Key directions for a social, emotional, cultural and spiritual wellbeing population health framework for Aboriginal and Torres Strait Islander Australians in Queensland

June, 2009

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Rural & Remote
Mental Health
QUEENSLAND

Executive Summary

This document provides key directions for a social, emotional, cultural and spiritual wellbeing framework relevant to Aboriginal and Torres Strait Islander Australians in Queensland. The aim of the document is to inform population level policy, program development and practice across the range of relevant sectors and agencies regarding key directions for development.

The document defines social, emotional, cultural and spiritual wellbeing (SESWB) and provides a strong rationale for focussing on this as the way to promote Indigenous health and wellbeing and reduce Indigenous disadvantage. The methodology for development of the document comprised input from a nationally recognised Expert Working Group.

A background to focussing on Indigenous SESWB is provided, including some pertinent demographic information and the relevant policy contexts – internationally, nationally and specifically for Queensland.

The conceptual framework adopted is the population health approach, which incorporates the Ottawa Charter for Health Promotion and is based on knowledge of the underlying influences of the social determinants of health. These translate into generic and unique risk and protective factors for Aboriginal and Torres Strait Islander Australians in Queensland.

To determine future directions for investment in promoting SESWB, the current evidence base is examined and shown to be severely limited. Consequently, discussion of what comprises appropriate evidence in this field and some principles of best practice to build the evidence base is provided.

Based on an understanding of the current state of evidence for SESWB, three key directions for future investment are described. These are:

- **Key Direction 1: Build Evidence**
  Devise a methodology to enable development of the evidence base to support informed decisions

- **Key Direction 2: Enhance Capacity**
  Build the capacity and sustainability of initiatives that support family and community wellbeing

- **Key Direction 3: Develop Workforce**
  Support development of the workforce needed to promote SESWB

For each key direction a rationale, examples of current initiatives, and recommended actions are detailed. It is argued that investing in these key directions and their corresponding actions will provide the best way forward to promote SESWB for Aboriginal and Torres Strait Islander Queenslanders at this point in time.

Contents

Introduction

Aim

This document summarises key directions for a social, emotional, cultural and spiritual wellbeing framework relevant to Aboriginal and Torres Strait Islander Australians in Queensland. The aim of the document is to inform population level policy, program development and practice across the range of relevant sectors and agencies regarding key directions for development.

Definition of social, emotional, cultural and spiritual wellbeing (SESWB)

Social and emotional wellbeing, or more recently, social, emotional, cultural and spiritual wellbeing (SESWB), is a term that has come to represent the Aboriginal and Torres Strait Islander holistic conception of health, mental health and wellbeing. The term attempts to encompass the Aboriginal and Torres Strait Islander extended conception of the self that involves a pattern of vital interconnections with others and the environment. The term recognises that achieving optimal conditions for health and wellbeing requires a holistic and whole-of-life view of health that encompasses the social, emotional, spiritual and cultural wellbeing of the whole community (AIHW, 2009).

> *"The Aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. Land is central to well-being. This holistic concept does not merely refer to the 'whole body' but in fact is steeped in the harmonised interrelations which constitute cultural well-being. These inter-relating factors can be categorised as largely spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill-health will persist."* (Swan & Raphael, 1995, p.13).

Rationale

Indigenous SESWB has been the focus of a wide range of initiatives over the last decade but with little to show in terms of well-documented evaluation (both for SESWB outcomes and in relation to other health outcomes). It has also become the focus of Indigenous suicide prevention initiatives which has been driven by the absence of an evidence base specific to suicide itself and because of its common-sense (but unproven) role as a mediating factor. SESWB has thus become the focus of interest for a range of sectors and institutions that relate to social policy, population health and mental health. There is a Commonwealth framework, *National Strategic Framework for Aboriginal Peoples' Mental Health Emotional Wellbeing 2004-2009*, which provides key strategic directions for action. However, this has not provided guidance in terms of where the evidence for intervention is strongest nor where the gaps in the evidence base are located that need to be addressed. It has not, as yet, significantly influenced coordination of programs and projects at the State level.

The current document draws on recent initiatives to define social, emotional, cultural and spiritual wellbeing amongst Aboriginal and Torres Strait Islander Australians and to inform population health practice in Queensland through identification of strategies that:

- facilitate comprehensive action including partnerships, sustainability and transferability;

- engage Aboriginal and Torres Strait Islander communities and partners in the planning, implementation and evaluation of interventions;

- improve community capacity and value Aboriginal and Torres Strait Islander culture, identity, safety and community responsibility; *and*

- address professional development and workforce capacity opportunities and issues.

Methodology

The methodology for the development of these key directions for a SESWB population health framework has comprised:

- Constitution of a nationally-recognised Expert Working Group with expertise in the relevant areas of population health, mental health, Indigenous health, suicide prevention, mental health promotion, and health policy. The role of this Expert Working Group was to provide oversight of the project, access to relevant information, and develop and prioritise the recommendations. Appendix 1 lists the membership of the Expert Working Group.

- A review of the literatures related to suicide and SESWB undertaken by the University of Queensland for this project, elements of which are incorporated in this report, the original documents being:

  ○ Krysinska, K., Martin, G., & Sheehan, N. (2009). *Identity, Voice, Place. A Framework for Suicide Prevention for Indigenous Australians in Queensland based on a Social and Emotional Wellbeing Approach.* Unpublished report by The University of Queensland for the Centre for Rural and Remote Mental Health Queensland, Cairns.

  ○ Sheehan, N., Martin, G., & Krysinska, K. (2009). *Sustaining Connection. A Framework for Aboriginal and Torres Strait Islander Community, Cultural, Spiritual, Social and Emotional Wellbeing in Queensland.* Unpublished report by The University of Queensland for the Centre for Rural and Remote Mental Health Queensland, Cairns.

- Development of this key directions document through consideration of the literature reviews, other key sources of information identified by the Expert Working Group, and direction from members of the Expert Working Group.

Background

The *National Mental Health Policy 2008* acknowledges Australia's Indigenous heritage. As the original peoples of this continent, the *Policy* attaches importance to the grounding and unique contribution of Aboriginal and Torres Strait Islander peoples' culture and heritage to our Australian nation. The *Policy* recognises Indigenous people's distinctive rights to status and culture, self-determination, and the land. It makes explicit that this recognition and identity are fundamental to the wellbeing of all Australians. It reflects the realisation of all Australians that mutual resolve, respect and responsibility are required to close the gap on Indigenous disadvantage and improve SESWB.

Aboriginal and Torres Strait Islander Australians live within historically-based endemic whole person and whole community disadvantage. In recent years, however, the political and policy environment for Aboriginal and Torres Strait Islander health and wellbeing has changed rapidly. Internationally, the *United Nations Declaration on the Rights of Indigenous Peoples* has contributed to recognition of the plight of Indigenous peoples worldwide and the actions needed to ensure survival (Hunter, Milroy, Brown, & Calma, in press). The *Declaration* also highlights the need to support self-determination and participation of Indigenous peoples and their rights to a distinct culture, language, and connection to homelands – all of which are necessary to improve SESWB.

In Australia, the *Apology* delivered by the Prime Minister, Kevin Rudd, on behalf of the nation and Australian peoples in February 2008, recognised the harm caused by the mistreatment of Indigenous Australians through the policies and practices of past governments of all persuasions, and their legacy for current and future generations. The *Apology* acclaimed the need for new solutions and approaches, as well as adherence to the principles of mutual respect, resolve, and shared responsibility in moving forward to a better future.

The announcement in February 2009 of the *Healing Foundation for Stolen Generations* to address the historical legacy of trauma and grief in Aboriginal and Torres Strait Islander communities is further evidence of the changing policy environment and increased commitment to addressing the complex array of factors contributing to the poorer health, wellbeing and life outcomes of Indigenous Australians. Asserting the imperative to 'close the gap' in infant mortality, life expectancy, education, employment, and life opportunities, the *Close the Gap* campaign (see www.closethegap.com.au) has prompted a bipartisan and whole-of-government approach to addressing Aboriginal and Torres Strait Islander disadvantage.

With recognition of the historical legacy and unique situation of Indigenous peoples in Australia and worldwide, the strength of survival, resilience of culture and family, and ongoing contribution of community to the future of Australia becomes apparent. This opens a doorway to respectful relationships through which it may be possible to address the very real burden of ill-health and disadvantage. In the National Mental Health Policy 2008, for the first time in national mental health policy, the unique status and contribution of Aboriginal and Torres Strait Islander Australians has been recognised prior to discussing their special needs, risk factors or high burden of illness. This reframing helps create a context for promoting a more positive, socially inclusive, strengths-based approach to the SESWB of Aboriginal and Torres Strait Islander Australians; it may also help create a space in which Aboriginal and Torres Strait Islander Australians may participate, as equals, in the debates and actions that are necessary to 'close the gap'.

Demographics

The estimated resident number of Indigenous Australians as at June 2006 was 517 200 people, including 463 900 Aboriginal people, 33 100 Torres Strait Islanders and 20 200 people identifying as both Aboriginal and Torres Strait Islander – altogether comprising 2.5% of the total Australian population (ABS & AIHW, 2008).

Twenty eight percent of Indigenous Australians (146 400 people) live in Queensland (3.6% of the population of the State) (ABS & AIHW, 2008). Based on the Remoteness Area classification, 26% of Indigenous Australians in Queensland live in major cities, 20% in inner regional areas, 32% in outer regional areas, 8% in remote and 14% in very remote areas (ABS, 2007).

Indigenous Australians face unique health challenges. Best available data indicate that overall mortality rates among Indigenous persons are almost three times higher than for non-Indigenous Australians, and there is a 17-year gap between life expectancy at birth for Indigenous and non-Indigenous males and females – 59 vs. 77 years and 65 vs. 82 years, respectively. (ABS & AIHW, 2008).

Geographical location has an impact on the health and welfare of Indigenous Australians. *The Baseline Report* (Partnerships Queensland, 2006) shows differences between the status of Aboriginal peoples and Torres Strait Islanders living in major cities, inner and outer regional, and remote/very remote locations, including health factors, disability, cultural strength, mortality, and family and community wellbeing. Overall, people living in Aboriginal Deed-of-Grant-in-Trust (DOGIT) communities in Queensland (these are largely ex-missions and government settlements that became DOGIT communities in the mid-1980s and shires under the Local Government Act in January 2005) face the most difficult conditions across a range of health and welfare indicators, including non-fatal and fatal suicidal behaviour.

Suicide rates are a particularly disturbing indicator of poor SESWB. Among Indigenous Australian males, overall suicide rates are almost three times higher than suicide rates for non-Indigenous Australian males, with the biggest differences in younger ages (ABS & AIHW, 2008). Suicide rates among Indigenous Australian females aged 10-24 are five times the rate of other Australian females, although in age groups 45-54 and over, suicide rates are similar or lower compared to rates for non-Indigenous Australian females.

Of special concern is the high and increasing number of suicides among Indigenous Australian children and adolescents (Commission for Children and Young People and Child Guardian Queensland, 2007). In 2006-07, Aboriginal and Torres Strait Islander Australian children and adolescents accounted for approximately 39% of young suicide victims, despite comprising only 6% of the State's youth population.

In 2000-02, suicide rates among Aboriginal and Torres Strait Islander Australians were highest in remote areas (55 per 100 000), lower in inner and outer regional areas (37 per 100 000 and 35 per 100 000, respectively), and lowest in major cities (16 per 100 000). Highest suicide rates were found in DOGIT communities (68 per 100 000) – twice the overall Indigenous Australian rate (30 per 100 000). Suicide rates are lower in Torres Strait Islander Australians (18 per 100 000) (Partnerships Queensland, 2006).

Notably, the health and wellbeing of Indigenous Australians is unfavourable by comparison with other Indigenous populations (Freemantle, et al., 2007), and little has changed since 1995 when Ring observed that "expectations for life for Indian populations in Canada and the United States, and for the Maoris in New Zealand are at least 10 years more than for Australian Aborigines, an enormous difference" (Ring, 1995; p. 228). This health gap between Aboriginal and Torres Strait Islander Australians and the rest of the Australian population measured in terms of life expectancy at birth is more than twice the gap existent between Native and other Canadians and three times the health gap between Native Americans and the population average of the USA.

These health inequalities persist despite the average expenditure on health for Aboriginal and Torres Strait Islander Australians being approximately 17% higher than for other Australians ($4718 per capita compared with $4019) (ABS & AIHW, 2008). However, this level of expenditure is not sufficient to match the greater needs that stem from higher levels of morbidity, nor the increased cost of delivery particularly to rural and remote communities.

Health inequalities can be shown to relate directly to social determinants of health. Their causes derive from the history of colonialism, dispossession and dominance, and current racism, social marginalisation, cultural exclusion, poverty, and resultant trauma. These lead to destructive cycles of hopelessness, despair, criminality, self-harm, addiction and violence, emerging from and then contributing to community disease. Threats to Aboriginal and Torres Strait Islander health and SESWB can be seen to arise from social domination and exclusion, social disregard, denial and racism that linger in Australian attitudes, governance and institutions. Trauma arises from cultural dispossession, personal dislocation, humiliation, and dissolution embedded in the social, cultural, community and family life experiences of Aboriginal and Torres Strait Islander people. The threats and the associated trauma can be shown to exist across the life course.

The resulting physical, emotional, behavioural, and social problems may be seen primarily as 'ill health' and/or 'poor mental health' or as the 'burden of disease'. This perception leads to costly medical and service-based interventions and responses, and makes little sense given the strength of the evidence for the historical, cultural and social determinants of health problems (Hunter, 2008).

Importantly, the cultural resilience of Aboriginal and Torres Strait Islander Australians is a major strength and ameliorating presence that has historically proven value to their general health. This resilience is likely to be all the more important in the face of anticipated environmental and attendant accelerating social changes (Hunter, 2009). Building on this with targeted and well-evaluated programs to enhance all aspects of SESWB across the life course is the way forward for all Aboriginal and Torres Strait Islander Australians.

Policy context

International context

The World Health Organization (WHO) defined health in 1948 as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'. This definition has remained unchanged, and was strongly reaffirmed at the *WHO International Conference on Primary Health Care* in Alma-Ata in 1978. This conference further declared that health 'is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector'. The subsequent *Ottawa Charter* (WHO, 1986) and *Jakarta Declaration* (WHO, 1997) have reaffirmed this view.

Specifically, in relation to the heath and wellbeing of Indigenous populations, the recent WHO Commission on Social Determinants of Health final report states:

"Indigenous People worldwide are in jeopardy of irrevocable loss of land, language, culture, and livelihood, without their consent or control – a permanent loss differing from immigrant populations where language and culture continue to be preserved in a country of origin. Indigenous Peoples are unique culturally, historically, ecologically, geographically, and politically by virtue of their ancestors' original and long-standing nationhood and their use of and occupancy of the land. Colonisation has de-territorialised and has imposed social, political, and economic structures upon Indigenous Peoples without their consultation, consent, or choice. Indigenous Peoples' lives continue to be governed by specific and particular laws and regulations that apply to no other members of civil states. Indigenous People continue to live on bounded or segregated lands and are often at the heart of jurisdictional divides between levels of government, particularly in areas concerning access to financial allocations, programmes, and services. As such, Indigenous Peoples have distinct status and specific needs relative to others. Indigenous Peoples' unique status must therefore be considered separately from generalised or more universal social exclusion discussions." (Nettleton, Napolitano, & Stephens, 2008; p. 36)

National context

The 'holistic' construction of health promoted by the WHO was adapted to Aboriginal and Torres Strait Islander needs from the late 1970s (Brady, Kunitz, & Nash, 1997) and affirmed in the late 1980s and early 1990s in the *National Aboriginal Health Strategy* (National Aboriginal Health Strategy Working Party, 1989), and in *Ways Forward*, the national consultancy on Aboriginal and Torres Strait Islander mental Health (Swan & Raphael, 1995). Subsequently, a large number of relevant policy documents have been developed related to population health and mental health in Australia (see Appendix 2 for a list of major policy documents of relevance). Of most relevance to SESWB, was the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004-2009*. This *Framework* was designed to complement the *National Mental Health Plan 2003-2008* and the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2002-2013*.

The overarching national policy document is the *National Mental Health Policy 2008* and its *National Mental Health Plan 2003-2008 (NMHP)* committed to by all Australian governments in 2003 (and currently being redeveloped for 2009-2014). It describes mental health as a state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential. The NMHP went on to note 'The strong historical association between the terms 'mental health' and 'mental illness' has led some to prefer the term 'emotional and social wellbeing', which also accords with holistic concepts of mental health held by Aboriginal peoples and Torres Strait Islanders. The *NMHP* had four priority themes:

- promoting mental health and preventing mental health problems and mental illness;
- increasing service responsiveness;
- strengthening quality; *and*
- fostering research, innovation and sustainability.

The NMHP identifies Aboriginal and Torres Strait Islander Australians as a priority population group and the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004-2009* considers mental health and social and emotional wellbeing specifically for this population group. This document identified five key strategic directions:

1. Focus on children, young people, families and communities.
2. Strengthen Aboriginal Community Controlled Health Services.
3. Improved access and responsiveness of mental health care.
4. Coordination of resources, programs, initiatives and planning.
5. Improve quality, data and research.

This social and emotional wellbeing *Framework* sits within the broader general health focus of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013*. Social and emotional wellbeing is identified as one of nine key result areas with four immediate and nine longer-term priority actions identified that align with the Council of Australian Governments (COAG) initiative *Overcoming Indigenous Disadvantage: Key Indicators* (SCRGSP, 2007). The current implementation plan (2007-2013) identifies the following objectives to be achieved under the social and emotional wellbeing key result area (Commonwealth of Australia, p.23):

- Reduced intergenerational effects of past policies, social disadvantage, racism and stigma on the social and emotional well-being of Aboriginal and Torres Strait Islander people.
- Increased resilience and stronger social and emotional well-being in Aboriginal and Torres Strait Islander people, families and communities.
- Promotion and prevention approaches that enhance social, emotional and cultural well-being for Aboriginal and Torres Strait Islander people including families and communities.
- Reduced prevalence and impact of harmful alcohol, drug and substance use on Aboriginal and Torres Strait Islander individuals, families and communities.
- Accessible mainstream services that meet the social and emotional well-being needs of Aboriginal and Torres Strait Islander people, particularly those living with severe mental illness and chronic substance use.
- Coordination of policy, planning and program development between mental health, social and emotional well-being and drug and alcohol agencies that provide services to individuals and families with specific attention to individuals and families with mental health conditions and co-morbidities to ensure care planning, provision of coordinated services and referral to services as required.
- A workforce that is resourced, skilled and supported to address mental health, social and emotional well-being and substance use issues for children, adults, families and communities across all Indigenous settings.
- Improved data collection, data quality and research to inform an evaluation framework for continued improvement in services, policy and program review, and the development/promotion of best practice.

Oversight of implementation, monitoring, and reporting is taking place through the overall monitoring process for the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*. The most recent report (AIHW, 2008) reveals that:

- Indigenous persons are more likely to report high levels of psychological distress than non-Indigenous persons and in 2004–05 around 77% of Indigenous adults reported having experienced at least one stressor in the last 12 months, the most common stressor being death of a family member or close friend (42%).
- While there have been improvements in several key health determinants in recent years, areas of concern continue to be exposure to violence, overcrowding, alcohol and other drug abuse, imprisonment, suicide,premature death and financial stress, and child abuse and neglect.
- Heath services have limited capacity to address underlying social and economic difficulties that many Aboriginal and Torres Strait Islander families and communities suffer.
- Mental health services will continue to face large and possibly increasing demand for primary and acute care.

Queensland context

The Queensland Government has recently published a *Queensland Plan for Mental Health 2007-2017*. The Plan recognises the 'complex interplay of biological, psychological, social, economic and environmental factors [influencing] mental health', especially for 'Aboriginal and Torres Strait Islander people who view social and emotional wellbeing holistically' (Queensland Government, 2008a). It has been influenced by the large number of current relevant national and Queensland policies and plans.

The *Queensland Plan* lists two relevant priorities:

Priority 1 (Mental health promotion, prevention and early intervention) – with a key action to 'Reduce suicide risk and mortality within Queensland communities, within identified high risk groups such as Aboriginal and Torres Strait islander populations, rural communities, and young people'.

Priority 2 (Integrating and improving the care system) – includes a key action of improving mental health services to Aboriginal and Torres Strait Islander people by employing additional Aboriginal and Torres Strait islander mental health workers and a specialist hub to support Aboriginal and Torres Strait islander workers in the development and delivery of clinical services.

These priorities directly address the COAG targets set since December 2007 for closing the gap between the outcomes experienced by Indigenous and non-Indigenous Queenslanders, and align with the strategic approach being developed by the COAG Indigenous Reform Working Group.

The Queensland Government has committed to addressing six COAG targets to:

1. Halve infant mortality in ten years.
2. Have all four year olds in remote communities in early childhood education in five years.
3. Halve the gap in reading, writing and numeracy in ten years.
4. Halve the gap in employment outcomes in ten years.
5. Close the life expectancy gap within a generation.
6. At least halve the gap for Yr 12 student (or equivalent) attainment rates by 2020.

The Queensland Government produces a Quarterly Report on key indicators for Queensland's discrete Indigenous communities. There are six key indicators measured and reported that are relevant for community wellbeing (Queensland Government, 2008b). These indicators are:

1. Number of reported offences against the person (Source: Queensland Police Service).
2. Number of hospital admissions due to assault (Source: Queensland Health).
3. Number of persons convicted for breaches of alcohol restrictions (Source: Queensland Department of Justice and Attorney-General).
4. Number of Aboriginal and Torres Strait Islander children attending school (Source: Education Queensland).
5. Number of Aboriginal and Torres Strait Islander children subject to substantiated notifications (Source: Queensland Department of Child Safety).
6. Number of Aboriginal and Torres Strait Islander children subject to a finalised child protection order (Source: Queensland Department of Child Safety).

Of special note, a specific reform taking place in Queensland is the Cape York Welfare Reforms, which aim to restore positive social norms, re-establish local Indigenous authority, improve the capacity for Aboriginal and Torres Strait Islander Australians living in these remote areas to find employment, reduce dependency on welfare, and support home ownership. The Family Responsibilities Commission (FRC) has been established to support individuals and families to meet their responsibilities. Twenty four local Commissioners, many of whom are respected elders, were appointed from Aboriginal and Torres Strait Islander communities to assist the Family Responsibilities Commissioner. Since commencement in August 2008 in the Aurukun, Coen, Hope Vale and Mossman Gorge communities, the FRC has promoted the reinvigoration of communities through Aboriginal and Torres Strait Islander languages and culture (ABC Radio, 2008).

Conceptual Framework

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004-2009* reaffirms and expands upon the concept of health as multi-dimensional and recognises the strengths, resilience and diversity of Aboriginal and Torres Strait Islander communities. This is supported by the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009*, which states that recognition of cultural differences is essential if we are to deliver services to Aboriginal and Torres Strait Islander people that do not compromise their legitimate cultural rights, practices, values and expectations.

Focussing on improving SESWB encompasses this holistic view of health and life for Indigenous Australians. It also seeks to recognise Aboriginal and Torres Strait Islander Australians' unique experiences of grief and trauma through colonisation, separation from families, and loss of land and culture. To intervene in such a complex domain requires adopting a population health approach, which incorporates understanding of the social determinants of health and the impact of key risk and protective factors. It is also essential to examine mainstream initiatives, adapted mainstream initiatives, and Indigenous specific initiatives to determine the best mix of interventions to meet the needs of different population groups, communities, and settings.

Population health approach

The population health approach is based on an understanding that the influences on health, mental health, and SESWB occur in the events and settings of everyday life. Health and ill health result from a complex combination of events and conditions that take place in biological, individual-psychological, social-psychological, and structural domains. The complex interplay of biological, psychological, social, environmental and economic factors at the individual, family, community, and national levels must be acknowledged and addressed to effectively promote and support population-based approaches to SESWB. The interplay between the individual and their environments is critical.

The population health model encompasses the full range of risk and protective factors that determine health — at the individual, family, community, sector/system and society level. *Protective factors* are those that give people resilience in the face of adversity and moderate the impact of stress and transient symptoms on the person or community's SESWB. Protective factors reduce the likelihood that ill health will develop. *Risk factors* increase the likelihood that ill health will develop, and exacerbate the burden of existing illness or disorder. Risk factors indicate a person's vulnerability, and may include genetic, biological, behavioural, socio-cultural, and demographic conditions and characteristics.

Most risk and protective factors for SESWB lie outside the domain of mental health and health services — they derive from conditions in the everyday lives of individuals and communities. Risk and protective factors occur through income and social status, history, physical environments, education and educational settings, working conditions, social environments, families, biology and genetics, personal health practices and coping skills, sport and recreation, the availability of opportunities, as well as through access to health services.

Making changes to the conditions that affect SESWB, therefore, generally requires long-term sustained effort across multiple sectors of the community. Effective interventions are not confined to traditional health or mental health services and domains. Interventions in all sectors of the community and at all levels can enhance SESWB. This requires widespread recognition of the interrelatedness of the domains of life and an understanding that the responsibility for SESWB, along with the benefits, reside in all sectors of the community. These benefits will become increasingly evident over time, as they comprise a long-term investment in SESWB.

Ottawa Charter for Health Promotion

It is essential to acknowledge the central role of the *Ottawa Charter for Health Promotion to Achieve Health for All by the Year 2000 and Beyond* (WHO, 1986) within a population health approach. The *Ottawa Charter* was adopted at the First International Conference on Health Promotion in 1986 and was a basis for development of the *Jakarta Declaration on Leading Health Promotion into the 21st Century* (WHO, 1997) and *Bangkok Charter for Health Promotion in a Globalized World* (WHO, 2005).

The Ottawa Charter defines health promotion as:

> *"the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being."*

The *Charter* identified several fundamental prerequisites for health and indicated that health improvement requires a secure foundation in:

- peace;
- shelter;
- education;
- food;
- income;
- a stable eco-system;
- sustainable resources; and
- social justice and equity.

Promoting health is achieved through five platforms for action:

1. Building healthy public policy.
2. Creating supportive environments.
3. Strengthening community actions.
4. Development of personal skills.
5. Reorientation of health services.

Social determinants of health

The population health approach adopted by the *Ottawa Charter* and subsequent documents emphasise the underlying fundamental social determinants of health. Mortality rates for most major causes of death, ill-health (both physiological and psychosocial) and use of health care services are all directly related to socio-economic status (Turrell, et al., 1999). There are substantial, avoidable and systematic health inequalities that cannot be explained by individual make-up or behaviour. Worldwide, people of lower socioeconomic status experience poorer health than their higher status counterparts for almost every major cause of mortality and morbidity (Marmot, 2000; Syme, 1998). Social inequality is not, therefore, solely an issue of human rights and social justice, but also a major risk to physical and mental health.

The World Health Organization (Wilkinson & Marmot, 1998) synthesises research findings into ten aspects of the social determinants of health. These include:
- the need for policies to prevent people from falling into long-term disadvantage;
- how the social and psychological environment affect health;
- the importance of ensuring a good environment in early childhood;
- the impact of work on health;
- the problems of unemployment and job insecurity;
- the role of friendship and social cohesion;
- the dangers of social exclusion;
- the effects of alcohol and other drugs;
- the need to ensure access to supplies of healthy food for everyone; *and*
- the need for healthier transport systems.

Most of the social determinants relate directly to social disadvantage, and particularly derive from poverty. However, while poverty is a critical health determinant, even in a situation where poverty is not a factor, health still remains unequally distributed according to social hierarchy. This has been shown in longitudinal studies on a large group of British civil servants, who were not materially deprived, referred to as 'the Whitehall studies'. Of the four classes in the civil service hierarchy, those in each lower class had a greater burden of disease than their superiors in the next higher class (Devitt, Hall, & Tsey, 2001). Exploration of the 'social gradient of disease' suggests one of the most critical psychosocial factors is the amount of control people have over their lives, including whether they are part of an integrated social network and whether they have access to supportive relationships. In particular, it is the level of control an individual has within their environment that determines whether the demands and stresses they experience have neutral, positive or negative consequences in terms of health. This has become known as 'control of destiny' or 'the control factor' (Syme, 1998).

According to Syme (1998), "the higher social classes have, from their earliest years, been given more training, opportunity, resources and skills to deal with the wear and tear of day-to-day life problems; the lower a person's position in the social hierarchy, the less likely he or she is to have received these benefits" (p. 494). He identifies the concept of mastery as an important factor and describes this as being able to traverse life's difficulties and solve everyday problems so that they do not overwhelm us. Syme links the concept of 'the control factor' with the concept of empowerment, a term that has been defined as a process through which people reduce their powerlessness and alienation and gain greater control over all aspects of their lives and their social environment. It provides people with resources, opportunities, knowledge and skills; critical among these skills are the capacity to reflect and analyse one's situation (Mullaly, 1997; Ife, 1999).

Since the early 1990s, there has been international and national recognition that many years of policy and intervention effort have not delivered desired health outcomes to disadvantaged peoples. The Federal Government's report *Socioeconomic determinants of health: Towards a national research program and a policy and intervention agenda* (Turrell, et al., 1999) grouped health determinants into upstream (macro), midstream (psychosocial processes and health behaviours), and downstream factors (individuals' neuroendocrine stress responses that translate into health or disease). A key point is that there is no single entry point for addressing health inequalities; policies and strategies need to be multilevel and multifaceted (Harvey, 2001; Turrell, et al., 1999).

The more recent *WHO Commission on the Social Determinants of Health Final Report* (WHO, 2008) also recognised that there needs to be a fairer distribution of power in societies through the macro policy instruments of taxation, universal and accessible education and primary health care, and income and employment protection. The WHO identified the equal importance of micro-level individual, community and neighborhood-focused initiatives that empower and promote civil participation and social inclusiveness. According to the report, empowerment and participation are particularly important because they are the essential ingredients in people's capacity to take advantage of changing opportunities to make healthier choices within the macro structural environments.

Given the complex and multi-layered nature of the social determinants of health, attempts to remedy the social gradient of disease require multi-level approaches that intervene simultaneously at different levels of people's lives – individual/family, organisation/group, and community/structural levels (Wallerstein, 1992). Marmot (2005) suggests that improving the health of disadvantaged people can be built on two intertwining pillars: the material conditions for good health; and addressing capability and spiritual or psychological needs, through control of life circumstances or empowerment. In the first pillar, comes availability of healthy food, opportunities for exercise, and crime-free neighbourhoods. The second pillar is empowerment at both the individual level and at the level of the community, to reduce chronic stress and secure resources for health.

In the Australian Indigenous context, Pearson (2006) emphasises that capabilities need to go hand-in-hand with responsibility because of the relative breakdown of social norms in communities. Attempts to address the fundamental inequalities and broader determinants of Indigenous health require long-term approaches and coordinated intersectoral collaboration to change macroeconomic factors and social policy, improve living and working conditions in disadvantaged areas through community development programs, change unhealthy behaviours and/ or reform health care, and redistribute resources (Turrell, et al., 1999). Importantly, health and other service providers can contribute towards reducing social inequality by considering their work within this broader context, creatively seeking to enhance linkages between services and programs, and supporting community processes for empowerment and change at multiple levels (Tsey, et al., 2003).

Risk and protective factors for Aboriginal and Torres Strait Islander Australians

Studies have found that there are a number of protective and risk factors that are associated with increased or decreased resilience to environmental stressors and negative events. The factors can be categorised: firstly, on an individual level such as personality, temperament, level of self-mastery, cognitive ability and the presence or absence of neurological disorders and/or psychopathology; secondly, on a family level including high/low parental conflict and criticism, and high/low warmth and support; and thirdly, on an environmental level such as high/low levels of social support, the presence or absence of valued social roles in the community, and membership to a religious church or organisation (Hauser, Vieyra, Jacobson, & Wertlieb, 1985; Werner, 1989; Robins & Rutter, 1990; Emery & Forehand, 1994; Palmer, 1997; Gilligan, 1997). These factors apply across population groups and appear to be relatively generic in terms of risk or protection.

For Aboriginal and Torres Strait Islander Australians there are, however, some unique and culturally-specific risk and protective factors for SESWB. Most importantly, there are critical strengths in Aboriginal and Torres Strait Islander communities that should be acknowledged and supported. The on-going focus on problems in Indigenous communities, much fuelled by the media, makes it too easy to forget that Indigenous Australians are "exceptional survivors" (Merritt, 2007; p. 11). Moreover, "Aboriginal society has much to teach the rest of the world about sharing, caring, and human connections - about human survival and wellbeing. It is ironic that these 60 000 years of collective wisdom with respect to mental health and human and ecosystem interdependencies are ignored at the same time that biomedical health sciences are just discovering the importance of supportive and caring connections between people" (Reser, 1991; p. 281).

Some of the key protective factors for Aboriginal and Torres Strait Islander Australians include:

• Kinship – Kinship systems were central to the structures and functioning of traditional Aboriginal and Torres Strait Islander societies (Cambridge, 1971; Hamilton, 1981; Martin, 1993). While certain features of resilience-enhancing traditional kinship-based practices may, in contemporary settings, increase vulnerability, as has been suggested in terms of the obligations of "demand sharing" in a subsistence-level, welfare economy (Macdonald, 2000; Peterson, 1993; Sutton, 2001), kinship still remains the basis for the "interconnectivity" supporting wellbeing within contemporary Indigenous communities (Durie, Milroy, & Hunter, 2008).

• Family and community – Integrally related to kinship is the importance of family and community wellbeing. For example, Torres Strait Islander peoples employ the image of a coconut palm tree as a metaphor for community wellbeing. The structure of the coconut palm tree displays the important role that the roots (grandparents, ancestors), trunk (parents through the union of male and female), and leaves (uncles, aunties, siblings, elders), play in sharing, retrieving, learning, recording and teaching Torres Strait culture and tradition. The roots hold the tree in place and keep the living whole strong while the trunk lifts the leaves high where they can grow and provide shelter. The young shoots grow from the centre at the top of the tree and are supported by the surrounding older leaves so that the whole is strong and the fruit (knowledge) is passed on to sustain the tree forever. The young are supported by the old and are instructed in the importance of 'apasin' (respect) and to show 'good pasin' (share our good ways). In this way, through a shared supporting whole and the principles of respect and sharing Torres Strait culture is maintained for the good of all future generations (Mam, et al., 1993; Whap, 2001; Hunter, et al., 1999).

• Spirituality – Aboriginal and Torres Strait Islander spirituality has been described as a land-centred spirituality derived from a sense of belonging and connection to the land, to the sea, to other people, and to one's culture. Its essence lies in the time when occupation of the continent was unchallenged. It resides in stories, ceremonies and dance, values and structures. These complex and various ritual systems provide a depth of belief and certainty through addressing questions about origins, meaning, purpose and destiny. (NAHSWP, 1989). Of special note, traditional ceremonies and spirituality have been shown to have a protective effect (McCoy, 2007; Tse, Lloyd, Petchkovsky, & Manaia, 2005).

• Culture and cultural identity – Underlying all these protective factors is the importance of cultural strength and empowerment. Notably, over half of Queensland's Aboriginal and Torres Strait Islander population aged 15 years and older identified with a clan, language or tribal group in 2002 (Partnerships Queensland, 2006). Cultural community wellbeing recognises that people are responsible for their own recovery and healing: the cultural community provides the container within which all the resources for full participation in a healthy life exist; and connection to culture and a sound identity can transform the historical and reoccurring trauma of racism, which is a primary cause of community illnesses (Azzahir & Barbee, 2004). The *Cultural Respect Framework* for Aboriginal and Torres Strait Islander Health (AHMAC, 2004) defines cultural respect as the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Australians.

In contrast to these vital protective factors, a growing body of research reveals that Aboriginal and Torres Strait Islander Australians are exposed to high levels of many risk factors that impact on SESWB. An exhaustive list of the evidence showing the risks for Aboriginal and Torres Strait Islander Australians SESWB will not be attempted here. The reporting framework for the *Overcoming Indigenous Disadvantage* initiative provides a comprehensive list of many of the socioeconomic indicators of risk, which align with the key social determinants of health. Notably, this reporting framework emphasises the causal role of Indigenous disadvantage and highlights the importance of the domestic settings of child rearing and interactions between families and schools.

Major indicators of risk are listed as (see Taylor, 2006):
• Life expectancy at birth
• Rates of disability
• Years 10 and 12 school retention
• Post-secondary participation and attainment
• Labour force participation and unemployment
• Household and individual income
• Home ownership
• Suicide and self-harm
• Child protection notifications
• Deaths from homicide and hospitalisations for assault
• Victim rates for crime
• Imprisonment and juvenile detention

The *Partnerships Queensland Baseline Report* (2006) provides baseline data on a range of vital socioeconomic risk factors. The summary of key findings reveals high levels of risk in many key indicators. A sample of these risks includes:

• Infant mortality rates in babies born to Aboriginal and Torres Strait Islander mothers were between 1.7 and 2.5 times those of non-Indigenous babies (2000 to 2002).

• Aboriginal and Torres Strait Islander babies in Queensland were between 1.6 and 1.9 times more likely to have a low birthweight than non-Indigenous babies (2002-03 to 2003-04).

• Aboriginal and Torres Strait Islander babies were between 3.3 and 4.6 times more likely than non-Indigenous babies to be placed in out-of-home care (30 June 2005).

• Young children residing in Aboriginal DOGIT communities were between 23 and 44 times more likely to be hospitalised for assault than all Queensland non-Indigenous young children.

• Aboriginal and Torres Strait Islander children aged 10-14 years were between 10.4 and 10.9 times more likely to be charged by police than their non- Indigenous peers (2004-05). Aboriginal and Torres Strait Islander children offending in Aboriginal DOGIT communities were the most likely to be charged by police.

• Only 56.7 per cent of Aboriginal and Torres Strait Islander students commencing year eight in 2000 continued to year 12 in 2004 compared with 82.4 per cent of non-Indigenous students.

• An estimated 45.1 per cent of Aboriginal and Torres Strait Islander students studying English in year 12 in 2004 received a low or very low achievement as their final outcome compared with only 16.3 per cent of non-Indigenous students.

• Aboriginal and Torres Strait Islander young people were between 4.8 and 4.9 times more likely to be charged by police than non-Indigenous young people (2004-05).

• Labour force participation rates for Aboriginal and Torres Strait Islander young people and adults are 1.3 times lower than non-Indigenous Queenslanders.

• Aboriginal and Torres Strait Islander adults were 3.2 times more likely to be admitted to hospital for chronic disease than their non-Indigenous peers.

• Aboriginal and Torres Strait Islander residents of Aboriginal DOGIT communities were between 7.8 and 8.5 times more likely to be unemployed or in CDEP than all non-Indigenous Queenslanders.

For Aboriginal and Torres Strait Islander people, multiple and often mutually reinforcing risk exposure is not only common but, particularly in Queensland's discrete DOGIT communities, is often the norm. The vulnerability of the residents in these settings reflects the destructive histories of State-sanctioned family violence and institutionalisation that differ only in degree to that experienced across Australia and which, as elsewhere: "devastated the purpose, volition and agency critical to cultural continuity and integrity, resulting in a state of discontinuity and incoherence within a dominant society which remains invested in denial, rationalisation and trivialisation of past policies and practices" (Hunter & Milroy, 2006). Ironically, it is since Indigenous Australians have been freed from the onerous constraints of racist legislation and discrimination that many of the now common social and mental health problems have increased dramatically. This reflects what Brody (1966) called "cultural exclusion" – persistent marginalisation through social, rather than statutory, denial of means to realise ideals, which has significant mental health impacts particularly across the spectrum of emotional difficulties associated with low self esteem, self-blame, and the internalisation and externalisation of such frustrations and anger (violence and self-harm).

The destruction of Indigenous Australian culture has resulted in ongoing grief, despair and confusion, including the disruption of traditional gender roles (especially for men), cultural values and pride, disruption of kinship networks and support systems, and the confusion of people forced to balance between two, often irreconcilable, cultures. In contrast, the protective factors derive from strong culture, family, and community.

Awareness of the nature of the risk and protective factors for SESWB reveal three main areas on which to focus for intervention (Taylor, 2006). These are to develop:

1. Safe, healthy and supportive environments with strong communities and cultural identity.

2. Positive child development practices and settings, and prevention of violence, crime and self-harm.

3. Improved wealth creation and economic sustainability for individuals, families and communities.

Future Directions for Investment in SESWB

Identification of future directions for investment requires understanding of the state of the current evidence base to support decisions in this area, as well as awareness of the fundamental principles for best practice in promotion of SESWB.

The current evidence base

To determine the state of the current evidence base related to SESWB, it is first necessary to consider what comprises 'evidence'. The nature of evidence in the context of health promotion, and for Indigenous communities in particular, also must be examined. With this understanding, the current state of the evidence underpinning directions to promote SESWB for Aboriginal and Torres Strait Islander Australians in Queensland can be determined.

What is evidence?

The 'gold standard' of evidence is the randomised controlled trial (RCT). This view comes from guidelines such as those proposed by the National Health and Medical Research Council (NHMRC) that classifies types of evidence for the development of clinical practice guidelines (see Appendix 3). RCTs are studies in which people are randomly assigned to intervention or control groups. It is only through random assignment to groups, and ensuring that the intervention and control groups differ only on the intervention condition, that a causal relationship between the intervention and outcome measure can be established.

The highest level of evidence according to the NHMRC is where the results of multiple RCTs are pooled to provide an estimate of the average intervention effect, using a technique called meta-analysis. The effect size yielded by a meta-analysis is a very useful statistic in many contexts, but is does not convey any clear sense of the practical significance of an intervention. For example, very small statistical effects can have a major public health benefit if they address a factor that is highly prevalent or of considerable public health relevance.

RCTs are usually *efficacy* studies, which determine the outcomes of an intervention undertaken under experimental or 'controlled' conditions. Such studies are only a first step for establishing evidence, however, as they do not provide information related to all the outcomes of interest (Aveline, 1997). *Effectiveness* studies also need to be undertaken to test the 'real world' impact of interventions that have been shown to be efficacious under controlled conditions. However, effectiveness studies are easily confounded by uncontrollable real world factors, including the difficulties commonly associated with describing, measuring, and maintaining the content and quality of multimodal interventions and in distinguishing between specific and non-specific, and effective and ineffective, treatment elements. Interventions conducted under highly controlled conditions often do not translate successfully into the real world with its variation and indeterminancy.

For health promotion, attempting to build an evidence base on RCTs and meta-analysis is particularly inappropriate (Rada, et al., 1999). Health promotion interventions are multifaceted and focus on multiple levels, including community. By their nature, the interventions take place in the 'real world'. The foundations of health promotion practice draw together knowledge generated from a wide range of disciplines. As a result, the aims and ways in which health promotion activities are implemented are extremely varied. Applying the positivist traditions of medical research and the types of evidential classification systems such as that adopted by the NHMRC becomes unrealistic and unworkable to the point of irrelevance in this context.

Furthermore, negative consequences can arise from applying such a positivist scientifically rigorous approach to building the evidence base for some population groups. This applies particularly to Aboriginal and Torres Strait Islander communities, where the efficacy and effectiveness of an intervention are affected by a complex interplay of social, environmental, cultural and psychological factors that cannot be deconstructed to fit within an experimental design (a situation compounded by political forces such as the Northern Territory Emergency Intervention or, in Cape York, the Welfare Reform initiative, as well as by the raft of interventions through COAG). To be effective, interventions must be innovatively tailored to the unique characteristics of a particular community and setting. It has been argued that insisting on 'evidence-based' interventions, as defined by the scientific approach, can exacerbate health inequalities, because "innovative interventions for disadvantaged and minority groups are generally not included among programs considered to have 'best evidence' for effectiveness" (Hawe, et al. cited in Hunter & Garvey 1998, p7).

Another essential dimension for building the evidence for health promotion, generally, and SESWB, in particular, is that the interventions and research programs must work with people and communities within a participatory framework: an empowering approach is prioritised over individual behaviour change (Lahtinen, Koskinen-Ollonqvist, Rouvinen-Wilenius, Touminen, & Mittlemark, 2005). Critical factors relate to who sets and undertakes the research agenda. The emerging role of research partnerships with Indigenous community organisations is pivotal to shifting the Indigenous health research paradigm to one in which communities are supported in identifying their own priorities and taking the role of leaders or active participants in community-based SESWB programs.

Importantly, the design, implementation and evaluation of SESWB initiatives require a workforce that has the skills to practice collaboratively, across cultures and disciplines. Developing culturally appropriate approaches to the evaluation of SESWB programs is a significant challenge. It requires the development of evaluation methodologies that respond to local history and current practice, yet are rigorous and standardised enough to withstand translation across ethnographic settings and peer review, so as to enable publication and dissemination of findings.

Researchers have begun to develop alternative quality criteria for health promotion research, which move beyond the confines of the traditional scientific method for establishing causal relationships (Fossey, et al., 2002). Lahtinen, et al. (2005) argue that the criteria should comprise judgements of relevance, values, innovation, discourse, practice, action, context, scientific quality, defined scope, anticipated outcomes, operationalisation, feasibility, process evaluation, and documentation and dissemination. The research should be judged as to whether each of these criteria have been fully fulfilled, fulfilled to some extent, or not fulfilled at all. Similarly, the RE-AIM model has five dimensions: reach, efficacy, adoption, implementation and maintenance (Glasgow, Vogt, & Boles, 1999).

A useful framework specifically for program evaluation research is the context, input, process and product (CIPP) evaluation model (Stufflebeam, 2003). It sets out the following 10 domains that comprise a comprehensive evaluation approach:

1. *Contractual agreements:* grounded in explicit advance agreements and updated throughout the evaluation.

2. *Context evaluation:* assesses needs, assets and problems within a defined environment.

3. *Input evaluation:* assesses competing strategies and work plans and budgets of the selected approach.

4. *Process evaluation:* monitor, document and assess program activities.

5. *Impact evaluation:* assesses a program's reach to the target audience.

6. *Effectiveness evaluation:* assesses the quality and significance of outcomes.

7. *Sustainability evaluation:* assesses the extent to which a program's contributions are successfully institutionalised and continued over time.

8. *Transportability evaluation:* assesses the extent to which a program has (or could be) successfully adapted and applied elsewhere.

9. *Meta-evaluation:* assessment of an evaluation's adherence to pertinent standards of sound evidence.

10. *Final synthesis.*

It must be recognised that multiple kinds of evidence need to be valued, including qualitative and narrative forms, and especially lived experience (Waddell & Godderis, 2005). The holistic nature of SESWB and its breadth means that the question of how to address this area in the form of evidence demands a nuanced response which draws on multi-disciplinary approaches and effectively deploys both quantitative and qualitative research methods. Combining such different approaches is challenging, however, in terms of judgements of relevance, ethics, and research validity and integrity (Riley, Hawe, & Shiell, 2005). An important resource to draw upon is the NHMRC document *Keeping Research on Track* (NHMRC, 2006). Berry (2008a) notes that this document identifies the following six values to guide researchers in undertaking ethically appropriate research with Aboriginal and Torres Strait Islander communities:

1. Spirit and Integrity
2. Reciprocity
3. Respect
4. Equality
5. Survival and Protection
6. Responsibility

Keeping Research on Track also sets out eight steps that are likely to comprise the research journey:

1. Building relationships
2. Conceptualisation – thinking
3. Development and approval
4. Data collection and management
5. Analysis – looking at the meaning
6. Report writing
7. Dissemination – sharing the results
8. Learning from our experience

Finally, the critical element of addressing 'cost-effectiveness' cannot be avoided in this field. Cost effectiveness is all the more important given increasing competition for scarce resources. To date, there are few initiatives addressing Indigenous SESWB that have sought to provide such evidence (although an evaluation of HITnet attempted to include a cost-benefit analyses – see Dossel, Travers, & Hunter, 2007; HITnet team, 2009). As 'value' is likely to be prioritised by both governments and social enterprises in this arena it is worth considering how 'cost-effectiveness' can be measured and, even more importantly, interpreted by various stakeholders.

The current state of evidence for SESWB

In 1995, in the *Ways Forward* report, Swan and Raphael noted 'an absence of adequate information on Aboriginal mental health, lack of understanding of the processes which influence it and of risk and protective factors … and methods to evaluate the effectiveness of health interventions' (p. 95). A decade later in 2006, published research on Indigenous health in Australia was shown to be predominantly descriptive through a review of the number and nature of Indigenous health publications in Australia, Canada, New Zealand and the United States (Sanson-Fisher, Campbell, Perkins, Blunden, & Davis, 2006). The authors suggested that a focus on intervention research may provide more direct assistance in understanding how to improve Indigenous health outcomes. Henderson, et al. (2005) observed that information dealing with SESWB interventions was generally to be found in grey literature, and that although there were many relevant programs being implemented within the community controlled sector and reported in the form of project reports, this work was rarely translated into peer reviewed publications.

An example of this state of the evidence base is provided by an examination of research specifically related to spirituality, which has been identified as a key protective factor for Indigenous SESWB. Indeed, the Western Australian Child Health Survey has demonstrated that there is a correlation between the proportion of primary carers with poor family functioning and lower levels of religious/spiritual beliefs (Zubrick, et al., 2006). A literature search to locate Indigenous Australian health intervention studies that had integrated spirituality into their evaluation design was conducted in 2008. The literature search encompassed published studies in peer-reviewed journals between 1995 and 2007. Relevant articles were identified by conducting searches on all major health and social science databases. The results indicated that between

1995 and 2007 there was no original research published in Australian peer-reviewed journals that integrated the concept of spirituality into an Indigenous health intervention program evaluation. Although there were several relevant initiatives in existence, these were reported in the grey literature and their reports provided little more than brief program overviews (McEwan, Tsey, & Empowerment Research Team, 2008).

In terms of the evidence base overall, the social determinants of health inequity are increasingly well established in the literature and a strong international evidence base shows a direct correlation between health status and social equity, human rights, and community autonomy. In particular, research from Canada and the United States provide an evidence base that links cultural wellness, 'cultural connection', cultural strengths, and family wellbeing to a range of positive SEWB indicators (Kelly, et al., 2006). Evidence is starting to emerge in Australia that confirms some of these associations. In particular, the Western Australian Aboriginal Child Health Survey has begun to identify the factors influencing health, mental health and wellbeing for Aboriginal children (Zubrick, 2005). However, this cross-sectional study cannot clearly demonstrate the origins of SEWB nor necessarily be transferable to Queensland contexts. In Queensland, research is beginning to establish the critical importance of family wellbeing for SESWB, but this work is yet to emerge in the published literature (McEwan, Tsey, & Empowerment Research Team, 2008).

Importantly, there are no studies that examine contextual differences between Aboriginal and Torres Strait Islander communities as a basis for capturing the link between social determinants and health through comparative analysis. Data are being collected from Aboriginal and Torres Strait Islander (DOGIT) communities in Queensland under the Community Wellbeing plan but comparative differences based on SESWB or health determinants are not included in this monitoring schema (Queensland Government, 2008b).

Suicide interventions in Indigenous communities have received some of the most intense research attention, internationally at least if not in Australia. A comprehensive review of suicide prevention programs in communities of the American Indians and Alaska Natives in the United States showed that many programs are developed by the tribes themselves (Middlebrook, LeMaster, Beals, Novins, & Manson, 2001). The majority of programs are local grass-roots initiatives, informal and independent of any centralised planning or control, and relatively few are evaluated and reported in the published literature. The review identified nine programs, including five suicide-specific programs and four programs addressing related mental health and wellbeing issues, such as alcohol and drug abuse and teen pregnancy. These programs in varying degrees, addressed the generic factors associated with suicide (i.e. stress, depression, and hopelessness) and culture-specific factors relevant to Indigenous peoples, such as loss of ethnic identity and cultural and spiritual development, cultural confusion and acculturation. The review led to rather disappointing conclusions that information on the effectiveness of suicide preventive intervention programs among American Indians/Alaskan Native communities is scarce, and that there were few descriptions of programs in the literature and even fewer with any type of evaluation effort. A more recently published report on suicide among Aboriginal people in Canada (Kirmayer, et al., 2007)

presents an updated list of promising suicide prevention programs within communities. It is important to note that each of these programs was: (1) created or driven by the community; (2) adapted by the community in part or as a whole; or (3) intended to mobilise the community toward development or implementation of its own prevention initiatives. The programs are ongoing, wide-reaching, include an evaluation component, and information about the programs is easily accessible via the Internet or through contact organisations.

Principles of best practice

Developing directions for future investment in health promotion for SESWB requires acknowledgement of some fundamental principles for best practice for health promotion investment. The following principles have been identified from the literature and through discussion with the Expert Working Group. These should be used as key guides for decisions regarding investment choices.

- **Investments should support Indigenous agency, autonomy and control**

  A core theme evident throughout the literature related to SESWB is the essential nature of empowerment. It is widely recognised that programs require local community control and action for them to be effective: the community needs to be able to determine what their issues are and how to address them. Importantly, it must be recognised that in Australia, Aboriginal community controlled organisations are often in a position to facilitate community engagement (Tilton, 2001).

- **There must be an explicit theoretical or conceptual basis for strategy and investment in programs and projects**

  Due to the lack of guiding 'evidence' in this emerging field, other explicit ways to direct investment need to be found. In the absence of a strong evidence base, the next best guide for investment is a clear and explicit theoretical or conceptual argument that supports the direction being taken. Importantly, the theoretical and conceptual frameworks regarding issues such as culture and family are well-developed in a number of disciplines. They are also more strongly developed in the international literature, which is an important source to draw upon, although it is essential to be aware of a potential lack of translation to our local contexts.

- **Investments should be guided by realistic timeframes that allow sufficient time for development, implementation and evaluation**

  By their very nature, health promotion interventions are long-term investments. They often have a long lead time in terms of development and implementation, particularly because they must be built upon partnerships with the local community that take time to develop and more time to sustain. Furthermore, outcomes will be multi-faceted and both short and long-term. It is, therefore, essential to acknowledge the potentially changing nature of investments as the community changes, and incorporate rolling evaluation and action research strategies that are able to accommodate such change and complexity.

- **Investments need to be holistic – across the spectrum of interventions**

  To address a domain as complex as SESWB a population health approach must be adopted, which means that investments need to be implemented across the whole range of population need, including people who are currently well and those who are at different stages of risk and ill-health. A useful framework to apply is the Spectrum of Interventions for Mental Health, originally developed by Mrazek and Haggerty, but adopted and adapted in a number of policy contexts in Australia (see Commonwealth Department of Health and Aged Care, 2000). Briefly, the Spectrum argues that interventions need to comprise mental health promotion, which applies to the whole population to improve health and wellbeing; prevention interventions to reduce ill-health and applied across population risk groups, including the entire population and those at higher levels of identified risk; early intervention so as to intervene as early as possible to reduce the impact of ill health; as well as interventions that comprise appropriate holistic continuing care and relapse prevention for people who have experienced ill health.

- **Investments need to be coordinated to increase overall knowledge**

  Currently, there is a paucity of research regarding effective SESWB interventions, and what little has been undertaken is not publicly or widely available. The available knowledge is generally not to be found in the published literature, and is mostly in the grey literature, which is not easily accessed or widely promoted. Consequently, the knowledge base in the area is limited and fragmented. To build the evidence base, investments need to be coordinated through collaborative and cooperative approaches that have as a primary aim building and disseminating knowledge. Furthermore, due to the wide diversity and multi-faceted nature of SESWB approaches, it is essential that knowledge that derives from the varied disciplines and approaches is pooled and used synergistically.

- **Investments need to be sustainable**

  A significant challenge for SESWB investment is sustainability. Pilot and seeding programs that do not have a strategy for longer-term implementation are unethical: they raise expectations and needs within communities that are then not met. A report of the effectiveness of health promotion seeding grants to reorient health services toward health promotion concluded that seeding grants, on their own without significant additional effort to enable sustainability, had limited impact (Cass, Sullivan, & Ritchie, 2004). If a program is shown to be effective and appropriate, there is an ethical obligation to have the resources in place to continue to provide the intervention in an ongoing way once the pilot program is complete. "Negative effects of short-term funded projects that raise expectations then end before their objectives can be realised. In order to build trust and gain good community involvement, particularly in sensitive areas …, regions need access to dedicated, consistent, long-term resources. Resources are also needed for strengthening workforce capacity within regions—both skills and positions (particularly for Aboriginal workers)—to continue and extend initial work" (Stacey, et al., 2007, p. 252). It is also inappropriate to initiate one-off intervention programs that benefit only one small cohort of people at a particular point in time. It has been clearly demonstrated that SESWB interventions take time to implement and more time for the outcomes to be demonstrated. Investments need to have both the time to achieve their aims and, if effective, have mechanisms for ongoing implementation and to become embedded as sustained practice.

- **Innovation needs to be enabled by making space for 'creative' investments and for supporting capacity of otherwise excluded options**

  It was noted earlier that insisting on 'evidence-based' interventions, as generally defined, can exacerbate health inequalities for Aboriginal and Torres Strait Islander Australians because there is little such evidence available. Consequently, there must be space for investment in innovative and creative approaches that are novel and unique, although they should be based on sound theoretical or conceptual arguments. An attitude of 'authentic inclusion' needs to be adopted, to fully encourage and support new ideas and approaches. It is only through genuine innovation that the complex range of factors that impact on SESWB will be addressed.

Key Directions

Deriving from the current poor state of the evidence base and the principles that have been described for best practice, three main directions have been identified for the best investment in promoting the social, emotional, cultural and spiritual wellbeing of Aboriginal and Torres Strait Islander Australians in Queensland over the next five years. The first direction acknowledges the very basic state of knowledge in this field and the urgent need to build a better knowledge base to inform investment and practice. The second direction articulates the imperative to build on current initiatives and develop sustainable capacity, rather than continuing to invest in one-off pilot studies that do not contribute to the need for long-term sustainable investment in the area. The third direction acknowledges the vital importance of continuing to develop the workforce working in settings relevant to improving the SESWB of Indigenous Queenslanders. All three directions derive from the conceptual framework and are argued to be the best ways forward for promoting SESWB in Queensland.

The directions identified are:

Key Direction 1: Build Evidence
Devise a methodology to enable development of the evidence base to support informed decisions.

Key Direction 2: Enhance Capacity
Build the capacity and sustainability of initiatives that support family and community wellbeing.

Key Direction 3: Develop Workforce
Support development of the workforce needed to promote SESWB.

Key Direction 1: Build Evidence
Devise a methodology to enable development of the evidence base to support informed investment decisions

Rationale

The state of the evidence base upon which to make decisions regarding investment for SESWB is severely limited. It is currently not possible to identify and compare relevant initiatives and make fully informed decisions regarding investment. Consequently, a vital first step is to build capacity to develop the evidence base. Consistent with the identified principles of best practice, to contribute to improving the evidence base broadly, evaluation is not only mandatory but must be able to be integrated so as to increase overall knowledge and support sustainability.

Building the evidence base in this field has been inhibited by the absence of research tools that are consistent with the principles identified for best practice in promotion of SESWB. What is required is the development of some agreed methodologies and a suite of research and evaluation tools that can be used across a range of initiatives, settings and contexts. Methodological tools need to be developed to determine appropriate and effective ways to design research and evaluation that can be applied to more formative and holistic approaches, effectively measure agreed outcomes, and improve communication in the field.

The development of a basic set of methodological tools would provide a resource applicable across the entire range of SESWB initiatives. It would enable the development of a shared research and evaluation communication approach, which would then provide the foundation for effective decision making regarding the outcomes and value of investments. Importantly, this is a feasible undertaking within a shorter-term time frame (less than 5 years).

Current initiatives

Within an evaluation plan that combines an appropriate approach to evaluation blended with the eight steps described in *Keeping Research On Track* (NHMRC, 2006), it is necessary to select measures and data gathering approaches that will collect appropriate information. Given the diversity of Indigenous communities and the broad range of interventions possible to address SESWB, to support such informative evaluation will necessarily demand using a range of approaches and tools that will require balancing contextual specificity against comparability. Consequently this may mean drawing on mainstream, adapted mainstream, and Indigenous-specific approaches and tools.

Fundamentally, despite widespread recognition and acknowledgment of the importance of SESWB, there is lack of consensus regarding its operationalisation and measurement (Kowal, et al., 2007). To date, a range of tools have been developed or adapted to attempt to measure SESWB among Indigenous people in Australia.

Most of the few studies in the field have drawn on standard mainstream measures of life events and stress. These include the *Western Australian Child Health Survey*, which used a mixture of instruments for its study of families and children, including the mainstream Strengths and Difficulties Questionnaire (Goodman, Ford, Richards, Gatward, & Meltzer, 2000; Zubrick, et al., 2005). This important survey also used a range of socioeconomic and demographic indicators, and was able to demonstrate the relationship between the circumstances of life and burden of life events on families and vulnerability or resilience in children.

The National Aboriginal Social Survey (NATSISS, ABS, 2002) also focussed on life stress using the Negative Life Events Scale (Kowall, Gunthorpe, & Bailie, 2007), and demonstrated that life stress is common for Indigenous Australians. This scale has subsequently been used in the Northern Territory in an effort to measure SESWB.

Measures of psychological distress are often used to indicate SESWB, particularly the Kessler Psychological Distress Scale (ABS, 2006) and the Medical Outcome Short Form Health Survey/SF-36 (ABS, 2006). Westerman (2003) has developed one of the few Aboriginal-specific measures, through the Westerman Aboriginal Symptom Checklist.

Another critical factor jeopardising SESWB is substance use for which various adaptations of mainstream tools have been undertaken. The Indigenous Risk Impact Screen (IRIS), developed in Queensland, is now the best validated instrument for use as a screen in Aboriginal and Torres Strait Islander communities (Schlesinger, Ober, McCarthy, Watson, & Seinen, 2007).

An important limitation of many studies to date, however, has been that the focus taken is mostly on problems and deficits. This is exemplified in the approach taken by the AIHW (AIHW, 2009) in identifying eight potential domains for a module to assess Indigenous SESWB, these being:

1. **psychological distress** domain (K-5) - a modified version of the Kessler Psychological Distress Scale-10 (K-10);

2. **impact of psychological distress** domain to detect the impact of psychological or emotional distress on the respondent's life;

3. **positive wellbeing** domain to identify positive emotional states such as happiness and vitality, in order to provide balance with the first two items;

4. **anger** domain to capture various manifestations of anger that could be analysed against other dimensions of the module;

5. **life stressors** to identify other factors potentially affecting social and emotional wellbeing;

6. **discrimination** that was recognised as having an adverse effect on social and emotional wellbeing;

7. **cultural identification** to recognise the importance Indigenous people place on a sense of belonging; *and*

8. **removal from natural family** to capture significant events that are likely to have impacted on an individual's social and emotional wellbeing.

Of the eight, only two – 'positive wellbeing' and 'cultural identification' – are strengths-focussed, the others all focusing on deficits. This emphasises the challenge of developing positive measures of wellbeing and, more so, the challenge of thinking in terms of positives when considering Indigenous health and wellbeing. A change in focus demands, not only innovation in terms of tools, but also in terms of evaluation approaches.

Importantly, there will be no end to endemic Indigenous disadvantage without restitution for past wrongs in ways that redress the loss of power that fuels every aspect of 'the gap' between Indigenous and other Australians. Of necessity, this redress must include self-determination and the right to custodianship of traditional lands. For this reason, all evaluations will need to include material that pertains to Indigenous access to, use of and abuse of power.

There are many approaches to assessing power and empowerment, the latter recognised as a vital social determinant of health. A collaborative project involving the University of Queensland and James Cook University has responded to the need for a psychometrically sound instrument able to rapidly measure psycho-social empowerment and wellbeing and routinely evaluate the impact of efforts aimed at empowering people to achieve health improvement. This instrument is being developed in the context of evaluating the Family Wellbeing program, which is a multi-faceted intervention aimed at addressing disadvantage through improving family wellbeing and empowerment (Tsey, et al., 2003). The tool has three main components: Kessler 10 Psychological Distress Scale (K10), and two newly developed instruments: a 13-item Emotional Empowerment Scale (EES) and set of 12 scenarios (12S). A

validation study has been completed involving over 150 people who work or volunteer in Indigenous social health activities. Preliminary psychometric analysis of the two new instruments supports their validity and reliability. These instruments show promise in enhancing analytical understanding and enabling measurement of psychological and social progress towards greater empowerment. This may help to monitor the broader impact of empowerment-oriented interventions on people's lives. Importantly, the tool should enable policy makers and health economists to better estimate the value of programs.

Consistent with the Family Wellbeing program, another critical intervention currently being evaluated is the Cape York Welfare Reform Trials. These Reform Trials are a multi-faceted, coordinated intervention forming an integrated reform package aimed at addressing profound disadvantage and the norms and behaviours that it has engendered (Berry, 2008b). A theory-driven approach is being adopted, which comprises a cycle of theory development and evaluation and testing. They are currently working on the development of appropriate measures of social capital and wellbeing.

Finally, two health promotion projects in remote Queensland Indigenous communities involving multimedia (Hunter, Travers, Gibson, & Campion, 2007) and the visual arts (Dyer & Hunter, 2009) are using a combination of qualitative, quantitative and performative sources of information for evaluation. Indigenous representation is embedded within each project, and this serves not only as an outcome in its own right, but also as a vehicle enabling feedback in meaningful and empowering ways and as a check on the integrity and validity of the projects' aims and claims.

Recommended actions

1. Undertake research to develop the methodological tools required to build the evidence base relevant to promotion SESWB. This action recognises the need to develop and consolidate a suite of basic measurement tools and research designs for undertaking research and measuring outcomes across a broad range of interventions. This is a task that is likely to challenge contemporary health promotion praxis. To start with, basic methodological requirements need to be identified. These are likely to include: appropriate designs for holistically-based research approaches; designs capable of responding to innovative intervention approaches; clear and agreed definitions of outcomes to be measured; relevant quantitative, qualitative and performative measurement tools including formative assessments; and appropriate and effective methodologies for providing feedback to communities. In addition, the research needs to develop mechanisms to demonstrate cost effectiveness and to share and implement the knowledge and outcomes gained.

2. Ensure comparability across SESWB research and project/program evaluations in Queensland, including both adapted mainstream and indigenous-specific interventions, by communicating, recommending and encouraging the approaches and resources developed from the previous action. Of particular importance, the approaches and resources developed will need to include measures of empowerment, control, and cultural strength as these have been identified as fundamental protective factors to be enhanced to promote SESWB.

Key Direction 2: Enhance Capacity
Build the capacity and sustainability of initiatives
that support family and community wellbeing

Rationale

Family or kin are acknowledged as the fundamental unit of contemporary Indigenous Australian society. Challenges to and improvements in wellbeing occur within the context of family relationships. Families, schools and communities appear to be the best settings for programs and interventions targeting resilience and wellbeing in Indigenous Australian children and adolescents (Craven & Bodkin-Andrews, 2006; Eckersley, Wierenga, & Wyn, 2006).

In relation to SESWB initiatives, capacity needs to be considered and facilitated at individual, family and community levels. A suitable approach would recognise the significant and complex challenges Indigenous Australians face in reasserting or strengthening control in the face of long-term, ongoing social exclusion. Building individual capacity involves enhancing and/or developing personal aptitude, strength, coping and/or independence (Commonwealth of Australia, 2007). The idea of capacity overlaps with 'the control factor', recognised as an important psychosocial variable in epidemiological patterns of disease. Increased control means that people have greater capacity to deal with day-to-day challenges of life without being overwhelmed by them (Syme, 1998).

The personal strengths and life-skills of individuals within a community have important implications for the success and sustainability of SESWB initiatives. A worker's or organisation's ability to build trust, manage crises, provide support and resolve conflict across time underpins the effectiveness and durability of any community-based initiative. An increasing body of literature supports the idea that degree of control over social, emotional and economic life is a key determinant of the health of individuals, families and communities (Peterson & Zimmerman, 2004; Syme, 1998; Wallerstein, 2006).

Community capacity refers to the ability of a community's organisations, groups and individuals (collectively) to build structures, systems, people and skills so they are better able to define and implement strategies to achieve shared objectives (Commonwealth of Australia, 2007). Long term social exclusion has implications for community capacity. Many community-based workers, for example, live and have grown-up in the community in which they work. It is highly probable that they will have confronted similar emotional, socio-economic and educational barriers, and experienced the same grief and loss as their fellow residents. For this and other reasons, health and social workforce capacity in Indigenous communities is often fragile and requires substantial support, including one-to-one mentoring for those currently working and for those who require assistance to reach a state of work preparedness. In addition, those with high levels of capacity or skills are often over-burdened with responsibility while others experience extreme social marginalisation.

Successful negotiation of community and clan politics, establishing relationships with individual clients, groups or organisations, and responding to individual SESWB needs requires extensive skills and practice. The long-term nature of skills acquisition and associated resource requirements is another important factor to consider in the development of community capacity.

Notably, short-term funding is generally insufficient where the aim of a program is to change and maintain complex behaviours (Sorensen, Emmons, Hunt, & Johnston, 1998), such as those associated with recovery from substance abuse, violence, suicide, mental illness and chronic disease (Merzel & D'Affliti, 2003). A five-year timeframe is often recommended as the minimum duration necessary to facilitate community mobilisation, action and social change (Mittlemark, Hunt, Heath, & Schmid, 1993). With short-term funding arrangements, many groups struggle to find new resources, and the lack of funding certainty can limit implementation efforts in an initiative's later stages. Efforts to institutionalise programs may compete with the time-consuming task of fund-raising (Thompson, Lichtenstein, Corbett, Nettekoven, & Feng, 2000). In these circumstances, loss of momentum and departure of key staff are also likely (Cornerstone Consulting Group, 2002). By contrast, there is evidence indicating that early and ongoing support for sustainability results in institutionalisation of community programs, policies and community development practice (e.g., Paine-Andrews, Fisher, Campuzano, Fawcett, & Berkley-Patton, 2000). Lead agency support and community leadership are also factors associated with sustainability.

Matching intervention strategies to fit needs, objectives and context is critical to successfully facilitate the type of social change associated with improved SESWB, which include: safe, healthy and supportive environments; strong cultural identity; positive child development; and the prevention of violence, crime and self-harm (Merzel & D'Affliti, 2003; Glasgow, Klesges, Dzewaltowski, Bull, & Estabrooks, 2004; Sorensen, Emmons, Hunt, & Johnston, 1998). Central to program sustainability is the need to identify local relevant organisations willing to integrate programs into their core business and/or provide space, ongoing organisational support and mentorship (Empowerment Research Program, 2009).

Current initiatives

The Family Wellbeing program

The Family Wellbeing (FWB) Program is an empowerment strategy that aims to build communication, problem-solving, conflict resolution and other life skills to enable the individual to take greater control in their life choices (Whiteside, et al., 2006). FWB was developed in 1993 in Adelaide by members of the Stolen Generation whose aim in establishing the program was to pass on the life skills and values they had drawn upon in overcoming adversity.

Over the past decade, FWB evaluations have provided evidence of a range of benefits for participants and their communities. These effects are most evident at the level of personal empowerment and include an increased sense of self-worth, improved analytic skills, better understanding of children's needs and more empathic communication with children and other family members, and an increased ability to cope with the stresses of daily life and help others to do the same. Many participants report constructive behavioural changes such as reducing their alcohol intake, changing their diet and doing more physical exercise. In addition, many have reported using their improved life skills to strengthen their role in the workplace, local organisations and political affairs. In some cases, completion of FWB has led to people organising groups to address community issues such as poor school attendance rates, family violence and the overrepresentation of Indigenous men in the criminal justice system (Empowerment Research Program, 2008).

Triple P-Positive Parenting Program

Triple P-Positive Parenting Program is a multi-level parenting and family support strategy developed in Queensland, which aims to prevent behavioural, emotional and development problems in children by enhancing the knowledge, skills and confidence of parents. The program targets the developmental periods of infancy, toddlerhood, pre-school, primary school and adolescence, and has been adapted for use in Indigenous settings (Sanders, 2003). Triple-P incorporates five levels of intervention, which vary from targeting a whole population to specific groups of high-risk children. For example, Level 1 aims to increase community awareness of parenting resources, whereas level 5 involves practitioners working with parents and caregivers experiencing relationship conflict, parental depression and high levels of stress.

The cumulative evidence in support of the efficacy of Triple-P has evolved over a period of 30 years. It began with single case experiments and has expanded to include evaluations at a population level. A considerable body of evidence has accrued that demonstrates the efficacy of various Triple P programs (see www.pfsc.uq.edu.au for a current list of all evaluation studies).

Nurse Visitation Programs

There is accumulating evidence that programs for pregnant women and parents of young children, especially nurse home visiting programs, hold significant promise for improving children's life-course trajectories and for reducing developmental and health problems (Gluckman, et al., 2005; Olds, Sadler, & Kitzman, 2007). David Old's Nurse Home Visitation model is currently being trialled in a number of sites across Australia, including Wuchopperen Aboriginal Health Service in Cairns. The Nurse Home Visitation program involves nurses paying regular visits to mothers, or families, who are socially or economically disadvantaged. The basic premise is that poor, first-time parents often lack the problem solving and interpersonal skills that make a good parent, and that an intensive program of regular visits by specially trained nurses, starting during pregnancy, can provide those skills. This approach can also give mothers the intellectual resources to take charge of their own lives and better their circumstances.

In the United States, nurse visitation programs have been subject to evaluations in a variety of settings, over three decades. Some of the positive effects of the programs for low income mothers have included improved diet and decreased smoking during pregnancy, with children born at higher birth weights. Mothers who have participated in the program have also been shown to make better use of local services. Follow-up after 15 years has demonstrated longer-term positive outcomes for the then adolescent children.

School-based resilience: the Resourceful Adolescent Program

There are examples of promising school-based resilience enhancing, skill-building and suicide prevention programs for Indigenous youth in Canada and the United States (Kirmayer, et al., 2007; LaFromboise & Lewis, 2008) and youth skill-building programs have been applied to diverse adolescent prevention programs, especially in school-based settings. These programs have focused primarily on the enhancement of competence in youth development work (e.g., self-regulation), as well as the reduction of at-risk behaviours and the prevention of mental health problems. Outcome data from these prevention interventions have been promising, especially when coupled with parent and family training and support (LaFromboise & Lewis, 2008).

In Australia, the Resourceful Adolescent Program (RAP) has been developed to build resilience and promote positive mental health in teenagers (see www.hlth.qut.edu.au/psyc/rap). RAP draws on research of successful treatments for adolescent depression and the known psychosocial risk and protective factors at the individual, family and school level. Since its beginnings as a pilot program in 1996, RAP has been subject to systematic evaluation. Results of published randomised controlled trials have indicated that the RAP program prevents future depressive symptoms in adolescents and is significantly better than a placebo control. RAP is now widely used throughout Australia. A Supplement for adapting RAP-A for use with Indigenous Australian adolescents has also been developed (Shochet, Hoge, & Wurfl, 2004). This Supplement has undergone evaluation, with significant results related to improvements in student–teacher relationships, management of school workload and student help-seeking behaviour (Robinson, et al., 2005).

Indigenous Men's (and Women's) Groups

Although there is a dearth of published research on Indigenous men's and women's groups, these local, micro-level initiatives have the potential to play a crucial role in defining community priorities and building people's capacity to take advantage of changing opportunities within macro social environments, to make healthier choices and develop local solutions to complex issues.

It is estimated that since the late 1990s there has been approximately 20-25 Indigenous men's groups established in Queensland (McCalman, et al., 2009). In general, these groups offer regular support meetings, support and advocacy for men through the courts and diversionary programs, including Family Well Being. They are also often involved in organising local sporting, social and traditional cultural programs/activities, particularly targeting young people. Sport and recreation programs in Indigenous communities may strengthen social cohesion, improve school attendance, and serve as powerful protective factors against juvenile crime, substance abuse, violence and self-harm (Beneforti & Cunningham, 2002; Cunningham & Beneforti, 2005).

Men's groups advocate on issues such as the need to increase employment opportunities, the need for a 'men's place', and improvement in men's access to health services. Outcomes achieved by men's groups at individual, family, community and men's group levels include group sustainability, generation of significant funding across time, identification of future priorities, and innovation resulting from the capacity of men to draw on both traditional culture and western approaches to issues of identity and resilience.

Suicide prevention

Overall, efforts to understand and prevent Indigenous suicide in Australia have been hampered by problems related to data collection and interpretation (Hunter & Harvey, 2002; Beautrais, 2006). Until recently, these difficulties have been underscored by a lack of engagement with Indigenous communities on the issue.

Suicide is a serious health issue for many Indigenous cultures. Within this context, the work of Chandler, Lalonde and colleagues in Canada is significant in that it seeks to move toward an understanding of the relationship between individual suicide risk and larger issues of cultural continuity. In particular, Chandler and Lalonde (1998) have observed that

those Canadian aboriginal bands that meet all or most of the following set of markers of cultural continuity suffer no suicide, whereas those that do not have suicide rates of more than 150 times the national average. The protective markers are when the community has:

• taken steps to preserve their cultural past;
• attained some level of self-government;
• attained measurable control over health, education, child protection, and jural systems; and
• effectively advocated for title to traditional lands.

Among Canadian aboriginal bands, suicide often occurs in clusters, within particular communities (Chandler & Lalonde, 1998; 2009). Patterns of suicide incidence among Indigenous Australia are similar (Hunter, 2004; Eliott-Farrelly, 2004). Although there is little Australian evidence that has been collected regarding the correlation between self-determination markers and suicide incidence, cultural identity has been identified as a protective factor for suicide for Aboriginal and Torres Strait Islander Australians.

Chandler and Lalonde outline that the clustering pattern of suicide points to the variability in rates of youth suicide between Canadian Aboriginal bands and groups. To average these rates across the population obscures the fact that some communities have accomplished all or most of the measures of self-determination and do not experience suicide. It can be concluded that these groups already know much about how "to create a world in which aboriginal youth can find a life worth living" (Chandler & Lalonde 1998: p. 6). It is on this basis that Chandler and Lalonde urge that the knowledge Indigenous communities already possess be transferred laterally, between communities. Communities in which suicide has not occurred are especially likely to possess knowledge and engage in practices that could be of enormous help to others. This argument formed the basis of the recent *Building Bridges* project based in Queensland and funded by the National Suicide Prevention Strategy.

In summary, control and resilience are key elements of community and individual capacity and wellbeing. Efforts to improve individual, family and community SESWB, therefore, need to focus on initiatives which facilitate control, build resilience and strengthen cultural identity, especially for children and young people. This requires long-term commitment. SESWB initiatives should be implemented through partnership models in which appropriate community-based organisations are supported to identify local priorities and integrate project objectives and human resources into their core business. The primary role of other partners is to provide support, mentoring and to facilitate dissemination of findings in academic and culturally relevant media.

Recommended actions

1. Support well-conceived SESWB programs that aim to strengthen cultural identity, communities and families through participation in sports, recreation and arts activities.

2. Support and enhance current initiatives that focus on facilitating individual and community capacity and resilience to build their evidence base, particularly to enable comparability of outcomes through the integration of standardised measurement tools and evaluation methodologies.

3. Enable current initiatives to 'scale up' or 'network' with the aim of translating proven micro-level community-based strategies into system and organisation-wide level activities that impact the broader culture and philosophy of services and institutions. This support should include opportunities for programs, their participants or community-based groups, to share knowledge and support each other across settings and regions.

4. Develop a mechanism to assess SESWB funding proposals against a set of criteria based on core concepts of capacity, empowerment, community control, partnerships and sustainability such that:

   • SEWB community based programs are undertaken as partnerships between Indigenous communities and other relevant parties.

   • Program development involves a community engagement phase in which communities are given an opportunity to consider proposals, evidence and community priorities.

   • Communities and community-based organisations are supported in identifying local priorities and strategy development.

   • To optimise program sustainability, a key community-based organisation undertakes to integrate the proposed SESWB program into its core business and provide organisational support.

   • The partnership approach includes participation of the tertiary sector with the aim of building organisational capacity related to evaluation processes.

   • That evaluation processes employ culturally relevant methodologies.

   • Community-based workforce are provided with adequate mentoring and support.

   • Programs support the development of workforce skills and experience related to defining, implementing and managing community-driven priorities.

Key Direction 3: Develop Workforce

Support development of the workforce needed to promote SESWB

Rationale

The accessibility of health services for Aboriginal and Torres Strait Islander Australians is affected by a number of factors, including the distance to and availability of health professionals, services and facilities, availability of transport, the degree of proficiency in English (of some Aboriginal and Torres Strait Islander people as patients), and the cultural appropriateness of service delivery. Clearly, these factors are heavily influenced by the size and composition of the health workforce. In 1999, there were 2-3 times as many medical practitioners, nurses and pharmacists per person in capital cities as in most remote areas, and about seven times as many medical specialists per person in capital cities than in remote areas (AIHW & ABS, 2003). As a higher proportion of Indigenous Australians than of the total Australian population live in remote areas, this highlights an area of need. However, it should also be noted that Indigenous people who live in metropolitan areas might also suffer from poor access for cultural or other reasons.

The *National Aboriginal Health Strategy* (1989) identified workforce issues, particularly those related to education and training as a major priority area. This included both the need for recognition through a professional award structure and accredited training for existing Indigenous health workers, as well as education programs for non-Indigenous health professionals working in Aboriginal and Torres Strait Islander health. In response to the *Strategy's* recommendations, activity in the area of health worker training has increased dramatically over the last two decades. However, the array of different professional settings within which health workers are required to function, a lack of national coordination, and the time taken to develop the health worker career structure and award have resulted in a range of complex issues that now need to be addressed.

Numerous State/Territory reviews of Aboriginal and Torres Strait Islander health worker training have been undertaken and a national review completed, which, in part, contributed to the 2002 release of the *National Strategic Framework for the Aboriginal and Torres Strait Islander Workforce*. This framework was endorsed by the Australian Health Ministers' Advisory Committee in 2003 and proposed a comprehensive reform agenda and argued that urgent attention be given to the Indigenous health workforce in the Australian health system as a whole, as well as in the delivery of comprehensive primary health care to Aboriginal and Torres Strait Islander communities.

One of the most difficult areas of policy discussion in relation to Aboriginal health has been Aboriginalisation of the health workforce. The employment of Aboriginal and Torres Strait Islander staff is an important factor in whether Indigenous people are able to effectively access services. Unpublished data from the Department of Health and Ageing and NACCHO suggest that in 2000-01, 67% of full-time equivalent positions in Commonwealth-funded Aboriginal primary health care services were held by Aboriginal and Torres Strait Islander peoples. However, examination of the workforce composition shows that Indigenous staff were largely employed as health/field workers (97%), while non-Indigenous staff were more likely to be employed in professional positions. Most doctors (98%), nurses (87%), allied health professionals (89%), and dentists (88%) were non-Indigenous (AIHW & ABS, 2003). The need for strategies to increase the number of Indigenous health professionals is a key component of the NSFATSIW.

Aboriginalisation of the workforce in Indigenous health can also be linked to the policy principle of cultural security and to the key policy action area of building community capacity. The former recognises the right of Indigenous people to be able to access a health service without risk to their culture, while the latter recognises that strategies to foster Indigenous leadership and responsibility need to be implemented. This will facilitate enhanced community control of health and other services and to move towards greater community and individual self-sufficiency and empowerment (NSFATSIW, 2002).

The exponential growth in service level funding over the past decade or so, particularly in initiatives specifically related to mental health, has resulted in an increased number of workers, as well as diversification in terms of workforce roles and responsibilities. This has significant implications in terms of the availability of a skilled workforce, training and professional development needs, and service infrastructure required to support the additional staff.

The dependency upon government funding for service operations makes it difficult to plan strategically and develop workforce plans accordingly. Rather, the services find themselves in a position of responding to health system changes through the application of additional funds to the employment of new workers. For example, most of the money that was allocated to implement recommendations of the *Bringing Them Home Report* has resulted in the employment of drug and alcohol workers, mental health workers and counsellors. It is not uncommon for generalist staff to then become specialist workers without necessarily having a minimum set of required skills. Similarly, the implementation of specific initiatives such as the National Mental Health Plan 2003-2008 has resulted in demand for specialist workers in this regard. The lack of a nationally consistent approach to the employment and skill level requirements in these specialised roles needs to be addressed as a matter of priority. It is noted that the national competencies for Aboriginal health workers have now been endorsed and the challenge is to ensure all workers have a core set of skills to respond appropriately to mental health issues, as well as a group of highly specialised mental health workers.

In their review of Aboriginal Mental Health Services, Urbis Keys Young identified substantial and undesirable variation in the skill and qualification levels of Aboriginal mental health workers, and substantial service difficulty recruiting and retaining suitably qualified staff. They attribute the high turnover and staff burnout in the Aboriginal mental health workforce to a range of factors including the need for staff to:

• possess a highly specialised skills mix;

• manage large caseloads and work-related emotional stress;

• meet high community expectations;

• receive an uncompetitive salary;

• endure inadequate professional support opportunities; *and*

• receive minimal access to training (Wilczynski, et al., 2007).

In summary, the significance of Aboriginal and Torres Strait Islander health workers cannot be underestimated. However, there remains concern about the skill level of health workers, pressures placed upon them when working in their own communities, high rates of staff turnover, lack of a consistent approach to employment and training, and role relationships with other health professionals. The degree of specialisation required is also inconsistently applied. Furthermore, the increasing need for Aboriginal and Torres Strait Islander workers within the services to have skills in management, including financial planning and reporting, human resource management, maintenance of data systems, evaluation and reporting has resulted from the complex reporting arrangements associated with multiple funding sources and increased program responsibilities.

Current initiatives

A range of initiatives are underway across Australia related to building the Indigenous health workforce in appropriate ways. These include the following programs outside Queensland that have been reported on and evaluated in some way:

• In the Northern Territory, the Aboriginal Mental Health Worker Program, NT (Harris & Robinson, 2007), Tiwi Island Mental Health Service, NT (Norris, et al., 2007), and Australian Integrated Mental Health Initiative Northern Territory Indigenous stream, NT (Nagel &Thompson, 2006).

• In Western Australia, the Maga Barndi Unit, WA (Laugharne, et al., 2002).

• In NSW, the Aboriginal and Torres Strait Islander Child and Adolescent Mental Health Traineeship Program, NSW (Bartik, et al., 2007) and Djirruwang Aboriginal and Torres Strait Islander Mental Health Program, NSW (Brideson & Kanowski, 2004).

Within Queensland, the following are examples of promising initiatives that are being implemented.

Career Pathways for Aboriginal Health Care Workers

In 2008, Queensland Health provided funding to the Centre for Indigenous Health at the University of Queensland to develop a model for career pathways for Aboriginal health workers into a range of health professions. The model is based on the National Competency Standards that were adopted in March 2007 and provides opportunities for Aboriginal Health Workers at Certificate 4 level to transition smoothly into a range of health professions, including medicine, dentistry, nursing and public health. It offers a very real opportunity for Aboriginal health workers to specialise in a field such as mental health or drug and alcohol and to then achieve higher level professional qualifications.

When Sharin's not Carin

The Centre for Indigenous Health developed this interactive training resource for Aboriginal health workers and others who come into contact with Indigenous injecting drug users. It was funded by COAG and gave recognition to the fact that there is a range of professionals that come into contact with injecting drug users, often for different reasons, and that it is important not to narrowly focus on the Indigenous health workers. Similar approaches could be taken for mental health. The training package was developed in close consultation with Indigenous communities and is available in both hard copy form and as an interactive electronic resource. The workers targeted in this process were police, environmental health workers, drug and alcohol workers, hostel staff and a range of others.

Brisbane Inner City Drug and Alcohol (and homelessness) Project

The Brisbane Indigenous Coordination Centre in partnership with the Department of Health and Ageing (DoHA) are developing a service model for the delivery of drug and alcohol services operating for Indigenous people in Brisbane (see Shannon, Ogwang, & Doumany, 2009). The aim is to establish a partnership model or collaboration of mainstream and Indigenous specific substance misuse services that:

• provides a suite of coordinated drug and alcohol services for Indigenous people;

• ensures a seamless path of service delivery for Indigenous clients;

• government can better align investment to; and

• government can share the leadership of addressing substance misuse with the Indigenous community.

In addition, the partnership is intended to establish a level and standard of drug and alcohol related services agreed to by community-based organisations and government that is responsive to the priorities of the Indigenous community. The project has a focus on immediate and long-term capacity building needs of the mainstream and Indigenous organisations to ensure that the partnership is well placed to respond to the substance misuse issues faced by Indigenous people living in Inner Brisbane, including homeless or transient members of the community.

Protocols for the delivery of social and emotional wellbeing and mental health services in Indigenous communities: guidelines for health workers, clinicians, consumers and carers

These protocols have been developed based on an awareness that Indigenous mental health remains an area where there is little evidence on which to base practice guidelines (Haswell-Elkins, et al., 2009). They acknowledge the mistakes and fallout that specialist mental health services have made that have added to the entrenchment of Indigenous disadvantage. The protocols aim to provide guidance to ensure that service providers help rather than harm, and work safely with Indigenous people. Despite the weight of history and harm Indigenous people have suffered, the protocols are based on hope and optimism that things can improve through advances in mainstream and Indigenous primary health care incorporating empowerment/recovery interventions that emphasise wellbeing and consumer-defined recovery. The writing of the protocols was supported through a National Health and Medical Research Council Partnerships Grant in Mental Health (AIMhi – Australian Integrated Mental Health Initiative) to the University of Queensland with many key partners including Queensland Health, the Royal Australian and New Zealand College of Psychiatrists, Northern Territory Health, and the Menzies School of Health Research.

Recommended actions

1. Develop mechanisms to coordinate and evaluate workforce training programs relevant to SESWB, as programs have emerged from a wide range of (largely uncoordinated) government, community-controlled, and COAG initiatives that span many diverse sectors including social services, mental health and health promotion. To help build sustainability and enhance workforce capacity, a first step would be to map the Indigenous SESWB and health promotion workforces and their training needs across mainstream, community-controlled, and non-government sector services. This would enable the identification of gaps and overlap in an area that has been expanding so quickly that it is not well defined or documented.

2. Develop and disseminate appropriate resources for training and practice to build a stronger knowledge and practice base for the SESWB workforce. These resources should be based on: information drawn from the mapping exercise; the evaluation and monitoring suite of tools identified as a priority in KD1; and appropriate, evidence-based protocols (such as the *Protocols for the delivery of social and emotional wellbeing and mental health services in Indigenous communities: guidelines for health workers, clinicians, consumers and carers*). This would enable the adaptation and application of principles, approaches and resources in those settings specifically targeting the Indigenous workforce, but also able to be utilised in programs designed for non-Indigenous workers wishing to pursue a career in Indigenous mental health and SESWB.

3. Devise a strategy for implementation and ongoing support to ensure that the resources transform practice and build workforce capacity. An appropriate evaluation and monitoring component needs to be included in the implementation strategy.

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Appendix 1 : Membership of Expert Working Group

In alphabetical order:

Jeff Allen, Health Promotion Queensland

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Bruce Gynther, Queensland Health, Mental Health

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Alexandra McEwan, James Cook University, Qld

Helen Milroy, University of Western Australia

Cindy Shannon, University of Queensland, Qld

Ian Shochet, Queensland University of Technology

Komla Tsey, James Cook University, Qld

Greg Pratt, CRRMHQ

Appendix 2 : Major Policy Documents Relevant to this Framework

Queensland

- *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008* (Queensland Health, 2003a) and *Reducing Suicide: Action Plan: Queensland Government Suicide Prevention Strategy 2003-2008* (Queensland Health, 2003b)

- *Queensland Mental Health Policy Statement: Aboriginal and Torres Strait Islander People* (Queensland Health, 1996)

- *Queensland Plan for Mental Health 2007-2017* (Queensland Government, 2008)

Australia

- *Living Is For Everyone (LIFE) Framework: A Framework for Prevention of Suicide in Australia* (Commonwealth of Australia, 2007)

- *National Mental Health Plan 2003-2008* (Australian Health Ministers, 2003)

- *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000* (Commonwealth Department of Health and Aged Care, 2000)

- *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Australian Government Implementation Plan 2007-2013* (Australian Government Department of Health and Ageing, 2003)

- *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009* (National Aboriginal and Torres Strait Islander Health Council, 2004)

- *Values and Ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander Health Research* (National Health and Medical Research Council, 2003).

- *Keeping Research on Track: A Guide for Aboriginal and Torres Strait Islander Peoples About Health Research Ethics* (National Health and Medical Research Council, 2005).

- *Guidelines for Ethical Research in Indigenous Studies* (Australian Institute of Aboriginal and Torres Strait Islander Studies, 2000)

International

- *Universal Declaration of Human Rights* (United Nations, 1948)

- *United Nations Declaration on the Right s of Indigenous Peoples* (United Nations, 2008)

- *Prevention of Mental Disorders: Effective Interventions and Policy Options. Summary Report* (WHO, 2004)

- *Promoting Mental Health: Concepts, Emerging Evidence, Practice* (WHO, 2005)

Appendix 3 : NHMRC Levels of Evidence

Levels of evidence

Level	Type of Evidence
I	Evidence obtained from a systematic review of all relevant randomised controlled trials (RCT).
II	Evidence obtained from at least one properly designed RCT.
III-I	Evidence obtained from well-designed pseudo-randomised controlled trials (alternate allocation or some other method).
III-II	Evidence obtained from comparative studies with concurrent controls and allocation not randomised (cohort studies), case control studies, or interrupted time series with a control group.
III-III	Evidence obtained from comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group.
IV	Evidence obtained from case series, either post-test or pre-test and post-test.

Source: NHMRC (1999) p.56