

## Chapter 8: Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander People within the Broader Context of the Social Determinants of Health

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### Introduction

The social and emotional wellbeing of Aboriginal and Torres Strait Islander people is affected by a range of social determinants of health. These determinants include forms of State violence and inter-generational trauma, imbalanced power relations and limited access to services within the mainstream population, and systemised and individualised discrimination and racism. These contribute greatly to the perpetuation of lower income and standards of living, including poor quality and overcrowded housing and community infrastructure, and poorer outcomes in health, education, employment and the justice system. Indigenous Australians continue to experience higher levels of poverty, incarceration and ill health than the rest of the Australian population. Given these experiences, and the resulting disadvantage they exert on Aboriginal and Torres Strait Islander people's employment opportunities, it is not surprising that welfare payments originally designed as safety nets for the small minority, that is 5–10 per cent of the mainstream population that become unemployed at any given time, have become a trap for some Aboriginal and Torres Strait Islanders, where up to 80 per cent of residents live on some form of welfare. The pervasive effects of inter-generational welfare on such communities are clearly visible and continue to entrench the 'downtrodden image' of Aboriginal and Torres Strait Islander people in the media. The experience of these inequities promotes adoption of risk behaviours such as smoking, inhalant use and harmful drinking, as well as poor nutrition and the morbidity associated with chronic diseases such as diabetes, cardiovascular disease, renal disease and mental illness, and many infectious diseases (ABS & AIHW 1997, 1999, 2001, 2003, 2005).

A number of reports outline the factors that influence/determine the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. These include: Dunlop 1988; NAHSWP 1989; RCIADIC 1991; Burdekin 1993; Swan and Raphael 1995; HREOC 1997; and Zubrick *et al.* 2005. The Commonwealth Department of Health and Ageing (DHA) has published a

*Social and Emotional Wellbeing Framework* policy document (hereafter the *Framework*) using a population health model for national action against the high incidence of social and emotional wellbeing problems and mental ill health among Aboriginal and Torres Strait Islander people (DHA 2004). The *Framework* is based on a holistic Aboriginal definition of health (NAHSWP 1989; Swan & Raphael 1995), and uses nine guiding principles extracted from the *Ways Forward* report (Swan & Raphael 1995) to emphasise this holistic view. The development of the *Framework* was based on widespread consultations, the available literature and some specific research (e.g. OATSIH 2002), and was created in response to the growing need to manage mental health issues in a more appropriate manner.

There is a feeling among Aboriginal and Torres Strait Islander people that the term mental health has some stigma associated with it, and that they may prefer the less 'loaded' term—social and emotional wellbeing. This term has the advantage of alluding to the social and historical nature of human wellbeing as against the perceived individualistic nature of the term 'mental health'. This feeling is shared by other populations: for example, Patel (1996) suggests dropping the word 'mental' when discussing mental disorders in primary care in African countries. On the other hand, the increasing recognition of the significant burden of disability and loss associated with mental health disorders all over the world, the growing influence of consumers over services and public discourse, the placing of mental health within a human rights framework, plus efforts to reduce stigma, are all leading to greater acceptance of the word and adoption of its broader meaning.

The literature about social and emotional wellbeing in general, and individual mental health and mental ill health in particular, is broad in scope. We have, therefore, focused our review on the social determinants of Aboriginal and Torres Strait Islander health, as directed by the Cooperative Research Centre for Aboriginal Health (CROAH).

We would like to acknowledge at the outset that any future research in this area must recognise the critical importance of engaging and collaborating with Aboriginal and Torres Strait Islander people and communities so that their needs

and priorities are properly addressed by the research, and that practical outcomes flow from such investigations. This approach should also ensure that the heterogeneity of Aboriginal and Torres Strait Islander people is captured.

This review has four main sections:

1. the social determinants framework of health;
2. social and emotional wellbeing;
3. measuring and assessing social and emotional wellbeing; and
4. towards a research agenda in social and emotional wellbeing.

Each section has a short introduction and summary.

We have used a variety of sources for this review, including electronic library databases, HealthInfoNet, Google, websites of government and non-government agencies, and discussions with colleagues. The information on Aboriginal and Torres Strait Islander wellbeing available in academic journals was relatively limited compared to the wealth of material found in the various types of 'grey literature', such as unpublished reports, conference proceedings and websites. This indicates that the area is highly interactive, evolving and attracting substantial attention.

As this literature review was limited both by time and resources, our aim has been to capture a summary of the emergent themes in the current discourse, rather than to complete a systematic and exhaustive review. The rationale was thus to identify the major documents, to highlight the main themes and to provide a rich resource for further exploration of specific issues.



# The social determinants framework of health

## Introduction

In this section we explore the literature on social determinants of health from both an international and Aboriginal and Torres Strait Islander perspective.

## International understanding

Although questions have been raised as to the applicability of internationally accepted social determinants of health to Aboriginal and Torres Strait Islander people (e.g. Morrissey 2003; Dance *et al.* 2004:29), we will use such determinants as a guide to our understanding of Aboriginal and Torres Strait Islander health, until research provides evidence to the contrary.

The importance of social factors on health outcomes is convincing internationally (e.g. WHO 1986; Marmot & Wilkinson 1999, 2006; RACP 1999; Yen & Syme 1999; Eckersley, Dixon & Douglas 2001; Berkman & Kawachi 2001; Siegler & Epstein 2003; Wilkinson & Marmot 2003; Marmot 2004; Wilkinson 2005). There is also a substantial international literature on the association between social factors and health throughout the life-course (e.g. Kuh *et al.* 1997; Blane 1999; Wadsworth 1999; Lynch & Kaplan 2000; Cashmore 2001; Vimpani 2001; Ben-Shlomo & Kuh 2002; Gilman 2002; Harper *et al.* 2002; Gilman *et al.* 2002; Wadsworth & Butterworth 2006).

Yen and Syme (1999) broadly describe the social environment as neighbourhoods, groups to which we belong, workplaces, and policies that governments and others create to order our lives. Shaw (2004) suggests how housing can affect wellbeing through 'the meaning of home'. A range of authors also discuss the association between the social environment and morbidity and mortality risks independent of individual risk factors, and the influence of the social environment on disease pathways, including mental ill health (Yen & Syme 1999; Faris & Dunham 1960; Gunnell *et al.* 1995; Payne *et al.* 1993; Yen & Kaplan 1999). Najman (2001) considers that not only are these social origins of health

substantial and persistent, but that they offer the greatest prospect for improvements in population health.

Psychosocial interventions are used widely in nursing, social work, behavioural science, psychiatry, and sociology (Glass 2000). Cashmore (2001) explores pathways that children follow to particular physical, social, emotional and cognitive developmental outcomes throughout their development, and discusses risk and protection mechanisms, vulnerability and resilience, and preventive interventions. O'Dea and Daniel (2001) discuss psychosocial characteristics in the context of the social gradient in health, such as depression, hostility, psychological stress, and their associated health outcomes. The social gradient in health refers to social inequalities in health whereby life expectancy is shorter and most diseases are more common further down the social ladder in each society (Wilkinson & Marmot 2003; Marmot 2004).

Socio-economic factors throughout the life-course can affect adult physical and mental health and disease in two main ways. First, these factors can expose individuals to circumstances that cause or increase the risk of injury and disease, and reduce protective factors during gestation, infancy, childhood, adolescence and young adulthood. Secondly, through learned behaviours, social chains of risk operate throughout the life-course resulting in adult socio-economic circumstances that increase disease risk through exposure to causal factors in later life (Kuh *et al.* 1997). Cullen and Whiteford (2001:21) discuss two associations between mental disorders and poor social circumstances. The first is that mental disorder impairs psychological and social functioning leading to downward 'social drift' (Goldberg & Morrison 1963; Jones *et al.* 1993). The second is that individuals in socially disadvantaged situations are exposed to more psychosocial stressors, and these stressors trigger the onset of symptoms of ill health and the loss of psychological abilities for social functioning (Bebbington *et al.* 1993).

Wilkinson and Marmot (2003) suggest a number of factors that help to explain the sensitivity of health to the social environment. Such factors include the social gradient, stress, early life, social exclusion and social support, addiction, and work and unemployment. Within each area, behavioural issues around parenting, nutrition, exercise, and substance abuse, and structural issues around unemployment, poverty and experience of work are discussed. For example, the report points out that stress and psychosocial risk factors such as social isolation, lack of control over work and home life, low self-esteem, insecurity and anxiety may lead to mental ill health.

## Beyond Band-aids

Exploring the Underlying Social Determinants of Aboriginal Health

## Aboriginal and Torres Strait Islander understanding

There is a substantial body of literature on Aboriginal and Torres Strait Islander health and social disadvantage (e.g. ABS & AIHW 1997, 1999, 2001, 2003, 2005). The determinants of mortality and morbidity in Aboriginal and Torres Strait Islander health are complex and multidimensional, and evidence from social epidemiology indicates that social factors are implicated in the production and persistence of health inequality (Anderson 2001). More recent publications provide a framework to better understand the complex issues (for example, policymaking, education, employment and welfare, history, housing, racism, concepts of health and illness) that make up the social determinants of Aboriginal and Torres Strait Islander health (McDonald *et al.* 2006; Carson *et al.* 2007).

Morrissey (2003:31) considers that much of the research into the social determinants of Aboriginal and Torres Strait Islander health 'is indifferent to social theory and dominated by a simplistic quantitative positivism which is incapable of capturing the complex aetiology and pathways of chronic disease', and moreover, 'strips away the essential political elements'. Morrissey argues for an alternative research methodology, both qualitative and quantitative, based on a transdisciplinary and complex perspective (Higginbotham, Albrecht & Connor 2001; Higginbotham, Briceno-Leon & Johnson 2001). We agree that a transdisciplinary approach is necessary and that the research needs strengthening. However, significant work has focused on the complexities of the social, historical, political, economic and cultural factors affecting Indigenous health and wellbeing—although not always in 'social determinants' jargon. This perspective is reflected in the holistic Aboriginal and Torres Strait Islander definition of health as embodied in key health policy documents: for example, in the National Aboriginal Health Strategy (NAHSWP 1989), in the pioneering work of Swan and Raphael (1995), in the *Bringing Them Home Report* (HREOC 1997), in the underlying issues sections of the various Royal Commission into Aboriginal Deaths in Custody Reports, and in the philosophy and operation of community-controlled comprehensive primary health care services.

Further, the work of Dunlop (1988), Sheldon (2001) and Cox (2000) make important contributions to an understanding of the complexity of this field. Cox's ethnography addresses 'the social sources of suffering' with a study of everyday life, while all three authors give accounts of how the various local

Aboriginal and Torres Strait Islander groups perceive and describe social and emotional distress and how this fits (or not) with mainstream psychiatric perspectives.

In her exploration of an Aboriginal and Torres Strait Islander community's perceptions of current difficulties, Cox (2000) found that various traumatic events and forms of distress (suicide, interpersonal violence, homicide and sickness) were understood in the light of salient moral domains that originated from local priorities and sensibilities. These demonstrated the residents' human need for meaning and control. These findings led to an exploration of the historical erosion of local forms of power and control during periods of exploitation, protection, removal, integration, and assimilation. This erosion of power is also manifest in contemporary social processes such as self-management, land rights and native title. Thus past and present forms of marginalisation are deeply implicated in present tensions in local governance and in the problem of establishing legitimate forms of authority at the community level. This level of analysis is crucial in establishing the dimensions of Aboriginal and Torres Strait Islander social and emotional wellbeing, and identifying the factors that undermine or enhance it.

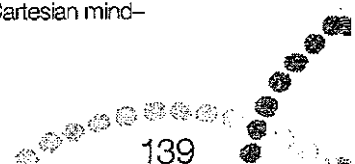
## Summary

There is a large and compelling international literature, mainly from work in developed countries, describing the complex and multidimensional nature of the social determinants of health. A much smaller body of work describes, not always in 'social determinants jargon', the importance of social factors in the health inequality experienced by Aboriginal and Torres Strait Islander people.

## Social and emotional wellbeing

### Introduction

The concept of social and emotional wellbeing is sometimes used interchangeably with the term mental health. However, as mentioned above, the term wellbeing is preferred by many Aboriginal and Torres Strait Islander people, partly as a way of subverting the stigma associated with mental illnesses. Indigenous definitions of health reject the biomedical view of disease as the result of damaging physiological events that disrupt normal physical or mental processes. These definitions are also inconsistent with the Cartesian mind-



body split on which separate care pathways for social and emotional health, and physical and mental disorders, have been based.

Whichever term is adopted, it is critical that the many issues that underlie Aboriginal and Torres Strait Islander people's health and wellbeing be recognised as associated with what Swan (1988) referred to as 'reality factors'. These factors have not been effectively included in health service research and provision, on the basis of being too broad, encompassing everything and therefore being too impractical. Their significance, however, is demonstrated by the inability of a health system that focuses on individuals to achieve significantly better mental health and wellbeing outcomes for Indigenous people despite decades of effort and biomedical advancement. We believe that whole-of-government and community-driven approaches are needed that encompass all aspects of life including economic, political, social and cultural dimensions.

### Aboriginal and Torres Strait Islander specific issues

Aboriginal and Torres Strait Islander people have suffered terribly from the consequences of colonisation and evolving forms of social, bureaucratic and legislative marginalisation for more than 200 years. Although it is outside the scope of this review to detail this suffering and its profound effects on Aboriginal and Torres Strait Islander people's social and emotional wellbeing, we are able to highlight some of the major issues raised in the broad anthropological and cross-cultural psychiatric literature that documents these effects (e.g. Eastwell 1977 a, b; Gault *et al.* 1979; Reid 1982, 1983; Karmien 1976a, b; Cavte 1969, 1972, 1973, 1974, 1976; Hunter 1993a, b, c, d, e, f, g, h, i, j; Reser 1991; Mobbs 1991; Cox 1997, 2000).

There is a growing literature on important issues around the removal of children and forced separation (ABS & AIHW 2003, 2005; HREOC 1993, 1997; Kendall 1994; King 1997; Kinnear 2000; Koolmatrie & Williams 2000; Read 1981, 2000; Petchovsky & San Roque 2002; Zubrick *et al.* 2005), inter-generational trauma (Raphael

*et al.* 1998), violence (ABS & AIHW 2003, 2005; Anderson 2002; Atkinson 1990a, b, 1991, 1992; Blagg 1999; Bolger 1990; Eckermann & Dowd 1988; Memmott *et al.* 2001; Reser 1990b; Smith & Williams 1992), self-harm and suicide (e.g. Cox 2002; Gunnell *et al.* 1995; Radford *et al.* 1999; Tatz 1999, 2001), and alcohol and drug use (Mathews *et al.* 1988; Harold 1989; Brady 1995a, 1998, 2000, 2002; Dance *et al.* 2004).

The peer-reviewed literature in this area of research primarily highlights the fact that governments at all levels, health care professionals, non-government organisations, the private sector, and other groups and individuals in our society have failed to produce significant improvements in Aboriginal and Torres Strait Islander wellbeing. The government's minimal interest and commitment in health and welfare issues specific to Aboriginal and Torres Strait Islander people are highlighted by a number of sources (Jonas 2003; Read 2000; SNAICC 2003), with some reports focusing on common legacies of distress (HREOC 1997; Kinnear 2000; MHCA & CAA 2001), which government agencies have thus far failed to address. The peer-reviewed literature is also essential in reiterating the true nature of Aboriginal and Torres Strait Islander dimensions of wellbeing, the legitimacy of which is often attacked by members of Parliament (HR 2000) and the media (Jonas 2003).

There are a number of important government-initiated or sponsored reports on Aboriginal and Torres Strait Islander wellbeing issues, the principal being the *Bringing Them Home: Report of the National Enquiry into the Separation of Aboriginal and Torres Strait Islander Children* (HREOC 1997). This report is a comprehensive review of testimonies collected from individuals who were removed under government-initiated policies. It discusses the effects of such policies and what reparations are required for survivors of these removals and their families to begin the process of healing. We note the actions the Commonwealth Government took to set up the National Regional Centre Program for social and emotional wellbeing under the 1996 *Emotional and Social Wellbeing (Mental Health) Action Plan* (DHA 1995; Urbis Keys Young 2001) following the *Bringing Them Home* and *Ways Forward* reports (HREOC 1997; Swan & Raphael 1995). The activities of several of these regional centres are in the broader literature (e.g. Urbis Keys Young 2001; Anon 2002; Dukes *et al.* 2004; KAMSC 2003; Frith *et al.* 2007).

## What is social and emotional wellbeing?

Social and emotional wellbeing is a much broader concept than mental health (Mobbs 1991; Reser 1991). Swan and Raphael (1995) recognise this by advocating a holistic view of Aboriginal and Torres Strait Islander mental health that should be understood in the context of the impact of colonisation, loss of traditional lands, loss of culture, separation of children from their families, racism, social inequity, trauma and grief. Social and emotional wellbeing is determined by a wide range of factors, and an understanding of these factors varies between cultural groups and individuals, as well as along the age and development spectrum (DHA 2004).

The factors that diminish social and emotional wellbeing—including grief, loss, trauma, abuse, violence, substance misuse and physical health problems—are well known. Conversely, the positive and stabilising influences that promote self-care and self-defined recovery for all kinds of illnesses, addictions and traumatic experiences are similarly recognised (DHA 2004).

The historical origins of barriers to social and emotional wellbeing experienced by Aboriginal and Torres Strait Islander people are highlighted by the Human Rights and Equal Opportunity Commission (HREOC 1997). Hunter (1998b) describes five levels of activity required to address social and emotional health problems. These are: political (reconciliation and social equity); community development (including health promotion and prevention initiatives); appropriate mainstream services; adapted mainstream approaches (such as the adaptation of narrative therapy to Aboriginal and Torres Strait Islander needs); and Aboriginal and Torres Strait Islander therapies.

Cox (2000) provides a historically and culturally contextualised comparison of interpretations of certain phenomena, understood by Aboriginal people as spiritual and pathologised by Western psychiatry (see Cawte 1974, 1988). The problem of misdiagnosis is also covered here and is further discussed by Indigenous authors such as Swan (1991), O'Shea (1996) and Gulash *et al.* (1999)—the latter in terms of a discussion of the inappropriateness of Western diagnostic tools when applied to Aboriginal and Torres Strait Islander populations.

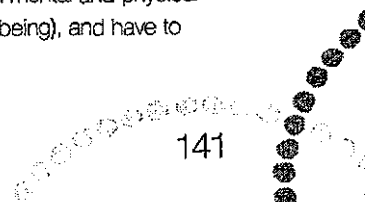
The relatively small research literature on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people focuses on the following broad aspects: perspectives on social and emotional wellbeing, healing, sharing and regeneration; social health in urban settings; individual and

family wellbeing; personal and community development; Aboriginal stories about kidney disease; psychosocial problems of adolescents; Aboriginal self; wellbeing in the context of drug and alcohol use; resilience and vulnerability; the social meaning of petrol sniffing; disturbed behaviour, environment and social stress in traditionally oriented Aboriginal societies; early interventions for social and emotional wellbeing; issues affecting adults removed as children; healing traditions; unresolved grief and the removal of children; training in Aboriginal and Torres Strait Islander social and emotional wellbeing; the socio-cultural context of wellbeing, illness and healing; better medication management for Aboriginal people with mental health disorders and their carers; measuring social and emotional wellbeing; and the control factor and taking control, empowerment, and stress and coping. (See Adams 2002; Anderson 1996; Atkinson & Edwards-Haines 2003; Atkinson 1994; Brady 1992a, b, 1993, 1995a, b, c, 1998, 2000, 2002; Brice 1994; Brice *et al.* 1992; Bushby & Moodjit 2002; Cawte 1973; Cox 2000; Daly *et al.* 2004; Davidson *et al.* 1978; de Crespigny *et al.* 2005; Deema 2001; Devitt & McMasters 1998a, b; Dunlop 1988; Finlayson & Anderson 1996; Fredericks & Atkinson 1997; Gault *et al.* 1970; Gray *et al.* 1995; Gridley 2000; Gulash *et al.* 1999; Hamilton 1975; Harnett *et al.* 1998; Heil 2003; Holmes *et al.* 2002; Hunter 1998b; Kowanko *et al.* 2003a, b, c, 2005; Kendall 1994; Kirmayer *et al.* 2003; Koolmatrie & Williams 2000; Lowe & Spry 2002; Lynn 2001; McGuire 1999; McMahon & Reck 2003; Mobbs 1991; NACCHO 1993; 2003; Radford *et al.* 1999, 1991a, b, c, 1990 a, b; Raphael *et al.* 1998; Reid 1982, 1983; Robson & Sibum 2002; Toby 2000; Tsey & Every 2000 a, b, c; Tsey 2000; Tsey *et al.* 2002, 2003 a, b, c, d, 2004; Vino *et al.* 1996; Wanganeen 1994).

## Health and wellbeing

Examples of the holistic notion of Aboriginal and Torres Strait Islander health are provided by the National Aboriginal Health Strategy Working Party (NAHSWP 1989:ix-x), the National Aboriginal and Islander Health Organisation (NAIHO), the National Aboriginal Community Controlled Health Organisation (NACCHO), and definitions cited by Swan and Raphael (1995, Part 1:14), while Heil (2003:22-5) explores the history of contemporary meanings of the concepts inherent in 'Aboriginal and Torres Strait Islander health and wellbeing'.

Aboriginal and Torres Strait Islander people do not make the Platonic and Cartesian divide between mental and physical being (i.e. they have a holistic view of being), and have to



struggle with the dominant (Western) culture's language of health and illness (McDonald 2006; Cox 2000). Anderson (1996) discusses how Aboriginal people have used various definitions of health with an analogous range of meanings. The core elements of these definitions include 'the physical, social, emotional, cultural and spiritual wellbeing not only of the individual but the whole community' (Anderson 1996:68). He describes how the 'Ngarinman mob' from the Northern Territory have a word *punya* with a range of meanings including 'wellbeing', and explains '... like *punya*, wellbeing connects people, place and Law, and is a whole-of-life view including the traditional concept of life-death-life as well as the relationship to the land' (Anderson 1996:68). Nathan (1980, cited in Mobbs 1991) gives more detail on how some urban Aboriginal and Torres Strait Islander groups conceptualise health.

The link between wellbeing and community features strongly in a number of international descriptions of health and wellbeing that are relevant to the holistic Aboriginal and Torres Strait Islander concepts (e.g. WHO 1986; Bristow 2003). In a study of health and wellbeing of Indigenous people from diverse parts of the world, family connections, community relations, peace, spirituality, environmental factors and control of services are highlighted as important components of wellbeing, with happiness and health repeatedly recognised by respondents as essential components of wellbeing (Bristow 2003).

A New Zealand Maori model of health and wellbeing is Whare Tapa Wha, visualised as a 'four-sided house': Taha Wairua (spiritual)—capacity for faith and wider communion; Taha Hinengaro (mind)—capacity to communicate, think and feel; Taha Tinana (physical)—capacity for physical growth and development; and Taha Whanau (extended family)—capacity to belong, to care, and to share. The link between these four components is fundamental. 'A person's synergy relies on these foundations being secure. Move one of these, however slightly, and the person may become unwell' (Durie 1998, cited by McPherson *et al.* 2003:444).

## Mental health and mental ill health

The holistic Aboriginal and Torres Strait Islander understanding of mental health also influences interpretations of personal states (Swan & Raphael 1995, Part 2:29). It is well recognised that the response to distress and interpretation of 'different' behaviours can vary across cultures. Thus, interpretations of 'mental health' and 'mental illness' that are framed from Western medicine are limited (Reser 1991; Cox 2000). Swan and Raphael (1995, Part 2:29–33) review the literature of explanatory frameworks of mental illness, illness experience and aberrant behaviour from Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander perspectives, including the work of Dunlop (1988).

The term 'mental health' is defined holistically in the *National Mental Health Plan 2003–2008* (AHM 2003) as quoted in the DHA Framework document (DHA 2004:7). For Aboriginal and Torres Strait Islander people, this mainstream definition must incorporate strengths—such as the importance of land, culture, spirituality, ancestry, family and community—and acknowledge inherent resilience (DHA 2004:7). The DHA Framework document also discusses 'mental ill health', where mental health problems and mental illness are differentiated on the basis of severity, duration, as a temporary or expected reaction to life stressors, and whether presenting problems meet the criteria and threshold for a diagnosis according to classification systems for mental disorders (DHA 2004:8).

Some of the mental health literature boundaries that separated research in psychiatry from research in social and emotional wellbeing are fading (Hunter & Tsey 2003). Psychiatric research has shifted emphasis from developing and establishing the most effective therapies for specific mental illnesses to identifying the 'common factors' across therapies that effect the most change (Rosenzweig 1936 cited in Hubble *et al.*, 1999; Frank 1961; Lambert 1992; Hubble, Duncan & Miller 1999; Bertolino 2003). These 'common factors' include change in non-clinical aspects of a person's life (e.g. family and career, housing, employment/ meaningful occupation, recreation) that assist individuals towards connectedness and wellbeing (Lambert 1992; Bertolino 2003).

The importance of a collaborative partnership between clinicians, primary health workers and the carer and family, who enhance a person's wellbeing on a daily basis, is clear (O'Kane & Tsey 1999; MHCA & CAA 2000). At the same time, mental health consumers have pioneered new ways of looking at severe mental illnesses. Common stages and

experiences detailed in accounts of illness indicate that consumers can successfully redefine themselves and their lives, despite the continued presence of the illness, in ways that represent personal definitions of recovery. A group of Maori consumers from New Zealand have described the core elements of their recovery journeys in a document titled 'Tuituia'. This document highlights the importance of cultural identity and the concepts of 'Whanau Ora', which encompass the notions of inclusiveness, collectivity and interdependence in relationships within family and Maori society (MH-SMART Tangata Motuhake/Whaiaora Roopu 2005).

From the social and emotional wellbeing perspective, people with mental illness are often among the least empowered individuals in any community. There is little documentation detailing levels of stigma among Aboriginal and Torres Strait Islander communities. However, Dunlop (1988) and Cox (2000) provide evidence that in some such communities there is a high degree of tolerance for individuals experiencing difficulties, and that those who experience social and emotional distress tend to remain integrated in community and family life. The underlying social disadvantage in these communities—lack of employment opportunities, environmental problems such as overcrowded housing, limited access to mental health services, and the availability of drugs and alcohol—profoundly affect the lives of people who must face the additional challenges of managing mental illness (Hunter 1998b). When traumatic events occur in the community, consumers are often deeply affected and may experience a severe relapse, which, in turn, may further add to the communities' grief and lack of control.

The relatively large research literature about mental health and mental ill health among Aboriginal and Torres Strait Islander people focuses on the following broad aspects: overviews of mental health; mental health service programs and practice; mental health promotion; mental ill health prevention; early interventions for mental health; suicide; depression; distress; violence; self-mutilation; resilience; vulnerability; psychiatric disorders; social and cultural influences on mental health; ethno-psychiatry; spirituality; forced separation and its psychiatric sequelae; child development; Aboriginal and Torres Strait Islander perspectives on mental health; and mental health workers (Bianchi *et al.* 1970a, b; Biernoff 1982; Bonner 1980; Brady 1987; Brideson 1998; Brown 1999, 2001; Bullen 2001; Cantor *et al.* 1995; Cawte 1965a, b, c, d, 1969, 1976, 1988; Davidson *et al.* 2000; Eastwell 1977a, b; Fagan 1991a, b; Gunnell *et al.* 1995; Hennessy 1996; Higgins 1996; Hoban 2002; Hunter & Garvey 1998; Hunter 1988a, b, c, 1990a, b, c, d, 1991a, b, c, d, e, 1992a, b,

1993a, b, c, d, e, f, g, h, i, j, 1994a, b, c, 1995a, b, c, 1997a, b, 1998a, b, 1999, 2002, 2003; Hunter *et al.* 2001; Jones 1972; Jones & Horne 1972; Kamien 1975, 1976a, b; Kessler *et al.* 2002, 2003; King 1997; Kinnear 2000; Kyaw 1993; Laugharne *et al.* 2002; McKendrick 1990; McKendrick & Thorpe 1994; McKendrick & Charles 1992, 2001; Mushin *et al.* 2003; O'Kane & Tsey 1998, 1999; O'Shea 1996; Parker 2003; Petchkovsky & San Roque 2002; Radford *et al.* 1991a, b, c, 1999; Reser & Morrissey 1991; Reser 1990a, b, 1991; Sheldon 1997, 2001; Sheehan *et al.* 2002; Swan 1991; Tatz 1999, 2001; Troth & Grainger 2000; Turale 1992, 1994; Zubrick *et al.* 2000).

## Resilience

Resilience is a multifaceted characteristic of the wellbeing of individuals and communities that helps protect against the risks associated with adversity. Resilience is particularly important for Aboriginal and Torres Strait Islander people given their continuing experience of colonisation and their relative socio-economic and cultural disadvantage by most indicators.

### International understanding of resilience

A generalised definition of resilience is the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances (Masten *et al.* 1990). Masten and colleagues (1990) identify three kinds of resilience: (1) 'overcoming odds', which is commonly used to refer to the belief that individuals have a particular quality or personal strength that enables them to withstand adversity; (2) coping in the face of sustained and acute negative circumstances (e.g. continuous family conflict); and (3) recovery from trauma (e.g. death of a sibling or parent).

The general literature on childhood and adolescent resilience is quite extensive (e.g. Compas *et al.* 1995; Howard *et al.* 1999; Serbin & Karp 2004). Rutter (1984, 1985, 1987) has discussed protective factors and mechanisms in children that promote psychosocial resilience. These include factors that reduce both risk exposure or impact and negative chain-reactions following bad events or experiences, as well as those that promote self-esteem and self-efficacy through achievements. Positive relationships and new opportunities that provide needed resources or new directions in life also enhance resilience.



## Aboriginal and Torres Strait Islander and broader Australian understanding of resilience

Little is known about resilience among Aboriginal and Torres Strait Islander people (e.g. Brady 1992a, 1993, 1995c; Hamett *et al.* 1998; Hunter 1990c, 1993a:240; Toby 2000; Caddi 2002; Holmes *et al.* 2002; Westerman 2003; Robson & Silburn 2002). However, it is worth remembering that Aboriginal and Torres Strait Islander people are likely to use different terms for this concept, such as strength or survival as in Bart Willoughby's song *We Have Survived* released in 1982 by the Australian band No Fixed Address.

International and Australian research into resilience includes family and community, not just the individual. The Australian literature on resilience frequently concentrates on preventative/intervention programs often aimed at parenting skills (Jenkin & McGenniss 2000; Scott 2000; Gauntlett *et al.* 2000; McDonald & Hayes 2001; Silberberg 2001; RPR Consulting 2004a, b). However, few of these programs are Aboriginal and Torres Strait Islander specific or designed to transcend cultural differences. Gauntlett *et al.* (2000:23) noted that 'many discussions of prevention and early intervention strategies specifically for indigenous communities emphasise very similar problems to those of mainstream Australia', but went on to say that 'there is a recognised need to have programs and studies that are focused specifically on the wellbeing of Indigenous communities'. RPR Consulting (2004b) reviewed the Early Intervention Parenting program and Good Beginnings Prototype, the two main subcomponents of the Child Abuse Prevention program. With respect to Aboriginal and Torres Strait Islander communities, the consultants stressed the importance of a whole-of-community approach, as in the Indigenous RAP-P (Resourceful Adolescent Program for Parents) Program and the Strong Men, Strong Families project in Roebourne (RPR Consulting 2000b:8). Gauntlett *et al.* later noted that

*the current needs of Aboriginal and Torres Strait Islander people are a consequence of having their strengths destroyed through processes of colonialism. Strategies to promote stronger Aboriginal and Torres Strait Islander communities, to develop their resilience and to foster social capital within them clearly have to start from this premise (2000:24).*

There is some evidence to suggest that Aboriginal and Torres Strait Islander people in remote and urban locations have developed resilience strategies to survive the range of social and health problems that affect them. The potential for achieving gains in mental and physical health and wellbeing through enabling Aboriginal and Torres Strait Islander people to practise cultural knowledge in natural resource management, 'caring for country', gathering and eating bush tucker, market gardening and living on outstations to reconnect with their country has been described in many reports (Bear-Wingfield 1996; CAT 1996; Mills, Pensio & Sailor 1997; McDermott *et al.* 1998; Brown *et al.* 2001). Toby (2000) found that Aboriginal female prisoners developed protective factors to help them cope with the stress of being in prison. The various works of Tsey and colleagues with Aboriginal and Torres Strait Islander people on family wellbeing, control issues and with men's groups has also improved our understanding of resilience issues. This research has demonstrated that participation in family wellbeing programs and men's groups resulted in high levels of personal empowerment, including an increased sense of self-worth, resilience, ability to reflect on root causes of problems and problem solving ability, ability to address immediate family difficulties as well as belief in the mutability of the social environment. Evidence also suggests a ripple effect of increasing harmony and capacity to address structural issues within the wider community. These issues include poor school attendance rates, workforce development, debates about contemporary Aboriginal and Torres Strait Islander spirituality, the critical housing shortage, endemic family violence, alcohol and drug misuse, higher levels of chronic disease and over-representation of Aboriginal and Torres Strait Islander men in the criminal justice system (Tsey 2000; Tsey & Every 2000a, b, c; Tsey *et al.* 2003a, b, c; Tsey *et al.* 2004).

Brady (1992a) discusses the social, geographical and historical factors influencing the prevalence of petrol sniffing, from its commencement in the 1950s to the early 1990s, and suggests that young Aboriginal men involved in the cattle industry have been able to develop independence and self-esteem that helped them resist taking up petrol sniffing. Brady (1995b) also discusses the causes of Aboriginal and Torres Strait Islander vulnerability to drug and alcohol problems resulting from social and economic marginalisation.

Work by Chandler and Lalonde (1998) with First Nations tribes in British Columbia has focused on similar issues in relation to youth suicide. They have demonstrated that cultural continuity and local community control are linked to low rates

of suicide, and transcend the impact of remoteness and social and economic disadvantage to promote a sense of purpose and identity in their young people.

The National Health and Medical Research Council (NHMRC) has identified research on Aboriginal and Torres Strait Islander resilience and wellness as one of six priority research themes, and supported the recent International Collaborative Indigenous Health Research Partnership Grant Program on Resilience that aims to stimulate research in this area (NHMRC 2004a, b).

## Summary

The second section on social and emotional wellbeing has summarised some of the literature and perspectives on the concept of social and emotional wellbeing among Aboriginal and Torres Strait Islander people. It gives an overview of definitions and concepts before moving into a brief summary of the main topics addressed by the literature in this field. The concept of resilience, another term that focuses on social rather than individualistic approaches, was also discussed. We considered some international perspectives on this topic as well as its relevance among Aboriginal and Torres Strait Islander groups.

## Measuring and assessing social and emotional wellbeing

### Introduction

This section explores what we know from the available literature, both Australian and international, of how social and emotional wellbeing can be measured, how such measures can be used, and their relevance to the health of Aboriginal and Torres Strait Islander people.

### What we know

There are hundreds of tools that have been developed to measure and assess various aspects of social and emotional wellbeing, quality of life and related concepts (e.g. see <http://acqpl.deakin.edu.au/instruments>). These tools are used for many purposes, including monitoring clinical care, measuring the impact and outcomes of interventions, identifying priority groups for resource allocation, identifying individuals at risk of mental health problems, assessing the economic benefit of

various programs to justify expenditures, and so on. The vast majority have been developed for mainstream populations, with very few developed or validated for use with Aboriginal and Torres Strait Islander people (Westerman 2003). As a result, Aboriginal and Torres Strait Islander programs and services have faced greater difficulty in demonstrating their outcomes in quantitative terms in the absence of appropriately validated tools.

The whole issue of measuring social and emotional wellbeing, especially that of Aboriginal and Torres Strait Islander people as a sub-group within the larger Australian population, raises difficult and sensitive issues. Any quantitative measure of health can be experienced by Aboriginal and Torres Strait Islander people as disempowering. Given the magnitude of health disadvantage experienced by Aboriginal and Torres Strait Islander people, statistics can be presented in a way that reinforces the perception that the situation is hopeless and any efforts to change it are futile. On the other hand, strengths-based approaches to measurement that capture subtle incremental change towards larger improvements can enable people to gain confidence and hope, and ensure that positive change, not harm, occurs. Although few such tools are widely used at present, a number are in developmental stages (e.g. Kingi & Durie 2000; NACCHO 2003).

However, there are many technical issues to consider in quantification. The Australian Government agencies responsible for health data collection and analysis have stated that the measurement of the social and emotional wellbeing of Aboriginal and Torres Strait Islander people continues to be limited by a number of constraints including the following:

*A lack of data definitions, standards, and data collection instruments that encapsulate the holistic nature of social and emotional wellbeing in a culturally appropriate way while allowing for statistical measurement needs to be met;*

*Inaccuracies in available data as a result of misdiagnosis of people with symptoms of social and emotional distress. Certain behaviours, which might be appropriate in terms of Indigenous culture, may be diagnosed as mental illness in non-Indigenous terms (HREOC 1993). The use of psychological tests based on concepts alien to Indigenous culture is another potential source of inaccurate diagnosis. Misdiagnosis may also occur because of language problems, particularly in the elderly (HREOC 1993);*



*Under-reporting of mental and behavioural disorders and associated conditions because of the under-identification of Indigenous people in administrative records such as hospital and death records;*

*National surveys have not had sample sizes sufficiently large and/or geographically representative of the Indigenous population to produce results about mental health for Indigenous people... However, even if the survey[s] had been able to produce results for Indigenous people, the questions used may not have been appropriate (ABS & AIHW 2001:143).*

The Australian Bureau of Statistics (ABS) has developed a background document on measuring wellbeing (ABS 2001) that acknowledges wellbeing as a complicated concept that is influenced and affected by a range of internal and external factors:

*From birth to death, life enmeshes individuals within a dynamic culture consisting of the natural environment (light, heat, air, land, water, minerals, flora, fauna), the human made environment (material objects, buildings, roads, machinery, appliances, technology), social arrangements (families, social networks, associations, institutions, economies), and human consciousness (knowledge, beliefs, understandings, skills, traditions). Wellbeing depends on all the factors that interact within this culture and can be seen as a state of health or sufficiency in all aspects of life (ABS 2001:6).*

The ABS has identified eight areas for measurement: family and community (support and nurture through family and community); health (freedom from disability and illness); education and training (realisation of personal potential through education); work (satisfying and rewarding work both economic and non-economic); economic resources (command over economic resources, enabling consumption); housing (shelter, security and privacy); crime and justice (personal safety and protection from crime); and culture and leisure (time for and access to cultural and leisure activities).

The areas are highly inter-connected, and objective and subjective measures can be used within each area, although assessment may be difficult. The usefulness of this approach for measuring the wellbeing of Aboriginal and Torres Strait Islander people is unknown.

Following a national workshop in Canberra in 2003<sup>1</sup>, co-hosted by the two Australian Government agencies, a process began whereby, in consultation with NACCHO<sup>2</sup>, the ABS developed a 'social and emotional wellbeing' module for use in the 2004/2005 Indigenous Health Survey (IHS). Results of this survey were released in 2006 (ABS 2006). A follow-up workshop was co-hosted by the two Australian Government agencies in Canberra in November 2006, and the findings from this workshop may provide a useful guide for further research into the measurement of social and emotional wellbeing.

Information is available in the literature from a number of research projects exploring the measurement of Aboriginal and Torres Strait Islander mental health/social and emotional wellbeing (e.g. Brice 1994; Clayer & Divakaran-Brown 1991; Radford *et al.* 1990a, b, 1999; Hunter 1990a, b, c; Hunter *et al.* 1991; McKendrick *et al.* 1992, 2001; Turale 1992, 1994; Adams 1996; KAMSC 1999; Bullen 2001). These discuss the importance of community ownership, community involvement, community spiritual oversight, community-based ways of seeing, action-focused approaches, layers of community control, and cultural validation of survey instruments in the development of methodological approaches. They also identify pitfalls in the application of standard instruments, and urban versus non-urban inquiry methods. Further important work defining the issues involved in the application of mainstream mental status and outcomes assessment tools to Aboriginal and Torres Strait Islander populations in clinical contexts was undertaken by Gulash *et al.* 1999, Westerman 2004, Haswell-Elkins and Wargent 2005, emphasising and demonstrating the importance of family, Indigenous health workers and community informants.

Other Australian projects such as the *Western Australian Aboriginal Child Health Survey* using the Strengths and Difficulties Questionnaire (SDQ) (Zubrick *et al.* 2005), the New South Wales Health Survey using the Kessler 10-Psychological Distress Scale—unmodified (NSWHD 2000),

<sup>1</sup> A workshop on measures of social and emotional wellbeing of Aboriginal and Torres Strait Islander people was hosted by the Australian Institute of Health and Welfare and the Australian Bureau of Statistics, Thursday 14 August 2003, Canberra. A background paper for this workshop was prepared by Gavin Stewart of New South Wales Health (Stewart 2003).

<sup>2</sup> NACCHO prepared a draft review and discussion paper during this period (NACCHO 2003).

and the ABS 2004/2005 Indigenous Health Survey (ABS 2006), highlight the methodological difficulties involved in measuring the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

International projects of relevance to understanding how the social and emotional wellbeing of Aboriginal and Torres Strait Islander people is measured include:

(i) A Canadian project—The First Nations and Inuit Regional Longitudinal Health Survey—managed by the Assembly of First Nations Chiefs' Committee on Health. The instruments and methods used were developed by the National Aboriginal Health Organisation and included structured interview schedules designed for computer analysis and mental health questions.

(ii) A United States of America project—American Indian Services Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (AI-SUPERPPF). A variety of instruments were used (e.g. SF-36 and a modified version of the Composite International Diagnostic Interview), data collection was computer assisted, and the AI-SUPERPPF lay interview included assessment of risk factors such as life events, recent events, chronic strains and traumas, and protective factors such as ethnic identity, social support, coping, mastery and self-esteem. Details of this project are available on line (<http://www.uchsc.edu/ai/ncaianmhr/dac.htm>). Brice (1997) describes a 'Baseline Measures' project in the USA using tribally defined health status indicators and work in progress towards establishing a national Indigenous health database. The community-driven approach provides a holistic framework for action to advance Native American health, including mental health.

(iii) A New Zealand model of health and wellbeing called Whare Tapa Wha, and Hua Oranga—a Maori measure of mental health outcome (Kingi & Durie 2000). This work formed the basis of much focus on Indigenous issues within national approaches to mental health in New Zealand. For example, the Maori Monitoring and Review Group, which has responsibility for ensuring responsiveness of Maori in all aspects of New Zealand's national initiative, MH-SMART has developed a set of principles and training vignettes to guide the use of the Health of the Nation Outcomes Scale (HoNOS) with Maori consumers (Levy *et al.*, 2005a, b) that have both informed and been informed by work in Australia (Haswell-Elkins & Wargent 2005).

## Summary

Given the issues raised in the second section that perpetuate the inter-generational loss of social and emotional wellbeing among Aboriginal and Torres Strait Islander people brought about through colonisation, it is clear that defining and measuring Indigenous wellbeing requires great care. We have briefly identified problems that arise in the selection and development of appropriate tools for measurement, their implementation, and the interpretation and use of the data collected. We also describe a number of recent initiatives in Australia, Canada, New Zealand and the USA that are beginning to show the benefits of appropriately developed and used measurement tools in holistic action frameworks for the promotion of mental health and wellbeing.

## Towards a research agenda in social and emotional wellbeing

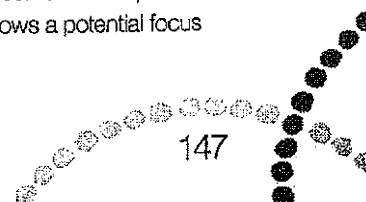
### Introduction

This section pulls together the main findings of the literature review, and makes recommendations on the practical measures that researchers and other stakeholders—such as practitioners, educators, policy makers and planners—can take in partnership with communities to help improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

### A research agenda

#### The approach

We would like to reiterate what we wrote in the introduction to this review: that is, the critical importance of involving Aboriginal and Torres Strait Islander people and communities right from the start in all research activity, and the need to clearly link research outcomes to government policy-making and implementation to achieve measurable improved health outcomes. We would also like to emphasise the critical importance of recognising (and allowing for) the dominant Western perspective (bias) that most of us bring to our research activities (e.g. Stanfield 1985; Scheurich & Young 1997). The concept 'social and emotional wellbeing' is not easily defined, but is a critical part of the holistic concept of health. We have reviewed some of its important components, and suggest in what follows a potential focus



for future research in a social determinants context. No single discipline, used in isolation, will be able to influence the search for new and effective ways of promoting social and emotional wellbeing. Transdisciplinary and multi-level research frameworks are needed to understand and address the complex social determinants of Aboriginal and Torres Strait Islander social and emotional wellbeing, including power, control, political parity and genuine self-determination.

### The policy context

We described in the Introduction and in the second section of this review how the DHA has recently developed a national strategic framework for social and emotional wellbeing for Aboriginal and Torres Strait Islander people (DHA 2004). In this document, the fifth strategic direction is to 'improve quality, data and research', with a key result area of 'developing and publishing culturally appropriate data and research that reflects Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing and that underpin improved service delivery'. The rationale for this key result area lists six action areas—including culturally sensitive data collection methods, support for community research initiatives, recruitment and retention of Aboriginal and Torres Strait Islander statisticians and researchers, and ethical conduct of research—to progress improvements in social and emotional wellbeing (DHA 2004:50–3). However, research and recommendations alone are not sufficient to achieve improvement. It is already known that under-resourcing, short-term funding, and the poor attitudes and behaviour of health professionals remain major barriers to

Aboriginal and Torres Strait Islander people accessing effective services. Available evidence indicates that institutionalised racism and discrimination is evident in the vagaries and constraints of funding availability in relation to the actual needs of Aboriginal and Torres Strait Islander social and emotional wellbeing services and programs, thus inhibiting the effectiveness of such programs (Henry *et al.* 2004 cited in Kreger *et al.* 2004). Recommendations made by Swan and Raphael (1995) ten years ago for an additional \$50 per capita to increase accessibility to mainstream specialist mental health care services, and a further \$150 per capita for Aboriginal and Torres Strait Islander organisations to provide 'social and emotional wellbeing' programs, have not been met. A national social and emotional

wellbeing policy review found that there was an expectation of achievement from Aboriginal and Torres Strait Islander community-controlled health sectors disproportionate to their under-resourcing. Such organisations are required to do 'too much' in 'too short a time' (Roxbee & Wallace 2003).

We recommend that researchers, communities and other stakeholders develop in partnership research projects around the fifth strategic direction and key result area described above, including resource allocation for Aboriginal and Torres Strait Islander social and emotional wellbeing services and programs.

### Measurement

We have shown in the third section that there are currently no generally accepted tools for measuring the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. The lack of valid and reliable tools to guide interventions and policies that seek to promote social and emotional wellbeing seriously disadvantages efforts to keep this a high priority in the broader public health agenda, where there is strong competition for resource allocation by more easily measured phenomena. We consider that an important research focus in the longer term would be the development of social and emotional wellbeing measurement tools that take into account the complexities of Aboriginal and Torres Strait Islander culture, language, history and inter-subjectivity against a background of inequality and power differential through which people define their holistic wellbeing.

We recommend that, in the shorter term and as a practical measure, researchers, communities and other stakeholders consider the instruments used in the ABS Indigenous Health Survey 2004/2005, and the *Western Australian Aboriginal Child Health Survey*, together with qualitative approaches, to undertake local priority research in social and emotional wellbeing.

### Resilience

We demonstrated in the section on resilience that there is little information in the literature on resilience among Aboriginal and Torres Strait Islander people, and that research in this area is a NHMRC priority. This situation may reflect both the short time frame and limited resources available for our review, and the inapplicability of Western concepts and language of resilience to Aboriginal and Torres Strait Islander communities. Researchers need to understand related concepts of resilient behaviours and language within an Aboriginal and Torres Strait

Islander context. Resilience has been an important aspect of the ability by Aboriginal and Torres Strait Islander people to survive more than 200 years of colonialism, and remains an important factor in determining good health and social and emotional wellbeing. We are currently living through a period of globalisation with rapid social and other changes in many aspects of our lives. Resilience is an important characteristic to help all age groups navigate these changes with good health and wellbeing outcomes. The practical research work of Tsey and colleagues with Aboriginal and Torres Strait Islander people in north Queensland is a good example of research in this area.

We recommend further research to understand what resilience actually means in Aboriginal and Torres Strait Island communities, and how this understanding can be used to strengthen individuals and communities.

### Healing and spirituality

We found in our review that the literature on healing and spirituality prominently featured both a number of Aboriginal and Torres Strait Islander scholars (Atkinson & Edwards-Haines 2003; Atkinson 1994, 2001, 2002; Atkinson & Ober 1995; Goreng Goreng 2004; Wanganeen 1994) as well as non-Indigenous scholars (e.g. Reid 1982, 1983; Cox 2000). Aboriginal and Torres Strait Islander healing and spirituality is an important aspect of social and emotional wellbeing research, particularly in the context of the history of colonisation in Australia. However, there was relatively little literature about healing and spirituality in the context of Aboriginal and Torres Strait Islander social and emotional wellbeing. We consider this a specific area for further research.

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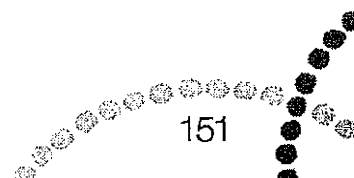
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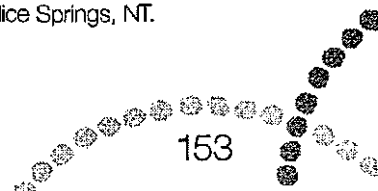
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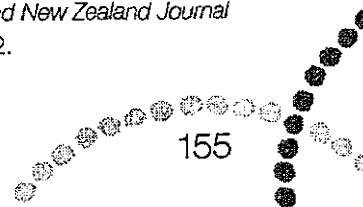
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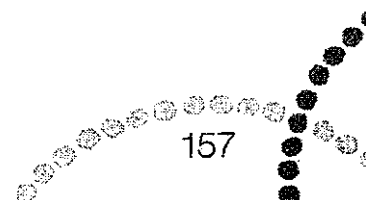
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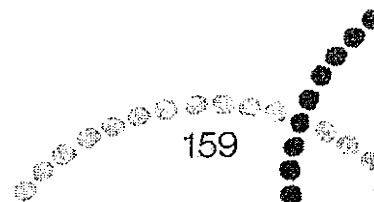
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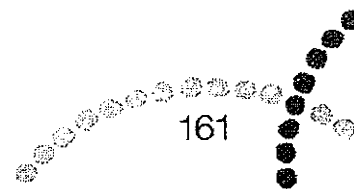
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