A review of the social and emotional wellbeing of Indigenous Australian peoples

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http://www.healthinfonet.ecu.edu.au/sewb_review

Darren Garvey is an Indigenous professional with experience as a recipient and provider of services aimed at addressing the social and emotional wellbeing (SEWB) needs of Indigenous people, and as an academic involved in the training of Indigenous and non-Indigenous professionals in providing such services.

Darren's perspective as 'insider' and 'outsider', and his professional interest in the development of a culturally competent workforce contributes to the narrative pursued in the review, and to the interplay of academic, policy and practical concerns.

Introduction

On February 13, 2008, the Prime Minister of Australia, Mr Kevin Rudd, offered an apology to members of the Stolen Generation on behalf of the Parliament of Australia. The apology attracted words and gestures of gratitude, relief, pride and sorrow. For some, the words of the nation's leader provided sufficient closure to a painful emotional wound created by their forced removal as children while for others the words were met more cautiously - judgement reserved until an idea of what was to come next was revealed [1].

Others saw the gesture as unnecessary or insufficient - irrelevant in contemporary Australia or not substantial enough [1]. Various professions were generally supportive in their comments [2, 3]. In a response titled '*Let the healing begin*', Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma, spoke of the apology as an act of 'hope, dignity and respect', acknowledging the existence and impacts of past policies and practices of forcibly removing Indigenous children from their families [4]. Reflecting upon his great grandmother's experience, he stated that in the

midst of often polarised opinion about the need, benefit or wisdom of an apology, that in essence the acknowledgement that it facilitated was about reinstating *belonging* for Indigenous people otherwise disconnected from family and country by prior policy and action. He couched the apology in terms of it representing an action that provided a place in which both Indigenous and non-Indigenous people might participate with a view to reconciling

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history in the present.

On June 22, 2007, the then Prime Minister, Mr John Howard announced plans for interventions in Indigenous communities in the Northern Territory aimed at addressing the safety and wellbeing of the children of these communities. Opinions were once again polarised as Indigenous and non-Indigenous Australians responded to the details of the plan, announced as a 'national emergency in remote Aboriginal communities' [5]. The undisputed urgency of the situation outlined in the *Ampe akelyernemane meke makarle - little children are sacred* report (a catalyst for the intervention based on alarming levels of documented sexual abuse) were countered by calls for consultation and discussion with those communities targeted [6, 7]. What were regarded as excessive tactics in the initial roll-out of the plan by some, were seen by others as necessary to exert a strong presence under the circumstances [8].

Both of these events and their repercussions impact and involve in some way the social and emotional wellbeing of Indigenous Australians. The first, an apology, represents a particular step aimed at acknowledging 'past mistreatments and a blemished chapter' in our nation's history with a view to reconciling Indigenous and non-Indigenous people to a better future. The second raises questions about how we treat and regard the current and future generations of Indigenous Australians and the role of non-Indigenous Australians within this venture. In terms of addressing what are long felt and more recent trauma for Indigenous people, both events attract a myriad of professional and stakeholder interpretations and general public views on how best to understand the issues and, in turn, what represent the best ways forward.

Of course, the social and emotional wellbeing of Indigenous Australians is also an ordinary and everyday proposition - a concern negotiated in the midst of stressors that are at times similar to those facing the general population, and in circumstances more specific to Indigenous people. However, large scale and well publicised events and actions, such as those outlined above, can prompt a refocussing of attention on this aspect of Indigenous health. As well as what they reveal about the historical and contemporary contexts of Indigenous Australians, so too are we enlightened as to the broader attitudinal and practical milieu in which considerations and responses to the needs of Indigenous social and emotional wellbeing occur.

Aim of this review

The following review aims to describe aspects of the social and emotional wellbeing of Indigenous Australian people and elements of the Australian contexts in which they live. A deliberate emphasis is made here to highlight major signposts, research findings and interventions concerning Indigenous people[1]. A number of general and significant trends are identified in this review, but the diversity of Indigenous Australian experiences - both historically and in a contemporary sense - need to be acknowledged, as does its implications in considerations of competent and appropriate service provision[2]. In light of this, the review attempts to distil several considerations, challenges and opportunities for people involved in the area and for those considering more substantial involvement.

Indeed, the ability to delineate mental health research and other priorities can be challenging generally in a country such as Australia, with its ethnic diversity, a majority population descended from European settlers and a diverse, heterogeneous Indigenous population [9]. What is clear, however, is that the impact of problems relating to mental health exacts a tremendous burden on many in the Australian population - individually, socially and economically - and the need for clarity in terms of understanding and responses remains important for Indigenous Australian people specifically and the Australian population generally.

Structure of review

The review begins by examining aspects of an ongoing debate concerning the terminology used in the context of discussing Indigenous social and emotional wellbeing (SEWB). Subsequently, the consideration of this term by many Indigenous people to refer to what is more conventionally regarded as 'mental health' allows further exploration of some of the underlying and explicit tensions that exist within the area, beginning with matters of terminology, but extending to other challenges regarding appropriate service provision, policy, intervention and research priorities, and the means by which these practical and conceptual dilemmas might be resolved. What emerges is a picture of Indigenous SEWB that is at once stark in its account of the mental health problems prevalent among Indigenous people, yet encouraging in the resilience shown by Indigenous people in the face of such adversity. Promising too are the efforts made by a variety of health service and other professionals to better appreciate their roles in promoting good SEWB for Indigenous people and the exploration of the varied sites and opportunities in which such work can take place.

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1   It is acknowledged that the social and emotional wellbeing of Indigenous Australian people has been considered in an international context, but this aspect is not the focus of this review.

2   For further demographic information about the Indigenous Australian population

Coming to terms

'Social and emotional wellbeing' and 'mental health'

Many communities, including Indigenous Australians, prefer the term 'social and emotional wellbeing' to 'mental health' because it is perceived as reflecting a more positive approach to health [10]. Since its emergence in the Australian context in the 1980s, the concept of social and emotional wellbeing has helped cast a light onto considerations of the mental health of Indigenous people and encouraged observers - including Indigenous people themselves - to consider mental health holistically by acknowledging and examining the broader socio-historical and personal choices that influence it.

The term 'mental health' refers to 'a state of emotional and social wellbeing in which individuals can cope with the normal stresses of life and achieve their potential' [10]. In such a state, individuals may also contribute to community life, and engage in positive and beneficial relationships with others. Mental health is a negotiated state and the result of a complex interplay of factors, both internal and external to the person. It is sensitive to external stressors and mediated by internal biology and neurochemistry. As a resource for daily life, it can be promoted in ways that support and maintain it, or be compromised by other actions. Fluctuations in mental health are normal in that movement between periods of good mental health and periods when it is not as good by comparison are to be expected throughout the lifespan. *The National Mental Health Plan 2003-2008* recognised a continuum of mental health ranging from mental health that is good to mental health that has been compromised in some way, perhaps by the emergence of a diagnosable mental illness or other mental health problem [10]. The extent, duration and kinds of impact brought about by these are also diverse, as are the actions that can be taken to assist a return to better mental health. As a term, 'mental health' reflects the broad experiences for a person over the course of their lifetime and not merely those times when they are experiencing problems or are mentally unwell. Mental health is relative in that what is understood to be mentally healthy (and mentally unwell) is, to some extent, constructed and understood within a cultural context.

'Social and emotional wellbeing' (SEWB) is an integral component of the holistic view of health held by many Indigenous Australian people [11]. As a term preferred by many Indigenous people, social and emotional wellbeing provides a platform capable of encapsulating understandings of themselves and their experiences as they relate to mental health. For many Indigenous people, health has been viewed traditionally as concerning more than the physical health of individuals. The social, emotional, spiritual and cultural wellbeing of the whole community is paramount and essential for the health and wellbeing of the individuals that comprise it. Essential, too, for many Indigenous people traditionally and in contemporary contexts is the bond between person and land - a connection that constitutes one's sense of individual and social identity and responsibility. The integrity of relationships between people and spiritual entities and the clarity of connections between people and land contribute greatly to the SEWB of Indigenous people. Conversely, ruptures to significant relationships and markers of identity including access to culturally significant sites and socially significant persons can serve to compromise the quality of an individuals' or a community's SEWB [12] . SEWB for Indigenous people in these terms is very much a matter of the integration of the various priorities, practices and principles that comprise their lives.

As a descriptor, SEWB grew out of more conventional psychiatric terminology concerning mental health and mental illness and dissatisfaction with the ability of those terms to reflect and represent Indigenous conceptualisations of health and wellbeing. SEWB emerged as both reaction to imposed conceptualisations [13, 14], and response to the need to provide concepts articulated by Indigenous people themselves [10, 15]. In some instances, it was felt that conventional mental health terminology had 'problematised' Indigenous people and used diagnoses and terms imposed by those who had 'caused' the problems [16]. Furthermore, imposed diagnoses and labels, when coupled with prejudicial judgements of 'sickness' and 'inferiority', provided the grounds for many Indigenous people to question the value of this 'mental health business' [17].

The terms mental health and social and emotional wellbeing continue to be used in unison and interchangeably, despite calls for greater specification [18]. Notably, a 'hybrid' lexicon is emerging in other contexts that incorporates both recently introduced and traditional (Indigenous) nomenclature and definitions [see, for example, [19]. This variety of terminology should be noted as a characteristic of the development of interest in Indigenous mental health and the arrival at a language by which to speak about it. At this stage, it is by no means a 'common language' and so a variety of understandings may be expressed when it comes to discussing mental health and/or SEWB with Indigenous Australian people [20].

Considering the factors that impact on Indigenous SEWB

It is difficult to elaborate the specific impact of historical and contemporary circumstances on the SEWB of all Indigenous people, but it is often such requests for 'single' or simple answers

that characterise the discussion surrounding Indigenous mental health. That such a synopsis could be made belies both the historical complexity and contemporary diversity of Indigenous people. That it is requested is perhaps indicative of perceptions to the contrary that are a remnant of relationships between Indigenous and non-Indigenous people since colonisation. In the preface to the Western Australian Aboriginal Child Health Survey (WAACHS), Milroy identifies three critical themes that emerge from a psychological analysis of Indigenous history: the denial of humanity, the denial of existence and the denial of identity [18].

The repercussions of these imperatives still echo for many Indigenous people in contemporary Australian society - that is, how to gain acknowledgement in contexts that have otherwise excluded them? how to gain access to systems that have otherwise restricted them? and how to promote identity and culture in settings that have otherwise devalued them? If we consider that SEWB is determined and supported by the quality of the nexus of relationships in which Indigenous people locate themselves, then it is unsurprising that instances of poor mental health or compromised SEWB are widespread given the impact of the policies and actions perpetrated upon Indigenous individuals, families and communities. The ongoing effects of such trauma continue to play out for many Indigenous people today, supported and at times allowed by systems that require a critique of the ways in which they construct both the identity of and their relationships with Indigenous people.

What is apparent is that a comprehensive understanding of this aspect of Indigenous health remains elusive despite more than twenty years of systematic interest [21]. Reiterating the comment regarding evolving terminology, in one of earliest and, to that point, most substantial attempts to explore the breadth and meaning of Indigenous mental health, Reser [22] titled his chapter 'Aboriginal mental health: conflicting cultural perspectives'. His analysis brought to light the historical legacy apparent in introduced conceptualisations of mental health and the tension created by their attempted, uncritical application to Indigenous people. The 'unfamiliar' may have raised questions for many of the conventional descriptive and diagnostic categories, but, from an intra-Indigenous perspective, Indigenous cultures and ways of life in such diverse and, at times, demanding environmental contexts were both practically expedient and thematically rich in their expression. Thus, interest in the mental health of Indigenous Australians reflected much broader dynamics apparent between them and non-Indigenous Australians - another site in which deliberation over Indigenous and non-Indigenous perspectives were couched in conflicting terms.

The prevailing context is that we are still coming to terms with what Indigenous SEWB encompasses, who determines its parameters,

and how best to proceed when it comes to the development and implementation of services. We are also, quite literally, still 'coming to terms' with how to communicate about Indigenous SEWB, but the development of shared mental health literacies is helping to facilitate this [23]. The association of the term mental health and the word 'mental' (in particular with illness, deficit and (at times) danger) resulted in a wariness of those terms and an associated stigma attached to people labelled with 'mental problems'. Professions concerned with mental health have also been regarded with suspicion, particularly when seen to be linked to subsequent actions that resulted in the diagnosis, labelling and treatment of Indigenous people often without adequate explanation. Despite its otherwise broad parameters, 'mental health' was increasingly understood in narrow terms and as a primarily negative phenomenon - - becoming something to fear and avoid - - and those associated with it likely to attract a similar reception [17]. In contemporary contexts, for practitioners and policy-makers alike, their involvement in the area of Indigenous SEWB may activate lingering concerns and require reflection as to how best they negotiate their role within this often 'contested' context [21, 24]. Concurrently, an appreciation of the broader parameters of 'mental health' and SEWB are growing among Indigenous people, but mental health practitioners may still encounter a reluctance to agree to mental health interventions by some Indigenous people due to historical experiences and associations [25]. In recognition of this potential reluctance, many examples of formal policy and program development have been and are being attempted. The section on SEWB services for Indigenous people below describes several of these.

Summary

Practically then, the concept of SEWB reflects the broad definition of 'mental health' in that it was not solely concerned with mental illness or mental disorder. As a term, it is preferred by Indigenous people because of its more positive and holistic connotations and its acknowledgement of the emotional and social aspects of Indigenous health [10]. It also accommodates a more meaningful recognition of aspects of Indigenous history, particularly the periods and practices resulting in trauma and grief that have been identified as underlying the great burden of mental health problems among Indigenous people and which may lead to 'mental illness' [15]. SEWB acknowledges and accommodates those conditions conventionally regarded as mental illnesses and mental health problems (for example, schizophrenia and depression), as well as conditions/behaviours with a mental health component (such as suicide, alcohol and other drug problems, identity issues and family violence).

Overall, the debate as to what constitutes the SEWB of Indigenous people and the language with which to speak about it is more than a mere exercise in semantics. Interwoven into this discussion are remnants of other aspects of Indigenous and non-Indigenous history and relationships and the often disjointed and conflicting nature of these. Overlaid with the need to consider Indigenous diversity, it should come as no surprise then that much of what needs to be accomplished in the area of Indigenous SEWB concerns basic questions relating to communication about, and conceptualisation of, the way Indigenous SEWB is to be understood in both general and specific terms.

Factors contributing to Indigenous SEWB

Social determinants, risk and protective factors

Social determinants theory recognises that population health and inequality is determined by many interconnected social factors. Social determinants of Indigenous health generally are underpinned by socio-economic disadvantage across a range of indicators including gross household income, rates of unemployment and educational attainment. Social and economic status and the impact of poverty on health have been articulated as has the role that chronic stress and perception of control over life circumstances plays in influencing health status [26].

The importance of focusing on social determinants and risk and protective factors affecting mental health in relation to policy and strategies was outlined by the Commonwealth Department of Health and Aged Care [27]. Australia's second national mental health plan highlighted the ways in which determinants of health translate into protective and risk factors that influence the physical and mental health of individuals and identifiable population groups [28]. Risk factors increase the likelihood that mental illness will develop, while protective factors provide people with resilience and can moderate the impact of stress, thereby reducing the likelihood of mental health problems. Thus, if a population of individuals is exposed to a risk factor, then preventing or interrupting exposure to this factor can result in valuable reductions in the burden of associated disease. The plan states that many of these risk factors generally lie outside the ambit of mental health services and require long-term, sustained efforts across multiple sectors of the community, identifying the need for collaborative inter-sectoral partnerships. These imperatives reflect and focus the concerns relating to the aetiology of problems relating to mental health and the nature of interventions concerning Indigenous SEWB.

Insights from a major survey

The WAACHS measured many of the factors affecting health and wellbeing in a representative sample of Indigenous young people in Western Australia [18]. Many of these are relevant to good health for all children, but several findings highlighted the specific needs of many Indigenous children. Factors supporting healthy child development included low levels of major life stress, good family functioning, good speech development, and care of the child by the original parent. The survey also found that growing up in areas of isolation from mainstream Australia, where traditional cultures and ways of life are strong, may be protective against emotional and behavioural difficulties. Blair, Zubrick and Cox [29] cite the need for a coordinated approach to breaking the cycle of disadvantage affecting Indigenous young people. The cycle occurs in a context characterised by poor community and family resources contributing to young people making less than optimal lifestyle choices and thereby perpetuating the cycle of disadvantage. Services need to be geographically available and culturally acceptable - the role of Aboriginal Health Workers and Aboriginal community-controlled health services (ACCHSs) receiving specific mention. Concern about the availability of suitable services for adult Indigenous people was also a significant finding of the evaluation of the effectiveness of the Bringing Them Home Services [30].

The multifactorial path to SEWB means that it is not only mental health professionals or mental health-specific services that have roles to play in enhancing the SEWB of Indigenous people. This does not preclude the need to consider the unique circumstances of individuals, but it does call for closer consideration of the fundamental structural, social and economic inequities within societies and communities with the understanding that mental health will be maximised by a comprehensive approach that is integrated across all sectors of care and all levels of society [27, p.18].

Addressing the social determinants and related challenges

Operationalising the directions expressed in policy presents many challenges practically, and the question of where to start addressing social determinants of health in Indigenous settings remains a real issue for practitioners in the field [31]. According to Hunter, in order to achieve such holistic coverage, various activities must be coordinated at four levels [21]:

Level	Activity
Society	Social justice, reconciliation
Community	Community development empowerment
Family/clan	Family wellbeing and parenting programs
Individual	Indigenous therapies
	Adapted/appropriated therapies (e.g. narrative therapy)
	Culturally appropriate conventional therapies

Hunter's taxonomy outlines the multi-site opportunities for SEWB interventions that acknowledge both individual and collective services and the importance of these to address, among other things, the development, maintenance and restoration of interpersonal and cultural relationships.

Similarly, Nagel outlines four prerequisites for what she describes as an expected battle with depression and depression-related disability [23]. In doing so, an expanse of potential sites of involvement are reiterated and demonstrate the breadth of professional expertise required to provide comprehensive coverage in order to develop:

• a 'mental health literate' community

• accessible services;

• a trained workforce; and

• tools for assessment and treatment.

Nagel's research in the Northern Territory suggests that Australian and NT government strategies may be demonstrating some effectiveness in reducing hospital admissions for Indigenous people [23]. General practitioner support and specialist outreach services that complement the service provided by Top End Mental Health Services are two examples of service enhancement. The emerging trends require further analysis, but the data are encouraging and may be indicative of improved community capacity to treat mental illness supported by policy and workforce improvements. Nagel cautions, however, that action is still required to fully address the four key areas of need identified above and to ensure their effective integration. As well as specific developments in each of the four areas, the 'bigger picture' must also be monitored to ensure cumulative growth. Coordination of responses may also help to address the concerns regarding 'tracking' and the useful evaluation of services Westerman [32].

Indigenous understandings of the factors contributing to SEWB

On the question of how Indigenous people understand mental health, Ypinazar and colleagues found that five themes emerged from a meta-synthesis of peer-reviewed qualitative empirical research regarding Indigenous people's understandings of mental health [20]. These identified themes coalesce around (i) culture and spirituality; (ii) family and community kinships; (iii) historical, social and economic factors; (iv) fear and education; and (v) loss. These themes constituted the underlying components of an overarching theme that characterised Indigenous people's descriptions of mental health as being 'the dynamic interconnectedness between the multi-factorial components of life circumstances' [20].

The ongoing effect of a variety of losses is a recurrent theme in descriptions of the factors that have impacted negatively on Indigenous SEWB. Loss may refer to the loss of a person or the loss of relationships to people. Loss may also involve the disconnection from geographical and social spaces and the subsequent loss of the right to be able to access those. For many Indigenous people, the destruction of areas and objects of sacred and spiritual significance (or uncertainty as to their fate) remains a source of unrelenting turmoil and sadness.

Swan and Raphael [33] locate the primary causes of poor social and emotional wellbeing for Indigenous people as originating from the ongoing consequences of colonisation. The impact and effects have varied over time across Australia, but have resulted in trauma, grief and loss for successive generations. O'Shane offered an account of the psychological impact of these experiences that included dispossession, racism, exclusion, extermination, denigration and degradation [34]. She described them as striking at the:

> '...very core of our sense of being and identity. Many of our people assume any other identity than that of Aboriginal: the denial of self. Many say, as I have done for years, I shouldn't be here in this world, I don't belong. Yet we are the most ancient people in the most ancient land on Earth. We question who we are, what we are doing, where we belong. All around us we see our families and friends adopt the dejected, rejected demeanour...Many assume aggressive, off-hand resentful mannerisms of speech and behaviour, even amongst their own cohorts.' [34, p.27]

Comments such as these indicate that the history being referred to is neither 'ancient' nor trivial for many Indigenous people. *The*

National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families. for example, found that the effects of that history continue to permeate the lives not only of those removed, but also the lives of those related to or in some way associated with those forcibly removed [35]. Drawn from the testimony of witnesses and further research, the Inquiry found that there were a number of common features and effects emanating from the separation of Indigenous people from their primary carers. These effects, while variable in impact, were seen as generally having negative impacts on mental and physical health that could be linked to subsequent delinquency and behavioural problems, loss of cultural heritage, broken families and communities, experiences of racism and undermined parenting skills.

For many Indigenous people affected by these policies, it would appear that separation and 'education' for living in the broader society actually compromised their preparation as parents. Ban [36] comments on the pervasiveness and currency of this aftermath:

> *Children removed have suffered from identity and mental health problems as adults, often leading to substance abuse as a way of coping, which, in turn, has led to poor parenting, as well as social and financial problems.*

The approach promoted outcomes that failed to satisfy their best interests as caregivers and ultimately as Australian citizens. Processes aimed at Indigenous assimilation did not necessarily facilitate their transition into mainstream Australian society. Instead, the first Indigenous people who ventured into the dominant society were often confronted by official surveillance and public scrutiny. The efforts made to help them 'fit in' did not always prevent them from being made to 'stand out'. State violence, intergenerational trauma, imbalanced power relations, limited access to services within the mainstream population and systemised and individualised discrimination and racism characterised much of the ensuing social settings in which Indigenous people lived along with the concomitant impacts on their health [26]. Beresford and Omaji elaborated on the after-effects of forced separation, linking them to a variety of outcomes indicative of compromised SEWB on many levels:

overrepresentation of Indigenous people in the justice system;

• family violence;

• welfare dependency;

• substance and alcohol misuse;

• breakdown of traditional family structures;

• loss of cultural and spiritual identity;

• loss of individual self-esteem, security and happiness; and

• health problems - physical, mental and emotional [37].

Beresford and Omaji outline how the impact of these experiences

have affected those directly involved and how this in turn has affected their children and the communities in which they live [37]. Some have described this as transgenerational trauma [38], and current mental health problems as not merely mistakes of a 'distant past' [39]. Difficulties with 'fitting in' could also be seen as contributing to low levels of education, high levels of unemployment, low socioeconomic status and poor living conditions that are experienced by many Indigenous people today [40, 41]. Questions concerning identity, place and 'belonging' as identified by O'Shane [34] above seem likely in the midst of this milieu with people feeling 'lost' as a result of their physical and emotional losses [42].

This abbreviated scenario aimed at highlighting some of the consequences of the forced removal of Indigenous people does point to the need to critique what are deemed 'risk' and 'protective' factors. For example, attending school may generally be regarded as a protective factor, but if the school promotes assimilation or is the source of racism and discrimination, then this is potentially harmful. Paradies [43] notes that studies from around the world have found that experiences of racism are related to poor physical and mental health and are associated with depression, poor quality of life, psychological distress and substance misuse - findings that are mirrored among Indigenous people. Further, systemic racism against Indigenous people continues to be identified in the media, education and welfare system, in the provision of public housing and in the legal/criminal justice systems [44-46].

Projected loss refers to a theme emerging from the literature that describes a sense of 'what could have been?' or 'if only?' [16, p.163]. Such sentiments exist as lingering questions and form part of the reaction to real loss for some Indigenous people. Projected loss might be considered relevant if a person laments their removal from their family for reasons unknown to them and which may be exacerbated if their ability to re-establish their connections is difficult or impossible. As Koolmatrie and Williams [16, p.163] describe:

> *Indigenous parents and children have been deprived by the removal of the simple human experience of living together as a family. Time and time again in the stories of the removal this theme recurs - regret for the life that was not lived, for the cultural identity compromised or entirely lost in the institutions where a 'white' identity was to be aspired to, but never achieved. And, constantly in the stories of the children grown up there is the theme of struggle to rediscover or reconstruct a lost sense of worthwhile selfhood.*

Koolmatrie and Williams [16] explore the implications of the role of 'authorities' leading to what they term 'inexpressible rage'. They speculate about the 'just anger' of parents who have lost a child finding relief in the State's determined efforts to arrest and punish

the culprit. But what if the State itself is the culprit, essentially forbidding the expression of this otherwise 'just anger' - where do these feelings and questions go? Indigenous people may experience extreme feelings of impotence and guilt at their failure to protect their children [16]. McDermott [47] suggests that when emotionally significant events are not appropriately addressed, they do not necessarily go away but have the potential to be re-emerge explosively. Furthermore, Kessaris [48] outlines how the persons concerned may be blamed for their predicament, or at least for not possessing the skills to deal with it more constructively. Thus, there is no forum in which just anger can be expressed and the people concerned are told to either cope better - or worse still - blamed for their inability to cope.

Being told to 'put the past behind them' does not present itself as a useful or practical option for people experiencing this kind of loss. Hunter [49] suggests that the encouragement to rationalise history in this way may actually be made to serve other social and political purposes, rather than the healing of aspects of a traumatic history. Such psychological and other more tangible defences against the consideration of Indigenous experiences and realities have been diminished in relation to many SEWB activities. Instead, ways of working that incorporate Indigenous 'terms of reference' [50] are being brought to the fore by Indigenous and non-Indigenous people working towards the improvement, maintenance and promotion of Indigenous SEWB [23, 51].

Vicary and Westerman [17] reiterate the need to acknowledge existing frameworks of healing in Indigenous communities, particularly where they pertain to the resolution of mental health disorders. They state that the assessment process must be capable of accommodating the exploration of the individual's underlying cultural and/or spiritual issues. However, while the consideration of spirituality in relation to SEWB is being increasingly validated, the uncertainty as to how best to do this has often meant that professions continue to work within dominant paradigms that impose Western beliefs. This presents a challenge as professions aligned with mental health have for a long time been aware of the 'spiritual' dimension of Indigenous health and wellbeing , but have been unsure of how to work with it [52]. If mental health problems manifest themselves culturally or spiritually, their accurate assessment and resolution may best be resolved through those avenues illustrating that a willingness to consider Indigenous perspectives on mental health problems is one step in gaining a better appreciation of the influence spirituality (and other determinants) plays in the cause, explanation and remedy of mental health problems [19].

Impact, incidence, prevalence, mortality, hospitalisation and impact on functioning

Introduction

Despite more than two centuries interest in the cultures, lifestyles and beliefs of Indigenous people generally, and two decades of more specific focus, '...contemporary understandings of Indigenous mental health are confused and conflicted, the result no doubt, of a mental health database that is "woefully inadequate"' [53]. Concern too has been expressed about elements of research that has been conducted. In his review of early psychiatric studies, Reser [22] argued that the original research - and subsequent articles derived from the original research - did not appreciably advance cross-cultural understandings of Indigenous mental health. His critique of the major surveys conducted by [54] for example, includes:

- lack of any specifics with respect to method or procedure;
- reliance on the perception of non-Indigenous staff;
- reliance on another culture's classification and diagnostic scheme;
- discounting of clear discrepancies between Indigenous and Western labels and criteria; and
- cataloguing of culture-specific diagnostic categories: 'fear of sorcery syndrome', 'mimetic illness', 'shared depressive illness', which are then made to 'fit' into conventional categories, in this case the International Classification of Diseases (ICD) [22].

Although limited in their ability to provide a robust epidemiological picture of the mental health of Indigenous people at that time, these early surveys did trigger subsequent re-examination of Western cultural assumptions and models for understanding mental health cross-culturally [22].

These sources were reflective of the period that Hunter [24] termed 'before deregulation' (pre-1980) - before the abolition of those policies that had proved to be most restrictive of Indigenous people. He makes the point that both the kinds of research and the kinds of conditions would undergo many changes following deregulation. He noted that the succeeding two decades have seen the publication of far more studies and studies of much wider scope, both in terms of professional orientation and geographical location, but concludes that studies about Indigenous mental health prior to 1980 are 'scarce, generally psychiatric, and almost exclusively from remote settings.' [24].

The extent of mental illness and mental health problems has been recognised as a 'major difficulty for most [Indigenous] communities' [15], but the precise details remain poorly documented [55]. For

example, there remain glaring deficiencies in our knowledge about mental health disorders [24] and, until very recently, little coordinated effort to obtain it.

> *It is a matter of concern that the national mental health survey was undertaken in the late 1990s without an Indigenous component. The available material is from registers and service collections, data which are subject to problems of identification, categorisation, attribution and interpretation [53].*

Population studies have also tended to focus on Indigenous people aged 18 years and older with relatively few data available from which to describe the current social and emotional circumstances under which young Indigenous people live and develop. Zubrick and colleagues [18] highlight that there is a meagre epidemiological base, both within Australia and internationally, from which to draw conclusions about the scope, prevalence and burden of mental health problems in Indigenous children. Based on available information, they suggest that the prevalences of emotional and behavioural problems in Indigenous populations are likely to be higher than in the majority populations (p.4).

More recently, the principal sources of information about Indigenous mental health relate to mortality or the use by Indigenous people of mental health services. Thomson and colleagues [55] caution that such databases may underestimate actual rates and the fact that many people do not access mainstream mental health services also makes it difficult to construct a definitive picture. Thomson and colleagues also note that, in view of the greater mainstream attention in recent years to Indigenous mental health, it would be expected that a second specialist national epidemiological survey of mental health and wellbeing would also include an adequate sample of Indigenous people. It is expected that this survey will be conducted around 2007 (around 10 years after the original 1997 survey) [56]. In order to do so, adaptations of available clinical measures to improve their utility and validity for adult Indigenous consumers is being explored. It is also expected that new work will be undertaken to develop 'culturally valid alternatives for self-reporting of outcomes by Indigenous consumers and their families' [56, p.40].

With these caveats regarding research conducted into the SEWB of Indigenous people in mind, a number of observations are possible, based on the information that is available. It has been suggested that the health and wellbeing of Indigenous people prior to widespread Australian colonisation was robust by comparison to what it would become following settlement, and relatively better than that of those who had come to settle [57]. It is unlikely, however, that Indigenous people had an idyllic, untroubled existence, devoid of hardship and characterised by consistent

abundance. More likely, the diverse geographical and climatic conditions that characterise Australia's land and waterways would require Indigenous people to negotiate their place in the midst of what could at times be harsh physical environments and intricate social networks. That they were and are able to do so is testament to cultural imperatives and priorities inherent in their lifestyles and the ways in which their culture and lifestyles promoted integrated social and emotional wellbeing.

It is difficult to determine whether what are now widely regarded as mental illnesses were prevalent prior to colonisation, but recent investigations of the mental health of Indigenous people in remote settings provide a potential clue. Parker and Milroy [58] identify several studies that describe 'schizophrenia-like' illnesses among Indigenous people in Central Australia [59, 60]. Similarly, Hunter [24] reviewed early studies documenting what, at the time, appeared to be conditions among Indigenous people that satisfied the diagnostic criteria for mental illnesses, or were indicative of mental health problems. The reviewed material showed that a wide range of mental health disorders were prevalent, based largely on surveys of remote communities. Despite the aforementioned misgivings about early research concerned with the mental health of Indigenous people, they do tend to support the conclusion that 'serious psychiatric disorders occur in Indigenous populations, and are at least as common as in the mainstream population' [24]

Current evidence of the SEWB of Indigenous people

Despite long held concerns as the nature and extent of information concerning Indigenous people, what is known about the rates of mental health problems and mental illnesses among Indigenous people is enough to warrant concern and ongoing attention and research [24]. In the first decade of the 21st century, Indigenous people remain over-represented in mental health care across the country. Zubrick and colleagues [18] express particular concern that this remains the case for the Indigenous people of an otherwise affluent and prosperous country.

Evidence from population surveys

Australia-wide surveys

The first detailed information about the social and emotional wellbeing of Indigenous people was collected as part of the 2004-2005 National Aboriginal and Torres Strait Islander Health Survey (NATSISHS) [61]. After adjusting for differences in the structures of the Indigenous and total Australian populations, the survey found that Indigenous people aged 18 years or older were twice as likely as their non-Indigenous counterparts to feel high or very high levels of psychological distress.

Questions from the SF-36 focused on the respondents' positive feelings and energy levels during the four week period prior to their interviews [61]. Seven out of 10 respondents (71%) reported being happy, 56% feeling calm and peaceful, and 55% feeling full of life 'all or most of the time'. Almost four out of 10 respondents reported feeling that they had a 'lot of energy' 'all or most of the time'. Only 2-7% of respondents marked 'none of the time' for any of the above feelings.

In response to questions based on the Kessler Psychological Distress Scale, 12% of respondents reported feeling 'restless or jumpy' and 19% that 'everything was an effort' 'all or most of the time' [61]. Feeling 'without hope' and 'so sad that nothing could cheer [them] up' 'all or most of the time' was reported by 7% of respondents. On the other hand, 62% reported feeling 'so sad that nothing could cheer [them] up' and 38% 'that everything was an effort' 'none of the time'. Similarly, 44% felt nervous, 62% 'without hope', and 42% 'restless or jumpy' 'none of the time'.

The higher overall levels of psychological distress reported by Indigenous people than by non-Indigenous people are consistent with the relative frequencies with which the two populations experienced specific stressors in the previous 12 months. According to the 2004-2005 NATSIHS, 77% of Indigenous people experienced one or more significant stressors in the previous 12 months [61] (see Table). In comparison, 59% of the total population reported in the 2006 General Social Survey that they experienced one or more significant stressors in the previous 12 months [62]. The proportions reporting specific stressors were generally higher for Indigenous people than for the total population, particularly for the 'death of a family member or friend', 'alcohol or drug related problem', 'trouble with police', and 'witness to violence'. Almost one in five Indigenous people reported that a member of the family had been sent to jail in the previous 12 months, but that stressor was not reported for the total population.

Table 1. *Proportions (%) of stressors reported in previous 12 months, by Indigenous status, year and stressor type, Australia, 2004-2005 and 2006*

Type of stressor	Indigenous status / year	
	Indigenous	Total population
	2004-2005	2006
Death of a family member or friend	42	23
Serious illness or disability	28	30
Not able to get a job	17	13
Alcohol or drug related problem	25	8.6
Overcrowding at home	17	n/a
Member of family sent to jail/in jail	19	n/a
Witness to violence	14	3.9
Trouble with police	16	3.9
Discrimination/racism	12	n/a
Any stressor	77	59

Source: ABS, 2006 [61] ABS, 2007 [62]

Notes: 1. The total population proportion for 'serious illness or disability' data' has been estimated by adding proportions for the two sub-components, so may slightly overstate the true proportion

2. n/a: not available

Survey of Indigenous children in Western Australia

An important source of information about the SEWB of Indigenous children and youth is the WAACHS, a large-scale, scientifically rigorous survey that included attention to the developmental and environmental factors that enable competency and resiliency in Indigenous children and young people aged 4-17 years: [18]. The survey findings included:

• 24% of Indigenous children were rated by their parents as being at high risk of clinically significant emotional or behavioural difficulties, compared with 15% in the general Australian population;

• 70% of Indigenous children were living in families that had experienced three or more major life stress events (such as death in the family, serious illness, family breakdown, financial problems or arrest); 22% had experienced seven or more of such events in the 12 months prior to the survey;

• 16% of Indigenous young people aged 12-17 years had seriously considered ending their own life in the year prior to the survey; 39% of these had attempted suicide.

• exposure to family violence increased the likelihood of an

Indigenous young person considering ending their own life (22%) compared with those who had not been exposed (9%);

• Indigenous young people at risk of clinically significant emotional or behavioural difficulties were more likely to think about ending their own life (37%) compared with young people at low risk (10%);

• children of Indigenous carers who had been forcibly separated from their families were 2.3 times more likely to be at high risk of incurring clinically significant emotional and behavioural difficulties, and had twice the rate of both alcohol and other drug use.

Hospitalisation

In 2005-06, Indigenous males and females were almost twice as likely to be hospitalised for mental and behavioural disorders as other Australians [63, 64]. In terms of specific disorders, the rates of hospitalisation in 2005-06 for Indigenous people diagnosed with 'mental disorders due to psychoactive substance use' were 4.5 times higher for Indigenous males than for other Australian males and 3.3 times higher for Indigenous females than for other Australian females.

Nagel [23] reports that, based on NT hospitalisation rates, depression was second to psychosis and substance misuse as a reason for mental health-related hospital admissions in 2002-03. Women were also more likely to present with a mood disorder, such as depression. Nagel also expresses concern that, being based on hospital admissions, these figures and trends represent the 'tip of the iceberg'.

Mortality

In 2001-2005, Indigenous males were 5.8 times more likely to die from mental and behavioural disorders and Indigenous females 3.1 times more likely in 2001-05 than were their non-Indigenous counterparts [63]. In terms of specific disorders, the death rate for 'mental and behavioural disorders due to psychoactive substance use' was 14 times higher for Indigenous males aged 35-44 years than for non-Indigenous males in that age group. The rate for Indigenous females in this age group was 12 times higher than their non-Indigenous counterparts.

Intentional self-harm

The level of intentional self-harm has been recognised as a key indicator of Indigenous disadvantage [40, 41]. Death rates from intentional self-harm were generally between two and four higher for Indigenous males and females living in Queensland, WA, SA and the NT in 2001-2005 than for their non-Indigenous counterparts. Indigenous rates for death from intentional self-harm ranged from 32 per 100,000 for WA to 85 per 100,000 for the NT for males, and from 6.2 per 100,000 for WA to 21 per 100,000 for SA for females.

Reflecting the differences between Indigenous and non-Indigenous in death rates from suicide, admissions to hospital for intentional self-harm were also more common for Indigenous people than for non-Indigenous people living in people living in Queensland, WA, SA and the NT in 2004-05: admission rates were 2.3 times higher for Indigenous males and 1.5 times higher for Indigenous females than for their non-Indigenous counterparts [41].

SEWB services for Indigenous people

The holistic parameters of SEWB mean that many programs could be viewed as impacting on the mental health of Indigenous people, even though their activity is not been specifically designated as such. Further, the exact nature of the causal interactions affecting mental health problems and mental disorders are often unknown, or at least unable to be distilled to a single principal cause [27]. The potential focus of interventions also means that engagement may be aimed at a particular site or level of intervention or planned to address SEWB at a number of levels simultaneously. Therefore, a program or service may be affecting SEWB without it being explicitly known or deliberately planned. These comments about terminology and scope underline the complexity faced by services concerned with addressing SEWB needs. This has implications for the evaluation of services and the subsequent advice and direction that programs might offer to others. For the purpose of this section, the focus is on those programs and services that specifically target Indigenous mental health and/or SEWB and have in some way indicated this in their objectives. The selection highlighted here is by no means exhaustive, but they do provide an overview of a variety of interventions attempted, their target group(s), the kinds of personnel involved and, where available, an evaluation of their effectiveness. The first section highlights several services that may be broadly described as preventive and treatment oriented in their focus. The latter section describes a suite of interventions provided under the auspices of the Social Health Section of the Australian Department of Health and Ageing's Office for Aboriginal and Torres Strait Islander Health (OATSIH). Further detail about each program can be obtained via the associated references.

Preventive services

Two creative examples of SEWB activity are magazines designed to promote resilience and SEWB among Indigenous youth. In 2002, *Streetwize Communications* produced 'Talk good to Yaself/Blak n' Blues', a comic book resource aimed at demonstrating the effects of depression on young Indigenous people, and strategies to adopt in order to cope with and overcome depression [65]. *Deadly Vibe* is a magazine for Indigenous students that aims to enhance the academic and social outcomes of their schooling including: improved literacy and numeracy, self-esteem, self-concept,

regular school attendance and retention, career and employment opportunities and healthy lifestyles [66]. Evaluation of the resource among teachers and students found strong support for the efficacy of the magazine in terms of its positive impact among its target audience. Such novel approaches to mental health promotion address the aforementioned concerns regarding mental health literacy by using language and a format that are both appealing and understandable to the target audience.

The following four programs aim to promote resilience and wellbeing by actively teaching youth and adults skills and strategies to improve their immediate social situation and to overcome future life challenges. *MindMatters* is a national health promotion tool that aims to promote social and emotional wellbeing within secondary schools across Australia. Areas addressed include bullying, promoting resilience, loss and grief, and coping. An evaluation of the program implemented at Bwgcolman on Palm Island in Queensland revealed positive outcomes, including progress in behaviour management and increased health lessons for students and professional development opportunities for staff in the areas of Indigenous learning and culturally appropriate teaching methods [67].

The *Family Wellbeing* initiative is an empowerment program that addresses the physical, mental, emotional and spiritual issues that impact on an individual's wellbeing, family unity and community harmony [31]. Developed by the Aboriginal Education, Employment and Development Branch in Adelaide in 1993, and delivered in a number of Indigenous communities in South Australia, Western Australia and in the Northern Territory, Stage 1 of the four-stage program was piloted in North Queensland. Evaluation from the North Queensland experience confirms earlier findings regarding the Family Wellbeing's potential to engage and equip people with greater analytical and problem solving skills and abilities. It is argued that empowers people to exert greater control over their circumstances. The program is underpinned by two philosophies: recognition of the impact of past government policies and the denial of basic human rights and needs to generations of Indigenous people and their communities; and a strengths-based perspective recognises the experiences of many Indigenous peoples. Evaluations of the program have shown it to be effective for both adult and child participants.

The *Ngaripirliga'ajirri program (helping each other to clear a path)* provides school-based parenting programs for children from 7 to 12 years of age, referred by their schools for conduct problems and observed behavioural difficulties [68]. The program is run on the Tiwi Islands as an early intervention adapted from another program called Exploring Together [69]. The program emerged from a series of workshops on suicide prevention convened by the Tiwi Health Boards in response to a perceived crisis among young Tiwi people after the Northern Territory Coroner's report on four suicides in Nguiu in 1998 [70]. The program is a highly structured, multi group intervention based on group therapeutic principles developed originally for the Victorian Parenting Centre. A key aim of the program is to encourage assertive, non-aggressive parenting, facilitated by a program over nine-weeks in separate and combined training situations involving parents and children. An evaluation of the program reported improvements immediately following the program and, for 40% of children, improvements at 6 month follow-up. An examination of the cross-cultural, program and theoretical issues raised in the evaluation of the program has also been attempted that highlight the conflicts raised in the cross-cultural realisation of mainstream programs (Robinson and Tyler, 2005).

The *Stayin' Strong program* is a two-year, 24 hour/day strategy aimed at suicide prevention in Indigenous communities nationwide [55]. Regular radio messages are combined with community input to facilitate the development of strong networks between service providers and local Indigenous communities. As a project of the Brisbane Indigenous Media Association, the most recent edition profiles Olympian Kyle Vander-Kuyp giving some insights on how he has faced life and athletics challenges. A variety of other health related issues are also addressed by medical practitioners and community services are also profiled. To date, feedback given to the radio station via telephone, written and on-line messages has been largely positive.

A program that straddles the aims of prevention and treatment services is the Mental Health First Aid Course for Indigenous people. Following the model applied to conventional first aid, the Mental Health First Aid course was developed in 2001 and adapted to better address the needs of particular cultural groups, including Indigenous people (in consultation with key Indigenous professionals) [71]. Mental Health First Aid refers to the help given to someone developing a mental health problem or in a mental health crisis until appropriate professional treatment is received or until the crisis resolves. Another aim of the course for Indigenous people is to improve the mental health literacy of Aboriginal and Torres Strait Islander communities. The program has been evaluated and found to be effective in improving mental health knowledge, reducing the shame people feel regarding mental health issues, and increasing confidence for helping others [71]. Evaluation of its effectiveness with Indigenous Australians remains a particular priority. The guidelines concerning cultural considerations and communication techniques for Indigenous Australians are available from the Mental Health First-Aid web-site (http://www.mhfa.com.au).

Treatment services

The *Better Outcomes in Mental Health (BOiMH) project* aims to support general practitioners to improve the quality of care provided through general practice to Australians with a mental illness [72]. To ensure access to Indigenous communities, Indigenous health workers were included as practitioners able to deliver mental health services. Kohn and colleagues [73] found that the BOiMH initiatives were successfully delivering mental health care to consumers, many of whom who had not accessed mental health care previously. Trials of the initiative in the Riverina Division of General Practice are a specific example of its application in an Indigenous community. In this case, the BOiMH aims to improve the mental health status of patients who present to the local Aboriginal community-controlled health service (ACCHS) with mental health issues, mainly depression and anxiety.

The *Medical Specialist Outreach Assistance Program (MSOAP)* funds psychiatrists to travel to rural and remote communities to provide consultation-liaison services that emphasise the up-skilling of general practitioners and other health care workers, as well as providing direct psychiatric services to Indigenous communities [74]. Cord-Udy [75] found that the MSOAP contributed to substantial improvements in services for Indigenous children and adults in rural and remote South Australia. For example, psychiatrists who undertook the cultural awareness training to improve their effectiveness with Indigenous communities facilitated increased consultation and cooperation with ACCHSs and AHWs in an attempt to deliver more culturally appropriate services.

The '*Working both ways*' Aboriginal mental health worker (AMHW) program in the Northern Territory provided AMHWs in six Indigenous communities with support and ongoing training to enable them to work alongside general practitioners in their own communities [76]. The rationale for the program was to promote two-way learning - that is to provide general practitioners with someone who could assist them with cultural and local knowledge, and to provide AMHWs with someone who could assist them with medical knowledge. The work of AMHWs was most effective when their role was clearly established in the health care centres. General practitioners and registered nurses reported that AMHWs provided valuable services to health care practitioners: explaining cultural or relationship matters, assisting in management of difficult clients and in resolving often complex matters of client welfare.

The overarching goal of the *AIMHI* project is to improve mental health outcomes for individuals with chronic mental illness [77]. AIMHI is currently operating in five locations around Australia, two of which, the Northern Territory and Far North Queensland - are targeted specifically at Indigenous communities. The Northern Territory initiative includes establishment of baseline measures of mental illness, prevalence and relapse among the Indigenous population [78]. Mental health promotion resources and a mental health relapse prevention program are also being developed [79].

AIMHI Queensland focuses on six priority areas: assessment of mental health outcome measures; auditing existing mental health services; strengthening families and communities to provide support for individuals with a mental illness; improved information management to assist in the early detection; management and monitoring of mental illness; health promotion to facilitate increases in mental health knowledge; and Indigenous workforce development [80].

The *Pathways Recovery Oriented Rehabilitation Project* provides recovery-focused rehabilitation programs to individuals with chronic mental illness [81]. Approximately one-half of the program's participants are Indigenous. Evaluation to date is encouraging and shows that 13 out of 22 participants had achieved paid work in the open employment sector.

The *Dulwich Centre Program* provides counselling, training and networking in narrative therapy in South Australia [82]. Group narrative therapy among Indigenous men in South Australia has been found to contribute to reductions in drug and alcohol use, family violence and criminal offences, and improvements in training, employment and business and restoring relationships [83].

This brief description of a number of SEWB programs illustrates the variety of work being attempted. Notably, these interventions incorporate a variety of conventional, appropriated and traditional techniques in a variety of sites as suggested in Hunter's aforementioned taxonomy. Nagel's emphases on accessibility, literacy, assessment and treatment techniques and the development of a competent workforce also receive attention. Reflection on these aspects of the programs further confirms that a focus on (re)integrating aspects of Indigenous peoples' lives is paramount, as is the acknowledgement of Indigenous perspectives of what constitutes priorities and approaches. As a result, Indigenous people stand to receive better services, and service providers gain confidence and expertise in operating cross-culturally.

It is worth mentioning at this juncture that a more comprehensive review of innovative models and resources that increase mental health awareness and help-seeking in urban, regional and remote Indigenous communities is currently being compiled under the auspices of the Australian Psychological Society. A Working Party comprised of Indigenous psychologists has been involved in the project that aims to identify models and resources that attempt to address the SEWB needs of Indigenous people. A report outlining the findings and descriptions of the qualities of each service is in the final stages of production.

Social health programs

The second group of activities comprises those under the management of the Social Health Section of the Australian Department of Health and Ageing's OATSIH, including the Bringing Them Home Counsellors and Link-Up services. The Social Health Section is responsible for national policy and strategic program directions for:

- monitoring the implementation of the SEWB Framework;

- implementing the Council of Australian Government (COAG) Mental Health measure 'Improving the Capacity of Workers in Indigenous Communities';

- Bringing Them Home (BTH) Counsellors;

- the Link-Up Program;

- the Social and Emotional Wellbeing Regional Centres; and

- Mental Health Service Projects.

BTH Counsellors' clientele include those removed from their families as well as the children, grandchildren and relatives of those affected by family separation practices. Link-Up services provide family tracing and reunion services to Indigenous people wishing to reunite with their families. SEWB Regional Centres provide training, support and planning assistance for Aboriginal Mental Health Workers and specialist SEWB counsellors (including BTH counsellors and Link-Up workers). Mental Health Service Project Funding assists in the development and evaluation of culturally appropriate approaches to mental health service delivery for Indigenous peoples. Approximately $25.5 million is allocated to these programs per annum [84].

A multi-site evaluation of the programs undertaken in 2006 included direct consultation with clients, other government and non-government service providers, academic institutions, HREOC and OATSIH staff [30]. The evaluation found that culturally appropriate services had been provided to a large number of Indigenous clients in a culturally appropriate manner, and despite these reaching many Indigenous people who would not have otherwise received service, there is still a significant level of unmet need for the services. Notably, the impact of services seemed to weaken as a function of the geographical proximity of clients to services. That is, the further away from the services, the weaker the impact for clients. In addition, due to the levels of unmet need for general SEWB services, BTH counsellors were often attempting to fill the gap which subsequently made it difficult for them to concentrate on their core business. Attracting and retaining suitably qualified staff was also a difficulty noted by service providers. Support for workers was also more difficult for those working further away from the SEWB Centres. The needs of clients accessing Mental Health Service Projects were also

stretching the resources and competence of the workers. Overall, a need for greater national consistency in service delivery by each of the programs was indicated by the findings in terms of training and orientation for staff, data management and service location. In addition, there were concerns around the consistency and conduct of evaluation and monitoring beyond meeting the formal reporting requirements of the funding bodies. It was found that good service had been provided generally, but there was a better overall appreciation of the limited capacity to respond the client's full range of needs.

Issues impacting on service use by Indigenous people

The engagement of Indigenous people with mental health services has traditionally been fraught with difficulty [32]. Geographic isolation, a lack of culturally appropriate services, a lack of Indigenous staff within available services, limited training of mental health service staff regarding Indigenous issues, and stigma and stereotyping all contribute to the limited use of current mental health services by Indigenous people [85]. These factors may be accompanied by a fear of being admitted to hospital or confined in unfamiliar surroundings [86]. Progress towards better understandings and better working relationships has been sporadic, compounded by an historical legacy of miscommunication and, at times, mistrust as to the intent of mental health initiatives. Improvements are occurring due to changes in policy and the perception of the role of 'mental health' in the lives of Indigenous people. The willingness of mental health personnel to reflect on their conduct has also led to the development of better professional relationships [87].

There may also be conditions for which specialist treatment resides outside a clinic environment. The NSW Mental Health Coordinating Council [85] suggested that Indigenous people exhibiting symptoms of mental illness may be perceived by their community as experiencing a normal reaction to spiritual forces or a curse and, in turn, rely on their community for assistance and spiritual treatment. A challenge for clinical services is how well they are able to act as a conduit for arranging traditional treatments. That is, how do clinical staff act to facilitate a community-based intervention, rather than providing the intervention themselves? Examples of such collaboration exist: Sheldon [87], for example, observes that Western psychiatric systems were able to work well alongside local resources and that, in fact, the best outcomes for people experiencing problems were when both systems worked together, rather than in competition.

Westerman [32] suggests that the solution to increasing access to mental health services by Indigenous people lies in the integration

of specific cultural and clinical competencies within systems and individual practitioner levels. She describes how a failure to do so creates problems at the clinical level and the broader systems level. At the clinical level, practitioners may have the desire to be culturally appropriate, but are frustrated by the lack of empirically grounded conceptual frameworks that have proven to be effective with Indigenous people. Further, the lack of consistent theoretical frameworks applied to specific presenting issues makes tracking the reasons for successful outcomes difficult.

At the broader systems level, services may struggle to incorporate culturally appropriate practice within policy and procedural frameworks, particularly where these have relied on mono-cultural models of service delivery [9]. Consequently, absence of outcome-driven evaluative processes may fail to convince the service of the fiscal viability of adopting certain practices. The lack of guidance as to how to do so can also add to this reluctance.

Coordinated and integrated interventions considerate of Indigenous involvement at all stages of development and implementation are proving to be possible and rewarding [23]. Nagel identifies the need for an overarching framework of guidelines, policy and best practice in primary mental health care, along with better resources for quality feedback and outcome measurement. In particular, she says more attention needs to be paid to service delivery evaluation by searching for strategies to link guidelines with practice. This would serve to address the gap between the evidence of what is known to work in practice with the evidence of practice (what is actually done). Hunter [24, 88] shares this concern, and cautions against the development of 'straw program' solutions that don't consider theories of causality or the practicalities of intervention (including skills and training required, support and sustainability). He also cautions against these becoming institutionalised as long-term, silo responses to very broad social problems.

Eley and Hunter [89] describe the results of a 2004 mental health workshop aimed at identifying ways to meet Indigenous mental health needs in Toowoomba and surrounding shires in south-east Queensland (including rural and remote settings). In response to the question 'how can we meet the mental health needs of Indigenous people?' the sixty multidisciplinary delegates gave responses clustered around a number of themes, foremost of which concerned communication, cultural respect, culturally appropriate clinical tools, supportive management, patient compliance, and career structure.

Misunderstanding and miscommunication were seen as common hindrances to productive and effective service delivery, resulting in negative experiences for both patients and their carers [89]. Recommendations aimed at enhancing the quality

of communication included greater involvement of community members and family in the treatment and care of Indigenous mental health patients, Indigenous and non-Indigenous staff working in dedicated Indigenous health care facilities, and research into improved methods of achieving and maintaining better communication between patients and carers. The need to clarify and formalise a more structured pathway for mental health workers was seen as a priority that would require supportive management, and be progressed through the formation of a forum for the development and subsequent mentoring of a structured pathway to higher qualifications. The theme of empowerment concerned ways to enhance the involvement of both mental health workers and clients themselves (and their families) in their care. Better education opportunities were seen as one way of enhancing the likelihood of involvement and ownership of patient care strategies by mental health workers.

These themes target improvement with individual client interactions and broader social and organisational change, much along the lines of the clinical and systems concerns expressed by Westerman [32], and the need to consider the long term viability of strategies as outlined by Hunter [88] above. They also reinforce the need for better means of communicating about SEWB as a means of understanding its aetiology, characteristics and amelioration.

A barrier to this outcome rests in the preparation and professional development of mental health practitioners. Bailey [90] suggests that high levels of ignorance and misunderstanding pertaining to Indigenous culture and the intergenerational impacts of past policies on the social and emotional wellbeing of Indigenous people still exist among many non-Indigenous practitioners. In a review of 'traditional' Indigenous health beliefs, Maher [91] argues that Western health professionals often experience difficulties in providing health care to Indigenous people because of the distance between mainstream and Indigenous cultures. The differences in health belief systems exacerbate difficulties experienced in cross-cultural health delivery settings because there is poor compatibility between the underlying values of the Western medical system and traditional Indigenous health beliefs. It is not enough to provide a service. It is also important to understand the reasons why a service may (or may not) be sought. For example, differences in perceptions regarding the cause of illness or disability will affect management, compliance and how the person reacts to their illness. Health professionals should make an effort to understand and link into the belief system of their patients to ensure they have maximum effect. As such, the need for better communication is still stressed as a fundamental requirement underlying investigations of Indigenous mental health [92].

Westerman [32] recommends that professional development programs in this area target the development of culturally

competent practitioners. Such programs should incorporate knowledge, skills and attitudes that facilitate their improved involvement with Indigenous people. Cultural competence concerns the ability of practitioners to identify, intervene and treat mental health complaints in ways that recognise the central role that culture plays in mental illness [93, 94]. Practitioners have a role to play in ensuring the cultural security of the communities in which they work, and their work will be enhanced by the way in which they conduct themselves. The goal of interactions becomes a negotiation of how best the technical skills (clinical competence) of the practitioners can be incorporated into the lives of Indigenous people.

Improving services means reviewing both the 'what' and the 'how' of service delivery [32]. That is, with changing conceptualisations of Indigenous SEWB, the content of approaches may require amendment, while practitioner behaviours are scrutinised for the degree to which they demonstrate cultural competence. Policies and strategies aimed at negotiating these factors are the focus of the next section.

Policy implications

The concepts of mental health and SEWB may be well aligned from an Indigenous perspective, but Reser [22] and Hunter [53] identify a discord between the current (non-Indigenous, introduced) and previous (traditional, Indigenous) conceptualisations of mental health. The conflicting cultural perspectives - the first, a fairly conventional 'disorder' model, and the more recent SEWB construct - have consequences in terms of tensions relating to areas of responsibility and resource allocation. Westerman [32] reiterates the larger dilemma of where to focus social and emotional wellbeing resources. She considers whether efforts are best made to address individual needs or broader, societal targets? - a debate also explored by Hunter [21] who recognises that demands for limited resources come from those concerned with addressing causal social problems as well as those treating their downstream effects. Project evaluation remains a high priority in this context as questions regarding effectiveness and economics inform the 'where, how and how much' of resource allocation for Indigenous SEWB.

Hunter and colleagues [95] raise an additional issue concerning the professional and philosophical orientations of those conducting research that in turn may inform policy. In focussing on suicide in Indigenous communities of North Queensland, the authors disclose their academic preferences with a view to making explicit potential biases that each approach might bring to the analysis. They demonstrate that it is possible to provide a cohesive multidisciplinary analysis, but they caution against

letting differences of analytical orientation compromise the ensuing commentary. Research with Indigenous people generally is tending to require an examination of research and researcher via ethical and other protocol assurances [See, for example, [96]. Indigenous people provide scrutiny too as the directors of research concerning them and not merely as the subjects of such studies [12].

Recent policy developments in relation to Indigenous SEWB reflect a move towards greater Indigenous determination of policy content and policy parameters. Emphasis is increasingly being placed on local initiatives to address local concerns, an acknowledgement of the diversity of Indigenous peoples' histories and circumstances. There remains an incongruity between State and Commonwealth conceptualisations of mental health, however, with the Commonwealth and ACCHS emphasising holistic understandings, while the States and Territories, responsible for most service provision, retain more traditional, mainstream understandings.

Recent research highlights the need to focus on very basic questions about the contexts in which Indigenous people live and which, in turn, impact on their social and emotional wellbeing [92]. This not only refers to physical or geographical locations in the present, but also to the enduring legacy of prior policies. Hence, a greater appreciation of the lived experiences of Indigenous people remains the goal and, as part of this, a greater understanding of the influence of the myriad of factors that exert an impact on SEWB. This would go some way towards addressing the gaps in our knowledge and provide better contextual information with which to inform interventions and assess their impact and effectiveness.

> These deficiencies would best be addressed by carefully planned and executed longitudinal studies, which would give us a better understanding of social context and its impact on development. Learning more about these issues is important because interventions, if they are to be more than symptomatic remedies, must incorporate a social or capacity-building dimension [24].

Atkinson and colleagues [97] concur with the need to broaden the focus of research into the health of Indigenous people. They state that research into the health status of Indigenous peoples must begin to focus beyond statistical data and make reference to contextual information that embraces the 'where, why and how' of Indigenous health problems. For it to have real value, they state that research must find out if the strategies being implemented are working and why or why not. Activities aimed at influencing the social and emotional wellbeing of Indigenous people need to remain cognisant of the Indigenous terms of reference surrounding mental health. Western health care systems are slow to learn from Indigenous people that maintenance of wellness, not management

of illness, should be the goal [98]. Sherwood [99, p.29]agrees:

I have observed that mental health services separate mental health from health and they have compartmentalised it into another body. It is this model that does not work for Aboriginal people. We do not need to be fragmented or torn apart any further. Mental health services for Indigenous people need to reflect our world view and vision of how we see things at the moment...

The desire of Indigenous people to have a meaningful role in matters concerning their SEWB is as it was prior to colonisation, and is likely to continue. The past two decades may have done little to enhance our comprehensive understanding, but it has perhaps served to establish the foundations (in terms of processes, involvement and control) through which more specific knowledge may be derived. Large and wide ranging actions, such as formal apologies and radical community interventions, will, for better or worse, ensure that the discussion and debate concerning Indigenous SEWB continues.

Summary

The SEWB of Indigenous people, as it is arguably for all people, continues to be negotiated at the interface between particular histories, particular contemporary circumstances and the choices made there. Indigenous people continue to face many factors that serve to promote and diminish their SEWB and at times limit the available choices. In general terms, such factors are common for the maintenance of good mental health for all people, but, in policy and practice, Indigenous people have had to adapt to very specific impacts on their lifestyles and localities. Current understandings of SEWB reveal Indigenous people as having to confront a broad range of social, economic, educational and legal stressors seen as exacting an ongoing influence on their mental health - the ongoing legacy of a history aimed at their assimilation into mainstream Australian society that in many ways served to undermine any sense of belonging to it [15].

It has been noted that many of the practices that now promote SEWB are variations on those that had been discouraged during Australia's recent history . Hunter and Garvey suggest that what is new in Indigenous mental health promotion actually reflects much older activities and practices with cultural rejuvenation, educational opportunities, skills development and so forth doing much to offset the negative impacts of daily stressors and enduring historical factors. It should be stated that while this review has attempted to provide an overview of more formal attempts , the resilience, humour, adaptability and strength of many Indigenous people have as much to do with their state of SEWB as any formal or institutionalised attempt to address it.

SEWB for Indigenous people remains inextricably linked to historical precedent that has set the terms for what is understood as 'mental health' and what is understood as Indigenous identity. Events such as apologies and large scale interventions while serving to address symbolic and practical needs, also provide an opportunity to examine the contexts in which such actions take place, and the attitudes of those responsible for them. It should come as no surprise to those considering a deeper engagement in the area of Indigenous SEWB that they be required to consider their place within this contemporary milieu laced with varying qualities of prior cross cultural interaction. If doing so encourages a process aimed at developing clinically and culturally competent professionals, this may in turn address some of the associated concerns relating to the barriers to accessing SEWB service that some Indigenous people experience. This review has outlined policy and practice initiatives and described a variety of interventions and considered barriers to their use. Overall, enhancing the SEWB of Indigenous people remains a valid and essential endeavour and while the challenges are significant, they are not insurmountable.

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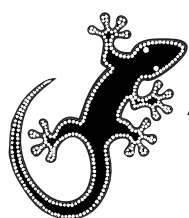
Australian Indigenous HealthInfoNet

The Australian Indigenous HealthInfoNet is an innovative Internet resource that contributes to 'closing the gap' in health between Indigenous and other Australians by informing practice and policy in Indigenous health.

Two concepts underpin the HealthInfoNet's work. The first is evidence-informed decision-making, whereby practitioners and policy-makers have access to the best available research and other information. This concept is linked with that of translational research (TR), which involves making research and other information available in a form that has immediate, practical utility. Implementation of these two concepts involves synthesis, exchange and ethical application of knowledge through ongoing interaction with key stakeholders.

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