Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People

Kerrie Kelly • Pat Dudgeon • Graham Gee • Belle Glaskin
on behalf of the Australian Indigenous Psychologists Association

Cooperative Research Centre for
Aboriginal Health

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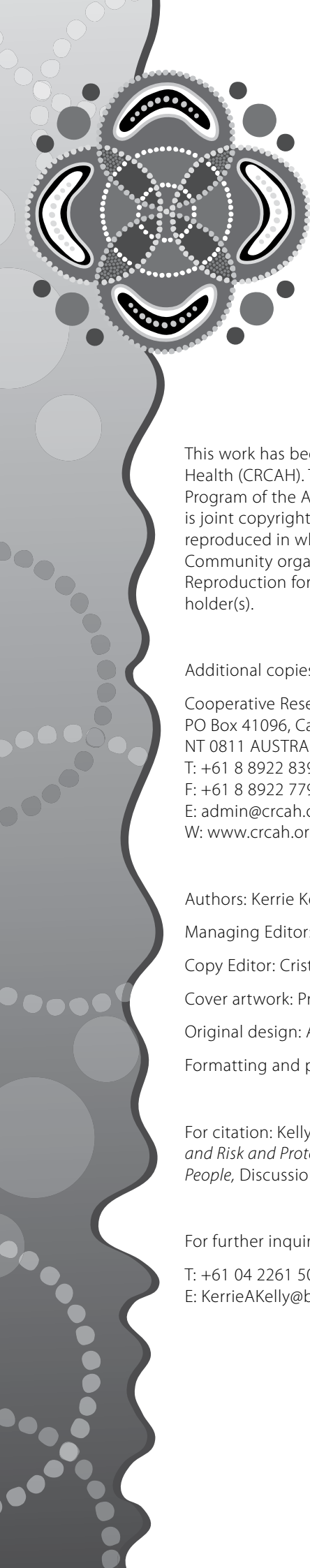Additional copies of this publication (including a pdf version on the CRCAH website) can be obtained from:

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Foreword

In my current role as Aboriginal and Torres Strait Islander Social Justice Commissioner, and in my former role as national Race Discrimination Commissioner, I am and was often called upon to speak about the human right to equal treatment regardless of race.

There is more to discrimination than explicit racism and racial stereotyping. The long-standing socioeconomic inequality suffered by Aboriginal and Torres Strait Islander people is indicative of systemic and indirect discrimination that must be addressed. The physical and mental health impacts of this discrimination are plain to see, and contribute to the 10–17 year life expectation gap between Indigenous and non-Indigenous Australians.

To achieve equality *in fact* we also need to ensure that Australian social norms and standards reflect an equal value being placed on the cultures of Indigenous Australia. Within the context of government and other service delivery in particular, measurable standards of cultural competence—the ability to interact effectively with people from different cultures—stand to make a valuable improvement to the experience of Indigenous Australians (and other minority cultural, social and ethnic groups) when dealing with service providers.

This discussion paper prepared by the newly founded Australian Indigenous Psychologists Association is, therefore, timely and stands to make an important contribution to efforts to understand and address the many physical and mental health impacts of discrimination as well as exploring the idea of cultural competence as it evolves.

The Australian Indigenous Psychologists Association is a valued member of the Close the Gap Steering Committee for Indigenous Health Equality, of which I am Chair, and is already making an important contribution to the ongoing achievement of Indigenous health equality through publications such as this one.

I commend this discussion paper as an essential read for those with concerns about Aboriginal and Torres Strait Islander social justice, particularly health and mental health.

Commissioner Tom Calma
Aboriginal and Torres Strait Islander Social Justice Commissioner
Australian Human Rights Commission

About the Cover Artwork

A Recipe for a Long Life
by Professor Helen Milroy

The river of life forges its way through existence with many elements forming islands of memory within the stream. It has its own unique ebb and flow with a sense of direction. There may be obstacles to negotiate, stages to traverse, formations repeated, a sense of symmetry and balance but not always in equal proportions. The inner core of life is precious and needs protecting, it flows through our backbone and keeps us strong and tall. Just like spinal fluid is protected by a filter that only allows certain things to enter, we must keep our mind healthy to ensure an eternity of consciousness.

We are born from two wombs, the spiritual and the physical to join in life and walk together; leaving our footprints so the earth knows who we are. We are held by the earth, to be born from the fire and passion within, to burst forth with new life. We are also cloaked with feathers from our spirit birds so we can be lifted up and carried at times. The seeds hold the full memory of the tree of life to form the intricate connections and branches necessary to 'grow' the mind. Memory needs to be born, reborn and allowed to flourish through life. The seedpods also contain our inheritance, knowledge and gifts, waiting to be opened as we begin our journey and will continue to nurture us through life.

In time, we will pass on our wisdom with compassion and understanding to the next generation. We cannot celebrate life if we live in a state of denial of who we are, where we have come from, and the right of others to exist alongside. We have to retain our integrity, respect and esteem for humanity and all things in existence.

Being part of the landscape, means we will endure above all else, from the beginning to the end of time.
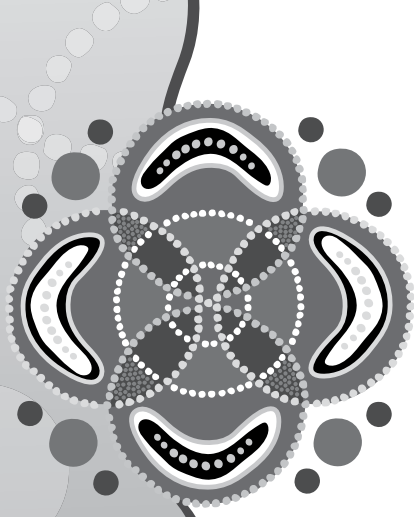
Professor Helen Milroy
Director, Centre for Aboriginal Medical and Dental Health
The University of Western Australia

Helen Milroy is a descendant of the Palyku people of the Pilbara region of Western Australia but was born and educated in Perth. She studied medicine at the University of Western Australia (UWA), worked as a General Practitioner and Consultant in Childhood Sexual Abuse at Princess Margaret Hospital for Children for several years before completing specialist training in Child and Adolescent Psychiatry. At present Helen works as a Consultant Child and Adolescent Psychiatrist at the Bentley Family Clinic and Families at Work residential program, and as a Professor and Director of the Centre for Aboriginal Medical and Dental Health at UWA.

Helen is a member of the Royal Australian and New Zealand College of Psychiatry Committee for Aboriginal and Torres Strait Islander Mental Health and has contributed to the development of position statements, guidelines and curriculum on Indigenous mental health for the college. She is also a member of the Royal Australasian College of Physicians' Aboriginal & Torres Strait Islander Health Committee. Helen is a past President of the Australian Indigenous Doctors Association, a current member of the National Advisory Council on Mental Health, the new Healing Foundation Development Group, as well as the Western Australian Indigenous Implementation Board. Helen's research interests centre on holistic medicine, child mental health and recovery from trauma and grief, as well as applications of Indigenous knowledge, Indigenous health curriculum development, implementation and evaluation, Aboriginal health and Aboriginal mental health.

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Glossary

ACCHSs	Aboriginal Community Controlled Health Services
AIPA	Australian Indigenous Psychologists Association
CDEP	Commonwealth Development Employment Scheme
COAG	Council of Australian Governments
HPF	(Aboriginal and Torres Strait Islander) Health Performance Framework
SEWB	Social and Emotional Wellbeing
SHRG	Social Health Reference Group
WAACHS	Western Australian Aboriginal Child Health Survey

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Major Sources of Data

Reports

Review of Government Service Provision Reports

The Review of Government Service Provision was established in 1993 by Heads of Government (now the Council of Australian Governments or COAG) to provide information on the effectiveness and efficiency of government services in Australia. The Review aims to assemble indicators of performance given the existing policy framework of governments. A compendium of Indigenous statistics by jurisdiction is produced each year and compares the performance of specified government agencies and programs in delivering services to Indigenous people. The reports are produced by the Steering Committee for the Review of Government Service Provision (SCRGSP), Canberra.

Overcoming Indigenous Disadvantage Reports

In April 2002, the Council of Australian Governments commissioned the Steering Committee for the Review of Government Service Provision (SCRGSP) to produce a regular report against key indicators of Indigenous disadvantage. This has the long-term objective of informing Australian governments about whether policy programs and interventions are achieving positive outcomes for Indigenous people. The Overcoming Indigenous Disadvantage (OID) Reports describe overall 'state-of-the-nation' outcomes for Indigenous people, with a view to all government departments and agencies together being responsible, so there is no reporting on an individual government agency basis. The OID serves as a public report card on progress against the COAG targets and other significant indicators. The reports are produced by the Steering Committee for the Review of Government Service Provision (SCRGSP), Canberra.

Aboriginal and Torres Strait Islander Health Performance Framework Reports

In July 2003 the Australian Health Ministers' Conference (AHMC) endorsed the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013*. The Aboriginal and Torres Strait Islander Health Performance Framework (HPF) is designed to provide the basis to monitor the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health and inform policy analyses, planning and program implementation. Each jurisdiction has committed to developing implementation plans against the National Strategic Framework, and to report annually on activity for the next decade. The HPF consists of 70 measures covering three Tiers— health status and outcomes, determinants of health and health systems performance. Biennial reports are produced as *Aboriginal and Torres Strait Islander Health Performance Framework* reports, published by the Office for Aboriginal and Torres Strait Islander Heath, Department of Health and Ageing, Canberra.

Aboriginal and Torres Strait Islander Health Performance Framework Report: Detailed Analyses.

These reports contain detailed analyses underlying the summary data presented in the *Aboriginal and Torres Strait Islander Health Performance Framework* reports and are published by the Australian Institute of Health and Welfare, Canberra.

National Aboriginal and Torres Strait Islander Social Survey 2002

The National Aboriginal and Torres Strait Islander Social Survey (NATSISS) is a multi-dimensional social survey of Australia's Indigenous population designed to enable analysis of the interrelationship of social circumstances and outcomes, including the exploration of multiple disadvantage that may be experienced by Aboriginal and Torres Strait Islander Australians. The survey is published by the Australian Bureau of Statistics.

Western Australian Aboriginal Child Health Survey 2002

This survey was a large-scale investigation into the health Western Australian Aboriginal and Torres Strait Islander children undertaken by the Telethon Institute for Child Health Research in conjunction with the Kulunga Research Network. The survey was the first to gather comprehensive health, educational and developmental information on a population-based sample of Aboriginal and Torres Strait Islander children and their families and communities. The report was published by the Telethon Institute for Child Health Research.

National Aboriginal and Torres Strait Islander Health Survey 2004–05

The 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) was conducted in remote and non-remote areas throughout Australia. It is designed to collect a range of information from Indigenous Australians about health related issues, including health status, risk factors and actions, and socioeconomic circumstances. The development of the interim social and emotional wellbeing module used in the survey is discussed in the report: Australian Institute of Health and Welfare (IHW) 2009, *Measuring the Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander Peoples*, Cat. No. IHW 24, AIHW, Canberra. The Survey is published by the Australian Bureau of Statistics.

General Social Survey 2006

The General Social Survey (GSS) collects information about personal and household characteristics for people aged 18 years and over resident in private dwellings, throughout non-remote areas of Australia. Data is gathered on a range of social dimensions from the same individual to enable analysis of the interrelationships in social circumstances and outcomes, including the exploration of multiple advantage and disadvantage experienced by that individual. The 2006 GSS is the second in the series, with the first GSS conducted in 2002. The survey is repeated at four-yearly intervals and its summary results are published by the Australian Bureau of Statistics.

A National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being 2004–2009

A National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009 is a five year plan to guide the work of the many agencies, both government and non-government, that work towards improving the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. The Framework has been endorsed by Commonwealth and State/Territory Governments and represents agreement among a wide range of stakeholders on the broad strategies that need to be pursued. It provides a common ground and a basis for cooperation among responsible agencies, which include a range of Commonwealth portfolios, State Government agencies, local government, and non-government service providers. The Framework was published by the Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing, Canberra.

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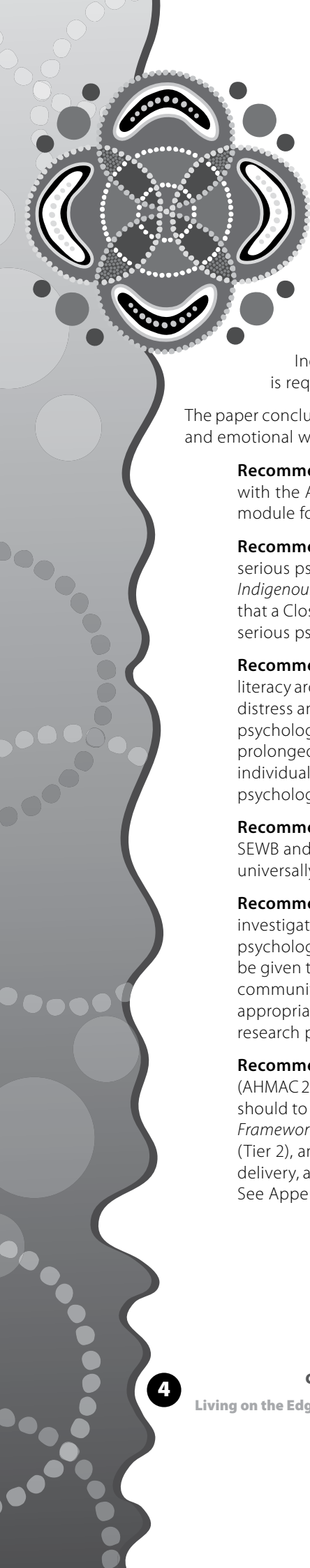
Executive Summary

This paper has been prepared by the Australian Indigenous Psychologists Association (AIPA) to generate discussion around the determinants of Indigenous social and emotional wellbeing (SEWB), and to provide a range of recommendations for addressing the current gap in social and emotional wellbeing between Indigenous and non-Indigenous Australians.

Part 1 introduces current definitions of social determinants of health, where inequalities in health are understood as arising largely from social injustice, inequitable social policy, unfair economic arrangements, and poor politics. Current understandings of Indigenous mental health and social and emotional wellbeing are discussed, with particular reference to the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009*. The importance of developing adequate measures of Indigenous social and emotional wellbeing is considered, as well as the timely introduction of the interim module of social and emotional wellbeing in the *National Aboriginal and Torres Strait Islander Health Survey 2004–05* (ABS 2006), hereafter referred to as NATSIHS 2004–05. Some of the domains in the interim social and emotional wellbeing module show promise in capturing useful information that will help to identify the determinants of Indigenous social and emotional wellbeing. However, more work is needed to further refine some of the domains, ensuring that each one meaningfully contributes to managing the risk to wellbeing and increasing the resilience of individuals, families and communities.

Part 2 discusses the high levels of non-specific psychological distress reported by Indigenous Australians. Specifically, the NATSIHS 2004–05 indicates that while the majority of Indigenous adult respondents reported only low levels of psychological distress, more than one-quarter reported serious psychological distress and were twice as likely to do so compared to other Australians. Serious psychological distress can be considered to be one type of global indicator of poor social and emotional wellbeing. It appears to be an independent predictor of, and part of the causal pathway that leads to, physical illness and mortality risk, with documented associations to reduced life expectancy, premature mortality, greater incidence and prevalence of disease, increased behavioural risk factors for ill health, and lower overall health status. Modifying the social determinants that lead to serious psychological distress should, therefore, result in a range of beneficial *health* as well as *mental health* outcomes and contribute to closing the gap in life expectancy between Indigenous and other Australians. Measuring and monitoring levels of psychological distress might also help to move Indigenous social and emotional wellbeing from a descriptive construct toward an explanatory framework.

Part 2 also collates some of the significant epidemiological data relevant to social and emotional wellbeing factors associated with serious psychological distress among Indigenous people. Drawing from a range of reports—such as, the NATSIHS 2004–05 (ABS 2006); the *National Aboriginal and Torres Strait Islander Social Survey* (ABS 2002); the *Indigenous Compendium of the Review of Government Service Provision* report (SCRGSP 2008); the *Overcoming Indigenous Disadvantage* report (SCRGSP 2009a); *Aboriginal and Torres Strait Islander Health Performance Framework Reports: Detailed Analyses* (AIHW 2008); and *The Western Australian Aboriginal Child Health Survey: The Health of Aboriginal Children and Young People* (Zubric et al. 2004)—a number of risk factors associated with poor SEWB, which have been identified by Indigenous Australians, are examined. These factors include: stressful life events; widespread trauma, grief and loss; child removals; cultural dislocation; unresolved grief and loss; cultural identity; economic and social disadvantage; physical health problems; incarceration; child removal by care and protection orders and juvenile justice supervision; violence; substance use and abuse. Some of the negative outcomes from serious psychological distress include suicide and intentional self harm; anger and aggression; problem gambling; and smoking. Systemic discrimination is also introduced as a determinant of serious psychological distress among Indigenous people and a barrier to those seeking access to support services to cope with distress.

In addition to the risk factors listed above, these reports also identify a number of important strengths or protective factors, such as social cohesion, a sense of positive wellbeing and resilience and connection to land, culture, spirituality and ancestry. At present, this is an under-researched area. Further research is needed to gain a better understanding of the nature and impact of protective factors related to social and emotional wellbeing.

Part 3 discusses the lack of culturally appropriate services available to meet the social and emotional needs of Indigenous Australians and the need to develop resources to promote SEWB and prevent serious psychological distress. The paper concludes that further development of SEWB measures and the development of culturally competent SEWB programs will help to close the gap in social and emotional wellbeing and morbidity and mortality between Indigenous and non-Indigenous Australians. Increasing our capacity to target risk and protective factors and prevent serious psychological distress among Indigenous Australians should be key priorities for any program or strategy that aims to improve social determinants of Indigenous health. For substantial and long lasting changes to the SEWB of Indigenous Australians, a long-term commitment across the community and government sectors is required.

The paper concludes with a number of recommendations to progress the development of the Indigenous social and emotional wellbeing field and prevention of serious psychological distress:

Recommendation 1: That relevant Indigenous professional bodies (including AIPA) work in partnership with the Australian Government to develop and refine the emotional and social wellbeing assessment module for Indigenous Australians used in national data collections.

Recommendation 2: That disparities between Indigenous people and other Australians experiencing serious psychological distress as measured by the Kessler scale, be a headline indicator for *Overcoming Indigenous Disadvantage and Aboriginal and Torres Strait Islander Health Performance Framework* reports and that a Close the Gap target be to achieve parity between Indigenous and other Australians experiencing serious psychological distress.

Recommendation 3: That good practice guidelines and resources are developed to increase: SEWB literacy around the potential impact and contribution of adverse life events towards serious psychological distress and Indigenous SEWB; education about factors that protect against the development of serious psychological distress following adverse life events; understanding of the consequences of high and prolonged levels of psychological distress on Indigenous health and mental health; and detection of individuals and groups who are at high risk of mental ill health due to high and prolonged levels of psychological distress.

Recommendation 4: That measures are taken to ensure that Indigenous Australians have access to SEWB and primary mental health care services in accordance to need, and that these services are made universally available through Aboriginal Community Controlled Health Services.

Recommendation 5: That Indigenous researchers are resourced to further develop measures of SEWB; investigate important cultural idioms of non-specific distress; examine the cultural validity of non-specific psychological distress; and investigate the concept of resilience in Indigenous settings. Priority needs to be given to further identify the protective factors that have assisted Indigenous individuals, families and communities to survive multiple and widespread adverse life events over several generations. Developing appropriate Indigenous measures that adequately assess such factors would be an essential part of this research process.

Recommendation 6: That the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health* (AHMAC 2004) is implemented across the mental health system. To detect systemic discrimination, reporting should to adhere to the structure provided by the *Aboriginal and Torres Strait Islander Health Performance Framework* (HPF): mental health status and outcomes (Tier 1), Determinants of SEWB and mental health (Tier 2), and Mental Health System Performance (Tier 3) for Indigenous SEWB and mental heath service delivery, and this information is included as part of *HPF and Overcoming Indigenous Disadvantage* reports. See Appendix A.

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Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People

Part 1

Introduction

This paper has been prepared by the Australian Indigenous Psychologists Association to generate discussion around the determinants of Indigenous social and emotional wellbeing, and the type of programs and support that may help to address the current gap in social and emotional wellbeing between Indigenous and non-Indigenous Australians.

AIPA is committed to improving the SEWB and mental health of Aboriginal and Torres Strait Islander individuals, families and communities by engaging in collaborative change with other Indigenous and non-Indigenous organisations committed to closing the gap between Indigenous and non-Indigenous health outcomes. AIPA's priorities include: working to increase the number of Indigenous psychologists; ensuring that non-Indigenous psychologists undertake cultural competence training; and advocating for more equitable policy and program delivery and working towards the ongoing development and implementation of culturally appropriate methods of assessment and treatment for Indigenous Australians. We hope this will lead to the change required to deliver equitable, accessible, sustainable, timely and culturally safe psychological care to Aboriginal and Torres Strait Islander peoples in urban, regional and remote Australia.

In 2008 the World Health Organization released the final report of the Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (WHO 2008). This report collated current international research about the social determinants of health and made recommendations to reduce health inequities.

The report defined the social determinants of health as the conditions of daily life (that is, the circumstances in which people are born, grow up, live, work and age) and the health systems available to them. The report stated that 'social injustice is killing people on a grand scale' (WHO 2008:8). The Commission recommended three principles of action:

1. Improve the conditions of daily life.

2. Tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life—globally, nationally, and locally.

3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

The report praised the national apology to the Stolen Generations and endorsed the Australian Government's initiatives to close the 17-year gap in life expectancy between Indigenous and non-Indigenous Australians. The Close the Gap campaign and the National Indigenous Health Equality Council are currently working with the Council of Australian Governments to form a partnership between all levels of government and to work with Indigenous communities to achieve the target of closing the gap on Indigenous disadvantage. AIPA has membership on the Close the Gap campaign Indigenous Leadership Group and the Steering Committee, which has developed a set of national Indigenous health equality targets (HREOC 2008).

Definitions of social and emotional wellbeing and mental health

The World Health Organization (WHO) has noted that the 'stigma surrounding mental illness has encouraged the euphemistic use of the term "mental health" to describe treatment and support services for people with mental disorders and other matters related to mental ill-health' (WHO 2004:14). It suggested this has contributed to confusion about the concept of mental health as well as the concept of mental illness. The stigma associated with the term 'mental health' has also been noted among Aboriginal and Torres Strait Islander people and it has been suggested that the term 'social and emotional wellbeing' is preferred because it offers a less 'loaded' term to describe 'mental health' (Henderson et al. 2007:137). However, rather than being just a euphemism to subvert the stigma associated with mental illnesses, the term social and emotional wellbeing should be seen as an Indigenous concept that differs in important ways to non-Indigenous concepts of 'mental health'.

The Social Health Reference Group (SHRG) for the National Aboriginal and Torres Strait Islander Health Council and National Mental Health Working Group responsible for developing in 2004 the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009* drew an important distinction between the concepts of 'social and emotional wellbeing' used in Indigenous settings and the term 'mental health' used in non-Indigenous settings:

> *The concept of mental health comes more from an illness or clinical perspective and its focus is more on the individual and their level of functioning in their environment.*
>
> *The social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual. Social and emotional wellbeing problems cover a broad range of problems that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage* (SHRG 2004:9).

Mental health is described by the WHO as 'a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (WHO 2001:1). The determinants of 'mental health' are seen to include a range of psychosocial and environmental factors such as income, employment, poverty, housing, education, access to community resources, physical health, and demographic factors such as gender, age and ethnicity (DoHA 2000).

It is likely the determinants of Indigenous social and emotional wellbeing include the above factors identified by the WHO and several domains specific to Indigenous people: grief, loss, racism, trauma and abuse, domestic violence, substance misuse, family breakdown, discrimination, adversity, and forcible removal of children. Of relevance to this discussion are the unique protective factors contained within Indigenous cultures that serve as sources of strength and resilience, such as connection to land, culture, spirituality, ancestry and family and community.

The definitions and determinants for mainstream mental heath and Indigenous SEWB suggest clear overlaps and important differences between the two concepts, and as many Indigenous scholars have noted, the relationship between the two continues to be discussed, debated and negotiated (cf. Garvey 2008). Consistent with the Social Health Reference Group AIPA acknowledges and recognises the importance of mental health, but positions it within the larger framework of SEWB—a framework that includes the domains of wellbeing that are unique and essential components of Aboriginal and Torres Strait Islander health.

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Developing the means to measure Indigenous social and emotional wellbeing

The need to measure the SEWB of Indigenous Australians resulted in the development of an interim module of social and emotional wellbeing, which was used for the first time in the 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS). The recently published report, *Measuring the Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander Peoples*, by the Australian Institute of Health and Welfare (AIHW) provides a comprehensive collection of data about Indigenous social and emotional wellbeing based on the findings of the NATSIHS (AIHW 2009). The development of this module is timely, and begins the important process of gaining a greater understanding about the determinants of Indigenous social and emotional wellbeing.

The interim social and emotional wellbeing module employed in the measurement has eight domains: psychological distress, impact of psychological distress, positive wellbeing, anger, life stressors, discrimination, cultural identification and removal from natural family. These domains show promise in capturing some of the factors associated with Indigenous social and emotional wellbeing. However, more work is needed to further refine some of the domains, ensuring that each one meaningfully contributes to managing the risks to wellbeing and increasing the resilience of individuals, families and communities.
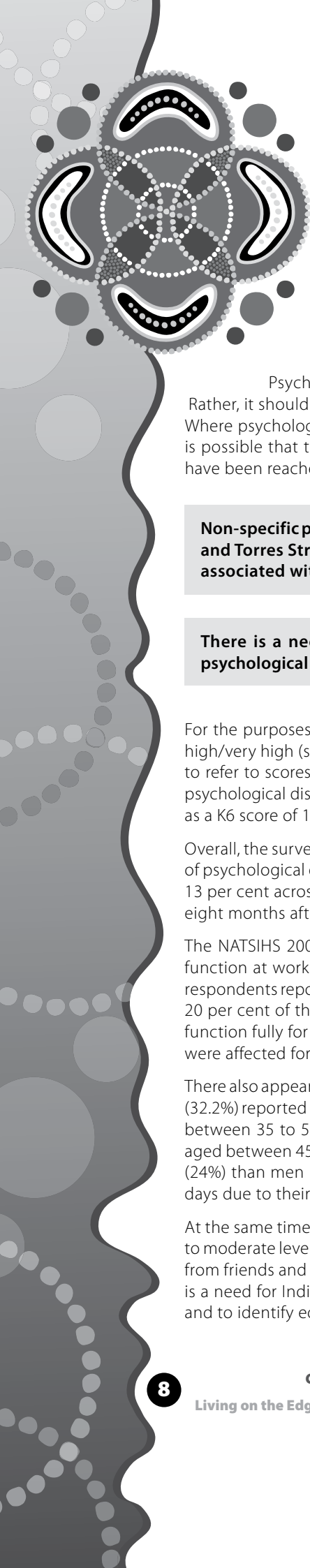
In addition, it is clear that many aspects of SEWB are not captured within these constructs, and AIPA supports the recommendation that questions relating to resilience and protective factors, spirituality and community cohesion are included in future surveys (AIHW 2009). The social and emotional wellbeing module must not only effectively reflect those factors impacting on the wellbeing of Indigenous Australians, but should also allow comparisons with non-Indigenous Australians. We propose that relevant Indigenous professional bodies, including AIPA, are invited to participate in the further development of this module.

Measuring psychological distress as a domain of SEWB

The possibilities presented by the concept of measuring psychological distress as a domain of SEWB in Aboriginal and Torres Strait Islander populations are promising. In Australia there is a need for Indigenous-led research to investigate the cultural validity of non-specific psychological distress and how this is described and measured in national surveys. For example, there may be important cultural idioms of non-specific distress that need to be identified and included in future national surveys. We wish to sound a note of caution by noting that any assessment tool aiming to provide a universal measure of psychological characteristics will require close examination for cultural bias, particularly with the diversity of cultures, peoples and regional variations found among Aboriginal and Torres Strait Islander communities.

The measure selected and modified to measure psychological distress in the NATSIH Survey 2004–05 was the Kessler Psychological Distress Scale (Kessler Scale). This is available as a 10-item (K10) or a modified 6-item (K6) scale. The K6, also referred to as the Kessler High Distress Measure, was used with one item related to feeling 'worthless' being removed for cultural reasons. Professor Kessler who developed the scale, supported the adaptation (AIHW 2009). The Kessler Scale was originally developed to yield a global measure of non-specific psychological distress based on questions about the level of nervousness, agitation and psychological fatigue in the four weeks prior to interview. It spans the range from few or minimal symptoms through to extreme levels of distress, and is commonly used in public health surveys here and overseas. For example the K6 has been used in American Indian communities and found to be a concise and accurate measure of psychological distress (NCAIANMHR 2007).

The psychological distress measured by the Kessler Scale is seen to be that which, if left unaddressed over a long period of time, may lead to the development of common disorders such as anxiety and depression. It may be that non-specific psychological distress could serve as an outcome measure of the Indigenous-identified determinants

of SEWB and, in turn, its flow-on effect on health and wellbeing. This is consistent with the World Health Organization's increasing recognition of the role of psychological distress as a major social determinant for morbidity and mortality:

> *Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life, have powerful effects on health. Such psychosocial risks accumulate during life and increase the chances of poor mental health and premature death. For brief periods, this does not matter; but if people feel tense too often or the tension goes on for too long, they become more vulnerable to a wide range of conditions including infections, diabetes, high blood pressure, heart attack, stroke, depression and aggression* (Wilkinson & Marmot 2003:12).

Psychological distress should not be equated with 'mental illness' requiring clinical treatment. Rather, it should be seen as 'worry, restlessness and sadness' in response to stressful or difficult circumstances. Where psychological distress has become so intolerable that the person is no longer able to function, then it is possible that the clinical threshold for a diagnosis of an anxiety or mood disorder such as depression may have been reached.

> **Non-specific psychological distress appears to capture the stress and pressure identified by Aboriginal and Torres Strait Islander people as 'normal human distress' in response to past and present events associated with colonisation.**

> **There is a need for Indigenous-led research to investigate the cultural validity of non-specific psychological distress and to identify equivalent Indigenous terms for the phenomena being measured.**

For the purposes of reporting the survey, a dichotomous grouping of 'low/moderate' (scores of 5 to 11.9) and high/very high (scores of 12 to 25) was used. For this paper, the term 'serious psychological distress' will be used to refer to scores of 12 or higher, which are referred to in the AIHW publication as 'high or very high' levels of psychological distress. This aligns with work in other countries, which categorises 'serious psychological distress' as a K6 score of 13 or higher (Aldworth et al. 2005).

Overall, the survey showed that just over one-quarter of Indigenous respondents reported high/very high levels of psychological distress and were twice as likely than other Australians to report this—27 per cent compared to 13 per cent across all age groups. Apparently this was similar to that reported in the New York City population eight months after the attack on the World Trade Center (Stewart & Delaney 2006).

The NATSIHS 2004–05 showed a clear relationship between serious psychological distress and the ability to function at work and at home. The higher the level of distress reported, the greater the number of days that respondents reported being unable to perform their usual roles. While the majority managed to keep functioning, 20 per cent of those with high and 30 per cent with very high levels of distress reported they were unable to function fully for three to 14 days of the previous year, and 13 per cent of those with very high level of distress were affected for 15 days or more (AIHW 2009).

There also appeared to be gender influences on reported levels of distress. For instance, more Indigenous women (32.2%) reported serious psychological distress than men (21.4%). The majority (76%) of female respondents aged between 35 to 54 years reported serious psychological distress, and the majority (54%) of male respondents aged between 45 to 54 years reported serious psychological distress (ABS 2006). A higher proportion of women (24%) than men (18%) indicated that they were unable to work or carry out normal activities for one or more days due to their feelings of distress (ABS 2006).

At the same time it is important to note that the majority of Indigenous respondents (71.3%) reported only low to moderate levels of psychological distress, which is usually seen to be alleviated by empathy and social support from friends and family (i.e. social and emotional wellbeing support as opposed to clinical interventions). There is a need for Indigenous-led research to investigate the cultural validity of non-specific psychological distress and to identify equivalent Indigenous terms for the phenomena being measured.

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Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People

Part 2

Serious psychological distress: An indicator of poor social and emotional wellbeing and a determinant of health risk behaviours and mortality
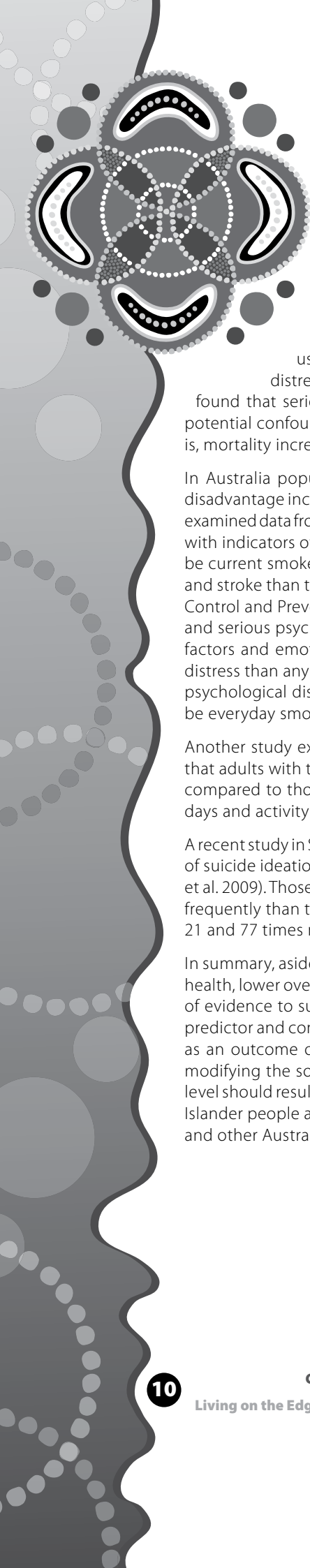
Overview of literature

Risk and protective factors for serious psychological distress may offer important insights into the factors contributing to the health and wellbeing of Indigenous people. There is an emerging body of international and Australian evidence to show that serious psychological distress is increasingly being seen as a risk factor for a range of physical health outcomes. It is now accepted that physical and 'mental health' are interdependent, such that the contribution of physical health to mental wellbeing and the effect of mental health on physical health must be considered when looking at the overall health of population groups (Mrazek & Haggerty 1994). Mental, social and behavioural health problems can also interact to intensify their effects on wellbeing (WHO 2004).

In Australia, we have yet to see the development of a body of knowledge that identifies the range of risk and protective factors impacting on Indigenous social and emotional wellbeing, so that the former can be minimised and the latter can be maximised to enhance wellbeing and resilience. Identifying the factors that contribute to non-specific psychological distress may be an important first step to developing such a framework.

> **Serious psychological distress can be an independent predictor and contributor to reduced life expectancy and premature mortality. Modifying the social determinants that lead to serious psychological distress should result in a range of beneficial health as well as mental health outcomes for Aboriginal and Torres Strait Islander people.**

Chronic stress is increasingly seen as a key determinant of mental health problems, poor health choices and a range of general health outcomes. Although the causes of stress can come from any number of sources, the pathway between stress and a range of poor health outcomes lies in the physiology shared by all human beings. Chronic stress can lead to increased insulin resistance, greater incidence of lipid and clotting disorders, and other biomedical insults that can serve as precursors to disease such as heart disease and diabetes (Brunner & Marmot 2006). An international review by Paradies (2006) examining racism and the relationship between psycho-social stress and chronic disease for Indigenous population groups and African Americans found that high levels of generalised stress independently contributed to chronic disease and was associated with general health status, diabetes, high blood sugar levels, heart disease, suicide and drug misuse among Indigenous people. Exposure to stress was also found to be associated with health-damaging behaviours such as drug misuse and cigarette smoking. Links were also established between self-reported race-based discrimination and psychological distress, depression and anxiety (Paradies 2006).

While stress may be a determinant for a range of negative health outcomes at a population level, it seems possible that social determinants are translated into individual risk factors when stressful circumstances produce serious psychological distress. Serious psychological distress appears not only to increase the risk of developing a range of diseases but, more importantly, recent research suggests it may also increase the risk of mortality as an outcome. A range of studies have established a number of links between serious psychological distress and increased risk factors for morbidity, poor treatment outcomes and increased mortality.

For instance, a study in north-west England found an association between psychological distress and premature mortality, with most premature deaths attributed to ischaemic heart disease and respiratory diseases. Importantly, a gradient was evident between the degree of distress reported and the risk of mortality, which supports the existence of a causal relationship (Robinson, MacBeth & McFarlane 1990). A re-examination of the relationship between psychological distress and coronary heart disease in the Whitehall Studies reported that psychological distress increased a risk of coronary heart disease in men that was not explained by health behaviours, social isolation or work characteristics (Stansfeld et al. 2002). A recent United States study by the National Center for Health Statistics, using four years of national health surveys, examined whether those with serious psychological distress had a greater risk of mortality than those without serious psychological distress. The study found that serious psychological distress was associated with increased mortality, even after adjusting for potential confounders and that K6 scores were related to increased mortality in a dose-response fashion: that is, mortality increased as psychological distress increased (Pratt 2009).

In Australia population health surveys have found that psychological distress increases as socioeconomic disadvantage increases (Centre for Epidemiology and Research 2007). Further, studies in the United States which examined data from National Health Interview Surveys found serious psychological distress tended to be associated with indicators of disadvantage, and those with serious psychological distress were more likely to be obese, to be current smokers and to have a higher prevalence of being diagnosed with heart disease, diabetes, arthritis and stroke than those without serious psychological distress (Pratt, Dey & Cohen 2007). The Centers for Disease Control and Prevention in the United States also recently examined the association between body mass index and serious psychological distress and, after taking into consideration obesity-related co-morbidities, lifestyle factors and emotional support, found that obesity was more strongly associated with serious psychological distress than any other variable (Zhao et al. 2009). The same group examined the relationship between serious psychological distress and smoking: those with serious psychological distress were three times more likely to be everyday smokers (Dube et al. in press).

Another study examining the relationship between serious psychological distress and chronic disease found that adults with three or more chronic disease were six times more likely to have serious psychological distress compared to those without chronic conditions. Those with serious psychological distress reported more sick days and activity limitation than those with either depression or diabetes (Shih & Simon 2007).

A recent study in South Australia examined the usefulness of the K10 scale of psychological distress as an indicator of suicide ideation and found a positive linear relationship between distress and suicide ideation (Chamberlain et al. 2009). Those with serious psychological distress were more likely to report suicide ideation and did so more frequently than those who were less distressed. Those in the high and very high categories were, respectively, 21 and 77 times more likely to report suicide ideation than those with no distress.

In summary, aside from the evidence that supports the impact of general stress on behavioural risk factors for ill health, lower overall health status and increased incidence and prevalence of disease, there is an emerging body of evidence to suggest that stress which progresses to serious psychological *distress* may be an independent predictor and contributor to reduced life expectancy and premature mortality by increasing the risk of mortality as an outcome of chronic diseases such as ischaemic heart disease, respiratory disease and suicide. Hence, modifying the social determinants that lead to serious psychological distress at an individual and population level should result in a range of beneficial *health* as well as *mental health* outcomes for Aboriginal and Torres Strait Islander people and may make a major contribution to closing the gap in life expectancy between Indigenous and other Australians.

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Living on the Edge: **Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People**

Risks to Indigenous social and emotional wellbeing

Risk and protective factors for 'mental health' are known to occur in all facets of everyday life such as: family and relationships; conditions in the workplace and schools; social, cultural and recreational environments; income and social opportunities; personal health practices and access to a range of health and other services. The balance of evidence suggests that social and emotional wellbeing may hinge on the discrepancy between stressors (risks) and the capacity to cope with these, and other protective factors: those who are psychologically overwhelmed or struggling to cope with multiple stressors are likely to effectively exhibit higher levels of psychological distress. Regardless of the source of stress, serious psychological distress is likely to indicate that social and emotional wellbeing is under severe threat.

Indigenous people have identified the determinants influencing their wellbeing: unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage (SHRG 2004). In addition, cultural concepts such as connection to land, culture, spirituality, ancestry and family, and community are commonly identified as protective factors that can serve as sources of resilience, and can moderate the impact of stressful circumstances on social and emotional wellbeing at an individual, family and community level. These factors can serve as a unique reservoir of strength and recovery when Indigenous people are faced with adversity.

Thus, it cannot be assumed that the determinants of social and emotional wellbeing and the risk and protective factors for serious psychological distress among Indigenous and non-Indigenous people will be the same across cultures. It is likely that the risk profile for developing serious psychological distress will also vary between different Indigenous cultures, e.g. between Aboriginal and Torres Strait Islander cultures, and between the diversity of Aboriginal cultures and communities. Measuring and monitoring serious psychological distress may help to begin moving Indigenous SEWB from a descriptive construct to an explanatory framework, initially by identifying which SEWB factors (or constellation of factors) are associated with serious psychological distress, then examining how this contributes to preventable morbidity and mortality, and the social gradient of health. Measuring non-specific psychological distress can also offer an opportunity to monitor the effectiveness of policies and programs designed to address the social determinants of health and SEWB.

In addition to programs promoting the positive SEWB of individuals, families and communities, it is important to be able to counteract the specific sources of stress that Indigenous people identify as impacting on their SEWB and which serve as risk factors for developing serious psychological distress. Risk factors can increase the likelihood that particular people will develop high levels of psychological distress, while protective factors can reduce that likelihood. However, strategies to manage risk must be pursued with caution:

> *The relationship between risk and protective factors is complex. It is not simply the presence of risk and protective factors but their interaction and accumulation of factors over time that effects the development of mental health problems and disorders* (DoHA 2000:53).

Single risk factors might have a minimal effect on their own but when combined with others can have a strong interactive effect, just as exposure to multiple risk factors over time can have a cumulative effect (Kazdin & Kagan 1994). Fraser (1997) describes 'risk chains' as multiple risk factors operating over time to influence and increase vulnerability. Protective factors can assist in reducing the exposure to risk, or they may be compensatory by reducing or mitigating the effect of risk factors (Rutter 1985).

Negative life events: Risk factors for serious psychological distress

Information about stressful life events or conditions that are seen to contain the potential to adversely impact on a person's life or the collective lives of their families are gathered in national surveys such as the General Social Survey (ABS 2006). Adverse events are conceptualised as having a negative impact on the person's capacity to live a satisfying and productive life and on the family's capacity to operate as a fully functioning family unit. The majority (77%) of Indigenous respondents reported at least one stressor in the 12 months prior to the survey, which contrasted with the 40 per cent of non-Indigenous respondents who indicated no stressors in the 12 months prior to the GSS (2006).

The set of possible stressful life events (referred to as 'stressors') used in the NATSIHS 2004–05 was previously employed in the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) administered in 2002 (ABS 2004). Minor adjustments were made and additional items relating to overcrowding at home, members of family being sent to jail and experiences of discrimination/racism were added. An evaluation of the negative life event scale found that when used in Indigenous settings, most items performed well in relation to endorsement, discriminative ability and reliability. Three items that related to divorce or separation, job loss and unemployment were found to be poorly endorsed by Indigenous samples, and showed poor discriminative ability and external reliability. Poor endorsement rates were interpreted to suggest that these phenomena were not widely experienced as stressors in the Indigenous samples (Kowal, Gunthorpe & Bailie 2007).

Participants in the NATSIHS 2004–05 were asked to choose from a list of 15 possible stressors or adverse life events that had impacted on them, their families or friends in the 12 months prior to the survey. Types of stressors included: serious illness or disability, serious accident, death of a family member or close friend, divorce or separation, inability to get a job, involuntary loss of job, alcohol-related problems, drug-related problems, witness to violence, abuse or violent crime, trouble with police, gambling problem, member of family sent to jail/currently in jail, overcrowding at home, and discrimination/racism.

Stressors reported by respondents were:

- Losing a family member or friend was reported by 42% of respondents and was highest (58%) in remote areas (AIHW 2009). This was 2.4 times the rate for other Australians.

- Serious illness or disability affected 28% and was highest (30%) in major cities. This compared to 23% of other Australians who reported a serious illness and 7% a serious disability.

- Alcohol related problems impacted on 20% of respondents and was highest (24.1%) in remote areas. Only 7% of other Australians reported alcohol or drug related problems in the General Social Survey (2006).

- Drug-related problems were reported by 16.4% of Indigenous respondents and were highest (19.2%) in major cities.

- Approximately 15% of Indigenous respondents had witnessed violence in the last twelve months. This was five times the rate of other Australians. Indigenous Australians in remote areas were nine times as likely as others in remote areas to witness violence, and twice as likely when compared to Indigenous Australians in non-remote areas (AIHW 2009).

- Gambling problems were reported by 13.5% of respondents and the rate was highest (19%) in remote areas. This was four times the rate reported by other Australians (3.2%).

- Trouble with police was reported by 16% of Indigenous adults, compared to 3% of other Australians.

- Being subject to abuse or being a victim of violent crime was reported by 10% of Indigenous adults, compared to 3% of other Australians.

- Being a victim of physical or threatened violence in the last 12 months was reported by 20% of Indigenous respondents, compared to 9% of other Australians (AIHW 2009).

- Having a serious accident was reported by 9.4% of respondents and was highest in remote areas (46%). This was almost twice the rate of other Australians (5.2%).

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Indigenous-specific items (not asked of other Australians):

- Having a family member sent to, or currently in jail affected 19% of respondents and was highest (25%) in remote areas.

- Over-crowding at home was reported by 17% of respondents and was highest in remote and very remote areas (29%). Indigenous people were five times more likely than other Australians to live in crowded housing (AIHW 2009).

- Experience of discrimination was reported by 11.6% of respondents, and was highest in remote and very remote areas (13%).

Indigenous respondents experiencing serious psychological distress reported more stressors than those with low or moderate distress. A low level of psychological distress was associated with an average of 1.9 stressful life events, moderate distress with 2.6 events, a high level of distress with 3.2 events and a very high level of distress with an average of 3.6 stressful life events. The largest group of respondents (50%) reported 1 to 3 stressors, with an overall average of 2.6 stressors, and 27 per cent had four or more life stressors to cope with in the previous year (AIHW 2009). This proportion was highest in remote and very remote areas where 33% reported four or more stressors.
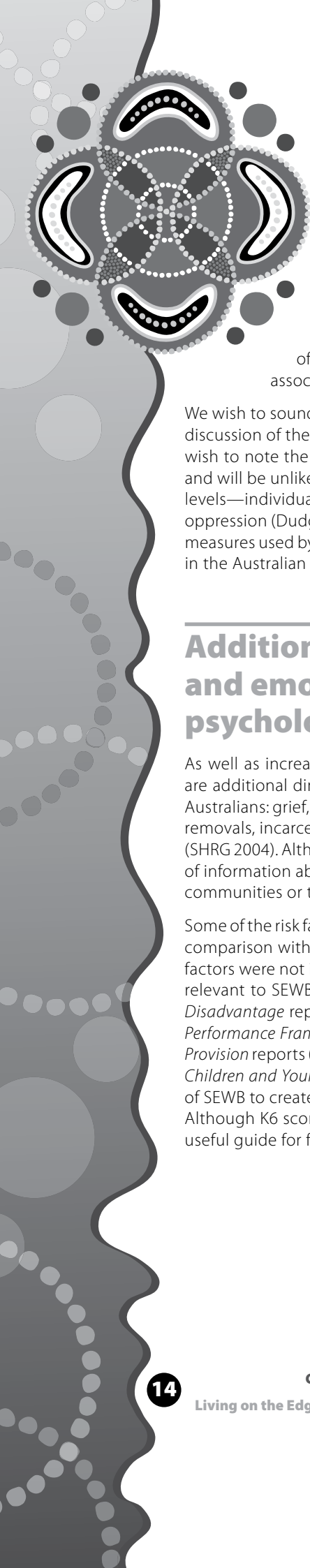
Geography influenced exposure to the number and type of stressors reported, with the greatest differences being observed between Indigenous respondents in major cities and remote/very remote areas. Respondents in major cities reported highest proportions for serious illness or disability (30%), not being able to get a job (20%), involuntary loss of job (12.4%), and drug related problems (19%). Respondents in remote/very remote areas reported highest proportions for: death of a family member or close friend (46%), overcrowding at home (29%), a member of family sent to jail or in jail (25%), alcohol-related problems (24%), witness to violence (23.5%), gambling problem (19%), trouble with police (19%), a serious accident (12%), and discrimination/racism (13%). Those in remote/very remote areas reported the highest number of stressors with an average of three stressors per person. Stressors reported by respondents in inner and outer regional Australia fell in between those reported above apart from divorce or separation, which was most commonly reported in inner regional areas (14%).

About 85 per cent of the serious psychological distress reported in the NATSIHS 2004–05 corresponded with the experience of life stressors, with only 15 per cent of respondents reporting serious psychological distress in the absence of identified stressful life events (AIHW 2009).

It should be noted that the relationship between stressors and serious psychological distress was not linear: the majority (65%) of those reporting the maximum number of stressors (12 to 15 from the list of 15 possible stressors) reported only low to moderate psychological distress, with only 35 per cent reporting serious psychological distress (AIHW 2009). It appears that serious psychological distress may peak among those reporting eight to 11 events, 46 per cent, before declining slightly (35%) among those dealing with the maximum number of stressors.

This non-linear relationship between psychological distress and the number of stressors reported deserves further examination. Important questions to investigate include: what happens to people who experience the cumulative physiological and psychological burden of the maximum number of stressors? What is the trajectory of coping and how is this influenced when additional stressors are added over time? Does distress peak and plateau once a certain threshold has been reached, regardless of number of stressors? Does distress decline rapidly if the individual disengages from coping efforts (i.e. 'gives up'), or does a decrease in indicators of distress indicate successful adaptation to an extreme set of challenges? Finally, how do resilience or protective factors moderate the levels of psychological distress experienced by those reporting a high number of stressors? These are important questions that future research needs to address.

Indigenous Australians were exposed to stressful life events at a ratio of 1.4 times that of other Australians, and the risk exposure for each of the stressful life events was between two to five times greater for Indigenous respondents than for others. Some events, such as losing a loved one, impacted on nearly half of all Indigenous respondents. While higher risk for all stressors was shared across geographic areas, risk exposure increased for some events depending on whether respondents lived in urban or remote locations. The risk exposure to events that contained the potential to bring about serious psychological distress was thus broader (exposure to more stressful events) and deeper (higher proportions exposed to each event) for Indigenous respondents than for other Australians.

There is some data to suggest that serious psychological distress may also have trans-generational effects. For example, the Western Australian Aboriginal Child Health Survey (WAACHS) collected information about the social and emotional wellbeing of Aboriginal and Torres Strait Islander children in 2001 and 2002. The survey reported that one in five children (22%) aged four to 17 years in Western Australia were living in households where seven or more stressful life events had occurred in the preceding 12 months. Of these children, 39 per cent were at risk of clinically significant emotional or behavioural difficulties compared to children in households where two or less life stressful events had occurred (Zubric et al. 2004). This suggests that the social and emotional wellbeing and resilience of children in families exposed to higher than the average number of adverse life events (3.6) associated with serious psychological distress is also under threat.
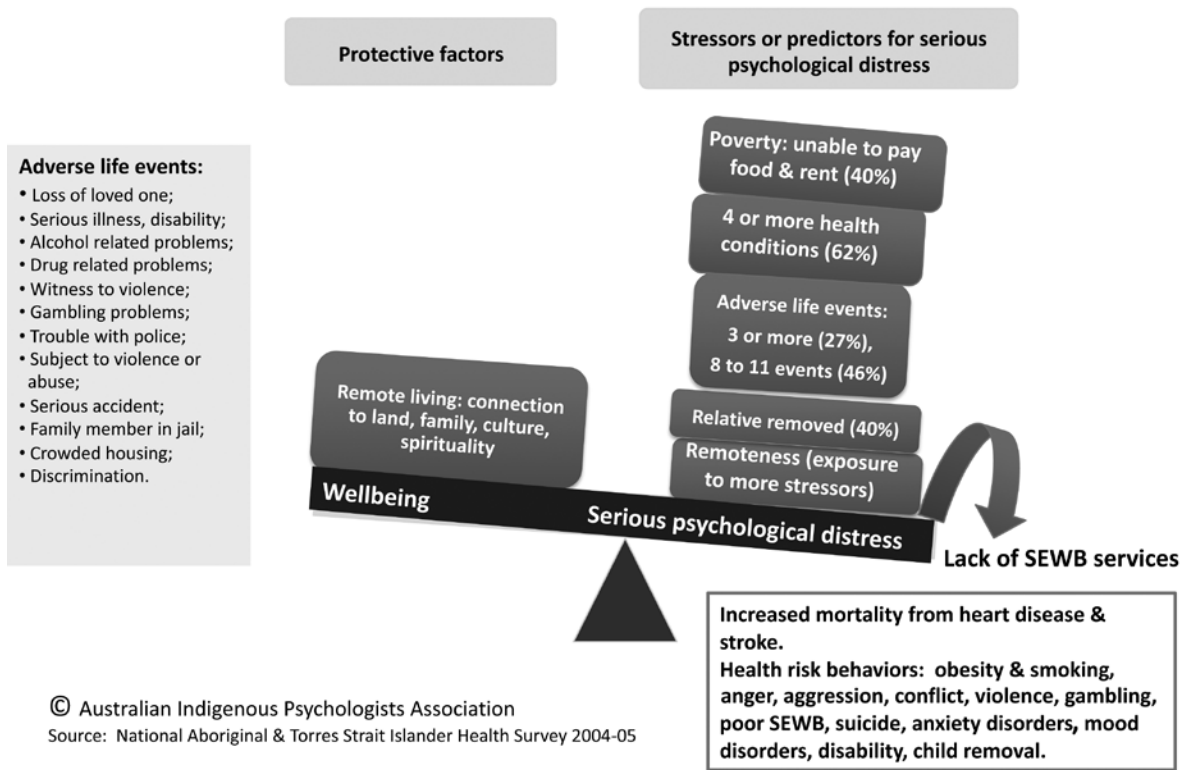
We wish to sound a note of concern about the measures of discrimination used in national surveys. While a full discussion of the issues surrounding the measurement of discrimination is beyond the scope of this paper, we wish to note the following issues: racism and discrimination can be so entrenched as to become 'normalised' and will be unlikely to reported by individuals responding to surveys; discrimination may be observed at many levels—individual, institutionalised and cultural; and surveys need to be able to take account of internalised oppression (Dudgeon & Oxenham 1989). This paper will not report extensively on the findings of discrimination measures used by the Australian Institute of Health and Welfare, since we believe these measures are inadequate in the Australian context.

Additional factors contributing to Indigenous social and emotional wellbeing and risk factors for serious psychological distress

As well as increased exposure to life events with the potential to cause serious psychological distress, there are additional dimensions of Indigenous social and emotional wellbeing that differ when compared to other Australians: grief, loss, trauma, abuse, violence, substance misuse, physical health problems, identity issues, child removals, incarceration, family breakdown, cultural dislocation, racism, discrimination and social disadvantage (SHRG 2004). Although data are available to document the frequency and extent of these events, there is a dearth of information about the impact on the social and emotional wellbeing of Indigenous individuals, families and communities or the contribution to serious psychological distress.

Some of the risk factors identified were included in the NATSIHS 2004–05 stressful life events scale, which allowed comparison with national surveys of the general population. However, some of the Indigenous-identified risk factors were not included in the NATSIHS and others deserve closer examination. It is possible to draw out data relevant to SEWB from the NATSIHS 2004–05 (ABS 2006); the NATSISS (ABS 2004); the *Overcoming Indigenous Disadvantage* report (SCRGHSP 2008b); the Detailed Analyses of the *Aboriginal and Torres Strait Islander Health Performance Framework* reports (AIHW 2008); the *Indigenous Compendium of the Review of Government Service Provision* reports (SCRGSP 2009); and *The Western Australian Aboriginal Child Health Survey: The Health of Aboriginal Children and Young People* (Zubric et al. 2004), and to align this data with Indigenous-identified determinants of SEWB to create a composite picture of the risk factors for the development of serious psychological distress. Although K6 scores may not be available to assess the impact of these risk factors, the picture may serve as a useful guide for future analysis of psychological distress and the targeting of SEWB support services.

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Figure 1: Risk and protective factors for serious psychological distress

Protective factors

Stressors or predictors for serious psychological distress

Adverse life events:
• Loss of loved one;
• Serious illness, disability;
• Alcohol related problems;
• Drug related problems;
• Witness to violence;
• Gambling problems;
• Trouble with police;
• Subject to violence or abuse;
• Serious accident;
• Family member in jail;
• Crowded housing;
• Discrimination.

Poverty: unable to pay food & rent (40%)

4 or more health conditions (62%)

Adverse life events: 3 or more (27%), 8 to 11 events (46%)

Relative removed (40%)

Remoteness (exposure to more stressors)

Remote living: connection to land, family, culture, spirituality

Wellbeing

Serious psychological distress

Lack of SEWB services

© Australian Indigenous Psychologists Association
Source: National Aboriginal & Torres Strait Islander Health Survey 2004-05

Increased mortality from heart disease & stroke.
Health risk behaviors: obesity & smoking, anger, aggression, conflict, violence, gambling, poor SEWB, suicide, anxiety disorders, mood disorders, disability, child removal.

Risk factors associated with psychological distress

Risk factor: Widespread grief and loss

The high rates of preventable mortality impact across the Indigenous population and increase the risk of developing serious psychological distress:

- The NATSIHS 2004–05 found that four out of 10 respondents (47%) had lost a family member or friend in the past 12 months, increasing to 60% in remote areas. Indigenous respondents were almost 2.5 times more likely to report having lost loved ones compared to other Australians (AIHW 2006).

  Almost one in two (47%) Indigenous respondents to the NATSISS reported they had attended a funeral in the past 12 months (ABS 2004).

- The age distribution of deaths among Indigenous people is different from that of other Australians. Approximately 70% of deaths among Indigenous people occurred before the age of 65 years, compared with 21% of deaths among other Australians (AIHW 2008). This was most marked in the Northern Territory, where the median age of death for Indigenous men was 45 years and women 55 years, a gap of 12 years and nine years.

Preventable grief and loss:

- In 2002 2006, deaths directly related to poor quality medical care occurred at four times the rate of other Australians. Health system failures occurred at the prevention, early intervention and treatment levels (AIHW 2008).

- Indigenous infants died at three times the rate of non-Indigenous babies (AIHW 2008). This was highest in the Northern Territory, with 17 deaths for every 1000 live births, compared to 4.7 deaths for other infants.

Experiencing loss and grief was the largest single risk factor to impact on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. Each year, Indigenous people grieved for twice as many deaths per head of population as other Australians. Many deaths involved infants, children, young adults, and men and women in their prime, and were sudden, unexpected and preventable (i.e. more traumatic). As seen in the amenable mortality figures above, many could have been prevented if timely and effective medical care had been available. Extended family networks would serve to extend grief across communities and regions, and the cost of funerals would deplete the financial reserves and resources of family networks. Data measuring the SEWB impact of multiple losses and widespread grief on the development of serious psychological distress among Indigenous people is not available in the NATSIHS 2004–05 or elsewhere. The interactive effect of this risk factor on other risks to SEWB also deserves further exploration.

Risk factor: Child removals, unresolved trauma, grief and loss

The NATSIHS 2004–05 included questions about whether respondents had been taken away from their natural families by a mission, the government or welfare; or whether a relative had been taken away (i.e. members of the Stolen Generations): 8 per cent reported they had been taken away and 43 per cent reported a relative had been taken away. Relatives most commonly removed from the family were grandparents (44%), followed by parents (28%) or aunties/uncles (27%). There was an association between removal and serious psychological distress, with a higher proportion of those reporting serious psychological distress indicating they had been removed from their family than those reporting low levels of psychological distress. A lower proportion of those who had been removed from their natural family reported positive wellbeing when compared with those who had not been removed.

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The WAACHS collected information about the social and emotional wellbeing of Aboriginal and Torres Strait Islander children in 2001 and 2002 and found that children with Aboriginal carers who had been forcibly removed were twice as likely to be at high risk of clinically significant emotional or behavioural difficulties than those whose carer had not been removed (Zubric et al. 2004).

Despite half of the Indigenous population being affected by forcible removal either directly or through their family, no systematic examination has been conducted to determine the psychological effects of Stolen Generations policies across the lifespan, across families and communities or across generations.

Risk factor: Cultural dislocation, identity issues

The NATSIHS 2004–05 included a cultural identification domain, which consisted of four items to identify the level of attachment to language group and traditional lands. Questions about cultural identification were only asked of those in non-remote areas (major cities, inner and outer regional). Most (60%) identified with a language group and knew where their traditional lands were, and 15 per cent of these were living on their own lands. About 38 per cent of Indigenous respondents living in urban areas reported that they did not know where their traditional country was. This is a surprising result since many Indigenous Australians know to which language group/family they belong.

The survey found no identifiable relationship between the level of psychological distress and whether or not a person identified with a language group or clan. Similarly, recognition of one's homelands did not seem to be associated with psychological distress (AIHW 2009). However, item responses in this survey may have been influenced by whether questions were framed by Indigenous or non-Indigenous surveyors. That is, the results may have been confounded by Indigenous respondents' unwillingness to disclose culturally significant information to non-Indigenous surveyors, and how the questions were asked needs consideration.
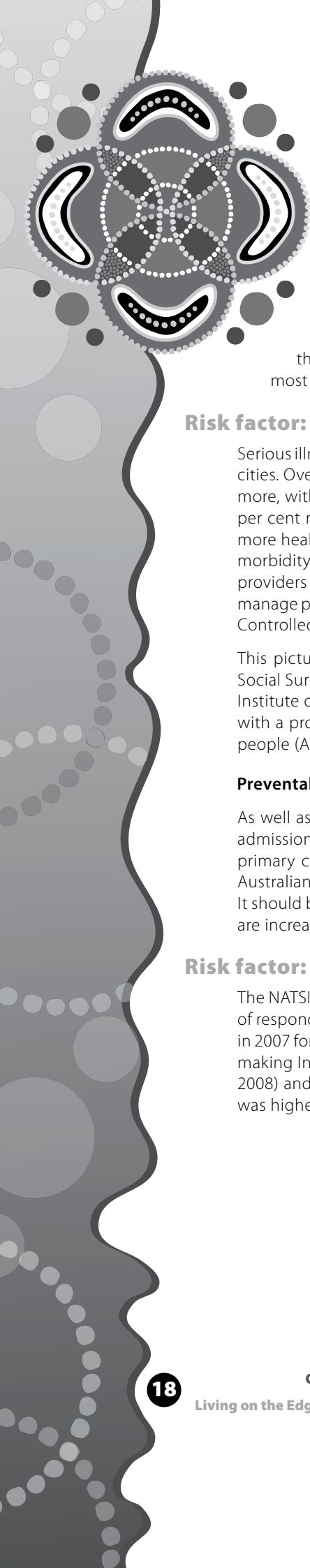
Risk factor: Economic/social disadvantage

Two household indicators were used to determine financial stress in the NATSIHS 2004–05: the ability to obtain $2000 within a week for something considered important, and whether respondents had money for basic living expenses such as rent and food during the last two weeks or the previous year.

More than half (54%) of Indigenous respondents reported they were in households that were unable to raise $2000 in a week if they needed it. This compared to 13 per cent of non-Indigenous Australians responding to the same item in the General Health Survey (2006). Many Indigenous households (40%) had insufficient money to pay for basic living expenses such as food and rent. Respondents from those households were twice as likely to report serious psychological distress.

Approximately 40 per cent of Indigenous respondents were in the bottom 20 per cent of Australian incomes (AIHW 2008). Yet the majority (68%) of those with the lowest incomes reported only low to moderate levels of psychological distress. At the same time, serious psychological distress tended to be less common among those earning the highest incomes: 13 per cent compared to 32 per cent in the lowest quintile. Thus, it appears that while the majority of Indigenous respondents appeared to be able to maintain their wellbeing irrespective of income, serious psychological distress was more likely to be found among those earning the lowest incomes, particularly if they were unable to pay basic living expenses.

Those who were employed, had completed Year 12, owned their own home, earned higher incomes, enjoyed good health and had experienced less than three stressful life events were more likely to report low or moderate levels of psychological distress than other Indigenous respondents (AIHW 2009). Conversely, those reporting serious psychological distress were more likely to report they had: experienced 8 to 11 stressful life events in the previous year, poor health, lower incomes, rented housing, not completing schooling beyond Year 9, and were unemployed.

This pattern of risk factors for serious psychological distress appears to mirror the social gradient of health associated with indicators of disadvantage and reported in international research about the social determinants of health (WHO 2008). Substantial socioeconomic inequalities are evident in Australia, with premature death rates being highest among the most disadvantaged. Moreover, death rates have been shown to increase with rising disadvantage (Draper, Turrell & Oldenberg 2004), and psychological distress to decrease as income rises (Department of Human Services 2005). While a similar gradient is evident within the Indigenous population, death rates for Indigenous people are substantially higher across all quintiles of socioeconomic disadvantage when compared to others: Indigenous people in the most well-off areas had death rates almost 2.5 times that of non-Indigenous people in the most disadvantaged areas (Glover et al. 1999).

Risk factor: Physical health problems

Serious illness or disability affected 28 per cent of Indigenous respondents and was highest (30%) in major cities. Overall, only 19 per cent of respondents did not report a serious illness of six months' duration or more, with 18 per cent reporting one condition, 30 per cent reporting two or three conditions and 33 per cent reporting four or more long-term health conditions. The majority (62%) of those with four or more health conditions reported serious psychological distress (AIHW 2009). The combination of multi-morbidity and serious psychological distress has been shown to inhibit the capacity of health service providers to manage these presentations in primary care settings (Fortin et al. 2006), unless support to manage psychological distress is provided as part of general health care—as it is in Aboriginal Community Controlled Health Services.

This picture stands in contrast to the majority (60%) of non-Indigenous respondents to the General Social Survey 2006 who reported they had no long-term health conditions or disabilities. The Australian Institute of Health and Welfare estimated that the proportion of Indigenous people aged over 18 years with a profound or severe core activity limitation was approximately 2.4 times that of non-Indigenous people (AIHW 2006).

Preventable admissions to hospital

As well as dying from poor quality medical care at four times the rate of other Australians, one in five admissions to hospital could have been prevented if effective medical care had been available in the primary care setting (AIHW 2008). Indigenous adults were hospitalised at 5.6 times the rate of other Australians for conditions usually managed in the primary care setting, for example, by GPs (AIHW 2008). It should be noted that Indigenous rates of preventable hospitalisations due to care-sensitive conditions are increasing rather than decreasing (AIHW 2008).

Risk factor: Incarceration

The NATSIHS 2004–05 found that having a family member sent to, or currently in jail affected 19 per cent of respondents, and was highest (25%) in remote areas. After adjusting for age, the rate of imprisonment in 2007 for Indigenous prisoners was 1787 per 100,000 compared to 134 per 100,000 for other Australians, making Indigenous people more than 13 times more likely than other Australians to be in prison (AIHW 2008) and 21 times more likely in Western Australia. The proportion of prisoners who were Indigenous was highest in the Northern Territory (84%) and lowest in Victoria (6%).

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among Aboriginal and Torres Strait Islander People

A study which analysed responses to the NATSISS 2002 to determine the economic and social factors which underpinned Indigenous contact with the criminal justice system found that respondents were far more likely to have been charged with, or imprisoned for, an offence if they abused drugs or alcohol, failed to complete Year 12 or were unemployed. Participating in the Commonwealth Development Employment Scheme (CDEP) reduced the risk of being charged (compared with being unemployed). Other factors that increased the risk of being both charged and imprisoned included: experiencing financial stress, living in a crowded household and being a member of the Stolen Generations (Weatherburn, Snowball & Hunter 2006). The two most important factors related to Indigenous prosecution and imprisonment were high-risk alcohol consumption and illicit drug use. Respondents in remote areas were about as likely as Indigenous people in major cities to be charged, however, those living in remote areas were more likely to be imprisoned.

Incarceration appears to be both a risk factor and an outcome of serious psychological distress and mental health problems. Those who reported one or more stressors were twice as likely to have been arrested in the past 12 months and were more likely to have been incarcerated in the past five years (AIHW 2008). Many of those in prison (40–61%) reported they had previously received psychiatric treatment (AIHW 2008). Half of those formally charged by police had a history of being removed from their natural family. In turn, released Indigenous prisoners in Western Australia were shown to have a risk of death almost 10 times that of the general population in that State and almost three times those of other released prisoners. The main causes of death were suicide, drug and alcohol events and motor vehicle accidents (AIHW 2008).

In summary, Indigenous people were exposed to the risk of being sent to jail or having a family member sent to jail at 13 times that of other Australians. The risk of being incarcerated was increased for those who had a history of removal (Stolen Generations), lived in remote areas, had experienced stressful events such as financial stress, living in crowded housing or being a victim of violence, used drugs or alcohol, and/or were receiving treatment for a mental illness (AIHW 2008). The risk of incarceration is a major risk to the SEWB of individuals, families and communities, and varies by jurisdiction and remoteness.
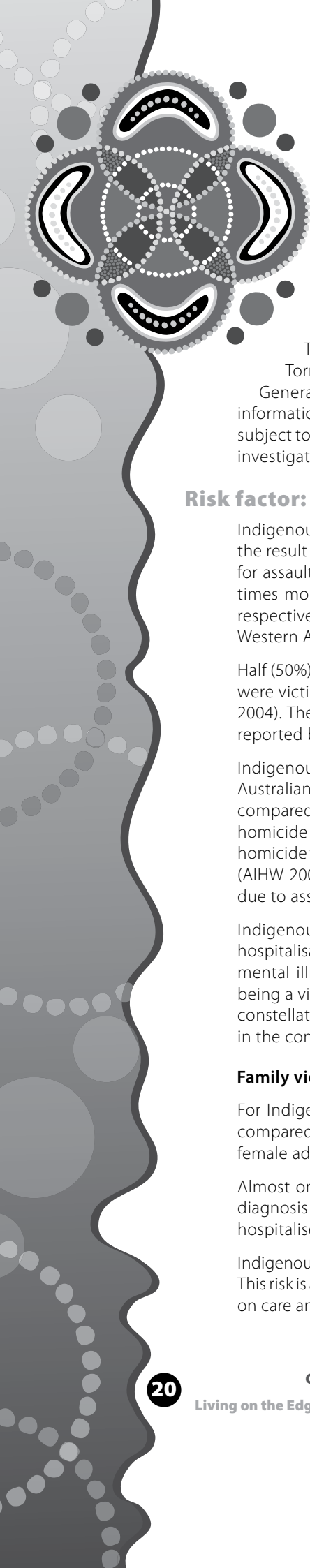
Risk factors: Notifications, investigations (substantiated and unsubstantiated), child removal by care and protection orders and Juvenile Justice supervision

In 2007–08, there were 29,823 notifications that Indigenous children were at risk: a rate of 144 per 1000 children aged 0–16yrs, compared to 36.5 per 1000 other children, a rate four times that of other families. Of the notifications about Indigenous children, 18,437 (62%) were investigated and only 7313 (25%) were substantiated: a rate of 89 and 35 per 1000 children, respectively (SCRGSP 2008b). This compares to 17 investigations and five substantiations per 1000 other children. Notification rates were highest in New South Wales: during 2007–08 there were 15,756 Indigenous notifications, 11,032 investigations and 3263 substantiations.

Across Australia, nearly one in 10 Indigenous families were subject to investigations about how they cared for their children: a rate four times greater than that of other families. The risk of being reported varied with jurisdiction of residence: notifications were eight times more likely to be made about Indigenous children in WA and three times *less* likely with Indigenous children in Tasmania.

Across Australia, the rate of Indigenous children aged 0–17yrs on care and protection orders was seven times higher than that of other children: 41 per 1000 Indigenous children compared to 5.3 for others (AIHW 2008). This rate was highest in Victoria, with Indigenous children on care and protection orders at a rate of 74 per 1000, compared to six other children per 1000. The most common reasons given for removal were parental substance abuse, mental health issues and family violence.

Young Indigenous people aged between 10–17 years were also placed under juvenile justice supervision at 27 times the rate of other young people in 2006–07. This was highest in Western Australia, where the rate was 42 times that of other young people: 662 Indigenous young people compared to 16 others per 100,000 population (AIHW 2008). Research suggests that families with low incomes or a reliance on pensions and benefits, those with alcohol use/abuse problems or a psychiatric disability and those with a history of family violence are over-represented in families that come into contact with child protection and support services (SCRGHS 2009).

Indigenous families are exposed to four times the risk that notifications will be made that they are neglecting or abusing their children, are more likely to be investigated by child protection authorities and to have notifications substantiated, and faced seven times the risk that their children will be removed on care and protection orders when compared to other Australians. This risk varied according to jurisdiction. Indigenous children aged 10–17 years faced 27 times the risk of other young people that they would be placed under juvenile justice supervision orders, and this risk also varied by jurisdiction. This risk was greater for families with substance abuse, violence and mental health issues.

The psychological impact of widespread reporting, investigating and removing Aboriginal and Torres Strait Islander children should be viewed in light of the history of forcible removal (Stolen Generations) and its ongoing impact on Indigenous individuals, families and communities. No information is available on the psychological distress suffered or support offered to Indigenous families subject to investigations of reports that were not substantiated, or the ongoing effect of unsubstantiated investigations on the social and emotional wellbeing of children and their families.

Risk factor: Violence

Indigenous Australians were three times as likely as other Australians to report a recent injury that was the result of an attack by another person (AIHW 2008). Overall, Indigenous Australians were hospitalised for assault at 14 times the rate of other Australians (AIHW 2008). Males and females were eight and 35 times more likely to be hospitalised for injuries due to assault as other Australian males and females respectively. The highest rates were in the Northern Territory (20 times the rate of other Australians) and Western Australia (23 times the rate of others) (AIHW 2008).

Half (50%) of the Indigenous Australians who reported 11 or more stressful life events also reported they were victims of actual or threatened violence in the 12 months before the NATSISS survey in 2002 (ABS 2004). The NATSISS 2002 also showed 42 per cent of those who reported high-risk use of alcohol also reported being a victim of actual or threatened violence.

Indigenous Australians died from assault at 10 times the rate of other Australians (AIHW 2008). Indigenous Australians were taken into custody for acts intended to cause injury at 727 per 100,000 adults population, compared to 18 per 100,000 for other Australians: a rate 22 times that of others. Most (63%) Indigenous homicide victims were killed by intimate partners or family members compared to 45 per cent of other homicide victims. Alcohol-related arguments were involved in one in five (22%) of all Indigenous homicides (AIHW 2008). Mental disorders were an associated cause of death for 8 per cent of Indigenous deaths due to assaults: all of these deaths were associated with psychoactive substance use.

Indigenous Australians are exposed to a very high risk of violence and its consequences, including hospitalisation, incarceration and death. Violence appears to be associated with substance abuse and mental illness. Alcohol appears to increase the risk that arguments will end in homicide. The risk of being a victim of violence is increased by experiencing multiple stressful events and using alcohol. This constellation of events appears to constitute a cycle of despair, especially when the risk of child removal in the context of violence is factored in as well.

Family violence

For Indigenous women, one in two hospitalisations for assault (50%) were related to family violence, compared to one in five for men (AIHW 2006). Spouse or partner violence accounted for 82 per cent of female admissions for family violence.

Almost one-third of Indigenous hospitalisations for family violence-related assaults had an additional diagnosis of mental disorder (31%). The most common type of mental disorder for Indigenous Australians hospitalised for family violence-related assaults was associated with psychoactive substance use (29%).

Indigenous women are exposed to a higher risk of being subject to family violence resulting in hospitalisation. This risk is associated with substance use. In turn, these factors increase the risk that children will be removed on care and protection orders and young people will be placed under juvenile justice supervision.

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Risk factor: Substance use/abuse

Despite experiencing serious psychological distress at twice the rate of other Australians, twice as many Indigenous people as others reported they had not drunk alcohol in the year before the survey, including four out of 10 adults living in Aboriginal communities (AIHW 2008). The proportion of Indigenous adults who reported drinking at long-term risky levels (16%) was similar to that of other Australians (14%). This figure was lowest in the Northern Territory (8%) and highest in Queensland and Western Australia (19%).

More than half (51%) of Indigenous respondents to the NATSIHS 2004–05 reported they had not drunk any alcohol in the previous week, and more than 80 per cent of respondents reported they had not drunk alcohol at risky/high-risk levels in the past 12 months (AIHW 2008).

Alcohol-related problems were reported by 20 per cent of Indigenous respondents to the NATSIHS 2004–05 and this was highest (24.1%) in remote areas (ABS 2006). Half of those who reported using alcohol reported drinking at short-term risky levels (i.e. 'binge' drinking') at least once in the previous 12 months.

The majority (71%) of respondents also reported that they had not used illicit substances in the past 12 months (AIHW 2008). In non-remote areas, 75 per cent of respondents who had experienced stressors in the past 12 months had never used any illicit substances (AIHW 2008).

Despite the similar prevalence of high-risk alcohol use among Indigenous and other Australians, those who used/abused alcohol appeared to be exposed to a range of risks to social and emotional wellbeing and the development of serious psychological distress not experienced by other Australians:

- Indigenous people were taken into custody for public drunkenness at 43 times the rate of other Australians in 2002, with the median length of time spent in custody being six hours (AIHW 2008).

- Mental and behavioural disorders due to psychoactive substance use were the most common mental health conditions for which Indigenous people were hospitalised (AIHW 2008).

- Indigenous males and females were hospitalised for diagnoses related to alcohol use at five and three times the rate of other Australians.

- Indigenous Australians were hospitalised for acute alcohol intoxication at eight times the rate of other Australians, for withdrawal states at 10 times the rate and for alcoholic liver disease and accidental poisoning by alcohol at five times the rate of other Australians (AIHW 2008).

- Indigenous Australians died from mental and behavioural disorders due to alcohol use at 10 times the rate of non-Indigenous Australians, from alcoholic liver disease at eight times the rate and from poisoning by alcohol at nine times the rate of others.

- Indigenous Australians were hospitalised for mental and behavioural disorders from use of volatile substances at around 32 times the rate of others (AIHW 2008).

Surprisingly, the NATSIHS 2004–05 found no statistically significant relationship between those who drank at long-term high-risk levels and those reporting serious psychological distress. This finding was similar to previous surveys undertaken with Indigenous populations in Western Australia and New South Wales, and is indirectly supported by findings that only 8.6 per cent of respondents who reported being unable to carry out normal activities due to psychological distress, also reported high-risk alcohol use (AIHW 2008).

Little has been done to investigate the apparent lack of a link between serious psychological distress and alcohol use as a coping strategy or to draw out the positive strategies used by Indigenous non-drinkers to cope with the high prevalence of serious psychological distress. However, it is clear that Indigenous people who do use/abuse alcohol are exposed to a range of risk factors to health and SEWB not experienced by other Australians, including: police custody, alcoholic poisoning, addiction, withdrawal states, liver disease, hospitalisation and preventable mortality. In addition, as noted previously, alcohol use appeared to be associated with mental health issues and violence, which increased the risk of either hospitalisation or incarceration and resultant psychological distress.

Protective factors for Indigenous social and emotional wellbeing

> Maintaining a spiritual, physical and emotional connection to the land is intrinsic to many Indigenous people's beliefs about social and emotional wellbeing.

> There is a need to investigate the concept of resilience in Indigenous settings. Priority needs to be given to further identifying the types of strength and protective factors that have assisted Indigenous individuals, families and communities to survive multiple and widespread adverse life events over several generations. Developing appropriate Indigenous measures that adequately assess such factors would be an essential part of this research process.

Protective factors can reduce the exposure to risk, or may reduce or mitigate the effect of risk factors (Rutter 1985). The presence of more protective factors, regardless of the number of risk factors, has been shown to lower the level of risk (Resnick et al. 1997). However, people who have high resilience (that is, the capacity to bounce back following adversity) may still be vulnerable to adverse events and circumstances. While a balance of risk and protective factors may improve wellbeing, it cannot be assumed that protective factors will always override the effect of risk factors, since resilience can be put under extreme pressure in some environments.

Little work has been undertaken to identify the factors that have helped Aboriginal and Torres Strait Islander people to survive several generations of trauma and extreme disadvantage. In addition, although national mental health plans require a population mental health approach to be adopted throughout the mental health system—that is, the implementation of universal, selected and targeted interventions (Mrazek & Haggerty 1994)—there are no universal primary prevention strategies in place to promote the social and emotional wellbeing of Indigenous communities and populations or early intervention strategies to prevent the development of serious psychological distress. Rather, it would seem Indigenous-specific SEWB strategies, where they exist, are either secondary (SEWB counsellors in some Aboriginal Community Controlled Health Organisations) or tertiary prevention strategies (specialist services such as Bringing Them Home counsellors and Link-Up workers), rather than population-wide primary prevention strategies as advocated by the WHO and enshrined in the last three national mental health plans. National programs such as suicide prevention and substance abuse programs are also targeted to 'at risk' Indigenous groups and as such are secondary or tertiary prevention programs.

In the absence of support from the mental health system, Aboriginal and Torres Strait Islander people have been forced to rely on each other—and the cultural, spiritual and other forms of SEWB support that are an integral part of some of the oldest continuous cultures on earth—to manage social and emotional wellbeing issues in individuals, families and communities. While SEWB support is often described as integral to the 'holistic' care provided as part of comprehensive primary health care delivered in Aboriginal Community Controlled Health Services, little research has been done to draw out or describe the protective elements of SEWB support drawn from Aboriginal and Torres Strait Islander cultures and delivered in these settings. While this informal system of SEWB support is in place in Aboriginal Community Controlled Health Services, this sector is under-resourced and not universally available or accessible to all Indigenous people. More work is needed to identify risk and protective factors understood by Indigenous people as part of SEWB knowledge.

The interdependent nature of family, kinship and community connectedness found in many Indigenous communities appears to offer some protection against developing serious psychological distress:

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Protective factor: Social cohesion

Social cohesion—defined as the quality of social relationships and the existence of trust, mutual obligations and respect in communities or in the wider society—helps to protect people and their health (Wilkinson & Marmott 2003). The strong cultural ties and the reciprocal relationships that underpin Indigenous cultures are likely to offer some protection against the ravages of multiple stressful events.

Protective factors: Connection to land, culture, spirituality, ancestry

The importance of land and the 'country' one belongs to is central to most aspects of Aboriginal culture, and maintaining a spiritual, physical and emotional connection to the land is intrinsic to many Indigenous peoples beliefs about mental and social and emotional wellbeing (Dudgeon et al. 2002).

> *To understand our law, our culture and our relationship to the physical and spiritual world, you must begin with land. Everything about Aboriginal society is inextricably woven with, and connected to, land. Culture is the land, the land is spirituality of Aboriginal people, our cultural beliefs or reason for existence is the land. You take that away and you take away our reason for existence. We have grown that land up. We are dancing, singing, and painting for the land. We are celebrating the land. Removed from our lands, we are literally removed from ourselves* (Dodson 1977:39).

Land is central to social relationships and the spiritual and emotional wellbeing of Indigenous individuals, families and communities. To fully understand social and emotional wellbeing it is necessary to understand the cultural dimensions of wellbeing.

The positive benefits of living in remote areas on or near ancestral lands is supported by similar levels of serious psychological distress being reported among those in remote and non-remote areas, despite increased risk exposure to a range of stressors in remote areas (death of family member, overcrowding at home, incarceration, alcohol-related problems, witness to violence, trouble with police, serious accident and discrimination, preventable hospitalisations). In addition, it seems those who were not living on homelands, and were not allowed to visit, were more likely to report serious psychological distress when compared to others. It is possible that living in remote areas or on, or near, traditional lands serves as a source of resilience that may help reduce the risk of developing serious psychological distress.

There is some biomedical research that has provided evidence for an association between land and Indigenous health. For example, a study researching the impact of the homeland movement on biological health indicators in central Australia found that homeland residents had a lower baseline prevalence of diabetes, hypertension and obesity along with lower mortality and hospitalisation rates, and that this finding had been sustained over a 10-year period (Rowley et al. 2008). Pre- and post-measures included the K6, and positive social and emotional wellbeing was seen to be indicated by low scores for psychological distress.

There is also some evidence to suggest that disconnection from land is directly associated with some forms of Indigenous psychopathology. In her work examining culturally appropriate assessment, Indigenous psychologist Dr Tracey Westerman identified a culturally specific illness termed *'longing for, crying for country'*, which has symptoms relatively congruent with depression but with an aetiology that involves the individual being removed from their spiritual country/place of dreaming for an extended duration (Vicary & Westerman 2004).

As well as being a source of resilience, the centrality of land to wellbeing might also give rise to risk factors for serious psychological distress that may impact across communities and language groups: such as, disputed, unsuccessful or delayed land claims; damage to sacred sites; threats for development; climate changes; and other issues which go beyond the simple measure of having access to lands.

Protective factor: Sense of wellbeing/resilience

Items were selected from the Short Form 36 Health Survey (SF-36), which provides a generic measure of health status, to be used in the NATSIHS 2004–05. Four items were selected from the mental health and vitality scales to provide a measure of positive wellbeing. These items measured the extent to which respondents felt calm/peaceful, happy, full of life, and had lots of energy in the month prior to the survey. Despite multiple levels of disadvantage, the majority (71%) of Indigenous respondents reported being a 'happy person' all of most of the time, with 56 per cent reporting they felt calm and peaceful all or most of the time, and 55 per cent feeling full of life all or most of the time during the previous month. Only a small proportion of respondents reported that they had not felt calm and peaceful (5%), happy (2%), full of life (6%), or had lots of energy (7%) *at all* over the previous month.

Importantly, there was an inverse relationship between positive wellbeing and psychological distress: the more distress, the less wellbeing reported (AIHW 2008). Those reporting serious psychological distress reported the lowest measures on all four positive wellbeing measures. Conversely, those reporting low distress reported the highest proportions on measures of positive wellbeing.

There were some observable differences in wellbeing measures, depending on whether respondents lived in non-remote or remote areas. Respondents in remote areas were more likely to report that they felt calm and peaceful, were a happy person, felt full of life and had lots of energy *all or most of the time* when compared to those in major cities (AIHW 2009). Conversely, fewer respondents in remote areas reported that they felt none of the positive indicators *at all* in the past month. While the majority or respondents in non-remote areas reported feeling calm and peaceful, happy and full of life *all or most of the time* in the previous month, this was in lower proportions when compared to those in remote areas. Proportionally more respondents in non-remote areas reported they felt nervous (10%), without hope (8%), restless or jumpy (14%) and that everything was an effort (18%) *all the time* in the month before the survey. Those in non-remote areas were more likely to report feeling *no* positive feelings in the past month. Respondents in non-remote areas also lost more days due to being unable to work or carry out usual activities (AIHW 2009).

A possible explanatory framework for differences in wellbeing between urban and remote respondents is the concept of 'minority stress'. Hypothesised as chronic stress experienced as a result of stigma, prejudice and discrimination, 'minority stress' creates a hostile and stressful social environment for minority populations. Indigenous respondents living as dispersed minorities in urban areas are likely to experience racism and discrimination differently from those living in small Aboriginal and Torres Strait Islander communities in remote areas where they form greater numbers and, in some cases, the majority of the population. Recent indirect evidence to support this hypothesis comes from a prospective study that documented a relationship between higher rates of emerging first presentation psychotic disorders in neighbourhoods with lower levels of ethnic density of immigrant groups in Western Europe (Veling et al. 2008). Put simply, people of an oppressed cultural group who form a minority within a larger population are likely to suffer greater mental health problems.

There is a need to investigate the concept of resilience in Indigenous settings. Priority needs to be given to further identifying the types of strength and protective factors that have assisted Indigenous individuals, families and communities to survive multiple and widespread adverse life events over several generations. Developing appropriate Indigenous measures that adequately assess such factors would be an essential part of this research process.

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Evidence of negative outcomes of serious psychological distress

What has emerged is a picture of disadvantage, failure of health systems and high levels of state intrusion into Indigenous lives. It appears Indigenous people suffering psychological distress as a result have been subject to a range of punitive rather than supportive interventions, such as incarceration and removal of children, which, rather than creating new opportunities for recovery or building on strengths, have served to exacerbate distress and to increase the risk of developing serious psychological distress. It seems highly likely that this level in itself is a determinant of serious psychological distress.

National surveys tend to concentrate on the social determinants of serious psychological distress but cannot capture the individual experiences of human distress: the grief, loss, confusion, trauma, anger, frustration and fear that may fall under the umbrella of non-specific and essentially 'normal human' distress, but which may lead to profound and catastrophic consequences for individuals and their families. The impact of serious psychological distress is likely to be experienced in at least three different ways:

i)   experiencing acute distress in the short term;

ii) experiencing the cumulative effect of chronically high levels of psychological distress and its effects on the health and wellbeing of individuals, families and communities over time; and

iii) the interactive effects of serious psychological distress and other determinants of health and wellbeing. There is an urgent need for Indigenous-led research to examine the effect of serious psychological distress as both determinant and outcome of other social determinants.

There are a number of SEWB outcomes, which may be closely linked to psychological distress and deserve further exploration.

Suicide and intentional self-harm

In 2005–06, in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined, Indigenous males were hospitalised for intentional self-harm at rates three times those of non-Indigenous men, and the rates were twice as high for Indigenous females (AIHW 2008). The suicide rate was almost three times that for non-Indigenous men and five times the corresponding age-specific rates for non-Indigenous women. Indigenous Australians died from self-harm at twice the rate of non-Indigenous Australians. Suicide was identified as the fourth most common preventable condition causing death of Indigenous Australians and represented 8 per cent of this burden. The Northern Territory had the highest rates for suicides: 48 per 100,000 Indigenous population compared to a rate of 15 for non-Indigenous Territorians.

Suicidal behaviour can arise from exposure to a number of risk factors. Recent Australian research, which has established a strong relationship between serious psychological distress and suicide (Chamberlain et al. 2009), suggests that the high levels of serious psychological distress found in Indigenous populations may be linked to high rates of suicide. It is a matter of urgency that Indigenous researchers are resourced to investigate this link.

Anger and aggression

The NATSIHS 2004–05 included five questions that were adopted from American Indian research in the United States (NCAIANMHR 2007). Respondents were asked to indicate how often in the past month they had been bothered by: feeling easily annoyed or irritated; having violent thoughts; wanting to break or smash things; getting into a lot of arguments; or shouting and throwing things. There appeared to be a strong association between serious psychological distress and expression of anger. Generally the higher the level of psychological distress reported, the higher the levels of anger reported (AIHW 2008).

Those reporting serious psychological distress were more likely to respond 'a lot' when asked how often they: wanted to break or smash things (77%); shouted and threw things (75%); got into a lot of arguments (72%); had violent thoughts (69%); and were easily annoyed and irritated (66%) (AIHW 2009). Those with serious psychological distress were two to three times more likely to report these angry behaviours compared to those with low/moderate psychological distress. Additionally, anger was associated with lower levels of wellbeing. The more anger reported, the more likely it was that respondents would report that they did not feel calm and peaceful, full of life, or had a lot of energy *at all* during the previous year (AIHW 2009). The relationship between serious psychological distress, anger and positive wellbeing requires further investigation.
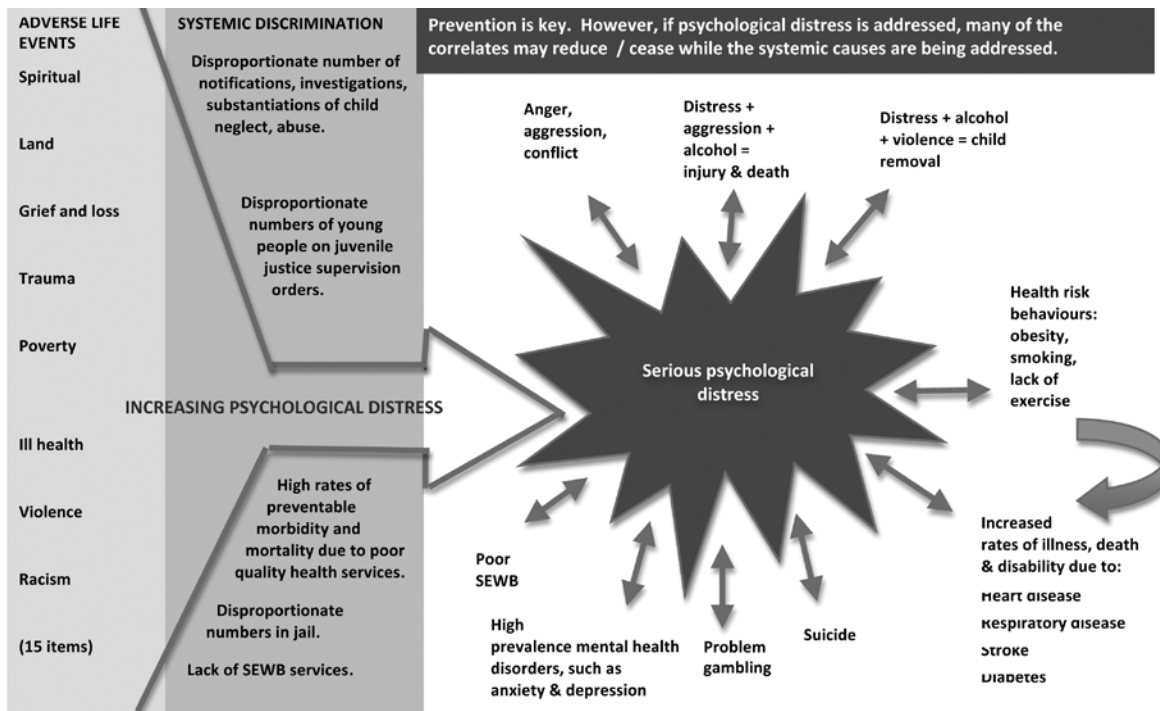
Problem gambling

No research data is available that examines the association between high levels of psychological distress and problem gambling in Indigenous settings. However, a recent study from the Problem Gambling Research and Treatment Centre found problem gamblers in Victoria were 18.8 times more likely to experience severe psychological distress compared to non-gamblers. Further, the study concluded that the distress was likely to have preceded their gambling problems, and that 'gambling to escape' is a key defining criterion of problem gambling (Thomas & Jackson 2008).

Smoking

The NATSIHS 2004–05 found that 50 per cent of Indigenous Australians were smokers. Smoking was more commonly reported among males and females in every age group when compared with the non-Indigenous population. Overall, Indigenous Australians were more than twice as likely as others to be current daily smokers. Indigenous respondents who had experienced more than one life stressor in the past 12 months had higher rates of current daily smoking (54%) than did those reporting only one or no stressful circumstances (46%). Those reporting high levels of psychological distress were more likely to be smokers (32%) than non-smokers (20%) (ABS 2006).

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Figure 2: Factors that contribute to serious psychological distress and its outcomes

ADVERSE LIFE EVENTS	SYSTEMIC DISCRIMINATION
Spiritual	Disproportionate number of notifications, investigations, substantiations of child neglect, abuse.
Land	
Grief and loss	Disproportionate numbers of young people on juvenile justice supervision orders.
Trauma	
Poverty	

INCREASING PSYCHOLOGICAL DISTRESS

Ill health

Violence | High rates of preventable morbidity and mortality due to poor quality health services.

Racism | Disproportionate numbers in jail.

(15 items) | Lack of SEWB services.

Prevention is key. However, if psychological distress is addressed, many of the correlates may reduce / cease while the systemic causes are being addressed.

Anger, aggression, conflict

Distress + aggression + alcohol = injury & death

Distress + alcohol + violence = child removal

Serious psychological distress

Health risk behaviours: obesity, smoking, lack of exercise

Increased rates of illness, death & disability due to:
Heart disease
Respiratory disease
Stroke
Diabetes

Poor SEWB

High prevalence mental health disorders, such as anxiety & depression

Problem gambling

Suicide

© Australian Indigenous Psychologists Association   Source: National Aboriginal & Torres Strait Islander Health Survey 2004-05

Summary

This section has sought to examine the determinants that Indigenous people have identified as impacting on their SEWB: unresolved grief and loss, trauma and abuse, domestic violence, substance misuse, physical health problems, identity issues, child removals, incarceration, family breakdown, cultural dislocation, racism, discrimination and social disadvantage (SHRG 2004). To do this we have examined a complex array of environmental, social, economic, cultural and historical factors that contribute to the SEWB of Indigenous people. What has emerged is a picture of entrenched disadvantage, failure of health and other systems on the one hand, and high levels of State intrusion into Indigenous lives on the other. Those suffering psychological distress as a result appear to be at increased risk of being subject to a range of punitive rather than supportive interventions—such as incarceration and removal of children—which, rather than creating new opportunities for recovery or building on strengths, have served to exacerbate distress and to increase the risk of developing serious psychological distress. It seems highly likely that these system failures may serve as determinants of serious psychological distress.

Part 3

Restricted access to social and emotional wellbeing support and primary mental health care: The effect of systemic discrimination on social and emotional wellbeing

Many of the factors that Indigenous people have identified as impacting on SEWB appear to be a result of what is described as systemic or institutional discrimination, which occurs when policies and procedures, or laws, serve to disadvantage a specific group or limit their rights (Krieger 1999). Although often viewed as neutral and sometimes acceptable, the application of beliefs, values, presumptions, structures and processes by the institutions of society (economic, political, social or cultural) can result in differential and unfair outcomes for particular groups.

Policy and practices that discriminate unfairly in their *effect, impact* or *outcome*, irrespective of the motive or intention, amount to unfair discrimination. Systemic discrimination is thus measured by outcomes and results rather than intentions: it is not necessary to examine the *motives* of the individuals involved but to instead examine the *results* of their actions. As systemic discrimination is built into the normal working relationships of institutions, its perpetuation requires only that people continue 'business as usual'. The eradication of systemic discrimination requires much more than good will, it requires active review of the assumptions and practices by which the institution operates, and revision of those found to have discriminatory results. Clearly there is an urgent need for a range of government departments and services to acknowledge the social and historic context of discriminatory conduct, and to audit their policies to identify those practices that are impacting disproportionately on Aboriginal and Torres Strait islander people and adding to psychological distress.

The social determinants of health are not just the circumstances in which people are born, grow up, live, work and age, but also include the health systems that are available (WHO 2008). The World Health Organization's International Conference on Primary Health Care held in Alma-Ata in 1978 declared, among other things, that access to primary health care is essential to leading a socially and economically productive life.

> *Primary health care is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process* (WHO 1978, para. VI).

Equity involves the conscious and deliberate effort to ensure appropriate health services are provided and are accessible to those who stand to benefit most from their uptake. The standard and quality of services should be the same for all, regardless of class, position, race, disability, age or gender.

The Kessler scale used in the NATSIHS 2004–05 is often used to identify population groups at risk but who are not accessing services to gain support (Saunders & Daly 2000). Despite widespread high levels of psychological distress, 87 per cent of respondents to the NATSIHS 2004–05 had not sought help from a doctor or other health professional to assist them to cope with their feelings in the month before the survey. Even if psychological distress did stimulate help-seeking, Indigenous Australians have restricted access to culturally appropriate SEWB support to resolve psychological distress or to break the cycle of distress and despair evident in some of the figures presented earlier.

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However, the ways in which health systems are organised and financed, together with the availability of services, can influence disparities in health outcomes, particularly for minority groups such as Indigenous people. Accessibility can be hampered by language barriers, the ability of practitioners to accurately assess presenting symptoms, cultural issues and geographic availability. To date, there has been no system-wide program to enhance the development of cultural competence of the mental health professions, primary and mental health services, or health service providers including mental health clinicians.

A key strategy to prevent serious psychological distress from yielding a high burden of mental illness among Indigenous peoples, particularly high-prevalence disorders such as anxiety disorders, depression and substance abuse disorders, is universal access to culturally appropriate SEWB and primary mental health care. GPs are often the first health professionals to be consulted about mental health concerns in Australia. Primary mental health services are being integrated into primary care systems in order to reduce stigma associated with help-seeking. However, there is strong evidence to demonstrate that Indigenous people do not have access to primary mental health care services or the early intervention strategies they provide.

Lack of access to general practitioners

The NATSIHS 2004–05 reported that 15 per cent of Indigenous people did not visit a doctor when they needed to. Reasons given were transport/distance, cost, waiting time and cultural issues (AIHW 2008). The proportion of Indigenous Australians using a doctor for their regular health care decreased with remoteness, from 80 per cent in major cities and inner regional areas to 6 per cent in very remote areas (AIHW 2008).

Lack of access to psychologists

The full-time equivalent rate of employed psychologists was highest in areas where less than 1 per cent of the population was Indigenous (89 per 100,000) and lowest in areas where 20 per cent or more of the population was Indigenous (7 per 100,000) (AIHW 2008).
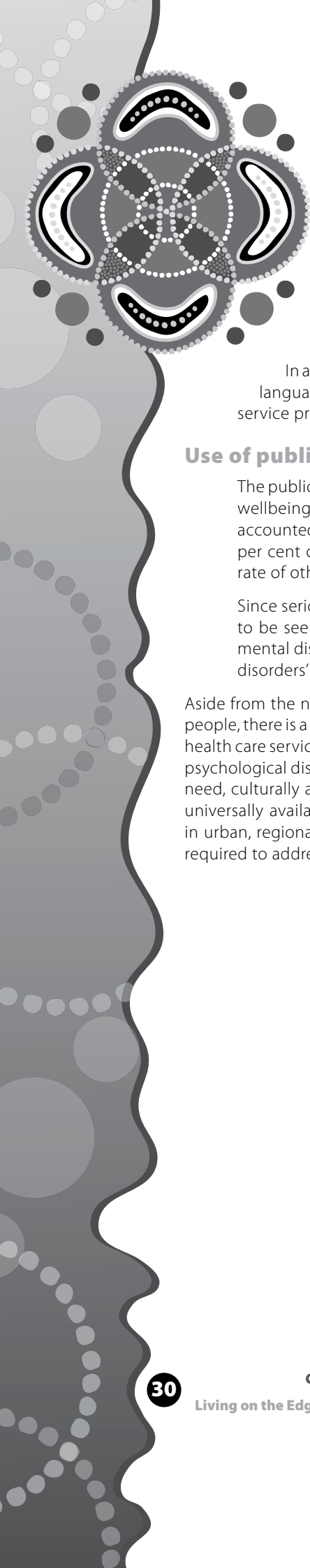
Restricted access to social and emotional support as part of comprehensive primary health care

There are approximately 140 Australian Government-funded Aboriginal Community Controlled Health Services (ACCHSs) in Australia. The proportion of Indigenous Australians who use ACCHSs for their regular health care increases with remoteness, from 15 per cent in major cities to 76 per cent in very remote areas. Although psychological distress is managed as a component of holistic health in ACCHSs, this sector is under-resourced with few services resourced to provide the 'social health teams' recommended in the *Ways Forward Report* (1995) and the *National Strategic Aboriginal and Torres Strait Islander Social and Emotional Wellbeing and Mental Health Framework 2004–2009* (SHRG 2004). While many Aboriginal Community Controlled Health Services provide access to specialised counselling for Stolen Generations survivors, only 19 (13%) of the 140 had been resourced to provide the general Aboriginal and Torres Strait Islander population with access to additional social and emotional wellbeing counselling services as part of comprehensive primary health care.

Lack of access to culturally appropriate primary mental health care in discrete Aboriginal communities in remote areas

There are an estimated 92,960 Aboriginal people living in Aboriginal communities on traditional and other lands, most of which are located in remote Australia (ABS 2007). Only 332 of these communities have more than 50 permanent residents and just 17 contain 1000 people or more. None contain more than 4000 people. Usually the larger communities have a single health service that receives the bulk of its funding either from the Australian Government as 'Aboriginal Community Controlled Health Services', or from State / Territory Governments as 'Other Primary Health Services'.

Less than half (47% or 41,450) of the Indigenous population in larger discrete communities has access to ACCHSs that provide social and emotional wellbeing support as part of culturally appropriate comprehensive primary health care, and where Aboriginal Health Workers are the first point of contact (ABS 2007).

The remaining 35,737 people, or 43 per cent of the population, in the larger discrete Aboriginal communities have access to 104 State-funded 'Other Primary Health Services', which are administered without community input, are not funded to provide comprehensive primary health care, have poor retention of Aboriginal Health Workers, and use mostly non-Indigenous nurses to substitute care usually provided by doctors (ABS 2007). Only 14 of the 'Other Primary Health Services' (serving a population of 11,344) provide access to a doctor on a daily basis, and only four of these are GPs who can provide access to major national programs such as Medicare, Better Access to Psychiatrists, Psychologists, PBS items etc. (AIHW 2008).

In addition, Indigenous people in remote Australia are more likely to report speaking an Indigenous language (42%) than those in non-remote areas (2%), and to report difficulties in communicating with service providers, with 19 per cent and 8 per cent respectively (NATSISS 2004).

Use of public hospitals

The public hospital system is over-burdened and does not have the capacity to offer social and emotional wellbeing support or primary mental health care services. Yet, Aboriginal and Torres Strait Islander peoples accounted for 5 per cent of mental health-related emergency department occasions of service and 6.2 per cent of separations for mental health care in public hospitals. This was more than three times the rate of other Australians (AIHW 2008).

Since serious psychological distress is not classified as a mental disorder, alternative diagnoses are likely to be seen in the data. Indigenous people are more likely to be admitted to hospital for 'unspecified mental disorders' (2 times), 'neurotic, stress related disorders' (1.5 times) and 'behavioural and emotional disorders' (1.3 times) when compared to others (AIHW 2008).

Aside from the need for universal strategies to promote the social and emotional wellbeing of all Indigenous people, there is a clear unmet need for culturally appropriate social and emotional wellbeing and primary mental health care services in urban, regional and remote Indigenous communities to intervene early to prevent serious psychological distress. To ensure that Indigenous people are able to access support services in accordance with need, culturally appropriate SEWB services must be resourced and integrated into ACCHSs. These need to be universally available to all Indigenous populations and communities regardless of whether they are located in urban, regional or remote Australia. This should be seen as an essential component of the sustained effort required to address serious psychological distress among Aboriginal peoples and populations.

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Conclusion

A key strategy to prevent serious psychological distress from yielding a high burden of mental illness among Indigenous people is universal access to culturally appropriate SEWB and primary mental health care which is integrated into primary care services in order to reduce stigma associated with help-seeking.

Policies and programs should aim to enhance the resilience and capacity of Indigenous individuals, families and communities to cope with a range of adverse life events that contribute to the development of serious psychological distress.

During the process of examining the factors impacting upon SEWB, we have found evidence to suggest that systemic discrimination in government services is contributing to serious psychological distress among Indigenous people. Disproportionately high levels of reporting and investigating neglect and abuse of children, poor quality primary health care, excessive incarceration of alcohol users and restricted access to early intervention in the primary mental health system, all appear to be contributing to a risk chain that will need a multi-systemic approach to break. At the same time there appears to be a poor understanding of Indigenous concepts of SEWB and restricted access to services to intervene when assisting those in distress.
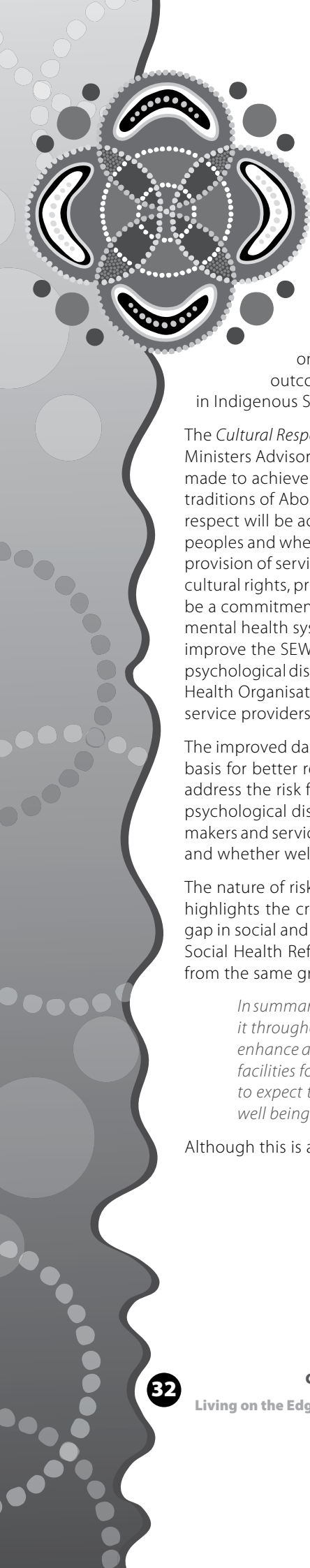
Indigenous social and emotional wellbeing is a complex concept, and the risk and protective factors require further examination if they are to be used to promote and maximise the SEWB of communities and populations and prevent the development of serious psychological distress in vulnerable individuals. It is important that non-Indigenous health service providers are able to understand Indigenous concepts of SEWB as well as the source and expression of psychological distress. Rather than being viewed as evidence of mental illness, psychological distress needs to be seen as a normal, adaptive human reaction to stressful events and an indicator that social and emotional wellbeing is under threat. If mitigated through practical and social and emotional support, distress may lead to growth and adaptation.

At the same time, it must be remembered that improvements in Indigenous SEWB cannot be achieved by improved access to services for those who are struggling to cope, and that the underlying causes of serious psychological distress lie in the social determinants of Indigenous SEWB. This requires long-term sustained effort across multiple sectors of the community and government to address.

Serious psychological distress should also be viewed as a possible 'common causal pathway' that may translate the social determinants of health into individual risk of increased morbidity and mortality. As such it should be recognised as a key issue to monitor and address in efforts to close the gap in a range of health outcomes.

SEWB policies and programs should aim to enhance the resilience and capacity of Indigenous individuals, families and communities to cope with a range of adverse life events that contribute to the development of serious psychological distress. There is an urgent need to train Indigenous SEWB workers to prevent and manage psychological distress, build resilience and promote recovery through the use of culturally appropriate social, emotional, cultural and spiritual interventions to ease distress before, or in parallel with, any assessments and treatments by mental health services.

Although national initiatives to deliver mental health first aid training to those working in the Aboriginal Community Controlled Health sector are valuable, this training aims to improve detection and referral of those with mental health problems, rather than provide workers with skills and strategies to prevent and manage adverse life events, to resolve psychological distress, or to address the psychological distress associated with substance abuse, family violence issues, incarceration, removal of children and so forth.

The cultural competence of the health and mental health system needs to be improved overall, and culturally appropriate psychological screening and assessment tools must to be developed for Indigenous settings and populations. Cultural competence is defined as a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations (Cross et al. 1989). Without the development of culturally competent health and mental health systems and culturally appropriate screening and assessment tools, there is a high risk that serious psychological distress will be misdiagnosed, and inappropriate treatments will be provided in response to help-seeking on the part of Indigenous people. Cultural competence is directly linked to producing positive outcomes, as it can only be said to have been achieved when there is a demonstrated improvement in Indigenous SEWB and mental health outcomes at an organisational, regional, system and population level.

The *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health*, endorsed by the Australian Health Ministers Advisory Committee in 2004, sets out the overarching commitments that Australian jurisdictions have made to achieve the 'recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples' (AHMAC 2004). The *Framework* proposes that cultural respect will be achieved when the health system is a safe environment for Aboriginal and Torres Strait Islander peoples and where cultural differences are respected. Cultural respect is a commitment to the principle that the provision of services offered by the Australian health care system will not knowingly compromise the legitimate cultural rights, practices, values and expectations of Aboriginal and Torres Strait Islander peoples. There needs to be a commitment to implement this framework in all mental health services. Until cultural competence of the mental health system and non-Indigenous service providers can be achieved, primary prevention programs to improve the SEWB of Indigenous populations in urban, regional and remote areas and to intervene early with psychological distress should be funded and coordinated through the National Aboriginal Community Controlled Health Organisation. Provision should be made for the mentoring and cultural supervision of non-Indigenous service providers in these settings.

The improved data from the social and emotional module developed for the NATSIHS 2004–05 provide a strong basis for better resourcing and targeting of a range of programs developed by or with Indigenous people to address the risk factors for developing serious psychological distress. These data and ongoing assessments of psychological distress and other measures of wellbeing could be used to increase the accountability of policy makers and service providers by measuring whether distress has been eased by programs targeted to risk factors, and whether wellbeing has been increased at an individual, community and population level.

The nature of risk and protective factors for social and emotional wellbeing and serious psychological distress highlights the critical importance of whole-of-government and whole-community partnerships to close the gap in social and emotional wellbeing and in general health outcomes. This paper began with a quote from the Social Health Reference Group formed to develop the SEWB Framework and we will end with another quote from the same group:

> *In summary, there needs to be the basic capacity to establish social and emotional well being early and maintain it throughout the life cycle. There also needs to be the resources to adequately prevent and intervene early to enhance and restore well being as problems arise. Finally, there needs to be access to a full range of services and facilities for treatment and rehabilitation for significant distress and disorders. Every community has the right to expect that resources and assistance will be available to establish, restore and treat social and emotional well being and mental health problems. Healthy, stable communities benefit the entire nation* (SHRG 2004).

Although this is an ambitious vision, the potential benefits to the population as a whole are considerable.

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Recommendations

Recommendation 1: That relevant Indigenous professional bodies (including AIPA) work in partnership with the Australian Government to develop and refine the emotional and social wellbeing assessment module for Indigenous Australians used in national data collections.

Recommendation 2: That disparities between Indigenous people and other Australians experiencing serious psychological distress as measured by the Kessler scale, be a headline indicator for *Overcoming Indigenous Disadvantage and Aboriginal and Torres Strait Islander Health Performance Framework* reports, and that a Close the Gap target be to achieve parity between Indigenous and other Australians experiencing serious psychological distress.

Recommendation 3: That good practice guidelines and resources are developed to increase: SEWB literacy around the potential impact and contribution of adverse life events towards serious psychological distress and Indigenous SEWB; education about factors that protect against the development of serious psychological distress following adverse life events; understanding of the consequences of high and prolonged levels of psychological distress on Indigenous health and mental health; and detection of individuals and groups who are at high risk of mental ill health due to high and prolonged levels of psychological distress.

Recommendation 4: That measures are taken to ensure that Indigenous Australians have access to SEWB and primary mental health care services in accordance to need, and that these services are made universally available through Aboriginal Community Controlled Health Services.

Recommendation 5: That Indigenous researchers are resourced to further develop measures of SEWB; investigate important cultural idioms of non-specific distress; examine the cultural validity of non-specific psychological distress; and the concept of resilience in Indigenous settings. Priority needs to be given to further identify the protective factors that have assisted Indigenous individuals, families and communities to survive multiple and widespread adverse life events over several generations. Developing appropriate Indigenous measures that adequately assess such factors would be an essential part of this research process.

Recommendation 6: That the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health* (AHMAC 2004) is implemented across the mental health system. To detect systemic discrimination, reporting should to adhere to the structure provided by the Aboriginal and Torres Strait Islander Health Performance Framework (HPF): mental health status and outcomes (Tier 1), Determinants of SEWB and mental health (Tier 2), and Mental Health System Performance (Tier 3) for Indigenous SEWB and mental heath service delivery, and this information is included as part of *HPF and Overcoming Indigenous Disadvantage* reports. See Appendix A.

Appendix A

Structure provided by the *Aboriginal and Torres Strait Islander Health Performance Framework* (AHMAC 2003):

Mental health status and outcomes (Tier 1)

Mental health conditions

- Prevalence of mental health conditions in Indigenous population.

Human function

- Indigenous disability due to mental health.
- Support services for Indigenous people with psychiatric disability.

Deaths

- Leading causes of Indigenous mortality due to mental health conditions.
- Avoidable and preventable Indigenous deaths due to mental health conditions.

Determinants of SEWB and mental health (Tier 2)

Socio-economic factors

- Indigenous access to housing.
- Employment for Indigenous people with a mental illness.
- Homelessness for Indigenous people with a mental illness.
- Per capita expenditure on Indigenous mental health services.

Community capacity

- Contact with the criminal justice system for Indigenous people with a mental illness and/or high level of psychological distress.
- Number of adverse life events reported by the Indigenous population.
- Child protection orders for Indigenous families with a mental illness and/or high level of psychological distress.
- Level of psychological distress (Kessler score) within the Indigenous population.
- Number of mental health awareness programs implemented in Indigenous community settings.

Mental health risk behaviours

- Indigenous tobacco use; drug and other substance use; high risk alcohol consumption; regular exercise.
- SEWB and mental health services for Indigenous people in justice system.

Mental health system performance (Tier 3)

Effective/appropriate/efficient

- Numbers of psychologists and other mental heath service providers to receive cultural competence training in the primary, and tertiary mental health care systems.
- Indigenous uptake of mental health related care in general practice.

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- Uptake of Medicare subsidised psychiatrist and allied health services by Indigenous people.

- Mental health and social and emotional wellbeing Service Activity Reports in Aboriginal Community Controlled Health Organisations.

- Chronic mental illness management in Indigenous people.

Responsive

- Numbers and proportions of Indigenous people discharged against medical advice.

- Proportion of mental health services in regional and remote areas which have implemented the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health.

- Proportion of mental health services which include Indigenous consumers and carers in governance arrangements.

Accessible

- Proportion of Indigenous people in client base.

- Indigenous access to SEWB services in Aboriginal Community Controlled Health services compared to need.

- Number of Indigenous SEWB counsellors/workers employed in Aboriginal Community Controlled Health services.

- Number of psychologists providing services in Aboriginal Community Controlled Health services.

- Geographic distribution of mental health workforce and number per 100,000 Indigenous population.

- Admitted Indigenous patients for mental-health related care: specialist and non-specialist care.

- Emergency department presentations of Indigenous people with a mental illness.

Continuous

- Indigenous access to after hours SEWB and primary mental health care.

- Indigenous presentations and average waiting times in emergency departments.

- Community follow up for Indigenous people within the first seven days of discharge from hospital.

- Indigenous readmissions to hospital within 28 days of discharge.

Safe

- Preventable Indigenous deaths due to mental health conditions.

- Amenable Indigenous mortality due to mental health conditions.

- Indigenous suicides in inpatient units, suicides while on day leave, absent without leave, and in the days and weeks immediately following discharge.

- Legal status of Indigenous admissions (involuntary admissions).

Capable

- Numbers and proportion of generalist heath providers trained to increase awareness of Indigenous SEWB issues and the management of high levels of psychological distress in Indigenous people.

- Cultural competence training is a requirement for mental health services to achieve accreditation under the National Mental Health Standards.

Sustainable

- Expenditure on Indigenous SEWB and mental health services compared to need.

- Training, recruitment and retention of Indigenous SEWB workers/counsellors, psychologists, psychiatrists and mental health nurses.

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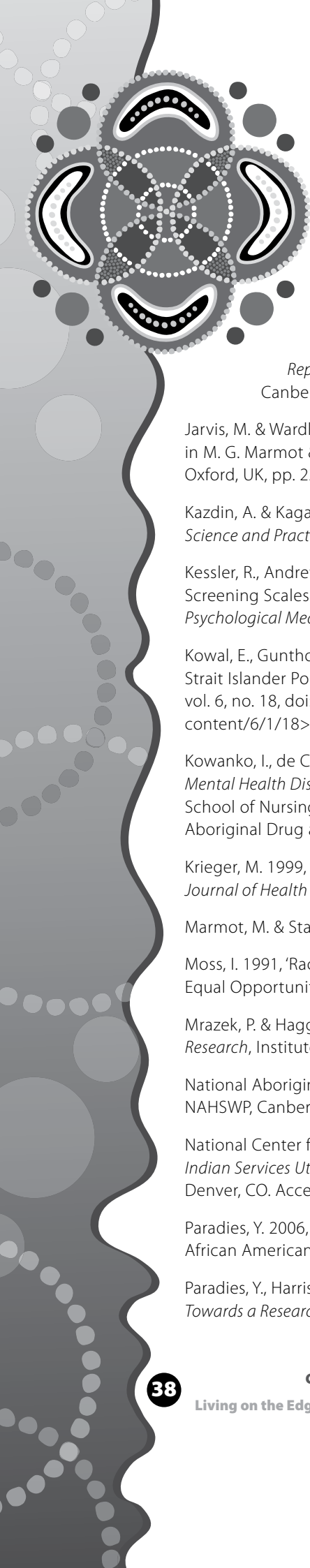
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Cooperative Research Centre for Aboriginal Health • Discussion Paper Series: No. 10

Living on the Edge: **Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People**

Discussion Paper Series

The Cooperative Research Centre for Aboriginal Health (CRCAH) has instituted this Discussion Paper Series as a forum for its researchers, students and associates. The purpose of the DPS is:

- To make informed and evidence-based contributions to critical policy debates affecting the health of Aboriginal people.

- To disseminate the research findings of CRCAH researchers, students and associates quickly, without the delays associated with publication in academic journals, in order to generate comment and suggestions for revision or improvement.

- To provide CRCAH researchers, students and associates with an avenue to present preliminary documents, circulated in a limited number of copies and posted on the CRCAH website, intended to stimulate discussion and critical comment on the broad range of issues associated with the CRCAH research agenda.

- To allow CRCAH researchers, students and associates to draw out the key issues in Aboriginal health research through literature reviews and critical analyses of the implications for policy and practice.

Submission criteria

Submission to the Discussion Paper Series is open to all CRCAH researchers, students and associates working on either funded or in-kind CRCAH projects. The research findings in discussion papers may already have been presented at conferences or workshops, but generally will not yet have been published in journals. Authors should try to ensure that the discussion paper will be sufficiently different from any future journal article that they plan to write so as not to create a redundant publication.

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All discussion papers will be reviewed either by internal CRCAH reviewers or, where appropriate, external referees. The CRCAH's editorial committee will assess the suitability for publication of all submissions and select reviewers for successful papers. Reviewers will include relevant scientific expertise, and representatives of governments and the Aboriginal health sector.

Feedback

The Discussion Paper Series is intended to promote the rapid dissemination of research results prior to publication; comments submitted directly to the authors are therefore welcomed. However, as results are often provisional any citation should take account of this.

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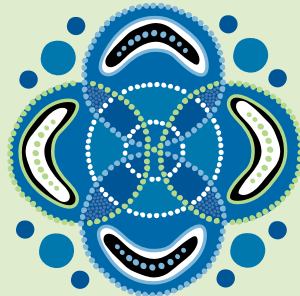
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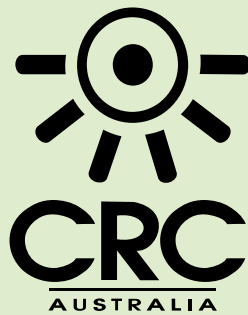
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