6

Social Determinants of Social and Emotional Wellbeing

Stephen R. Zubrick, Carrington CJ Shepherd, Pat Dudgeon, Graham Gee, Yin Paradies, Clair Scrine and Roz Walker

OVERVIEW

This chapter explores current understandings of the social determinants of Aboriginal and Torres Strait Islander social and emotional wellbeing and its development. We show that the determinants of this wellbeing are multiple, interconnected, and develop and act across the lifecourse from conception to late life. This chapter firstly focuses on the theoretical frameworks linking social factors to health and their applicability in Aboriginal population contexts. It then examines how social and emotional wellbeing develops in individuals, with a specific focus on the broad mechanisms that prompt, facilitate or constrain social and emotional wellbeing in all individuals. The chapter then discusses the social determinants and processes that pose a risk to the development of poor outcomes among Aboriginal and Torres Strait Islander peoples as well as the factors that promote or protect positive wellbeing. We highlight that there are a unique set of protective factors contained within Indigenous cultures and communities that serve as sources of strength and resilience.

It should be noted that this chapter primarily examines and refers to 'social and emotional wellbeing', as opposed to the terms 'mental health' or 'mental illness'. The social and emotional wellbeing concept reflects the broader, holistic view of health that is an intrinsic part of Aboriginal and Torres Strait Islander (herein referred to as 'Aboriginal') culture. It recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect individual's wellbeing.[1]

INTRODUCTION

What can be done to promote and protect the development of optimal social and emotional wellbeing (SEWB) among Aboriginal peoples? How is the development of poor SEWB prevented or reduced? To begin to address these questions it is necessary to have an understanding of the key determinants of the wellbeing of populations.

THE IMPORTANCE OF SOCIAL FACTORS TO POPULATION HEALTH

The health and development of individuals is shaped by an array of factors over time and by place and lifecourse stage. Genetic history, biology and environmental exposures can all have a marked impact on health, and form part of the complex aetiologies of physical and mental health problems.[2, 3]

In recent decades there has been an increased acknowledgment of the role of social factors in determining health outcomes. There is now a robust international literature

that consistently affirms that social factors have a marked influence on the health of populations. The quantitative and qualitative evidence base now widely supports the notion that health inequalities, such as those that exist between Aboriginal and non-Aboriginal Australians, are the result of factors and processes that fall outside of the traditional domains of health. They are heavily influenced by the structures of society and the social conditions in which people grow, live, work and age—or what are now popularly known as the social determinants of health.[4]

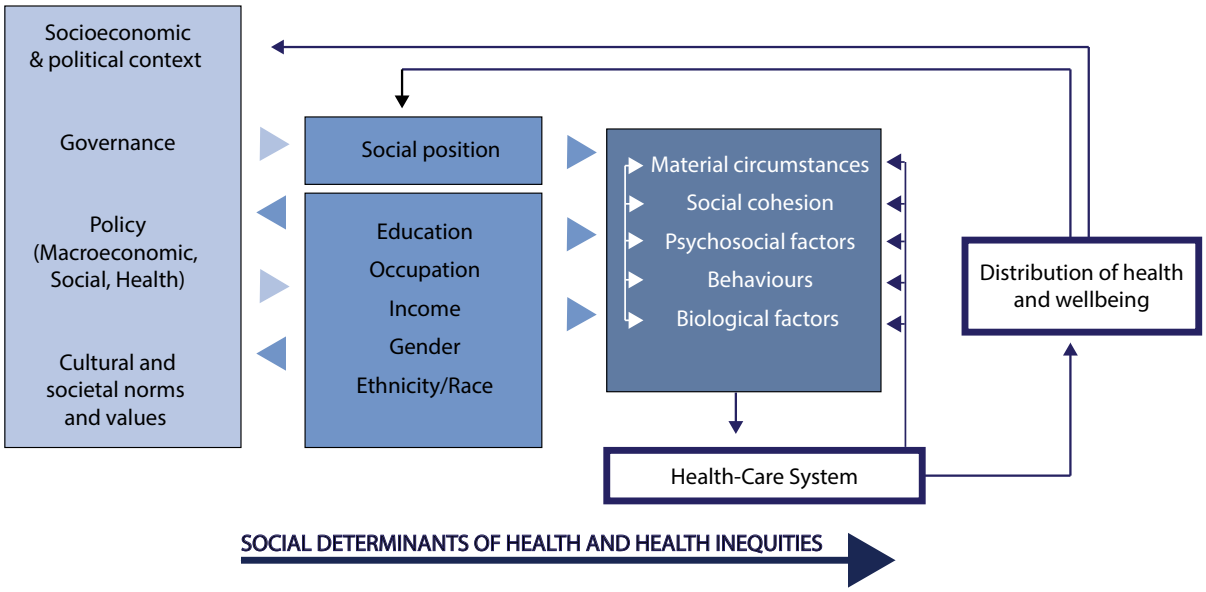
These social determinants of health comprise a wide range of factors, including those that describe the material and social environment of families and the communities in which they live, and the psychosocial conditions of life. These factors extend to income, employment, occupation, poverty, housing, education, access to community resources, and demographic factors such as gender, age and ethnicity.[5]

There are a number of theoretical frameworks that attempt to describe the relationship between health and their social determinants. Most place an emphasis on either psychosocial processes that increase an individual's susceptibility to illness (for example, lower social standing that causes stress, leading to alcohol misuse and a perceived loss of control over one's life, and consequent poor health), or broader economic and political influences that have an indirect effect on health via their impact on material wellbeing (for example, financial strain that results in restricted access to health care services), or both. Importantly, most determinants do not occur in isolation from others. Many pose a risk to health concurrently and many accumulate as time goes on. The number and type of risks (or protective factors) faced by an individual, and their timing, intensity and duration of exposure all influence the level of wellbeing experienced at any point in time.

The framework posed by the World Health Organisation's Commission on Social Determinants of Health (WHO CSDH) is a prominent example of an organising framework that implicates the circumstances of daily life and the broader structures of society as important health determinants.[6] It highlights that inequalities in society lead to inequalities in physical and mental health.[7] The elements of the WHO CSDH framework were determined on the basis of the empirical evidence globally and features determinants that have been shown to be amenable to policy intervention. In other words, the generally accepted social determinants of health are modifiable—that is, they can be influenced or controlled in ways that either reduce the incidence and/or prevalence of ill health and disease, or promote the likelihood of positive physical and mental health and wellbeing.

The WHO CSDH framework and its components are likely to have applicability to Aboriginal populations,[7-9] although it should be recognised that while the framework makes reference to ethnicity and race as a key determinant of health, they are not a central tenet. Models that consider specific population groups tend to place greater emphasis on characteristics of culture and historical circumstances. The model proposed by Williams (1997), for example, considers culture as a basic cause of health status and places aspects of racism, geographic origins and culture as central in understanding how health is formed.[10] The underlying message here is that we are still unsure about the saliency of conventional social determinants to the health of Aboriginal population groups—this is because there has been relatively little scrutiny of the relationship between social factors and Aboriginal health in general,[11] and SEWB specifically.[12]

Figure 6.1: Commission on Social Determinants of Health Conceptual Framework



Source: Amended from Solar & Irwin (2007) by Commission on Social Determinants of Health (2008),[6] used with permission.

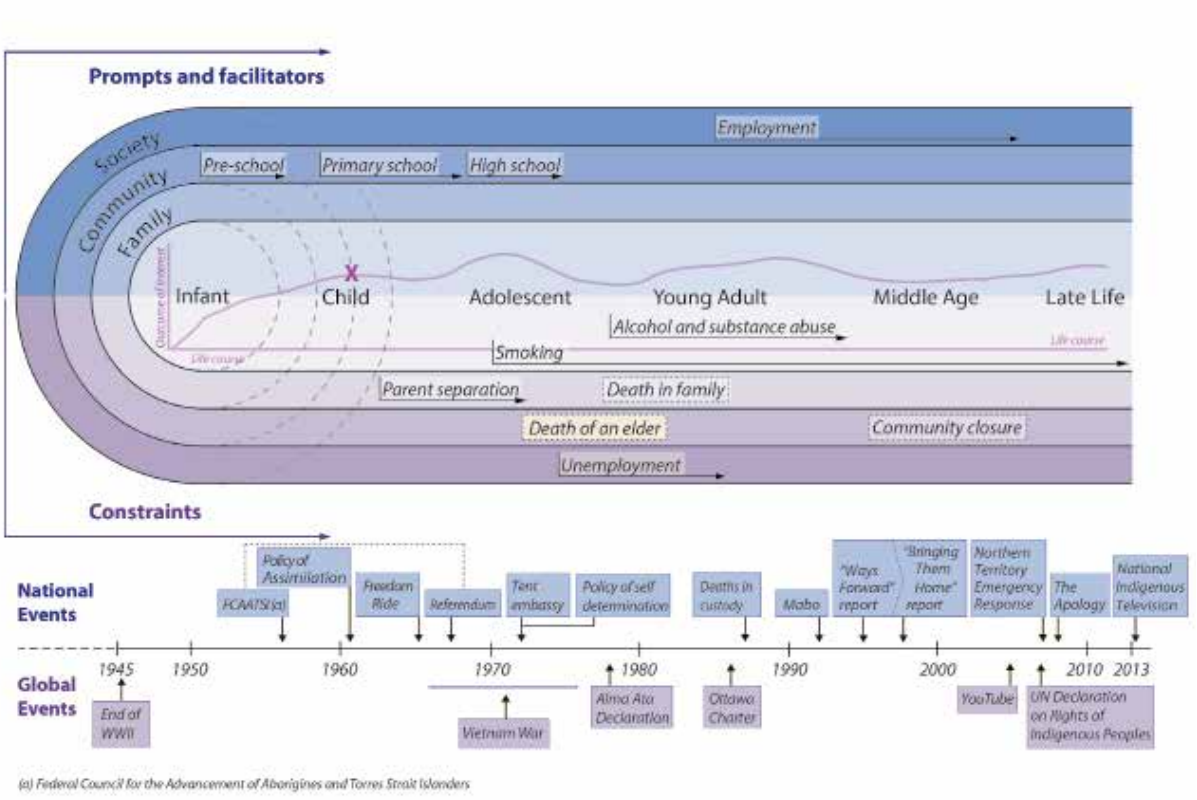
THE DEVELOPMENT OF SOCIAL AND EMOTIONAL WELLBEING

It is important to recognise that children's development—including the development of SEWB—is influenced not just by what happens in childhood but also by processes that take place in-utero and prior to conception. For example, maternal drug use can have a marked negative effect on early brain development. This, in turn, may restrict early learning experiences and further limit early cognitive development and emotional and behavioural regulation—and all of these experiences and outcomes are likely to have consequences for health throughout life.[2] As such, thinking about determinants needs to be done in the context of how humans develop through the lifecourse. Before we consider some *specific* determinants of social and emotional development, we present here some broad concepts about the development of SEWB.

The evidence in the child development literature suggests that the development of SEWB is shaped by a small set of mechanisms. These mechanisms either prompt, facilitate or constrain the development of skills, capabilities and strengths in early life, and can have a lasting impact on all facets of life. The term *prompts* refers to those mechanisms that require or cause development in wellbeing to occur at particular times or in response to specific circumstances. *Facilitators* are those factors that assist, or make easier, the growth, establishment, elaboration and maintenance of wellbeing. *Constraints*, not surprisingly, inhibit, delay or prevent the development of wellbeing.[13] These mechanisms operate similarly in Aboriginal and non-Aboriginal populations, albeit in vastly different population contexts. They also operate across the lifecourse. Figure 6.2 offers a lifecourse perspective on the development of SEWB in the context of a selection of global and national events (from the end of WWII to the present day) that are known to have had an impact on Aboriginal Australia, and highlights the hypothetical variation in SEWB from birth to late life. The variation in the status of SEWB can be thought of as the variation in the lifecourse of an individual life or as a time series of the population estimate over the relevant period. The figure features a range of family, community and society-level contexts and exposures. This includes important developmental facilitators such as educational experience and transitions, and a selection of developmental constraints that are, too often, part of the lives of Aboriginal children (parental separation, the death of family members and Elders, and community closures). All of these exposures (and SEWB outcomes)

can be influenced by broader factors—these include global and national events that occur over time.[14] For example, the establishment of the Federal Council for the Advancement of Aborigines and Torres Strait Islanders in 1958 provided a stimulus to anti-racism and equality campaigns across Australian states and territories. This activity culminated in the successful 1967 Referendum that provided the Commonwealth government with the power to legislate on issues directly affecting Aboriginal people and ensured Aboriginal people were included in the national Census.[15] Moreover, the Referendum was interpreted as recognition of Aboriginal citizenship rights and expected to spark substantial improvements in the welfare of Aboriginal peoples. These outcomes are likely to have provided direct benefits to the SEWB of individuals and communities around the time of the Referendum and indirect benefits over time, coinciding with a stronger push for Indigenous rights in Australia in the ensuing decades.

Figure 6.2: Child development in the context of the lifecourse, with an Aboriginal perspective



Source: Zubrick et al. (2009),[14] adapted with permission.

Prompts for the Development of Social and Emotional Wellbeing

The three major prompts of optimal SEWB are biology, expectations and opportunities.

Biology

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

Expectations

The social and emotional capacities in children are prompted by parent/carer expectations about the capacities of their children. Carers have expectations about the development of their children, some of which are explicitly acknowledged and others of which are not.

These expectations come in the form of carer values, attitudes and beliefs. Some of these are revealed in the encouragement given when parents respond to a child's first steps or words—or when they express concern about delays in these milestones. Other expectations are revealed in requests, demands and rules that govern such things as picking up after yourself, cleaning your room, making your bed, doing chores, doing your homework, reporting in, being home on time and being polite. Evidence shows an important relationship between carer expectations in the form of their parenting styles and practices and the wellbeing of their children.[13]

Opportunities

The social, emotional and cognitive development of children is promoted by the opportunities they have to engage in stimulating activities. Providing opportunities to talk, play, interact and read, particularly for very young children, can have significant onward developmental benefits for the child, in the form of both improved academic achievement and improved social and emotional capacities.[16, 17]

Facilitators of Social and Emotional Wellbeing

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

Intellectual Flexibility

SEWB is facilitated by intellectual flexibility and an outgoing personality, easy temperament and tolerance of new situations.[18]

Good Language Development

Survey data indicate that speech problems increase the risk of clinically significant emotional or behavioural difficulties in children.[13]

Emotional Support

Some examples of emotional support include encouraging young children to explore, to celebrate developmental milestones, providing guided rehearsal and extension of new skills, and protection from inappropriate disapproval, teasing or punishment.[19] Most parents want their children to succeed and generally protect them from excessively adverse experiences. For many children, encouragement in the face of difficulty, support in failure, and celebration of success can aid the development of secure relationships with their parents and their longer-term social development, and are critical facilitators of their SEWB.[20]

Constraints on the Development of Social and Emotional Wellbeing

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

Stress

Stress is defined as 'environmental circumstances or conditions that threaten, challenge, exceed or harm the psychological or biological capacities of the individual'.[21] When stress events occur often enough in early life they can have a damaging effect on the developing brain of a child and alter the functioning of important bodily systems, with negative consequences for cognitive, emotional, and systemic disorders throughout life.[22, 23] At the same time, stress can also affect the ability of adults to perform their role as parents in addition to disrupting community cohesion and the wider supports for optimal child development.

Chaos

As Zubrick et al. (2005) note:

> *[I]n 1996 Bronfenbrenner and colleagues reviewed what they termed 'growing chaos' in families, schools, unsupervised peer groups and other settings in which children and young people spend extended periods of time. They noted the damaging and disorganising effects of frenetic activity, lack of structure, unpredictability in everyday activities and high levels of ambient stimulation on the development of social and emotional capacities in children.*[24(p.559)]

Not only do such contexts disrupt SEWB, but they have the potential to establish alternative developmental processes that lead to poor outcomes.[25] Chaotic systems disrupt attachment, emotional regulation and autonomy.[26] Violence is a prime example of a disorganising influence on human development. Abuse, physical punishment, harsh parenting, bullying and other forms of harassment are harmful to human development and may be particularly damaging for individuals who are vulnerable to such harm.[13, 27]

Social Exclusion

Social exclusion can take many forms ranging from racism and vilification to bullying and more subtle experiences that entail refusals of friendship and non-recognition, all of which constrain wellbeing. These actions also span multiple settings and occur at home, at school, in the workplace, and in day-to-day social exchanges and transactions. Such experiences have the potential to establish reciprocal patterns of socialisation that weaken individual capacities, disrupt social cohesion and alienate groups. There is good evidence that racial discrimination is associated with a range of adverse health conditions including poor physical and mental health (especially depression and anxiety), as well as unhealthy behaviours such as smoking, alcohol and drug use.[28-30] Racism has been identified as a determinant of SEWB in its own right[28, 31, 32] and is discussed in greater detail below.

Racism

There are six main pathways through which racism can lead to ill health: reduced access to the societal resources required for health (e.g. employment, education, housing, health care) and increased exposure to health risks (e.g. unnecessary contact with the criminal justice system); negative self-esteem and self-worth leading to mental ill health; stress and negative emotion reactions which lead to mental ill health as well as affecting the immune, endocrine and cardiovascular systems; disengaging from healthy activities (e.g. exercise, adequate sleep, taking medications); maladaptive responses to racism such as smoking, alcohol and other drug use; and injury through racially motivated assault, resulting in further negative physical and mental health outcomes.[33]

There is strong evidence that systemic racism leads to reduced opportunities to access societal resources required for health, and hence that it contributes to socioeconomic disadvantage.[33] Systemic racism is the inherent ways in which policies, practices and processes of institutions—such as education providers, government agencies or the police—operate, leading to systematic, entrenched inequality between racial groups. While often viewed as neutral and sometimes acceptable, the application of beliefs, values, structures and processes by the institutions of society (economic, political, social) result in differential and unfair outcomes for particular groups. Policy and practices that discriminate unfairly in their effect, impact or outcome, irrespective of the motive or intention, amount to unfair discrimination.

Social Inequality

Social inequality results in the unequal distribution of, and access to, resources required for the development and SEWB of adults and children. These resources include human, psychological and social capital resources as well as income and wealth. This inequality may arise from inadequacies

in the laws and regulations for the redistribution of wealth and social benefit, differences in the use and accumulation of wealth by individuals and groups, and lack of access to the means for generating these resources by some groups relative to others.[13] Several studies have demonstrated the relationship between social inequality and developmental outcomes.[2, 34, 35] As specific groups experience the effects of social inequality—lack of resources and lack of access to services and diminished self-efficacy—there is potential for their stores of human, psychological and social capital to decrease, thereby concentrating the risks for particular groups and sub-populations.

In summary, this section has discussed the prompts, facilitators and constraints underlying the development of SEWB. While these mechanisms operate similarly among Aboriginal and non-Aboriginal people, the scale of the problems (constraints) are generally much larger for Aboriginal peoples. In addition, many of the factors that support development in early life are either missing in the lives of Aboriginal children or are too limited to produce sustainable benefits and opportunities in later life.[36] As a result, too many young Aboriginal people find themselves in a situation where they are overwhelmed by the stresses of everyday life and unable to cope effectively—and this typically leads to high levels of mental health problems,[13] including psychological distress.[37]

To this point we have considered the importance of social factors to the health of populations and outlined some of the key social determinants according to the international literature. We have also focussed on SEWB specifically and summarised the evidence from the child development literature to provide an understanding of how this aspect of wellbeing develops and is shaped over the lifecourse. We now consider some of these determinants and mechanisms as they pertain to Aboriginal peoples, as well as circumstances and characteristics that are unique to Aboriginal populations and critical to their health. In doing so, we provide a summary of the available evidence that describes the prevalence or incidence of these health determinants and their relationship to various SEWB outcomes.

RISKS TO ABORIGINAL SOCIAL AND EMOTIONAL WELLBEING

Many Aboriginal people face a set of interrelated risks to their social and emotional welfare.[38] While single risk factors—such as particular negative life events—might have a minimal effect on their own, when combined they can have a strong interactive effect, and exposure to multiple risk factors over time can have a cumulative effect.[39]

Many of the unique risks faced by Aboriginal peoples have persisted across generations. This reflects the fact that the health and wellbeing of Aboriginal peoples has been profoundly shaped by the circumstances of the past, and most particularly by the events and conditions in Australia since colonisation. The enduring legacy of colonisation on Aboriginal life has been pervasive and affected multiple generations and extends to all dimensions of the holistic notion of Aboriginal wellbeing, including psychological, social, spiritual and cultural aspects of life and connection to land. This has resulted in serious additional risks to wellbeing, including: unresolved grief and loss; trauma and abuse; violence; removal from family; substance misuse; family breakdown; cultural dislocation; racism and discrimination; exclusion and segregation; loss of control of life; and social disadvantage.[1]

Discrimination and Racism

Racism occurs at both interpersonal and systemic levels in Australian society and it impacts a disturbingly high proportion of Aboriginal people.[13, 31, 32, 40, 41] A recent national study indicated that 27 per cent of Aboriginal adults in Australia experienced discrimination, i.e. received unfair treatment as a result of being Aboriginal, in the 12 months to 2008.[42] It should be noted, however, that the reported prevalence of the experience of racism can differ depending on age and geographic location, and the aspect of racism being examined as well as the nature and number of questions asked.

The issues of violence, imprisonment, control, segregation and forced removal from family and traditional country (discussed below) have been in part fuelled by a persistent undercurrent of racism in Australian society which, in its various forms, is still a major problem in contemporary society. See Chapter 1 (Dudgeon and colleagues) for further discussion. For example, providing culturally inappropriate or insensitive public services can exclude Aboriginal people from accessing effective health care. This is one way in which racism in contemporary Australian society influences the state of Aboriginal health and reinforces existing socioeconomic disadvantage.[31] With less than one-in-seven Australians agreeing that Aboriginal and other people trust each other,[43] ongoing racism relates, in part, to a lack of trust which also represents a significant barrier to the process of healing and reconciliation in Australia.

An emerging body of evidence in Australia highlights that racism is a key source of stress (see section on S*tress*, below) and socioeconomic disadvantage faced by Aboriginal people and families, with negative impacts on SEWB and other health outcomes. This includes effects on conditions such as anxiety, depression, risk of suicide, mental and physical ill-health, emotional and behavioural difficulties, childhood illness, alcohol, smoking and substance use and poor oral health.[13, 31, 32, 41, 44-48]

Widespread Grief and Loss

Grief and loss have perhaps had the most profound impact on the wellbeing of Aboriginal people as discussed further in Chapter 17 (Atkinson and colleagues) and Chapter 28 (Wanganeen). National data illustrate that, in the 12 months to 2008, 40 per cent of Aboriginal adults had lost a family member or friend (compared with 19 per cent in the non-Aboriginal population),[42] and 39 per cent had attended a funeral.[49] These data reflect the substantially higher death rates among Aboriginal populations.[50] Too often, deaths involving infants, children, young adults, and men and women in their prime are sudden, unexpected and potentially preventable[51]—and therefore very traumatic. Extended family networks serve to extend grief across communities and regions and impact on community capability, and the funeral costs deplete the financial reserves and resources of family networks.

Child Removals and Unresolved Trauma

There are possibly no better examples of the deliberate and systematic disempowerment of Aboriginal people by white Australia than the suite of legislation enacted (mostly) in the beginning of the 20th Century that aimed to control Aboriginal peoples (see Chapter 1 for more details). These policies impacted the lives of virtually all Aboriginal people in Australia in some way. Their effects on the wellbeing of children were direct and unequivocal, as they gave rise to the widespread removal of children from their natural family and traditional lands.[52]

The effects of forcibly removing children from their natural families have been profound and enduring for Aboriginal people. This was made poignantly clear in the stories contained in the *Bringing Them Home* report, which linked forced removal to transgenerational trauma, feelings of helplessness, and loss of control in the lives of Aboriginal people and placed these realities into the public consciousness.[53] The first-hand accounts in this report are now supported by empirical evidence. Those who were forcibly removed as a child have poorer overall health and wellbeing[54] and higher rates of psychological distress.[55] Furthermore, the current generation of children are more likely to have emotional and behavioural difficulties if they have a family history of forced separation.[13] See Chapter 17 (Atkinson and colleagues) for further discussion of transgenerational trauma and Chapter 22 (Walker and colleagues) for further discussion of the emotional and behavioural issues experienced by young people.

Recent national survey data indicate that a substantial proportion of the current generation of Aboriginal adults had either a direct or indirect experience of forcible removal. Around 8 per cent of adults in 2004-05 had been taken away from their natural families by a mission, the government or welfare, while 43 per cent reported that a relative had been taken away.[49]

Life Stress

Research suggests that life stress may be the most important influence on the development of mental health problems among Western Australian Aboriginal children.[13] This research (in 2000–02) and subsequent studies have highlighted that Aboriginal children and adults are exposed to considerably greater life stress than other Australians.[36, 42, 56] Around three-quarters of Aboriginal adults across Australia experienced at least one major life stress in the 12 months to 2004–05, with over a quarter experiencing four or more stressors (2.6 stressors experienced, on average). Serious stress events, such as the death of a family member or close friend, trouble with police, and abuse or violent crime are experienced far more often by Aboriginal people when compared with other Australians.[42]

In addition, many Aboriginal people (particularly those in less remote areas) may experience the effects of acculturative stress. This can be faced by those who are striving to maintain their cultural heritage, negotiate a relationship with the dominant culture and deal with ongoing discrimination.[57] These are the stresses associated with living in 'two worlds' that have incompatible values and beliefs.[58]

Social Exclusion

Governments have a duty to minimise or prevent actions that result in the unjust exclusion of individuals or groups within the Australian population from participation in social, economic and civic life. This can be achieved through legislative and regulatory frameworks and/or providing support for mechanisms that promote access and equity in society.[13]

Relative to colonisation, it is only recently that governments have acted on that duty to provide Aboriginal Australians with a legal framework to address the fundamental aspects of social exclusion affecting them. Over the past 50 years a series of laws and judgments have played a central role in both recognising the existence of Aboriginal people before colonisation, and asserting their rights of participation and ownership (relevant policy milestones are discussed in Chapter 4). Key examples include:

- the 1967 Constitutional Referendum granting the Commonwealth concurrent power to make laws for Aboriginal people wherever they lived, as well as to allow Aboriginal people to be included in the national census
- the *Aboriginal Land Rights (Northern Territory) Act 1976* which recognised that Aboriginal people in the Northern Territory have rights to land based on their traditional occupation
- the 1992 Mabo judgment in which the High Court recognised that Aboriginal and Torres Strait Islander peoples' occupation of and 'native title' to their land survived the Crown's annexation of Australia in 1788
- the 1996 Wik Case which determined that the granting of a pastoral lease did not necessarily extinguish all native title rights and interests that might otherwise exist.[59]

Economic and Social Disadvantage

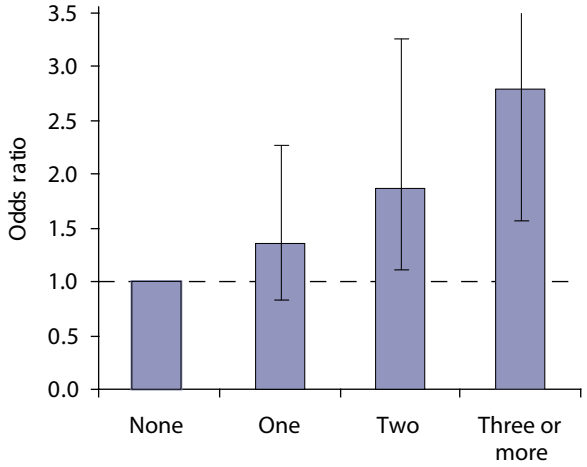
There is a plethora of government statistical and academic research reports that have highlighted the existence of deep-rooted social and economic disadvantage faced by Aboriginal peoples. This disadvantage is evident in measures of education, income, employment outcomes, occupational class, overcrowding and home ownership, and tends to be more pronounced in remote areas. For example, an alarmingly high proportion of Aboriginal people are under financial stress: almost half (47 per cent) of Aboriginal adults were unable to raise $2000 in a week if needed and 28 per cent ran out of money to pay for basic living expenses (such as food and rent) in the 12 months to 2008.[60] This underscores the fact that Aboriginal households have low income levels, in absolute and relative terms—13 per cent of Aboriginal people had an equivalised weekly household income of $1,000 or more, compared with 33 per cent of

non-Aboriginal people.[61] Poor outcomes in these areas give rise to other forms of disadvantage, leading to substantial proportions of the Aboriginal population experiencing multiple forms of socioeconomic disadvantage. For example, leaving school early can lead to difficulties in securing meaningful work and have consequences for long-term employment prospects and financial security.

The gaps in social and economic outcomes between Aboriginal and non-Aboriginal Australians have persisted over time, despite modest improvements in some indicators in recent decades. The trends over time signal that disadvantage is deeply entrenched in the lives of Aboriginal people, and, for many families, likely to have been passed down through generations. This has occurred despite considerable policy effort in recent decades aimed at improving Aboriginal education, employment and housing. The persistence of these trends in the face of long-term remedial efforts of governments makes it clear that Aboriginal disadvantage is complex and perhaps the long-term result of processes that began with the exclusion and marginalisation of Aboriginal peoples in Australia since colonisation.

It is generally agreed that better socioeconomic circumstances are associated with better mental health outcomes,[62, 63] although the links between these two elements are not fully understood.[64] Few studies have explored these links in Aboriginal populations, although a recent Western Australian study showed that higher socioeconomic status (particularly indicators of housing quality, home ownership and neighbourhood-level advantage) was associated with a reduced risk of mental health problems in Aboriginal children (see example of housing quality in Figure 6.3).[12] This suggests that improving the social and economic conditions of Aboriginal families may help to reduce the gaps in SEWB outcomes between Aboriginal and other Australians.

Figure 6.3: Relative odds of a mental health problem (a) in Aboriginal children aged 4–17 years in Western Australia, by number of indicators of poor housing quality (b)



(a) High risk of clinically significant emotional or behavioural difficulties.
(b) Regression model also adjusts for a range of factors related to the physical health of the child, the physical and mental health of the carer, and the circumstances of the family and household.
Source: Shepherd et al. (2012),[12] used with permission.

Incarceration and Juvenile Justice Supervision

The high rates of imprisonment of Aboriginal people (especially men) today are among the most alarming statistics of the Aboriginal circumstance. Aboriginal persons across Australia are 15 times more likely to be imprisoned than non-Aboriginal persons,[65] with rates over 20 times higher in Western Australia. In addition, Aboriginal children and young people are substantially

over-represented in the juvenile justice system: Aboriginal people aged 10–17 years were 14 times more likely to be under community-based supervision, and 24 times more likely to be in detention, than non-Aboriginal people of the same age in 2010–11.[66]

The relationship between contacts with the justice system and SEWB is multi-layered. Research highlights unequivocally that juvenile and adult offenders are more likely to have mental health problems,[67-69] and that high-risk alcohol consumption and illicit drug use is a common link between crime and wellbeing (these issues are discussed more fully in Chapter 10, Heffernan and colleagues). These relationships are likely to be exacerbated by a range of 'upstream' influences—including low educational attainment, unemployment, financial stress, overcrowded living and, for Aboriginal people specifically, being a member of the 'Stolen Generations'.[70]

Child Removal by Care and Protection Orders

Aboriginal children are vastly over-represented in the child protection system in Australia. When compared with non-Aboriginal children, Aboriginal children were nine times more likely to be on a care and protection order, ten times more likely to be in out-of-home care, and eight times more likely to be the subject of a substantiation of a child protection notification.[71] The reasons for this over-representation are complex, although they are likely to include the social and economic legacies of past practices of removal from family and culture, e.g. ongoing cycles of poverty, violence and drug and alcohol misuse in Aboriginal families and communities.[53, 71]

Children may come into contact with the child protection system for various reasons, including serious incidences of abuse, neglect and harm. While this system is designed to intervene as early as possible, it may not prevent or substantially reduce the effects of trauma that some children have been exposed to. The effects of various forms of abuse (e.g. traumatic violence) in early life can have profound consequences for emotional, cognitive and social development and wellbeing into adulthood.[23]

Violence

Exposure to violence is a key risk factor for the development of mental health problems in all populations.[13] The empirical literature indicates that Aboriginal people are far more likely to experience violence than others in the population, although the level of the relative risk varies depending on the type of violence (for example, physical violence or sexual violence) and the source data (for example, surveys, hospital data or police data). The 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) identified that 15 per cent of Aboriginal adults witnessed violence in the 12 months prior to the survey; 10 per cent reported being subject to abuse or being a victim of violent crime and 20 per cent had been a victim of physical or threatened violence in this period.[56] Deaths and hospitalisations from assault were 10 and 14 times higher for Aboriginal than non-Aboriginal Australians, respectively, although these relative rates were considerably higher among females. Alcohol-related arguments (22 per cent) and mental disorders associated with psychoactive substance use (8 per cent) were commonly linked to assault deaths of Aboriginal people.[68]

The broad range of risk factors for violent victimisation reflects sociodemographic circumstances, family and community difficulties, historical factors, and access to resources.[72] Evidence suggests that Aboriginal people are more likely to be faced with multiple risks and this may have a cumulative impact on the likelihood of experiencing violence.[73] For example, a person who engages in high risk alcohol consumption and experiences social stress will be at greater risk of violent victimisation than an individual who only experiences social stress.

Family Violence

A substantial proportion of violence experienced by Aboriginal people is related to family violence. This type of violence can be perpetuated throughout the lifecourse[74] and increases the risk of hospitalisation, death and incarceration and of children being removed on protection

orders. It is of particular concern that there is a disproportionately high rate of family violence among Aboriginal women: half of Aboriginal women hospitalised for assault were victims of family violence compared with one in five for males.[75] Spouse or partner violence accounts for 82 per cent of female admissions for family violence.

The implications of domestic violence on Aboriginal wellbeing, and approaches to assisting people, are explored in detail in Chapter 23 (Cripps and Adams).

Substance Use

Alcohol and substance use are among the most prominent preventable causes of death and disease in modern society, and account for a substantial proportion of the overall burden of disease in both Aboriginal and non-Aboriginal populations.[42, 76] Alcohol, tobacco and illicit substance misuse are strongly linked with poor SEWB outcomes. Alcohol misuse, for example, is one of the leading causes of hospitalisations for mental and behavioural disorders among Aboriginal people.[77]

Survey data suggest that 24 per cent of Aboriginal adults were impacted by an alcohol or drug-related problem in the 12 months to 2008 (that is, they—or someone close to them—had a problem). In terms of alcohol specifically, 17 per cent of Aboriginal adults had a long-term pattern of risky consumption, while 37 per cent were considered binge drinkers.[42] While it is acknowledged that risky consumption is generally more prevalent in Aboriginal than non-Aboriginal populations,[78] Aboriginal people experience a disproportionately high rate of problems from alcohol use.[79] For example, Aboriginal people are far more likely to be incarcerated from public drunkenness, and be the victim of serious physical violence.[68, 72]

The links between alcohol and substance use and mental health are discussed in more detail in Chapter 8 (Wilkes and colleagues).

Physical Health Problems

We have acknowledged that aspects of both physical and mental health can be influenced by social factors. However, it should also be borne in mind that physical and mental health are interdependent, i.e. physical health can impact on mental health and broader notions of SEWB, and vice versa.[5] This is important given the poor physical health profile of Aboriginal populations. Recent survey data indicate that 76 per cent of Aboriginal people had a long-term health condition, with many experiencing multiple conditions (15 per cent had two conditions; 43 per cent had three or more).[56] Further, Aboriginal adults were hospitalised at 2.4 times the rate of other Australians—with substantially higher relative rates (7 times) for potentially preventable chronic conditions.[50]

FACTORS THAT PROTECT ABORIGINAL SOCIAL AND EMOTIONAL WELLBEING

There are unique aspects of Aboriginal culture that can have a significant influence on Aboriginal health and that enables Aboriginal people to maintain spirituality central to the Indigenous notion of health. Connection to land, spirituality and ancestry, kinship networks, and cultural continuity are commonly identified by Aboriginal people as important health-protecting factors. These are said to serve as sources of resilience and as a unique reservoir of strength and recovery when faced with adversity, and can compensate for, and mitigate against, the impact of stressful circumstances on the SEWB of individuals, families and communities.[37, 80]

Connection to Land, Culture, Spirituality and Ancestry

The importance of land and the 'country' one belongs to is central to most aspects of Aboriginal culture, and maintaining a spiritual, physical and emotional connection to the land is intrinsic to many Indigenous people's beliefs about mental, social and emotional wellbeing:

> *To understand our law, our culture and our relationship to the physical and spiritual world, you must begin with land. Everything about Aboriginal society is inextricably interwoven with, and connected to, the land. Culture is the land, the land and spirituality of Aboriginal people, our cultural beliefs or reason for existence is the land. You take that away and you take away our reason for existence. We have grown that land up. We are dancing, singing, and painting for the land. We are celebrating the land. Removed from our lands, we are literally removed from ourselves.*[81(p.141)]

In addition to the importance of land and country, the wellbeing of individuals, families and communities are shaped by their connections to body, mind and emotions, spirituality, ancestry and broader, inter-related notions of culture and cultural heritage. These connections are complex and cannot be dealt with in detail here. However, some elaboration of the influences of these factors on SEWB is provided in Chapter 4 (Gee and colleagues). This includes a discussion on the importance of maintaining a secure sense of cultural identity and values, and participating in cultural practices.

Issues of cultural wellbeing are more readily being captured in household surveys, including level of attachment to language group and traditional lands. Data from the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) in 2008 highlight that:

- 11 per cent of Aboriginal adults spoke an Aboriginal or Torres Strait Islander language as their main language at home—the vast majority of whom lived in remote areas
- the majority of Aboriginal children aged 4–14 years (73 per cent) and adults (63 per cent) were involved in cultural events, ceremonies or organisations in the last 12 months
- 62 per cent of Aboriginal adults identified with a clan, tribal or language group[60]
- most Aboriginal people either lived on homelands (25 per cent) or recognised them (but did not live on them; 46 per cent).[42]

Biomedical research on the influence of the homelands on health in central Australia illustrates that there is an association between connection with land and lower prevalence of diabetes, hypertension and obesity, and lower mortality and hospitalisation rates.[82, 83] There is also evidence to support the view that connection to country and culture is beneficial to aspects of SEWB.[82, 84] Further, the literature consistently highlights that SEWB outcomes are more favourable among Aboriginal people in more remote settings,[13, 56] and these are typically the areas where Aboriginal communities maintain a greater connectedness with traditional culture, land and ways of life.

Kinship

Kinship and community relationships play a critical role in the lives and identity of Aboriginal people, and can be a source of strength and wellbeing. The unique status of every individual is defined by their connections with other people through their kinship, ritual and spiritual relationships. These are defined and understood from a very early age (with many Aboriginal people familiar with these relationships and responsibilities) and importantly, provide a sense of belonging. The centrality of kinship ties and relationships means that the bonds of reciprocal affection, responsibility and caring are inextricably linked to an individual's wellbeing. It is for this reason that any discussion of Aboriginal SEWB needs to recognise these cultural dimensions of wellbeing and the significance of support from the community to which they belong.

Self-determination, Community Governance and Cultural Continuity

The effective functioning of communities plays a critical role in supporting the economic and social wellbeing of families and children. Good community leadership and governance is well recognised as a primary driver of human development in Aboriginal communities. Failures in community governance, on the other hand, have been associated with catastrophic social dysfunction such as endemic alcohol misuse and family violence.[85, 86] The maintenance of

Aboriginal self-determination consistent with traditional cultural practices and values is another important driver of social functioning and human development, as evident in a number of studies of Indigenous communities in the USA and Canada.[87] For example, a study of variations in youth suicidal behaviour among First Nations communities across British Columbia's communities demonstrated that suicidal behaviour was dramatically lower in communities which had taken active steps to ensure good community governance structures, as well as preserve and rehabilitate their own cultures, languages and traditional practices.[88] One of the key findings from this research is the importance of fostering a secure sense of personal and cultural identity as a necessary protective factor against the threat of self-harm. This highlights the important role that maintaining cultural beliefs and traditional practices can play in assisting people to have a sense of personal continuity and cultural identity and enhanced sense of wellbeing.

In this section we have discussed some of the factors that are a source of potential strength and resilience for Aboriginal people. More research is required in this field to gain a greater appreciation of the complex set of interdependent factors that have helped Aboriginal cultures to survive several generations of trauma and extreme disadvantage.

CONCLUSION

This chapter has examined the complex array of factors in the social environment that influence and determine the SEWB of Aboriginal and Torres Strait Islander peoples. We have examined this topic from both a theoretical and empirical perspective, and highlighted that—despite improvements in the data and scientific literature in recent decades—the ways that social factors affect Aboriginal health are not fully understood. While the mechanisms that prompt, facilitate or constrain the development of SEWB are likely to be similar among Aboriginal and non-Aboriginal populations, the population context is very different. The current social and wellbeing circumstances of Aboriginal peoples reflect a history of profound dispossession, exclusion, discrimination, marginalisation and inequality, in various forms. The vicious cycle between these experiences and inequalities across the spectrum of health and social conditions has served to perpetuate the disadvantage faced by Aboriginal and Torres Strait Islander peoples. The ongoing effects of colonisation have been particularly harmful to people's SEWB and have created a burden that extends across generations of Aboriginal families.

History has provided a guide to understanding the set of factors that uniquely affect Aboriginal SEWB, and highlighted that there needs to be a multifaceted, holistic and long-term approach to improving people's SEWB. A social determinants approach is not a quick-fix to Aboriginal people's relatively poor wellbeing outcomes. Interventions need to target the reduction of risk factors (including pervasive systemic discrimination), increase protective factors across a number of domains and be based on the best available evidence. The challenge for mental health practitioners, policy makers and service providers is to identify and implement culturally secure, context specific strategies that are designed to recognise and reduce the impact of cumulative and overwhelming stress, developmental chaos, social exclusion and social inequality. This includes strategies that foster interagency cooperation and enhance cultural competence at the system, organisational and individual/practitioner levels as discussed further in Chapter 12 (Walker and colleagues).

The development and support of ongoing culturally appropriate SEWB programs and commitment to culturally competent organisations and practitioners will help to close the current gap in wellbeing between Aboriginal and non-Aboriginal Australians. However, for substantial and long-lasting changes to be made, a long-term commitment throughout the community and government sectors is also required.

REFLECTIVE EXERCISES

1. Consider and discuss the viewpoints below

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

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

In your discussion of the viewpoints above, do you agree or disagree? Consider the implications for your practice for clients.

2. Exercise

A study which analysed responses to the NATSIS Survey 2002 to determine the economic and social factors that underpinned Indigenous contact with the criminal justice system found that respondents were far more likely to have been charged with, or imprisoned for, an offence if they misused drugs or alcohol, failed to complete Year 12 or were unemployed. Other factors that increased the risk of being both charged and imprisoned included experiencing financial stress, living in a crowded household and being a member of the Stolen Generations. The two most important factors were high-risk alcohol consumption and illicit drug use. Respondents in remote areas were about as likely as Indigenous people in major cities to be charged, but those living in remote areas were more likely to be imprisoned.[70]

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

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

REFERENCES

1. Social Health Reference Group. National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional well being 2004–2009. Canberra; 2004.
2. Keating DP, Hertzman C. Developmental health and the wealth of nations: Social, Biological, and Educational Dynamics. New York: Guilford Press; 1999.
3. Susser ES. Psychiatric epidemiology: searching for the causes of mental disorders. New York: Oxford University Press; 2006.
4. Marmot MG, Wilkinson RG. Social determinants of health. Second ed. Oxford: Oxford University Press; 2006.

5. Commonwealth Department of Health and Aged Care. Promotion, Prevention and Early Intervention for Mental Health—A Monograph. Canberra; 2000.
6. Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva; 2008.
7. Marmot M. Social determinants and the health of Indigenous Australians. Medical Journal of Australia. 2011; 194(10):512-513.
8. Carson B, Dunbar T, Chenhall RD, Bailie R. Social Determinants of Indigenous Health. Sydney: Allen & Unwin; 2007.
9. Victorian Health Promotion Foundation (VicHealth). Life is health is life: Taking action to close the gap. Carlton: Victorian Government Department of Health; 2011.
10. Williams DR. Race and health: Basic questions, emerging directions. Ann. Epidemiol. 1997; 7(5):322-333.
11. Shepherd CCJ, Li J, Zubrick SR. Social Gradients in the Health of Indigenous Australians. American Journal of Public Health. 2012; 102(1):107-117.
12. Shepherd CCJ, Li J, Mitrou F, Zubrick SR. Socioeconomic disparities in the mental health of Indigenous children in Western Australia. BMC Public Health. 2012; 12:756.
13. Zubrick SR, Silburn SR, Lawrence DM, Mitrou FG, Dalby RB, Blair EM, et al. The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People. Perth: Curtin University of Technology and Telethon Institute for Child Health Research, 2005.
14. Zubrick SR, Taylor CL, Lawrence D, Mitrou F, Christensen D, Dalby R. The development of human capability across the lifecourse: Perspectives from childhood. Australasian Epidemiologist. 2009; 16(3):6-10.
15. Attwood B, Markus A. The 1967 Referendum: Race, Power and the Australian Constitution. Second ed. Canberra: Aboriginal Studies Press; 2007.
16. Loeb S, Fuller B, Kagan SL, Carrol B. Child Care in Poor Communities: Early Learning Effects of Type, Quality, and Stability. Child Development. 2004; 75(1):47-65.
17. Smith JR, Brooks-Gunn J, Klebanov PK. Consequences of living in poverty for young children's cognitive and verbal ability and early school achievement. In: Duncan GJ, Brooks-Gunn J, editors. Consequences of growing up poor. New York: Russell Sage Foundation; 1997. p. 132–89.
18. Werner EE. The children of Kauai: Resiliency and recovery in adolescence and adulthood. Journal of Adolescent Health. 1992; 13(4):262-268.
19. Ramey CT, Ramey SL. Early Intervention and Early Experience. American Psychologist. 1998; 53(2):109-120.
20. Silburn S, Walker R. Community learning for parenthood. Evidence into Action Topical Paper Australian Research Alliance for Children & Youth. Perth; 2008.
21. Grant KE, Compas BE, Stuhlmacher AF, Thurm AE, McMahon SD, Halpert JA. Stressors and Child and Adolescent Psychopathology: Moving From Markers to Mechanisms of Risk. Psychological Bulletin. 2003; 129(3):447-466.
22. McEwen BS. Early life influences on life-long patterns of behaviour and health. Ment. Retard. Dev. Disabil. Res. Rev. 2003; 9(3):149-154.
23. Shonkoff JP, Phillips DA. From Neurons to Neighborhoods: The Science of Early Childhood Development. Washington (DC): National Academy Press; 2000.

24. Bronfenbrenner U, Evans GW. Developmental Science in the 21st Century: Emerging Questions, Theoretical Models, Research Designs and Empirical Findings. Social Development. 2000; 9(1):115-125.

25. Evans GW, English K. The Environment of Poverty: Multiple Stressor Exposure, Psychophysiological Stress, and Socioemotional Adjustment. Child Development. 2002; 73(4):1238-1248.

26. Ackerman B, Kogos J, Youngstrom E, Schoff K, Izard C. Family Instability and the Problem Behaviours of Children From Economically Disadvantaged Families. Developmental Psychology. 1999; 35(1):258-268.

27. Collins WA, Maccoby EE, Steinberg L, Hetherington EM, Bornstein MH. Contemporary Research on Parenting: The Case for Nature and Nurture. American Psychologist. 2000; 55(2):218-232.

28. Paradies Y. A systematic review of empirical research on self-reported racism and health. Int. J. Epidemiol. 2006; 35(4):888-901.

29. Williams D, Mohammed S. Discrimination and racial disparities in health: evidence and needed research. J Behav Med. 2009; 32(1):20-47.

30. Priest N, Paradies Y, Trenerry B, Truong M, Karlsen S, Kelly Y. A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people. Social Science and Medicine. 2012.

31. Paradies Y, Harris R, Anderson I. The Impact of Racism on Indigenous Health in Australia and Aotearoa: Towards a Research Agenda. Darwin; 2008. Discussion Paper No. 4.

32. Priest N, Paradies Y, Gunthorpe W, Cairney S, Sayers S. Racism as a determinant of social and emotional wellbeing for Aboriginal Australian youth. Medical Journal of Australia. 2011; 194(10):546-50.

33. Paradies Y, Chandrakumar L, Klocker N, Frere M, Webster K, Burrell M, et al. Building on our strengths: a framework to reduce race-based discrimination and support diversity in Victoria. Full report. Melbourne; 2009.

34. Marmot MG, Smith GD, Stansfeld S, Patel C, North F, Head J, et al. Health Inequalities among British Civil-Servants - the Whitehall-II Study. Lancet. 1991; 337(8754):1387-1393.

35. Wilkinson R. Putting the picture together: Prosperity, redistribution, health and welfare. In: Wilkinson R, Marmot M, editors. Social determinants of health. Oxford: Oxford University Press; 1999. p. 256-74.

36. Shepherd CCJ, Zubrick SR. What shapes the development of Indigenous children? In: Hunter B, Biddle N, editors. Survey Analysis for Indigenous Policy in Australia: Social Science Perspectives, CAEPR Research Monograph No. 32. Canberra: ANU E Press; 2012. p. 79-102.

37. Kelly K, Dudgeon P, Gee G, Glaskin B. Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People. Darwin; 2009. Discussion Paper Series No. 10.

38. Silburn SR, Zubrick SR, De Maio JA, Shepherd C, Griffin JA, Mitrou FG, et al. The Western Australian Aboriginal Child Health Survey: Strengthening the Capacity of Aboriginal Children, Families and Communities. Perth: Curtin University of Technology and Telethon Institute for Child Health Research, 2005.

39. Kazdin AE, Kagan J. Models of Dysfunction in Developmental Psychopathology. Clinical Psychology: Science and Practice. 1994; 1(1):35-52.

40. Biddle N, Howlett M, Hunter B, Paradies Y. Labour Market and other Discrimination facing Indigenous Australians [accepted]. Australian Journal of Labour Economics. 2013.

41. Ferdinand A, Paradies Y, Kelaher M. Mental Health Impacts of Racial Discrimination in Victorian Aboriginal Communities: The Localities Embracing and Accepting Diversity (LEAD) Experiences of Racism Survey. Melbourne; 2012.

42. Australian Institute of Health and Welfare. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander People: An overview. Canberra: AIHW; 2011.

43. Auspoll. Australian Reconciliation Barometer 2012. [Internet]. 2013. Available from: http://www.reconciliation.org.au/getfile?id=1917&file=2012+barometer+final+ per cent2812+09+12 per cent29+ per cent282 per cent29.pdf.

44. Bailie RS, Wayte KJ. Housing and health in Indigenous communities: Key issues for housing and health improvement in remote Aboriginal and Torres Strait Islander communities. Australian Journal of Rural Health. 2006; 14(5):178-183.

45. Larson A, Gillies M, Howard PJ, Coffin J. It's enough to make you sick: the impact of racism on the health of Aboriginal Australians. Australian and New Zealand Journal of Public Health. 2007; 31(4):322-329.

46. Priest N, Paradies Y, Stewart P, Luke J. Racism and health among urban Aboriginal young people. BMC Public Health. 2011; 11(1):568.

47. Jamieson LM, Paradies YC, Gunthorpe W, Cairney SJ, Sayers SM. Oral health and social and emotional well-being in a birth cohort of Aboriginal Australian young adults. Bmc Public Health. 2011; 11(1):656-656.

48. Paradies Y, Cunningham J. The DRUID study: exploring mediating pathways between racism and depressive symptoms among Indigenous Australians. Soc Psychiatry Psychiatr Epidemiol. 2012; 47(2):165-173.

49. Australian Health Ministers' Advisory Council. Aboriginal and Torres Strait Islander Health Performance Framework Report 2010. Canberra: Department of Health and Ageing; 2011.

50. Steering Committee for the Review of Government Service Provision. Overcoming Indigenous disadvantage: Key indicators 2011. Canberra: Productivity Commission; 2011.

51. Australian Bureau of Statistics, Australian Institute of Health and Welfare. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples. Canberra: Australian Bureau of Statistics and Australian Institute of Health and Welfare; 2008.

52. Mellor D, Haebich A. Many Voices: Reflections on Experiences of Indigenous Child Separation. Canberra: National Library of Australia; 2002.

53. Human Rights and Equal Opportunity Commission. Bringing Them Home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families. Canberra: Human Rights and Equal Opportunity Commission; 1997.

54. Cunningham J, Sibthorpe B, Anderson I. Self-assessed health status, Indigenous Australians, 1994: Occasional paper. Canberra: Australian Bureau of Statistics and National Centre for Epidemiology and Population Health; 1997.

55. Australian Institute of Health and Welfare. Measuring the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. Canberra: Australian Institute of Health and Welfare; 2009.

56. Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Health Survey, 2004-05. Canberra: Australian Bureau of Statistics; 2006.

57. Berry JW. Immigration, Acculturation, and Adaptation. Applied Psychology. 1997; 46(1):5-34.

58. Kenny C, Ngaroimata T. Living Indigenous Leadership: Native Narratives on Building Strong Communities. Vancouver: UBC Press; 2012.

59. Reynolds H. This whispering in our hearts. Sydney: Allen & Unwin; 1998.

60. Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Social Survey, 2008. Canberra: Australian Bureau of Statistics; 2009.

61. Australian Bureau of Statistics. Census of Population and Housing: Characteristics of Aboriginal and Torres Strait Islander Australians, 2011. Canberra: Australian Bureau of Statistics; 2012.

62. Muntaner C, Eaton WW, Miech R, O'Campo P. Socioeconomic Position and Major Mental Disorders. Epidemiologic Reviews. 2004; 26(1):53-62.

63. Lorant V, Deliege D, Eaton W, Robert A, Philippot P, Ansseau M. Socioeconomic inequalities in depression: A meta-analysis. Am. J. Epidemiol. 2003; 157(2):98-112.

64. Adler N, Snibbe A. The role of psychosocial processes in explaining the gradient between socioeconomic status and health. Curr. Dir. Psychol. 2003; 12(4):119-123.

65. Australian Bureau of Statistics. Prisoners in Australia, 2012. Canberra: Australian Bureau of Statistics; 2012.

66. Australian Institute of Health and Welfare. Indigenous young people under supervision. Juvenile justice in Australia: 2010–11; 2013.

67. Kenny D, Nelson P, Butler T, Lennings C, Allerton M, Champion U. NSW Young People on Community Orders Health Survey 2003-2006: Key Findings Report. Sydney: University of Sydney; 2006.

68. Australian Institute of Health and Welfare. Australia's Health 2008. Canberra: Australian Institute of Health and Welfare; 2008.

69. Smith N, Trimboli L. Comorbid substance and non-substance mental health disorders and re-offending among NSW prisoners. Sydney; 2010. Crime and Justice Bulletin Number 140.

70. Weatherburn D, Snowball L, Hunter B. The economic and social factors underpinning Indigenous contact with the justice system: Results from the 2002 NATSISS survey. Sydney; 2006. Crime and Justice Bulletin Number 104.

71. Australian Institute of Health and Welfare. Child protection Australia 2009–10. Canberra; 2011. Child welfare series no. 51. Cat. no. CWS 39.

72. Bryant C. Identifying the risks for Indigenous violent victimisation. 2009. Brief 6.

73. Snowball L, Weatherburn D. Theories of Indigenous Violence: A Preliminary Empirical Assessment. Australian & New Zealand Journal of Criminology. 2008; 41(2):216-235.

74. Mouzos J, Makkai T. Women's Experiences of Male Violence Findings from the Australian Component of the International Violence Against Women Survey (IVAWS). Canberra; 2004.

75. Australian Institute of Health and Welfare. Family violence among Aboriginal and Torres Strait Islander peoples. Canberra; 2006. Cat. no. IHW 17.

76. Vos T, Barker B, Begg S, Stanley L, Lopez AD. Burden of disease and injury in Aboriginal and Torres Strait Islander Peoples: the Indigenous health gap. Int. J. Epidemiol. 2009; 38(2):470-477.

77. Australian Institute of Health and Welfare. Substance use among Aboriginal and Torres Strait Islander people. Canberra; 2011. Cat. no. IHW 40.

78. Australian Institute of Health and Welfare. 2004 National Drug Strategy Household Survey: Detailed findings. Canberra; 2005.

79. Australian Institute of Health and Welfare. 2007 national drug strategy household survey: First results. Canberra; 2008.

80. Rutter M. Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. British Journal of Psychiatry. 1985; 147(598â):611.

81. Dodson M. Reconciliation in crisis. In: Yunupingu G, editor. Our land is our life: Land rights—past present and future. St Lucia: University of Queensland Press; 1997. p. 137-149.

82. Burgess CP, Johnston FH, Berry HL, McDonnell J, Yibarbuk D, Gunabarra C, et al. Healthy country, healthy people: the relationship between Indigenous health status and "caring for country". Medical Journal of Australia. 2009; 190(10):567-72.

83. Rowley KG, O'Dea K, Anderson I, McDermott R, Saraswati K, Tilmouth R, et al. Lower than expected morbidity and mortality for an Australian Aboriginal population: 10-year follow-up in a decentralised community. Medical Journal of Australia. 2008; 188(5):283-7.

84. Dockery AM. Traditional Culture and the Wellbeing of Indigenous Australians: An analysis of the 2008 NATSISS. Perth; 2011.

85. Queensland Department of the Premier and Cabinet & Fitzgerald T. Cape York justice study. Brisbane; 2001.

86. Dudgeon P, Cox K, D'Anna D, Dunkley C, Hams K, Kelly K, et al. Hear our voices: Community Consultations for the Development of an Empowerment, Healing and Leadership Program for Aboriginal people living in the Kimberley, Western Australia. Perth: Telethon Institute for Child Health Research.

87. Sullivan P. Indigenous Governance: The Harvard Project, Australian Aboriginal Organisations and Cultural Subsidiarity, Working Paper 4. Alice Springs; 2007.

88. Chandler MJ, Lalonde C. Cultural Continuity as a Hedge against Suicide in Canada's First Nations. Transcultural Psychiatry. 1998; 35(2):191-219.