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Social Determinants of Aboriginal and Torres Strait Islander Social and Emotional Wellbeing

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OVERVIEW

This chapter explores current understandings of the determinants of Aboriginal and Torres Strait Islander social and emotional wellbeing (SEWB) and its development. We show that the determinants of this wellbeing are multiple, interconnected, and develop and act across the life course from conception to late life, all of which influence the expression of positive or negative wellbeing. This chapter discusses those determinants that prompt, facilitate or constrain social and emotional wellbeing in all individuals. It then discusses a range of risk factors identified by Aboriginal and Torres Strait Islander peoples as specifically influencing or determining the development and expression of their wellbeing. Importantly, the chapter focuses on those determinants, or combination of determinants, that increase the likelihood of poor outcomes for Aboriginal and Torres Strait Islander people—the risk factors as well as those that promote or protect positive wellbeing, and the unique protective factors contained within Indigenous cultures and communities that serve as sources of strength and resilience. Finally, it shows that the risk and protective factors impacting on the wellbeing of Aboriginal and Torres Strait Islander people differ in important ways from mainstream concepts of 'mental health' and the experiences of other Australians.

INFLUENCES ON THE DEVELOPMENT OF SOCIAL AND EMOTIONAL WELLBEING

What do we, as health practitioners, policy-makers and community and government agencies need to do to improve the social and emotional wellbeing of Aboriginal Australians? What do we do to promote and protect the development of optimal social and emotional wellbeing and to prevent or reduce the development of poor social and emotional wellbeing? To begin to address this question, it is necessary to have an understanding of the determinants of social and emotional wellbeing.

The Social Health Reference Group for the National Aboriginal and Torres Strait Islander Health Council and National Mental Health Working Group (2004) responsible for developing the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2004–2009* draws an important distinction between the concepts of 'social and emotional wellbeing' used in Aboriginal and Torres Strait Islander 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. (Social Health Reference Group, 2004, p. 9)

Most determinants do not occur in isolation from others. Many occur together and many accumulate as time goes on. The timing, intensity and duration of determinants and the presence or absence of protective factors are likely to influence the level of social and emotional wellbeing experienced at any point in time. The determinants of 'mental health' are generally accepted 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 (Commonwealth Department of Health and Aged Care, 2000).

The development of social and economic wellbeing can be prompted, facilitated and constrained by several key mechanisms that modify its determinants. The term *prompts* refers to those mechanisms that require or cause development in wellbeing to occur at particular times or in response to specific circumstances. *Facilitators* are those factors that assist, or make easier, the growth, establishment, elaboration and maintenance of wellbeing. *Constraints*, not surprisingly, inhibit, delay or prevent the development of wellbeing (Zubrick et al., 2005).

Prompts for the development of social and emotional wellbeing

The three major prompts of optimal social and emotional wellbeing are biology, expectations and opportunities.

Biology

Key biological processes form an important determinant of social and economic wellbeing. Biology prompts development in the form of milestones—crawling, walking and talking—and it prompts physical development and sexual maturation during early adolescence.

Expectations

The social and emotional capacities in children are prompted by parent/carer expectations about the capacities of their children. Carers have expectations about the development of their children, some of which are explicitly acknowledged and others of which are not. These expectations come in the form of carer values, attitudes and beliefs. Some of these are revealed in the encouragement given when parents respond to a child's first steps or words—or when they express concern about delays in these milestones. Other expectations are revealed in requests, demands and rules that govern such things as picking up after yourself, cleaning your room, making your bed, doing chores, doing your homework, reporting in, being home on time and being polite. Evidence shows an important relationship between carer expectations in the form of their parenting styles and practices and the wellbeing of their children (Zubrick et al., 2005).

Opportunities

The social, emotional and cognitive development of children is promoted by the opportunities they have to engage in stimulating activities. Providing opportunities to talk, play, interact and read, particularly for very young children, can have significant onward developmental benefits for the child, in the form of both improved academic achievement and improved social and emotional capacities (Loeb et al., 2004; Smith et al. 1997).

Facilitators of social and emotional wellbeing

The three major facilitators of optimal wellbeing in children and young people are intellectual flexibility coupled with an outgoing, easy temperament; good language development; and emotional support, especially in the face of challenge.

Intellectual flexibility

Social and economic wellbeing is facilitated by intellectual flexibility and an outgoing personality, easy temperament and tolerance of new situations (Werner, 1992).

Good language development

Good speech and language functioning is associated with physical health and wellbeing. Children with poor speech are at high risk of clinically significant emotional or behavioural difficulties relative to those children who do not have problems with speech. While there is an obvious association of hearing with speech (Zubrick et al., 2004), speech problems increase the risk of clinically significant emotional or behavioural difficulties (Zubrick et al., 2005).

Emotional support

Some examples of emotional support include encouraging young children to explore, to celebrate developmental milestones, providing guided rehearsal and extension of new skills, and protection from inappropriate disapproval, teasing or punishment (Ramey, 1998). Most parents want their children to succeed and generally protect them from excessively adverse experiences. For many children, parental encouragement in the face of difficulty, support in failure, and celebration of success are critical facilitators of their social and emotional wellbeing (Silburn & Walker, 2008).

Constraints on the development of social and emotional wellbeing

The four main constraints on optimal wellbeing in children and young people are stress that accumulates and overwhelms, chaos, social exclusion (including racism), and social inequality.

Stress

Stress is defined as 'environmental circumstances or conditions that threaten, challenge, exceed or harm the psychological or biological capacities of the individual' (Grant, 2003, p. 448).

Chaos

As Zubrick et al. (2005 p. 559) note:

> [I]n 1996 Bronfenbrenner and colleagues reviewed what they termed 'growing chaos' in families, schools, unsupervised peer groups and other settings in which children and young people spend extended periods of time. They noted the damaging and disorganising effects of frenetic activity, lack of structure, unpredictability in everyday activities and high levels of ambient stimulation on the development of social and emotional capacities in children (Bronfenbrenner & Evans, 2000).

Not only do such contexts disrupt social and emotional wellbeing, but they have the potential to establish alternative developmental processes that lead to poor outcomes (Evans, 2002). Chaotic systems disrupt attachment, emotional regulation and autonomy (Ackerman et al. 1999). Violence is a prime example of a disorganising influence on human development. Abuse, physical punishment, harsh parenting, bullying and other forms of harassment are harmful to human development and may be particularly damaging for individuals who are vulnerable to such harm (Collins et al., 2000; Zubrick et al., 2005).

Social exclusion

Social exclusion is a powerful disrupter of the development of social capacities in both children and adults because it restricts access to opportunities and choices to participate socially, economically and civically (Zubrick et al., 2005). Social exclusion operates across all levels from system-wide neglect through to interpersonal interactions. Zubrick et al. show how

social exclusion can take many forms ranging from racism and vilification to bullying and more subtle experiences that entail refusals of friendship and non-recognition, all of which constrain wellbeing. These actions also span multiple settings and occur at home, at school, in the workplace, and in day-to-day social exchanges and transactions. Such experiences have the potential to establish reciprocal patterns of socialisation that weaken individual capacities, disrupt social cohesion and alienate groups.

There is good evidence that racial discrimination is associated with a range of adverse health conditions including poor physical and mental health (especially depression and anxiety) as well as unhealthy behaviours such as smoking, alcohol and drug use (Paradies, 2006; Williams & Mohammed, 2009). Racism has been identified as a determinant in its own right (Paradies, 2006; Paradies et al., 2008) and is discussed in greater detail below.

With respect to addressing social exclusion at system-wide level, governments have a duty, through legislation and regulatory frameworks, to minimise or prevent actions that result in the unjust exclusion of individuals or groups within the Australian population from participation in social, economic and civic life, and to support mechanisms that promote access and equity (Zubrick et al., 2005).

Relative to colonisation, it is only recently that governments have acted on that duty to provide Aboriginal Australians with a legal framework to address the fundamental aspects of social exclusion affecting them. Over the past 50 years a series of laws and judgments have played a central role in both recognising the existence of Aboriginal people before colonisation, and asserting their rights of participation and ownership. Examples include:

- the 1967 Constitutional Referendum granting the Commonwealth concurrent power to make laws for Aboriginal people wherever they lived, as well as to allow Aboriginal people to be included in the national census

- the *Aboriginal Land Rights (Northern Territory) Act 1976* which recognised Aboriginal people in the Northern Territory have rights to land based on their traditional occupation

- the 1992 Mabo judgment in which the High Court recognised that Aboriginal and Torres Strait Islander people's occupation of and 'native title' to their land survived the Crown's annexation of Australia in 1788

- the 1996 Wik Case which determined that the granting of a pastoral lease did not necessarily extinguish all native title rights and interests that might otherwise exist (Reynolds, 1998; Zubrick et al., 2005).

Racism

After accounting for a range of other contributing factors, racism has been significantly associated with poor self-assessed health status, psychological distress, substance use and attempted suicide among Indigenous Australians (Paradies et al., 2008; Zubrick et al., 2005).

There are four main pathways through which racism can affect ill health: reduced access to the societal resources required for health (e.g. employment, education, housing, health care); negative self-esteem and self-worth leading to mental ill health; stress and negative emotion reactions which lead to mental ill health as well as affecting the immune, endocrine and cardiovascular systems; and maladaptive responses to racism such as smoking, alcohol and other drug use (Paradies et al., 2008).

There is strong evidence that systemic racism leads to reduced opportunities to access societal resources required for health. While there is little research that quantifies the health effects of systemic racism, Paradies et al. (2008) identified several studies in Australia which suggest that racism impacts on health care delivery. For instance Indigenous Australians are three times less likely to receive kidney transplants than other Australians with the same level of need (Cass et al., 2004; Paradies et al., 2008).
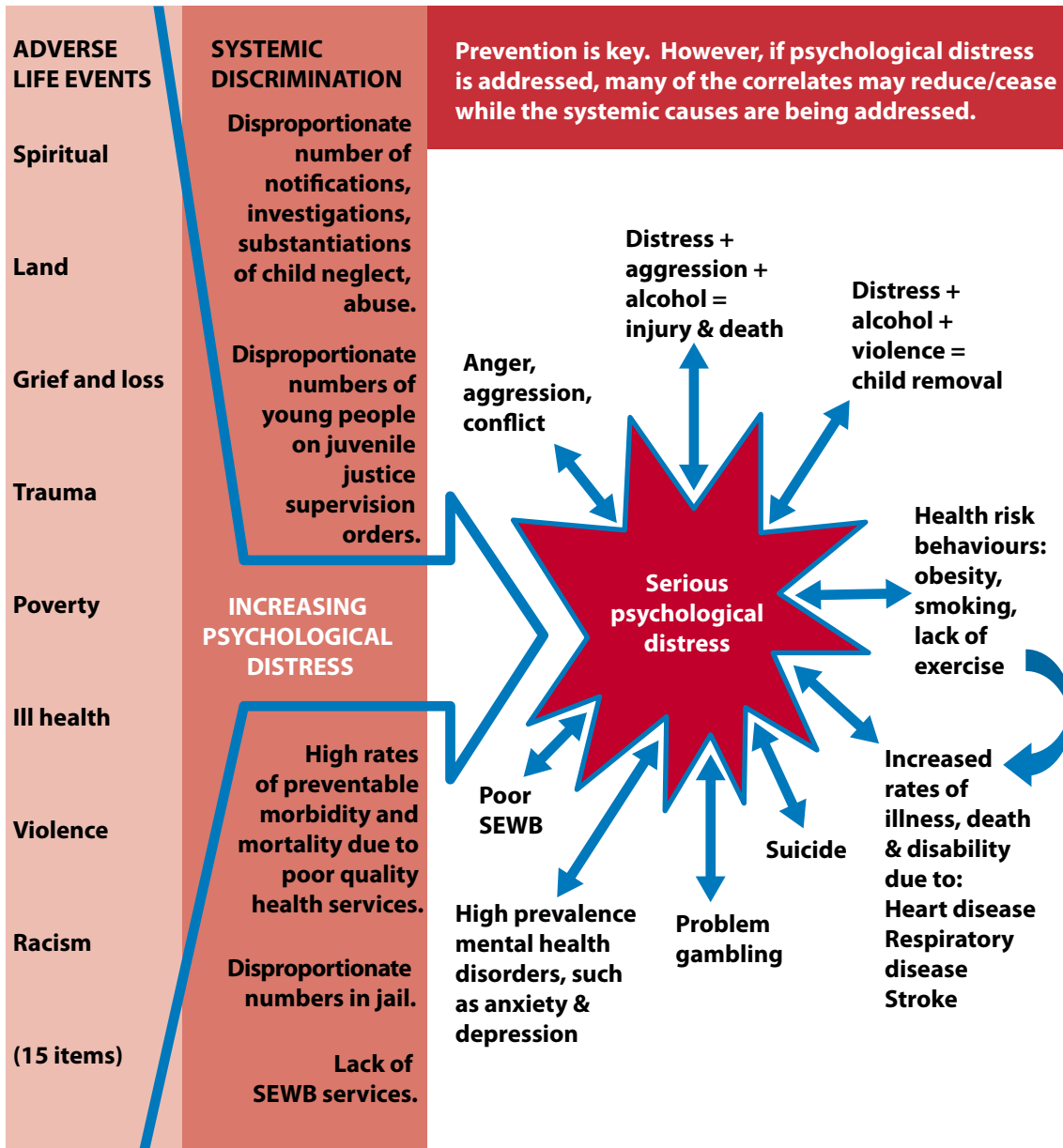
In addition, several studies provide good evidence that self-reported racism is associated with a range of adverse health conditions. After accounting for the effects of other contributing factors, racism was significantly associated with poor self-assessed health status, psychological distress, diabetes, smoking and substance use in the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) (Paradies, 2007), and with depression, poor self-assessed health status and poor mental health in the Darwin Region Urban Indigenous Diabetes (DRUID) study (Paradies, 2006). Analysis of the DRUID study indicated that racism explained a third of the prevalence of depression and poor self-assessed health status among Indigenous Australians (Paradies, 2006). A study in a rural Western Australian town demonstrated that racism was associated with reduced general physical and mental health after accounting for age, gender, employment and education (Larson et al., 2007). Racism was also associated with increased smoking, marijuana use and alcohol consumption in the West Australian Aboriginal Child Health Survey (WAACHS), after accounting for the effects of age and gender (Zubrick et al., 2004).

There is some preliminary evidence from the DRUID study that the effects of interpersonal racism on Indigenous health are mediated by acute and chronic stress and a lack of control over one's life (Paradies, unpublished data). These findings highlight the particular need to understand the role played by acute and chronic stress in the relationship between racism and ill-health (Ahmed et al., 2007; Paradies, 2007).

Social inequality

Social inequality results in the unequal distribution of, and access to, resources required for the development and social and emotional wellbeing of adults and children. These resources include human, psychological and social capital resources as well as income and wealth. This inequality may arise from inadequacies in the laws and regulations for the redistribution of wealth and social benefit, differences in the use and accumulation of wealth by individuals and groups, and lack of access to the means for generating these resources by some groups relative to others (Zubrick et al., 2005). Several studies have demonstrated the relationship between social inequality and developmental outcomes (Keating & Hertzman, 1999; Marmot et al., 1991; Wilkinson, 1999). As specific groups experience the effects of social inequality—lack of resources and lack of access to services and diminished self-efficacy—there is potential for their stores of human, psychological and social capital to decrease, thereby concentrating the risks both within and across contexts for particular groups and sub-populations. Social inequality has been a persistent feature of innumerable reports in which the circumstances of Aboriginal people are compared to those of the majority population. Findings from the WAACHS highlight the extent of social inequality affecting families with Aboriginal children (Zubrick et al., 2004). Along with the other constraints on development, social inequality poses a substantial barrier to effective gains in improving the physical health and the social and emotional wellbeing of Aboriginal children and young people.

In summary, this section has detailed the prompts, facilitators and constraints in the development of social and emotional wellbeing (see Figure 6.1). As well as increased exposure to life events with the potential to cause psychological distress, there are additional dimensions of Aboriginal and Torres Strait Islander wellbeing that differ when compared to other Australians. Generally, at an individual level, Aboriginal and Torres Strait Islander wellbeing will depend on the balance between the number of stressors experienced and the capacity to cope—those who are psychologically overwhelmed or unable to cope effectively are more likely to exhibit higher levels of psychological distress. Psychological distress indicates that an individual's wellbeing is under threat, regardless of whether the source is neurological, physiological, social, cultural, spiritual, religious, or economic (Kelly et al., 2009).

ADVERSE LIFE EVENTS	SYSTEMIC DISCRIMINATION	
Spiritual	**Prevention is key. However, if psychological distress is addressed, many of the correlates may reduce/cease while the systemic causes are being addressed.**	

ADVERSE LIFE EVENTS

Spiritual

Land

Grief and loss

Trauma

Poverty

Ill health

Violence

Racism

(15 items)

SYSTEMIC DISCRIMINATION

Disproportionate number of notifications, investigations, substantiations of child neglect, abuse.

Disproportionate numbers of young people on juvenile justice supervision orders.

INCREASING PSYCHOLOGICAL DISTRESS

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

Disproportionate numbers in jail.

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.

Distress + aggression + alcohol = injury & death

Distress + alcohol + violence = child removal

Anger, aggression, conflict

Health risk behaviours: obesity, smoking, lack of exercise

Serious psychological distress

Poor SEWB

High prevalence mental health disorders, such as anxiety & depression

Problem gambling

Suicide

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

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

Figure 6.1: Factors that contribute to serious psychological distress and its outcomes

The challenge for mental health practitioners, policy-makers and service providers is to identify and implement culturally secure, context-specific strategies that are designed to recognise and reduce the impact of cumulative and overwhelming stress, developmental chaos, social exclusion and social inequality. This includes strategies that foster interagency cooperation and enhance cultural competence at the system, organisational and individual/practitioner levels as discussed in Chapter 12.

We now consider some specific determinants that evidence shows to be related to the development of social and emotional wellbeing.

RISK AND PROTECTIVE FACTORS

Risk and protective factors for 'mental health' at an individual level 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.

There is ample evidence to show that many Aboriginal and Torres Strait Islander people experience the interrelated and cumulative effects of a set of risk factors that impact negatively on their social and emotional welfare. Single risk factors, such as particular negative life events, might have a minimal effect on their own, but when combined can have a strong interactive effect, and exposure to multiple risk factors over time can have a cumulative effect (Kazdin & Kagan, 1994). Additional risk factors are unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage (Social Health Reference Group, 2004).

Protective factors can be effective by reducing the exposure to risk, or compensatory, by reducing the effect of risk factors (Rutter, 1985). Aboriginal and Torres Strait Islander cultural concepts such as connection to land, culture, spirituality, ancestry and family and community are commonly identified by Indigenous Australian people as protective factors, which 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 (see Figure 6.2). For Aboriginal and Torres Strait Islander people, these factors can serve as a unique reservoir of strength and recovery when faced with adversity (Kelly et al., 2009).
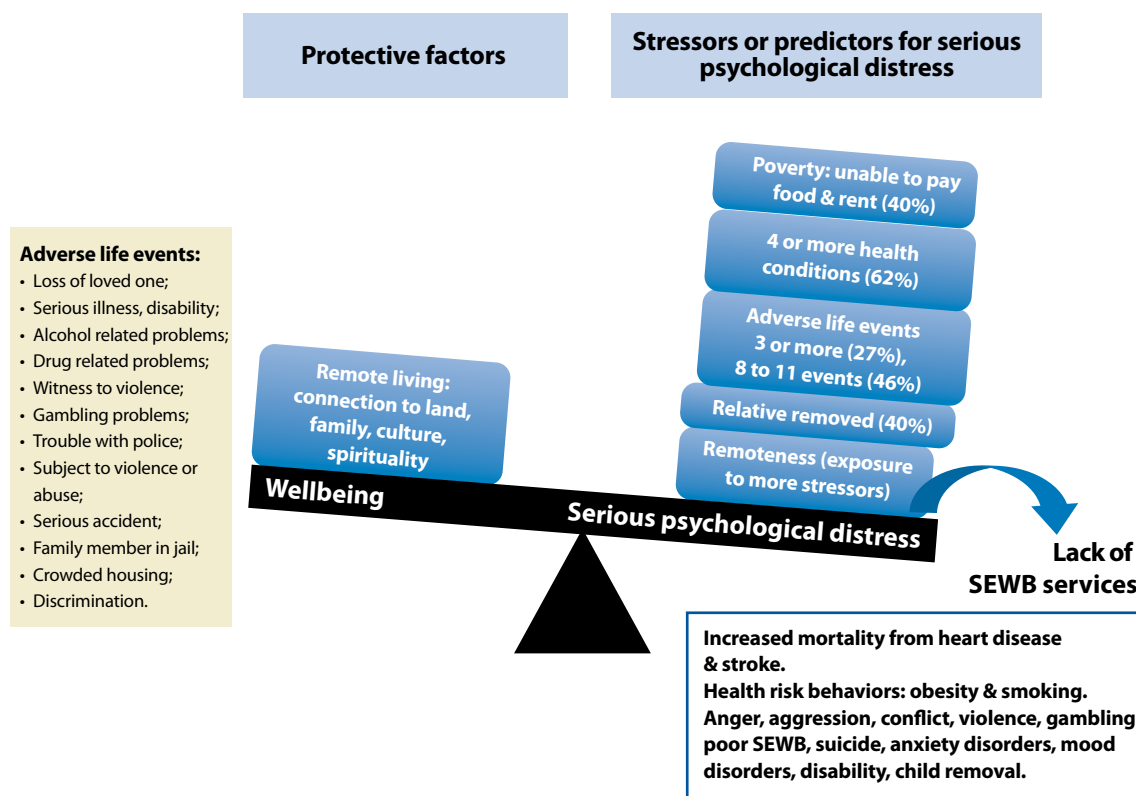
© Australian Indigenous Psychologists Association   Source: National Aboriginal & Torres Strait Islander Health Survey 2004-05

Figure 6.2: Risk and protective factors for serious psychological distress

Risk factors on Aboriginal and Torres Strait Islander wellbeing

This section considers some of the evidence that links specific risk factors to Aboriginal and Torres Strait Islander people's social and emotional wellbeing. In describing how these factors differ from mainstream concepts of 'mental health' and experiences, there is a risk that such evidence may be used in ways that disempower rather than empower Aboriginal Australians, and if presented in the wrong context may actually reinforce negative perceptions.

Many of the factors that Aboriginal and Torres Strait Islander people identify as impacting on their wellbeing are examples of systemic or institutional discrimination, which occurs when policies and procedures, or laws, serve to disadvantage specific groups or limit their rights

(Krieger, 1999). While often viewed as neutral and sometimes acceptable, the application of beliefs, values, structures and processes by the institutions of society (economic, political, social) 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. The National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2004–05 reported that 11.6% of Aboriginal Australian respondents in urban areas and 13% in remote and very remote areas experienced 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 rather the results of their actions.

National evidence shows that stressful life events or conditions can adversely affect the lives of individuals, families and communities. In some instances, an adverse event has the potential to have an ongoing impact on an individual's capacity to live a satisfying and productive life or the family's capacity to operate as a fully functioning unit. Participants in the NATSIHS were asked to select from 15 possible stressors or adverse life events which had impacted on them, their families or friends in the previous 12 months. Stressors included serious illness or disability; serious accident; death of a family member or close friend; divorce or separation; not able 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.

This section discusses relevant data pertaining to Aboriginal and Torres Strait Islander people's social and emotional wellbeing from the NATSIHS 2004–05, the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) 2002, and the 2006 and 2008 Overcoming Indigenous Disadvantage Reports—which draw from a range of national and jurisdictional data collections—and aligns or integrates these findings with *Aboriginal and Torres Strait Islander-identified determinants* of social and emotional wellbeing. These additional Aboriginal and Torres Strait Islander-identified risk factors include widespread grief and loss, child removals, unresolved trauma and cultural dislocation and identity issues. These determinants of wellbeing highlight how the cumulative and interrelated effects of determinants such as family violence, substance use/abuse and mental health disorders impact negatively on other aspects of life. Together these various findings create a composite picture of the risk factors influencing poor wellbeing. These are manifested in a range of conditions from anxiety and depression, through to serious psychological distress, depending on the frequency and intensity and range of stressors experienced by an individual or family or community as well as the existence of protective factors.

Aboriginal and Torres Strait Islander-identified risk factors to wellbeing

Aboriginal and Torres Strait Islander people 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 ranged from two to five times greater for Aboriginal and Torres Strait Islander respondents. Some events, such as losing a loved one, impacted on nearly half of all Aboriginal and Torres Strait Islander respondents. While Aboriginal and Torres Strait Islander people were at higher risk than other Australians for all stressors across all geographic areas, risk exposure increased for certain events where respondents lived in urban or remote locations. The majority of Indigenous adults (77%) reported experiencing at least one stressor in the 12 months before the survey. Most Indigenous respondents reported one to three stressors, with an overall average of 2.6 stressors, and 27% had four or more life stressors to cope with in the previous year (AIHW, 2009).

Widespread grief and loss

The survey findings confirm that grief and loss was the largest single factor to impact on the wellbeing of Aboriginal and Torres Strait Islander people. Many deaths involving infants, children, young adults, and men and women in their prime were sudden, unexpected and preventable and therefore very traumatic. Extended family networks serve to extend grief across

communities and regions, and the funeral costs deplete the financial reserves and resources of family networks. The NATSIHS 2004–05 found that almost half of Indigenous adults (47%) had lost a family member or friend in the last 12 months and almost half of (47%) Indigenous adults had attended a funeral in the last 12 months, 2.4 times the rate for other Australians (ABS, 2004).

Child removals and unresolved trauma

The NATSIH Survey 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. the Stolen Generations). Eight per cent reported they had been taken away and 43% reported that a relative had been taken away. Relatives most commonly removed from the family were grandparents (44%), followed by parents (28%) or aunties or uncles (27%). A lower proportion of those who had been removed from their natural family reported positive wellbeing (resilience) compared with those who had not been removed.

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.

Cultural dislocation and identity issues

The NATSIH Survey 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% of these were living on their own lands. About 38% of Aboriginal and Torres Strait Islander respondents living in urban areas reported that they did not know the location of their traditional country.

Economic and 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 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% 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. Overcrowding at home was reported by 17% of respondents and was highest in remote and very remote areas (29%) (AIHW, 2008).

Physical health problems

Serious illness or disability affected 28% of Indigenous respondents and was highest (30%) in major cities. Overall, only 19% of respondents did not report a serious illness likely to last six months or more, with 18% reporting one condition, 30% reporting two or three conditions, and 33% reporting four or more long-term health conditions. Indigenous adults were hospitalised at six times the rate of other Australians for conditions usually managed in the primary care setting, for example by GPs (AIHW, 2008). This 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.

Incarceration

Aboriginal and Torres Strait Islander individuals, families and communities were 13 times more likely than other Australians to be, or have a family member, sent to jail or already incarcerated. The risk of incarceration was increased by a history of being removed from natural family, being a victim of violence, and receiving treatment for mental illness (AIHW, 2008). Some 19% of respondents reported having a family member sent to jail, or currently in jail, with a higher proportion (25%) in remote areas.

A study which examined the factors that underpin Aboriginal and Torres Strait Islander 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, had not completed Year 12, were unemployed, experiencing financial stress, living in an overcrowded household, or were a member of the Stolen Generations (Weatherburn et al., 2006). The two most important factors related to Aboriginal and Torres Strait Islander prosecution and imprisonment were high-risk alcohol consumption and illicit drug use, with those living in remote areas more likely to be imprisoned.

Child removal by care and protection orders and juvenile justice supervision

Across Australia, nearly one in 10 Aboriginal and Torres Strait Islander families were subject to investigations about how they cared for their children—a rate four times greater than that of other families. The proportion of Aboriginal and Torres Strait Islander children aged 0–17 years on care and protection orders was 41 per 1000, seven times higher than other children (AIHW, 2008). The most common reasons given for removal were parental substance abuse, mental health issues and family violence (AIHW, 2008).

Young Aboriginal and Torres Strait Islander people aged between 10 and 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 Aboriginal and Torres Strait Islander young people per 100,000 population compared to 16 others (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 overrepresented in families that come into contact with child protection and support services.

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, p. 862). Males and females were eight and 35 times more likely to be hospitalised for injuries due to assault as other males and females, respectively. Indigenous Australians died from assault at 10 times the rate of other Australians (AIHW, 2008). Most (63%) Indigenous homicide victims had been killed by intimate partners or family members, compared to 45% of other Australian 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% of Indigenous deaths due to assaults: all of these were associated with psychoactive substance use.

Family violence

The survey findings suggest that family violence, substance use/abuse and mental health disorders increase the risk of hospitalisation, death or incarceration and of children being removed on protection orders. The implications of domestic violence on Aboriginal wellbeing and approaches to assisting people are explored in the next section. Fifty per cent of Aboriginal Australian women hospitalised for assault were victims of family violence, compared to one in five for males (AIHW, 2006). Spouse or partner violence accounted for 82% of female admissions for family violence. Almost a third of Indigenous hospitalisations for family violence-related assaults had an additional diagnosis of mental disorders (31%). The most common type of mental disorder for Indigenous Australians hospitalised for family violence-related assaults was associated with psychoactive substance use (29%).

Some 15% of Aboriginal and Torres Strait Islander adults reported witnessing violence in the last 12 months; 10% reported being subject to abuse or being a victim of violent crime and 20% being a victim of physical or threatened violence in the last 12 months (AIHW, 2008).

Substance use/abuse

The links between alcohol and substance use are discussed in detail in Chapter 9, so are only briefly covered here. The NATSIHS 2004–05 found that more than half of Aboriginal and Torres Strait Islander respondents reported they had not drunk any alcohol in the previous week, and over 80% of respondents reported they had not drunk alcohol at risky/high-risk levels in the last 12 months (AIHW, 2008). Alcohol-related problems impacted on 20% of respondents, and drug-related problems were reported by 16.4% of Aboriginal and Torres Strait Islander respondents. The proportions of Aboriginal and other Australians who engaged in long-term risky use of alcohol were similar. However, despite the similar prevalence of high-risk alcohol use, Aboriginal Australians who had used or abused alcohol appeared to be exposed to a range of risks negatively impacting on their wellbeing. For example, Aboriginal 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, p. 896).

Protective factors for Aboriginal and Torres Strait Islander wellbeing

Protective factors can reduce the exposure to risk, or may reduce or ease the effect of risk factors (Rutter, 1985). 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 (see Figure 6.2).

Little work has been done to identify the factors that have helped Aboriginal and Torres Strait Islander people to survive several generations of trauma and extreme disadvantage. Aboriginal and Torres Strait Islander people have been forced to rely on each other, and the cultural, spiritual and other forms of support that are an integral part of the oldest continuous cultures on earth, to manage wellbeing in individuals, families and communities. More work is needed to identify the protective factors known by Indigenous people as part of wellbeing knowledge. Certainly, the interdependent nature of family, kinship and community connectedness found in many Indigenous communities appears to offer some protection and warrants further examination.

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 & Marmot, 2003). Cultural identification and the reciprocal relationships that underpin Indigenous cultures would offer some protection against the ravages of multiple stressful events.

Connection to land, culture, spirituality and 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 people's beliefs about mental, social and emotional wellbeing:

> 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 and 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)

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

influence of the homelands on health in central Australia shows an association between connection with land and lower prevalence of diabetes, hypertension and obesity, and lower mortality and hospitalisation rates (Rowley et al., 2008).

Sense of wellbeing and resilience

Despite multiple levels of disadvantage, the majority (71%) of Indigenous respondents to the NATSIHS 2004–05 reported being a 'happy person' all or most of the time; 56% reported they felt 'calm and peaceful' all or most of the time, and 55% felt 'full of life' all or most of the time during the previous month. Interestingly, there were marked differences between the responses to the wellbeing measures of Indigenous respondents in non-remote areas and those living in remote areas; a greater number of respondents in non-remote areas reported feeling none of those positive feelings in the past month.

The survey suggests that, despite a higher proportion of Indigenous respondents in remote areas reporting more negative life events, living in remote areas on, or near, traditional lands appears to mitigate the effects of the negative risk factors on people's wellbeing. That is, remote living appears to improve resilience. Another possible explanation for differences in wellbeing in urban and remote Indigenous respondents is the concept of 'minority stress'. Aboriginal and Torres Strait Islander people living as dispersed minorities in urban areas are likely to experience racism and discrimination differently from those living in small communities where they form the majority, rather than the minority, of the population. There is a need to investigate the concept of resilience in diverse Indigenous settings.

Self-determination, community governance and cultural continuity

The effective functioning of communities plays a critical role in supporting the economic and social wellbeing of families and children. Good community leadership and governance is well recognised as a primary driver of human development in Aboriginal communities. Failures in community governance, on the other hand, have been associated with catastrophic social dysfunction such as endemic alcohol abuse and family violence (Fitzgerald, 2001). The maintenance of Aboriginal self-determination consistent with traditional cultural practices and values is another important driver of social functioning and human development, as evident in a number of studies of Indigenous communities in the USA and Canada. For example, a study of variations in youth suicidal behaviour among First Nations communities across British Columbia's communities demonstrated that suicidal behaviour was dramatically lower in communities which had taken active steps to preserve and rehabilitate their own cultures, languages and traditional practices (Chandler, 1998). This highlights the importance for communities of maintaining cultural beliefs and traditional practices that assist people, especially young people, to maintain their sense of personal continuity and cultural identity in the face of rapid developmental and cultural change.

In terms of social determinants of Indigenous people's social and emotional wellbeing, priority needs to be given to further identifying the types of protective factors that have assisted Indigenous individuals, families and communities to survive multiple and widespread adverse life events over several generations. Moreover, developing appropriate Indigenous measures that adequately assess such factors would be an essential part of this research process.

CONCLUSION

This chapter has examined the complex array of environmental, social, economic, cultural and historical factors that influence and determine the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. These include negative life events such as 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. We have also identified some of the unique protective

factors that have contributed to the resilience of Indigenous people and communities, and that underpin wellbeing.

It is important to be able to identify and counteract some of the sources of stress that Indigenous people identify as impacting on their wellbeing. More than anything, an examination of the determinants of Indigenous people's wellbeing shows that quick-fix solutions do not exist. Instead, interventions need to target the reduction of risk factors (including pervasive systemic discrimination), increase protective factors across a number of domains and be based on the best available evidence. The development and support of ongoing culturally appropriate SEWB programs and commitment to culturally competent organisations and practitioners will help to close the current gap in wellbeing between Indigenous and non-Indigenous Australians. However, for substantial and long-lasting changes to be made, a long-term commitment throughout the community and government sectors is also required.

Reflective exercises

1   **Consider and discuss the viewpoints below.**

Viewpoint One: One of the things about social determinants is that they are never really useful when working at an individual level. That is, for those incarcerated as a result of systemic discrimination, interventions for individuals are the same, regardless of how they got there. Also, telling someone that it is 'unfair' they are in jail (for example) will not help them in any way once they are there. So prevention is better than cure and population-level interventions are better than individual-level interventions when dealing with social determinants.

Viewpoint Two: It is important for all practitioners to be cognisant of how the complex array of social determinants may impact on their clients at an individual or community level. For instance, a practitioner may be dealing with a client in a particular setting for a range of complex reasons discussed in the chapter that they may not have previously understood or taken into account, and that might signal the need for strategies to support a person differently. For non-Aboriginal practitioners, understanding the social determinants at a system level may actually influence or transform the way they interact with people at an individual level: the degree of compassion they have, and the tacit values and prejudices that influence their practice.

Discuss the viewpoints above—do you agree/disagree? Consider the implications for your practice for clients.

2   **Exercise**

A study which analysed responses to the NATSISS 2002 to determine the economic and social factors that 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. 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. The two most important factors 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, but those living in remote areas were more likely to be imprisoned (Weatherburn et al., 2006).

a   If you were a counsellor working in a prison, how could you use this information to design a program to prevent recidivism among Aboriginal and Torres Strait Islander prisoners? What factors would you try to influence during your program to make it less likely that your clients would end up back in prison?

b   If you were asked to implement a cultural awareness program for police, what information would you present to try to reduce the high rates of imprisonment of Aboriginal and Torres Strait Islander people?

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