities, without judgement, in a safe environment was seen as a contributor to adolescent confidence. This was seen as particularly important for adolescents who were not feeling successful within other life domains such as in school or at home. Adult participants felt it was important for adolescents to have different avenues to develop skills that may not be offered at home or in school. The program was seen as an opportunity to facilitate this, and is in the

Table 2: Participant quotes.

Theme	Participant quotes
Improved adolescent confidence and empowerment	<p><b>Adolescents</b></p> <p>“Well um my confidence has come up a lot since doing this”.</p> <p>“Researcher: So does everyone think that's an important part of (the program) that you want to do more of (confidence building and empowerment activities)?” “Yep”—(multiple).</p> <p>“That was fun (in response to discussion of an empowerment activity)”.</p> <p><b>Health service staff</b></p> <p>“If you look at the (community event) for an example of where your mind and your empowerment is. When we first got there (you guys) were... and you seen people... and then you seen the clothes (uniform) that you had to dress in... you like uhh shame uhh I look silly uhh, uuh. But then... your self-esteem and your healthy mind kicked in where you're like, 'Oh', your chest stuck out, you're proud of yourself, you were proud of the job you'd done...”</p> <p>“When you first come, you would hardly say 'Boo' to me. You were very shy. But now, you pick on me. So, I feel that you felt comfortable and gain confidence”.</p> <p>“I feel that watching each one of you... I think you've gained confidence in yourselves”.</p> <p>“If you're like good at music or good at sports or whatever, like a lot of people, you... have little successes. Every time you are successful it makes you think... you can do other things. Whereas there are other kids, and I was one of these kids, who was never good at anything (in school). So... how do I know that I can try something and be good at it if I've never been good at anything before....”</p> <p><b>Community leaders</b></p> <p>“So the empowerment came from within here (referring to the program)”.</p> <p><b>Parents</b></p> <p>“Empowerment is important to incorporate to this program because it is a good time to co-operate with the (program) team”.</p> <p>“Empower children/families to make better choices for a healthier future”.</p> <p>“All (activities) help with life skills”.</p> <p>“Empower children/families to make better choices for a healthier future”.</p> <p>“Our children are so empowered because our children just gets in and gets every single bit done”.</p>
Preparation for adulthood	<p><b>Health service staff</b></p> <p>“And I reckon that flips too. If you're... if you're good at just say it was sport and you have success, I think on the flipside of that... for me, I was good at sport. Um got picked in pretty much whatever I tried my hand at. But, to go and get a job, I had no confidence whatsoever. I Had a complex with failure, so if you didn't want to do something in work in work or something like that to fail because I was too scared to fail. But in sport, like in sport, I just knew I wasn't going to fail... but, to go and do something different like... on the footy field, on tennis court whatever whatever it was, I had all the confidence in the world, you could not knock me down. But, to go and ask someone for a job or ask someone for something with the fear that they would say no or that I would fail at it, I just wouldn't do it” (<i>health service staff reflection on adolescent processes of becoming employment ready through the program</i>).</p> <p><b>Community leaders</b></p> <p>“She (employer within the community) means they don't know how to interview, they don't know how to work, they don't know how to dress, they don't know how to turn up on time yeah. They... They just like those really inherent like.. That we take for granted I guess a little bit. Like they're just not there and some of that's immaturity thing. But they're not gonna learn if they don't get the opportunity in a workplace too”.</p> <p>“So there is a level of expectation that goes with getting those roles (volunteering for community events through the program), like if you're going to be doing this at these places downtown, this is what these people are going to expect of you. They are going to expect good manners, well dressed, presentation and so on. So, you've already labelled your expectations. “And just with the... that (community event) thing, I don't know if the big buddy kids... like if the message got to them and I think it would be really important for future stuff. ...After people see their work, they will have more pride in their work and they will want to keep doing it”.</p>
Role modelling	<p><b>Community leaders</b></p> <p>“Like the (name removed) of this world... You've got that ongoing effect...(of role modelling)”</p> <p>“A lot of, it it's not even up to parents 'cause a lot of kids are in intergenerational households or maybe in, um, sort of kinship care and things like that where the person caring for them is a grandparent or an older person so they're not necessarily getting... and it's not because they're sitting on welfare and just they are looking after kids. ...and this idea of exposing kids to many opportunities and giving them some really solid role models to get this idea that 'OK this is how my life is at home and this is a path that, you know, my families taken or people in my immediate, um, circle have. But then there's also this option and gee, it looks like (name removed) and (name removed) and everyone are going pretty good in their life so maybe that's something that I'd like to do and 'cause I'm here I'm starting to get the skills and the things to... to go there”.</p> <p>“I mean, (health service staff) is only one (role model), I understand that, but... In the smaller community, the more they (adolescents) see the adults or young adults setting the example (the better)—community leader.</p>
Calls for ongoing and expanded program delivery	<p><b>Health-service staff</b></p> <p>“Especially with the kids at this age group, if you... you really need to be consistent with them with what you are doing. Like with the program that were doing if we run it for three weeks every Wednesday and then take three weeks off, we will lose them. So, it has to be... it doesn't matter whether it's me... or you, whatever, you have to be consistent. You can't be that people come in for a little bit and then go out for a bit and then a different person come in, or come back in again”.</p> <p><b>Community leaders</b></p> <p>“So maybe you guys have... have got it”.</p> <p>“So it's these sort of programmes that I really see a fantastic... and they're helping! and, if we can... if we can expand that, it might just be that we can (help more)... we can get some money for these guys and to employ another program co-ordinator and have a bigger programme”.</p> <p>“Even if you use grade 6 with Big Buddy or something, it'll be alright. Because a lot of them are in grade 6. A lot of kids in grade 6. So, before they go to high school next year”.</p> <p>“Because they've gone too far and we can't help them. We've gotta get the kids when they're 8–12 and get them on the right path so they don't end up in that bad space”—Community leader. So, it's these sorts of programs that I really see are fantastic... and they're helping! And, if we can... if we can expand that, it might just be that we can (help more) ...”</p> <p><b>Parents</b></p> <p>Parents agreed that the program could be expanded. Support the idea of increasing the program to up to five days (“After school 5 days maybe up to 2 hours”. P2)</p>

following, “I don't know which kids are coming in so I don't know what their stories and stuff is, but, like, if it's another avenue where they can go ‘Oh yeah, I did that thing that was really cool and now I can do X’. It's just like building your... your confidence... The stories you've told me about, it sounds like it's often what happens (at the program)”—health service staff.

### Theme 2: Preparation for adulthood

Adult participants acknowledged adolescence as an important developmental stage. The program was seen as well positioned to support adolescents during this critical life stage, providing them with the skills and resources needed for a healthy transition into adulthood and readying them to take their place in society more broadly. It was recognised that the skills and habits developed in adolescence would likely be carried through to adulthood and passed down through generations.

Particularly amongst community leaders and health service staff, employment skills emerged as a subtheme important to adulthood preparation. Such skills were seen as the penultimate success indicator for adolescent development. The sense of empowerment and confidence required for adolescents to seek and maintain employment, and the associated practical skills (for example, communication and presentation), were perceived as being fostered through the program. Adult participants felt that adolescents practicing employability skills within the program prepared them for employment by teaching them to meet the expectations of a functional, productive citizen and be “work-ready”. Therefore, this element of the program was highly valued amongst adult participants who wanted to see youth in their community succeed. For example, “Because if employers see what's actually happening here (at the program), they... Employ”—community leader.

Opportunities for positive youth development offered through the program were seen as particularly important in the context of rural living. Adult participants highlighted that opportunities to build skills were otherwise limited in rural towns compared to urban centres where greater employment, sporting, music and social opportunities exist. Hence, the program was seen as an important avenue to support adulthood preparation and general development in an environment closer to where rural adolescents live. For example, “It's so exciting, though, that those kids that are high achievers are getting that extra stuff... Because that's the opportunities that kids in (major city) would be getting access to... that additional training. That is probably the difference between them not making (the regional team) but making (the state team) or, you know... Continuing their progression. 'Cause like... kids are talented but it's the access to all that extra support and the pathways and stuff so it's... That's very exciting”—community Leader.

Although adolescents agreed with the idea that participation in the program made it easier for them to obtain local employment, they did not comment directly on how the program equipped them for adulthood. While obtaining employment was frequently celebrated amongst program participants, adolescents did not explicitly reference this as an outcome of the program in this research. This may be because the development of these skills was not seen as the focus of program by adolescents. In contrast to adult participants, adolescents were more likely to describe the program in terms of its fun and engaging nature and were less aware of the underlying educational elements. This idea is supported by the reflections of

adult participants, including in the voice of a health-service staff member: “But it's also, so, incidental knowledge they're getting. They don't realise that you're actually teaching them or that they are learning”.

### Theme 3: Role modelling

Adult participants discussed role modelling as an important element of the program that contributed positively to adolescent development. It was recognised that not all adolescents have positive role models within their home and family contexts. They perceived the program as exposing participants to different and positive role models through the associated staff. It was thought that this would inspire brighter futures amongst adolescents and stimulate intergenerational change. For example, “...You can't be what you can't see, and that's where I do think, the kind of beauty of (the program) is”—community leader.

Adolescents did not mention role modelling as a perceived impact of the program. This is consistent with ideas explored in theme 2 that some knowledge generation is “incidental” and may not be perceived by adolescents as the focus of the program. Hence, they were not mentioned in adolescent yarning circles.

### Theme 4: Calls for ongoing and expanded program delivery

The program was highly valued by all participants and regarded as a positive asset within the community. Perceived impacts included improved adolescent confidence and empowerment, amongst others. Adult participants saw the program as a vehicle to impart important life education lessons to youth without it feeling like school or a chore. For example, “To be part of this thing (the program), this is what we expect of you, and for them to want to do it, the expectation becomes absolutely secondary. Cause they really actually want to do it”—community leader. Meanwhile, adolescents were highly satisfied with the program and perceived it as fun and engaging. For example, “More fun games”, “(More) running around”. Adolescents agreed that they would like to see the program running more frequently. Parents/guardians also supported the program being run as frequently as possible.

Adult participants advocated for the program to be continued long term so that the benefits could be sustained and create intergenerational impact. Elders and community leaders were interested to see the program expanded to younger age groups, especially children of late primary-school age, so that they could develop better habits earlier and enter high school with a healthy mindset. For example, “Even if you use grade 6 with (the program) or something, it'll be alright. Because a lot of them are in grade 6. A lot of kids in grade 6. So, before they go to high school next year”—Elder.

Other adult participants also felt the program needed to be expanded—not to new age groups but to adolescents they perceived as “disengaged”. It was noted that participating adolescents were reaping the benefits of the program. However, adolescents not participating in the program were at a greater risk. Participants believed that without intervention, these youth were at a risk of entering the justice system, not finishing school or other unfavourable outcomes. This group was seen as needing support as a matter of priority, and participants suggested the program could provide this support if the right mechanisms to do so were identified.

For example, “*And it’s not you (adolescents in the program) that we need to perhaps be helping so much. It is the people who aren’t involved... Do we get them involved somehow into it? Or do we... we... we have to parallel it or something because I think... I think what you’re doing here is unbelievable*”—community leader.

## Discussion

This research explored 30 peoples’ perceptions of a rural Aboriginal and Torres Strait Islander adolescent social and emotional wellbeing program within a community-controlled health service. Collectively, the four themes identified through yarning indicate the program is highly valued. Despite differences emerging in how adult and adolescent participants perceive the program, all participant groups agreed the program was achieving target outcomes and should be upscaled.

The themes emerging from this study can be situated within *Social and Emotional Wellbeing from an Aboriginal and Torres Strait Islanders’ Perspective*.<sup>3</sup> Participant perceptions of the program align with several elements of the model. Notably, Connection to Mind and Emotions aligns with the theme 1 (improved self-confidence). Meanwhile, theme 3 (role modelling) speaks to Connection to Community.<sup>3</sup> Hence, elements of this study’s findings align with existing literature regarding Aboriginal and Torres Strait Islander social and emotional wellbeing.

In theme 1, participants suggested that the opportunity to try new activities within the program was a mechanism for building confidence and empowerment. This observation is consistent with empowerment theory—the individual intrapersonal domain of empowerment refers to self-perceived control, ability and competence.<sup>29</sup> The program was seen as a safe space for adolescents to develop their perception of control, ability and competence through trying different activities. Empowerment theory suggests that this would contribute to an elevated sense of self-empowerment and confidence, which was reflected by participants of this research.

Preparation for adulthood through the development of skills (theme 2) was seen as an important element of the program amongst adult participants. Literature on this topic affirms participant perceptions that adolescence is a critical time period to support positive development and future employment outcomes.<sup>30</sup> In this research, adolescent self-esteem and confidence (theme 1) and employability (theme 3) were viewed as separate but interconnected impacts of the program. This is reflected in existing literature connecting concepts of youth self-esteem and wellbeing with employment skills.<sup>31–34</sup> Previous research with adolescent parents/guardians found that parents/guardians recognise the importance of psychological capital for adolescents’ future career opportunities. This sentiment was reflected by parents/guardians who participated in this research, as well as by other adult participants such as community leaders and healthcare staff.

Participants’ perceptions of role modelling (theme 3) are consistent with Rhodes’s well-accepted definition: “*(role-modelling is) a relationship between an older, more experienced adult and an unrelated, younger protégé—a relationship in which the adult provides ongoing guidance, instruction, and encouragement aimed at developing the competence and character of the protégé*” (35). Adult participants perceived role modelling as a program asset contributing to improved outcomes for adolescents, which is

consistent with literature that identifies the benefits of youth role models and mentors. Such benefits include social, emotional and cognitive development, happiness and wellbeing and preparation for adulthood.<sup>35–37</sup> These benefits are predicated on the type and strength of the role model or mentoring relationship.<sup>38–40</sup> High-quality, highly connected, active and long-term role models (like those described in this research) confer unique benefits such as improved self-esteem, fewer alcohol problems, less depressed affect, greater academic engagement, higher social skills and psychological wellbeing.<sup>38,41,42</sup> Furthermore, adult, non-familial role models that are known to the adolescent outside of school settings (like those identified by this research) are uniquely placed to support adolescent development and wellbeing.<sup>43–45</sup> Such evidence supports why role-model relationships within the program were perceived as a success factor by participants.

In theme 4, participants call for ongoing and expanded program delivery, which strongly suggests that participants perceive the program as benefitting their community. Successful health and wellbeing programs with Aboriginal and Torres Strait Islander communities are marked by strong community relationships, responsiveness and community leadership.<sup>13</sup> Community-controlled services are uniquely positioned to understand and embody this practice.<sup>14</sup> The program in question is led by a community-controlled health service and embodies a flexible model allowing co-design and adaption to community needs. Furthermore, data collected demonstrate that strong relationships between program participants and staff were noticed by the broader community (theme 3—role modelling). This speaks to the general strength of community relations within the program. Hence, elements of a successful Aboriginal and Torres Strait Islander wellbeing program are demonstrated by the program,<sup>13</sup> which are likely contributors to the general high perception of the program amongst participants, including their calls for program expansion.

This research is the first peer-reviewed investigation of the program and offers new insights into what is valued in adolescent social and emotional wellbeing programs. Future efforts to capture other program outcomes are encouraged. For example, mixed methods could be utilised to better understand adolescent confidence, empowerment, and self-esteem. While several quantitative empowerment and self-confidence measurement tools currently exist<sup>46,47</sup> (for example, the Growth and Empowerment Measurement<sup>48</sup>), few have been validated with adolescent Aboriginal and Torres Strait Islander populations.<sup>2</sup> Such methods would need to be contextualised to the population<sup>2,49</sup> and learn how to engage adolescents in sharing intimate self-reflection and personal development stories.

Due to colonial structures that place greater value on Western epistemology and a long history of unethical research practice with Aboriginal and Torres Strait Islander peoples in Australia, it is possible to suggest that an unequal power dynamic between the research team and Aboriginal and Torres Strait Islander participants arose. The research team made a concerted effort to conduct culturally safe research by sharing power with Aboriginal and Torres Strait Islander colleagues and researchers in all elements of the research process. In alignment with Indigenous Standpoint theory, the knowledge and ideas of Aboriginal and Torres Strait Islander contributors have been respected and reflected in the research process.

### Limitations

It is important to acknowledge that the perceptions shared in this research may be impacted by participants' overall exposure to the program. Each participant is likely to have different perceptions based on their unique experiences and worldviews. This research purposively sampled participants who were either involved in, or had knowledge of, the program, hence capturing the views of a narrow pool of community members, rather than the whole community. Purposively sampled participants may be biased towards a positive view of the program by the fact of their involvement. For example, the views of adolescents or parents/guardians who may have trialled and since disengaged from the program were not captured.

Unequal power dynamics may have arisen between data collectors (adults) and adolescent participants. The research team is mindful that such imbalances may affect how participants engage in the research, particularly adolescents. To mitigate this, relationship building and the creation of safe spaces for open dialogue, were prioritised. However, the possibility remains that the way adolescents, and Aboriginal and Torres Strait Islander peoples, engaged (or not) in the research may have been influenced by the people undertaking data collection. It may also explain some of the hesitancy amongst adolescent participants to deeply share about their personal experiences of empowerment.

Finally, all parents/guardians participated via written survey rather than attending yarning circles. This is likely to have limited the richness of the perceptions captured from this group. Anecdotal feedback from parents/guardians was that in-person yarning circle participants were not feasible due to competing family and work demands.

### Implications for public health

Across the four themes identified, we found varying degrees of support across the participant groups. Noticeably, adolescents more strongly supported themes 1 and 4. To explain this finding, it is suggested that adolescents participating in the program viewed its primary outcome as enjoyment and entertainment. This is supported in the way adolescents repeatedly described the program as, foremost, "fun". It is interesting that adults observed positive outcomes that run deeper than "fun" and engagement. These findings could suggest the program reflects elements of a "stealth" intervention. Stealth interventions emphasise the process of behaviour change rather than outcomes by enhancing intrinsic motivation. They use elements of perceived control, self-efficacy, curiosity and gamification to position behaviour change as rewarding, easy and desirable.<sup>50</sup> While stealth interventions have been explored in relation to physical activity, gamification and other public health contexts,<sup>50–52</sup> this research explored community perceptions of a social and emotional wellbeing program to offer new knowledge about how stealth interventions may be viewed across different participant groups.

According to participants in this research, the program should be tailored to different age groups and engage adolescents most at risk within the community (theme 4). The ability of programs to engage the most at-risk participants is a long-standing and well-documented issue.<sup>53</sup> Further investigation into the operationalisation and aim of upscaling this program is recommended and should be done in partnership with the community. Any upscaling opportunity would

need the support of additional resources to potentially adapt the program to deliver outcomes to new groups.

### Conclusion

This research is an initial effort to understand community perceptions of an Aboriginal and Torres Strait Islander adolescent social and emotional wellbeing program in rural Queensland. The program is highly valued by the community it serves with wide-ranging benefits related to wellbeing. Further exploration is required to consider how to upscale and expand the program. Efforts to more deeply understand and report on its diverse outcomes are encouraged.

### Ethics

All procedures performed in this study were conducted in accordance with The University of Queensland Human Research Ethics Committee B (2020/HE002894).

### Conflicts of interest

The authors have no competing interests to declare.

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