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Aboriginal and Torres Strait Islander Mental Health: An Overview

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OVERVIEW

This chapter initially examines the concepts of physical and mental health and wellbeing for Aboriginal and Torres Strait Islander peoples as they were understood and practiced over the vast majority of the last 40,000 years or so. The devastating consequences of the European colonisation of Australia for Aboriginal and Torres Strait Islander peoples are described. Tracking global developments in human rights, the chapter concludes with some innovative thinking from Australia and overseas that may assist Aboriginal and Torres Strait Islander peoples to regain their 'health' that has been so significantly lost.

MENTAL HEALTH AS A HUMAN RIGHT

It has been well recognised in the past 40 years that health is an essential component of human development and an important ambition for individuals and their society. The 1978 International Conference on Primary Health Care at Alma-Ata[1] stated that 'health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and the attainment of the highest possible level of health is a most important worldwide goal'.[1(p1)] The 1986 Ottawa Charter for Health Promotion[2] was built on the initial foundations of the Declaration of Alma-Ata. The Ottawa Charter reported that health 'is therefore seen as a resource for everyday life, not the objective for living' and 'as a positive concept emphasising social and personal resources as well as physical capacities'.[2(p1)] The Charter went on to define the prerequisites for health as: 'peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity'.[2(p1)]

The Recovery Movement

In recent years, there has also been an increasing interest in Recovery for people affected by mental illness. Leff and Warner (2006)[3] note that:

> *the [Recovery] model refers both to the subjective experiences of hope, healing, empowerment and interpersonal support experienced by people with mental illness, their carers and service providers and to the creation of recovery-oriented services that engender a positive culture of healing and a support for human rights.*[3(p162)]

The authors add that, as a result of the Recovery movement, there is renewed interest in fighting the stigma that leads people with mental illness to lose their sense of self. There is an understanding of the need to provide access to the services and education that give mental health clients the knowledge and skills to manage their illness, empowering consumers to share responsibility with providers in the healing process and providing access to peer support

that validates the possibility of recovery.[3] Parker[4, 5] has suggested initiatives such as economic and public policy strategies similar to those outlined in the Ottawa Charter[2] for empowering Recovery and reducing Aboriginal disadvantage that are also closely aligned with the recent Canadian and Australian economic policy initiatives to reduce Aboriginal disadvantage discussed later in the chapter.

The concepts of health developed by the World Health Organisation (WHO) were reaffirmed in 2007 in the *United Nations Declaration on the Rights of Indigenous Peoples* through Article 7, which states: 'Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of the person.'[6(p5)]

Traditional Culture and Aboriginal Health

Archaeological evidence suggests that Aboriginal people have been present in Australia for the last 45,000–50,000 years. The ethnographic evidence from early contact suggests that Aboriginal people who survived infancy were relatively fit and disease-free.[7(p121)] Further, Australia's native foods supported a nutritious, balanced diet of protein and vegetables with adequate vitamins and minerals, with little salt, sugar and fat. Life on the move kept people physically fit.[7(p122)]

In terms of mental health, traditional Aboriginal culture had a number of strong reinforcing factors that have been well defined by Professors Helen and Jill Milroy.[8] Aboriginal sense of self was seen in a collective sense, intimately connected to all aspects of life, community, spirituality, culture and country. Their culture also provided for everyone by sharing rules and understanding relationships. Kinship was of prime importance in defining social roles. Aboriginal people were also given a sense of meaning and understanding of life experience through their connection to country and their Dreaming. Spiritual beliefs offered guidance and comfort and held a sense of connectivity and belonging despite distress, death and loss. Lore, the body of knowledge that defined the culture, was highly valued, as were the tribal Elders who contained and interpreted the Lore. Customary law defined rules and consequences. Over 200 traditional languages and other methods of communication allowed a rich expression of interaction in this social context, and formal ceremony enabled a method of dealing with life's transitions through birth, initiation and death. Men and women had defined economic and cultural roles. Children were well protected within the group with a range of aunties and older siblings able to take over the child care role if the mother was fulfilling other communal responsibilities or was stressed.

These concepts mean that Aboriginal society, before European contact, provided the optimal conditions for mental health and social and emotional wellbeing (SEWB) that have been enunciated in later documents such as *Ways Forward*. Swan and Raphael comment:

> *[T]he Aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. This holistic concept does not just refer to the whole body but is in fact steeped in harmonised inter relations which constitute cultural well being. These inter relating factors can be categorised largely into spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these inter relations is disrupted, Aboriginal ill health will persist.*[9(p19)]

Aboriginal Mental Health

In the context of such parameters for general mental health, reports of severe mental illness affecting Aboriginal people in traditional cultural settings do exist. For instance, in the 1970s Jones and de la Horne[10, 11] describe the occurrence of schizophrenia and mood disorders among traditional Western Desert cultures. Eastwell[12, 13] reported on a potential familial susceptibility to delusional disorder in Arnhem Land. Meggitt[14] also described Aboriginal people suffering from psychosis and a probable dissociative disorder due to severe cultural stress in the Central Desert. However, these reports appear to indicate that the experience of severe mental illness was a rare event in traditional Aboriginal culture. It is most likely that Aboriginal society and culture afforded protection for the less severe neurotic and adjustment disorders through the cultural permission to release hostile feelings rather than bottling them up, and through ascribing unusual events such as premature death to sorcery, a concept that carried significant conviction within the culture.[15]

Torres Strait Islander Mental Health

It is thought that a population may have been present in Torres Strait for 70,000 years. Statistics suggest that there may be better health, social and educational outcomes for current Torres Strait Islander peoples who continue to reside in their own traditional country.[16] It has been suggested that a cross-border treaty between Papua New Guinea and Australia in 1985 that enhances Torres Strait Islander economic and social prospects through sharing of fishing rights may be a further contributing factor to this improved health status.[17] However, this has been complicated in recent years by residents of Papua New Guinea, including those infected by HIV, moving into the Torres Strait communities to seek treatment.

Cultural Practices and Mental Health

Ketchell[18] reports on a number of cultural mechanisms that are important for Torres Strait Islander family members to maintain their mental health. These cultural issues revolve around the role of the *Mari Gethal* (Hand of the Spirit). This is a male relative of a deceased person who has to inform relatives of a loss and make arrangements for a funeral. On the *Umau Goega* or day of the death, the Mari Gethal brings tidings of the deceased to the community. *Mai* is the mourning conducted by the community for the deceased. A significant component of this is the formal dressing of the deceased, which is an important part of healing for the deceased's family and for the community. The 'dressing' signifies embalming the deceased. At the *Murama Theodan* or burial of the deceased, the *Mari Gethal* has the role of choosing the location of the burial site and organising its decoration. The funeral ritual concludes with the *Thoerabau Ai*, the burial feast. This used to be a feast to acknowledge the work of the *Mari Gethal* but is now generally regarded as a source of 'debriefing' for the entire community.

At the feast, the *Mari Gethal* can also assess the level of community grief and devise intervention strategies. Some time after the death, there is the *Tai* or *Markai* tombstone opening. This ceremony signifies that the deceased is finally housed and official grieving ceases. There is a feast and gifts are given to people who cared for the family of the deceased. Ketchell[18] notes that it is very important for Torres Strait Islander people to be able to fulfil these duties; mental illness may result if the duties are not able to be completed or if people are denounced by the clan group because they are perceived as not having fulfilled their responsibilities adequately. In addition, Ketchell[18] reports that Torres Strait Islanders may be affected by *Murr Merr* or *Uthia Tharan*. *Murr Merr* or *Uthia Tharan* are reports from community that damage the self-esteem of individuals. In a cultural context, they may be underlying issues causing anxiety, depression and paranoia and delusional disorders. In layman's terms it is 'gossip' despite all evidence or reason for not attending ceremonials.

CONTEMPORARY HEALTH AND WELLBEING

The reports of occasional mental illness in Aboriginal and Torres Strait Islander peoples notwithstanding, as detailed in Chapter 1 (Dudgeon and colleagues), colonisation has had far reaching consequences on Aboriginal health and SEWB. The decimation of Aboriginal populations, destruction of Aboriginal culture and significant disempowerment and marginalisation following the British colonisation of Australia has resulted in widespread, devastating effects on the physical and mental health of Aboriginal and Torres Strait Islander peoples. The issue of the Stolen Generations is a particular recent example of physical and psychological deprivation visited on Aboriginal children removed from their parents.

Aboriginal Health and Wellbeing

The current significant disadvantage of Aboriginal health and social determinants is well recognised. Hospitalisation rates for cardiovascular disease in Aboriginal and Torres Strait Islanders were 67 per cent higher in 2007–08 than for other Australians.[19] In 2009, rheumatic heart disease was 25 times more common for Aboriginal and Torres Strait Islanders than for other Australians in the Northern Territory.[19(p34)] Diabetes and renal failure also figure prominently in Aboriginal health issues. In 2004–05, three times as many Aboriginal and Torres Strait Islanders were reported to have diabetes or high sugar levels compared with other Australians.[20] Aboriginal and Torres Strait Islander peoples were 3.5 times more likely to be hospitalised with diabetes than other Australians.[21] End stage renal disease, often the consequence of poorly controlled diabetes, was almost eight times higher for Aboriginal and Torres Strait Islander peoples than for other Australians.[21] Given these alarming statistics, it is not surprising that life expectancy for Aboriginal and Torres Strait Islander peoples is estimated to be 11.5 years lower for males and 9.7 years lower for females than other Australians, an issue now well recognised in the *Closing the Gap* agenda.[21]

Aboriginal and Torres Strait Islander disadvantage is also apparent in other social indices. The 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) estimated that 25 per cent of the Aboriginal and Torres Strait Islander population aged over 15 years were living in overcrowded housing. The overcrowding becomes more common and problematic in remote areas where it is estimated that 48 per cent of Aboriginal and Torres Strait Islanders live in such housing.[22] In respect to education, the retention rate in 2010 for Aboriginal and Torres Strait Islander students in Year 7/8 to Year 10 was 96 per cent compared with 100 per cent for other students. Unfortunately, the retention rate for Aboriginal and Torres Strait Islander students from Year 7/8 to Year 12 was only 47 per cent compared with 79 per cent for other students.[23] Recent surveys have shown a welcome increase in Aboriginal and Torres Strait Islander participation in education and completion of Year 12.[24]

Some of the reasons for this disparity are illuminated in the case studies in Chapter 21 (Milroy) and Chapter 22 (Walker and colleagues) which discuss the emotional and behavioural issues for Aboriginal young people. Given this trend in education, and some of the complex issues surrounding the poor education outcomes, the accompanying statistics of significant Aboriginal and Torres Strait Islander disadvantage in employment and income compared with the rest of Australia are no surprise; neither are data from the Australian criminal justice system which show that Aboriginal and Torres Strait Islander peoples are 15 times more likely to be in prison than other Australians.[25] Refer to Chapter 10 (Heffernan and colleagues) for further discussion of Aboriginal mental health and the criminal justice system.

Poverty and Racism

Poverty and racism also provide a framework for these statistics related to Aboriginal health and wellbeing. Walter and Saggers[26] point to the significant association between poverty and adverse health outcomes. They note that a significant proportion of Australia's Aboriginal population live in a situation of absolute poverty as defined by the United Nations, where they have severe deprivation of basic human needs including food, safe drinking water, sanitation facilities, health, shelter, education and information. Some diseases, such as scabies and diarrhoea, which can have long term debilitating effects, are directly related to inadequate sanitation and living conditions.[19(p101)] The issues of Aboriginal poverty appear particularly marked in rural and remote areas. In addition, the failure of a recent plethora of policies to advance Aboriginal health has been attributed to a pervasive culture of welfare colonialism, an aspect of continuing poverty. According to Anderson, welfare colonialism affects Aboriginal communities that rely heavily on the provision of public sector resources.[27] Over time, the mechanisms to deliver these public sector resources overlie the traditional methods of Aboriginal governance, reducing the capacity of the communities to develop leadership in the solutions to their problems. In addition, the continuing experience of widespread racism against Aboriginal people generally within the Australian community appears to have a continuing negative effect, particularly on the mental health of Aboriginal people.[28]

In addition, recent data from the Australian Institute of Health and Welfare (AIHW) indicate that Aboriginal and Torres Strait Islander children are twice as likely to live in single parent families (who are more exposed to poverty) and Aboriginal and Torres Strait Islander adults were more likely to be unemployed and have higher rates of homelessness than other Australians.[21] Furthermore, overcrowding and exposure to stressful events continue to be problematic.[21]

Child Safety

A perception of safety is also a crucial element of SEWB and mental health. Surveys have shown that Aboriginal and Torres Strait Islander peoples aged over 18 years are twice as likely to report being victims of violence or threatened violence than other Australians.[19] Further, in 2006–07, the rate of substantiated child protection notifications for Aboriginal and Torres Strait Islander children was 32 per 1,000 compared with six per 1,000 for other children.[19(p112)] This alarming trend with respect to child safety appears to be continuing with the following disturbing statistics for children in care:

For children aged 0–17 years in 2009–10:

- *The rate of substantiated child protection notifications for Aboriginal and Torres Strait Islander children was 35 per 1,000 children, over 7 times the rate for other Australian children (4.6 per 1,000);*
- *The rate of Aboriginal and Torres Strait Islander children on care and protection orders was nine times higher than the rate for other Australian children (48 versus 5.4 per 1,000 children);*
- *The rate of Aboriginal and Torres Strait Islander children in out-of-home care was almost 10 times higher than the rate for other Australian children (48 versus 5.0 per 1,000 children).*[21]

Life Stressors

Aboriginal and Torres Strait Islander peoples report significantly higher levels of stress than the wider Australian community. Fifty-two per cent of respondents in the *2004–05 National Aboriginal and Torres Strait Islander Health Survey* reported at least two life stressors over the previous 12 months, while 27 per cent reported four or more life stressors over the same period. [29] Multiple stressors were more commonly experienced in remote areas. Reported stressors identified include:

- the death of a family member or close friend;
- overcrowding at home;
- alcohol or drug-related problems;
- serious illness or disability; and
- having a family member sent to jail or currently in jail.[29(p23-4)]

The significant effect of stress on Aboriginal children in Western Australia is also of concern. The Western Australian Aboriginal Child Health Survey (WAACHS) reported that a significant number of Aboriginal children aged 4–17 years were living in families where seven or more major life stress events had occurred over the preceding 12 months.[30]

Impacts of Trauma on Mental Health

Recent neuroimaging and associated studies have shown that early trauma can have long lasting effects on brain regions, such as the amygdala, which process emotion, and make affected individuals more vulnerable to mental illness such as anxiety and depression in later life.[31-33] Husain comments on resilience and vulnerability factors for children affected by trauma:

> *Many factors contribute to resiliency in a child. Positive temperaments, secure attachment during early childhood, a supportive family and a special and positive relationship with an adult are worth mentioning. Vulnerability, on the other hand, involves a wide range of child and family-related factors that may increase the risk of developing behavioural and psychiatric problems. Poverty, early bereavement, physical and sexual abuse and a broken family may increase the vulnerability of a child to mental illness.*[34(p279)]

Sadly, many Aboriginal and Torres Strait Islander children exposed to trauma appear to have the factors that predispose to vulnerability rather than resilience in the context of their continuing life experience following trauma.

This phenomenon of 'malignant grief' is the result of persistent stress experienced in Aboriginal communities. Malignant grief is a process of irresolvable, collective and cumulative grief that affects Aboriginal individuals and communities (Milroy, 2005). The grief causes individuals and communities to lose function and become progressively worse; ultimately it leads to death. This grief has invasive properties, spreading throughout the body, and many of Australia's Aboriginal people die of this grief. The issue of malignant grief should also be viewed in the context of repeated generational trauma that affects some Aboriginal and Torres Strait Islander communities and which is discussed further in Chapter 17 (Atkinson and colleagues).

Stolen Generations

The WAACHS also reports on the psychological wellbeing of members of the Stolen Generations and their families. The survey noted that members of the Stolen Generations were more likely to live in households where there were problems related to alcohol abuse and gambling. They were less likely to have a trusting relationship and were more likely to have been arrested for offences.

Members of the Stolen Generations were more likely to have had contact with mental health services. The survey commented that children of members of the Stolen Generations had much higher rates of emotional/behavioural difficulties and high rates of harmful substance use.[30(p465)]

Substance Use

Given the high levels of background stress, substance misuse also figures prominently as a background factor to mental illness. It is well recognised that Aboriginal and Torres Strait Islander peoples experience harmful rates of alcohol and other substance use and that this tends to be more pronounced in rural communities.[16] See Chapter 8 (Wilkes and colleagues) for a detailed discussion of harmful substance use and mental health.

Aboriginal and Torres Strait Islander men are hospitalised at over four times the expected rate for population with severe mental illness related to substance misuse, and over double the expected rate for severe chronic mental illnesses such as schizophrenia.[35(p112)] The rates of hospital admission for severe mental illness in Aboriginal and Torres Strait Islander women is also substantially above expected rates for their numbers in the population.[35(p112)] Hunter[36] has recently argued that very high rates of psychosis affecting Aboriginal people in Cape York is the end result of a range of significant measures of disadvantage in the neurodevelopmental environments of the affected individuals including the dramatic changes and social chaos that followed the introduction of alcohol to communities in the 1980s, in addition to factors of significant social adversity affecting their pregnancy and childhood—refer to Chapter 20 (Hayes and colleagues).

Death rates in the Aboriginal and Torres Strait Islander population secondary to substance misuse and mental illness are alarming. The death rate for Aboriginal and Torres Strait Islander peoples from mental and behavioural disorders due to psychoactive substance use is almost 12 time the rate for the Australian population in men and almost 20 times the rate of the Australian population for women.[35(p161)] In addition, the rates of death by suicide for Aboriginal and Torres Strait Islander men are almost three times the rates for the Australian population generally, discussed further in Chapter 9 (Silburn and colleagues).[35(p169)]

POLICY INITIATIVES FOR IMPROVING MENTAL HEALTH AND WELLBEING

The International Arena

Evidence from overseas indicates that enlightened government policy and enhanced control of socioeconomic factors by Aboriginal communities in respect to their health can lead to improved health outcomes, including mental health. Strengthening of the Maori health workforce in New Zealand has led to a number of successes including Maori-led, Maori-focused and Maori-targeted interventions, consistent investment over a prolonged period, and an emphasis on the development of dual cultural and clinical competencies.[37]

In the USA, a successful Native American Health Service development in the early 1990s appears to have been shaped by enhanced federal government administration for Native American Affairs in addition to the separation of the Native American Health Service from other Native American affairs and the provision of an integrated health service.[38] Ring and Brown[39] note a recent reduction in overall death rates for Indigenous people in the USA and New Zealand. While there does not appear to be a direct correlation between improved health services for Indigenous peoples in the two countries and improved mortality, there is a notable improvement in health status generally.

Studies of community control by First Nations groups in British Columbia and suicide rates within communities appear to show a direct correlation between increased cultural control within First Nation communities and reduced suicide rates.[40]

Another example of an overseas innovative government program was the strategic leadership recently shown in Canada through the Canadian Aboriginal Horizontal Framework.[41] A government policy closely aligned with principles for health developed in the Ottawa Charter[2] was coordinated between the Canadian federal government and provincial governments to address the disadvantage in Canadian First Nation social determinants across a wide front. Leadership from the top was a key initial factor in the development of the Framework, with the then Canadian Prime Minister committing to a round table discussion with all levels of Canadian government and First Nation leaders. A policy retreat followed with members of the Canadian Committee on Aboriginal Affairs and First Nations leaders. There was also a commitment to the development of an Aboriginal report card to track progress with the Canadian health strategy.

The Canadian Aboriginal Horizontal Framework was then developed as a strategic guide to funding priorities and cooperation between the various levels of government as well as allowing the establishment of performance indicators. The Framework appears to place the pillars of health at equal value. These pillars are:

- Health;
- Lifelong Learning;
- Safe and Sustainable Communities;
- Housing;

- Economic Opportunity;
- Lands and Resources; and
- Governance and Relationships.

Each of the pillars of the Framework can then be divided into sub-pillars. As an example, Safe and Sustainable communities are divided into Community Infrastructure, Social Support and Community Wellbeing, and Community Safety and Justice.

The Australian Policy Context

The Australian policy environment has recently produced a number of innovative solutions in government approaches to Aboriginal and Torres Strait Islander disadvantage. In 2007, Henry[42] suggested a broad approach across Australian Government departments to address Aboriginal and Torres Strait Islander health disadvantage, similar to the Canadian Framework and Ottawa Charter. Henry and other secretaries in the Secretaries Group on Aboriginal and Torres Strait Islander Affairs have identified seven platforms that need to be prioritised within a framework of Aboriginal and Torres Strait Islander capacity development:

- basic protective security for women and children;
- early childhood development;
- a safe and healthy home environment;
- an accessible primary care health service;
- ensuring that incentives in the welfare system do not work against promotion of investment in human capital;
- real job prospects as a result of education and governance systems that support political freedom; and
- social opportunities for local Aboriginal people to be engaged in policy development.

Henry[42] defines social elements of poverty that all have to be overcome before a society can move forward. These elements are the capacity to live without shame, the capacity to participate in the activities of the community, and the capacity to enjoy self-respect. Henry[42] further describes three key interdependent foundations to current Aboriginal and Torres Strait Islander disadvantage in Australia: poor economic and social incentives, the underdevelopment of human capital, and an absence of effective engagement of Aboriginal and Torres Strait Islander peoples in the design of policy frameworks that might improve these incentives and capacities.

Dillon and Westbury[43] also look to a number of ways that government can strengthen capacity within Aboriginal and Torres Strait Islander communities. They outline seven directions to enhance government's role.

Strengthening Capacity in Aboriginal and Torres Strait Islander Communities: Seven Directions to Enhance the Role of Government

- Acknowledgment of the 'tough' social and cultural environment surrounding Aboriginal and Torres Strait Islander health issues and a commitment to build sustained support structures that will operate effectively.
- Investment in cross-cultural communication and governance capacity.
- Rationalisation of short-term program delivery in Aboriginal and Torres Strait Islander communities through an increasing 'connecting government' approach.

Continued . . . .

Strengthening Capacity in Aboriginal and Torres Strait Islander Communities: Seven Directions to Enhance the Role of Government (continued)

- The re-establishment of a consistent and comprehensive regional framework for program delivery in remote Australia and the increasing use of Aboriginal and Torres Strait Islander local governments.
- A national commitment to a long-term development approach to strengthen capital stock such as essential services and housing in remote regions and build strong service delivery systems.
- Replacing a myriad of 'small niche programs' within Aboriginal and Torres Strait Islander communities with negotiated priorities for funding and support, and flexible program funding arrangements.
- Retaining or increasing the inherent flexibility of mainstream programs to deal with non-standard remote exigencies, to ensure that all Aboriginal and Torres Strait Islander citizens are getting equitable access to all program allocations.

Shifting Mental Health Perspectives

In the context of this emerging policy background, the approach of the broader Australian community to address issues of Aboriginal and Torres Strait Islander mental health and illness is of interest. Professor Hunter[44] notes an evolutionary progression of thought from an ethnographic fascination with issues of mental illness in Aboriginal and Torres Strait Islander peoples in the 1950s and 1960s, to an understanding of the social determinants of Aboriginal and Torres Strait Islander ill health in the 1970s and the increasing empowerment of Aboriginal and Torres Strait Islander health organisations in the 1980s and 1990s.

Other important factors such as the Royal Commission into Aboriginal Deaths in Custody (RCIADIC), the Commission into the Separation of Aboriginal and Torres Strait Islander Children from their Families and the establishment of the National Aboriginal Community Controlled Health Organisation (NACCHO), the Office of Aboriginal and Torres Strait Islander Health and the National Congress of Australian First Peoples also form a background framework for these and other initiatives. These developments are explored in more detail in Chapter 7 (Parker and Milroy) and in Chapter 5 (Zubrick and colleagues) which examines the evolving policy.

The achievement of better mental health and wellbeing will involve a revision of government attitudes and policies towards welfare generally. In addition it will require government commitment to specific programs to improve services for Aboriginal and Torres Strait Islander SEWB and for people suffering from mental illness.

It is increasingly recognised that improving community capacity with enhanced civic participation, leadership resources and stronger inter-organisational relationships will lead to improved health generally (including mental health) within the community.[45] There are a number of successful examples of this for Aboriginal and Torres Strait Islander communities. The OXFAM 'family placed projects' in the Gulf of Carpentaria aim to enhance community resilience against the effects of substance misuse by developing safe family place houses[46]. An innovative, community-based solution to an epidemic of suicide in the Tiwi Islands emphasised education in improved communication and coping skills for men's and women's groups in the community, in addition to developing enhanced community care and empowerment for vulnerable individuals.[47]

In addition to these innovative suggestions to rebuild the social capacity of Aboriginal and Torres Strait Islander communities—an essential prerequisite for re-establishing mental health—there

have been a number of programs specifically targeted to Aboriginal and Torres Strait Islander SEWB and services for those suffering from mental illness.

The Clontarf Foundation,[48] established in Western Australia (WA) in 2000, and now operating in over 40 schools throughout Australia, has had a number of significant achievements in keeping young Aboriginal males enrolled in school and then meaningful work following school. The Foundation works by establishing 'academies' within high schools that provide mentoring and educational support for the young men who wish to participate. The Australian Football League (AFL) is used as an attraction for youth's participation in the program and a number of ex-AFL players have become mentors for the Foundation.

The Billard Blank Page Summit[49] held at the Billard Community adjacent to Beagle Bay, WA, in 2009 developed some meaningful initiatives to reduce suicide in Aboriginal communities in the region. These included communities adapting a 'Community Code of Conduct' in the way individuals behave and nurture their children, training and supporting families to be functional and safe, and developing healing tools for individuals at risk of self-harm.

The most recent *Closing the Gap*: Clearing House report[50] also mentions a number of Aboriginal and Torres Strait Islander specific programs as well as general programs that may contribute to improved SEWB.

Other culturally-specific programs include:

- *the Family Wellbeing Program*[51] developed for people in South Australia and the Northern Territory that assists individuals to deal with day-to-day stressors and to assist others;
- *the We Al-li program* developed by Professor Judy Atkinson[52] that uses cultural practices and therapeutic skills to assist individuals to recover from transgenerational trauma—refer to Chapter 17 (Atkinson and colleagues);
- *the Marumali program* developed by Lorraine Peeters to train counsellors to assist individuals removed from their family as children—refer to Chapter 29 (Peeters and colleagues);
- *a women's healing camp* where guided mediation, reconnecting with past generations, narrative therapy and individual counselling were found useful for increasing the participants' sense of self-worth and assertiveness;[53] and
- *the Aboriginal Family and Community Healing Program* that works with Aboriginal families and communities in South Australia, involving them in education programs within the high schools, including nutrition and crisis support.[54]

A major strategic direction for the progression of mental health services for Aboriginal and Torres Strait Islander peoples was the development of the *Ways Forward* document in 1995. Swan and Raphael recommended a range of initiatives to deal with the major burden of mental illness within the Aboriginal and Torres Strait Islander population.[9(p11)] Key initiatives included self-determination within Aboriginal and Torres Strait Islander mental health service development, a holistic approach to mental health, specific services for population sub-groups, improved coordination of service delivery for people within mainstream health services, Aboriginal mental health worker (AMHW) and other staff development, and improved research. Many of these themes are continued in the key strategic directions of current policy frameworks for Aboriginal and Torres Strait Islander mental health, such as the *Social and Emotional Wellbeing Framework 2004–2009*.[55] Many of these themes are examined in detail in the chapters that follow. It has also been suggested that a formal organisation such as a college of Aboriginal and Torres Strait Islander health may significantly assist in the recognition of improved credentialing of standards for health professionals working with Aboriginal and Torres Strait Islander peoples, as well as improved recognition of the role of AMHWs.[56]

From the preceding, it can be seen that Aboriginal and Torres Strait Islander peoples appeared to have had a particularly effective understanding of mental health for the 40,000 years before European contact. This chapter has described pre-contact life as well as discussing some of the major impacts of colonisation on Aboriginal and Torres Strait Islander peoples. In the current policy environment, positive mental health requires major strategic review across a range of government policies. The aim would be to enhance Aboriginal and Torres Strait Islander economic and social capital in addition to specific policies to improve SEWB, as well as culturally appropriate services for people suffering from mental illness.

Other countries and other Aboriginal cultures appear to be leading the way here at present. However, in the current social and political environment of the Formal Apology to the Stolen Generations, *Closing the Gap*, and the current agreement that the Australian Government Department of Health and Ageing (now Department of Health)(DoHA) and the NACCHO is working towards, a brighter future for mental health for Australia's Aboriginal and Torres Strait Islander peoples is probable.

RESOURCE

The *Closing the gap clearing house: Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander People,* 2013[50] outlines a range of effective Aboriginal and Torres Strait Islander specific programs and general programs that have contributed to improved SEWB.

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