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## Australian Aboriginal and Torres Strait Islander Mental Health: An Overview

*Robert Parker*

### OVERVIEW

This chapter initially examines the concepts of physical and mental health for Aboriginal and Torres Strait Islander peoples over the vast majority of the last 40,000 years or so. The devastating consequences for Aboriginal and Torres Strait Islander peoples of the European colonisation of Australia are then described. The chapter concludes with some innovative thinking from Australia and overseas that may assist Aboriginal and Torres Strait Islander peoples to regain the 'health' that has been so significantly lost.

### MENTAL HEALTH AS A HUMAN RIGHT

It has been well recognised through the recent progress of the human race to set some benchmarks for the higher aspirations of mankind in general that health is an essential component of human development and an important ambition for individuals and their society. The International Conference on Primary Health Care at Alma-Ata in 1978 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 world wide goal'. This concept was recently reaffirmed in the United Nations Declaration on the Rights of Indigenous Peoples in 2007 through Article 7, which states: 'Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of the person' (United Nations 2007, p. 5).

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 (Flood 2006, p. 121). 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 (p. 122).

In terms of mental health, traditional Aboriginal culture had a number of strong reinforcing factors that have been well defined by Associate Professors Helen and Jill Milroy (Milroy et al., 2003). Aboriginal sense of self was seen in a collective sense, intimately connected to all aspects of life, community, spirituality, culture and country. The culture also provided for everyone by sharing rules and 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 allowed 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 aunts and older siblings able to take over the childcare role if the mother was stressed.

These concepts mean that Aboriginal society before European contact provided the optimal conditions for mental health that have been enunciated in later documents such as *Ways Forward*. Swan and Raphael (1995) 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. (p. 19)

In the context of such parameters for general mental health, reports of severe mental illness affecting Aboriginal people in the traditional cultural setting do exist. Jones and de la Horne (1972, 1973) describe the occurrence of schizophrenia and mood disorders in Central Desert cultures. Eastwell (1976, 1977) reported on a potential familial susceptibility to delusional disorder in Arnhem Land. Meggitt (1962) also described Aboriginal people suffering from psychosis and a probable dissociative disorder due to severe cultural stress in the Centre. These reports appear to indicate that the experience of severe mental illness was a rare event in traditional Aboriginal culture. Aboriginal society and culture probably 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 (Eastwell, 1988).

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 (Trewin & Madden, 2005). 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 (Altman, 2000) may be a further contributing factor to this improved health status. 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.

Marsat Ketchell (2004) reports on a number of cultural mechanisms that are important for Torres Strait Islander family members to complete for the maintenance of 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 *Uman 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. 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 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 reports that Torres Strait Islanders may be affected by reports of *Murr Merr* or *Uthia Tharan* (reports of sorcery affecting or being performed by a person suffering from depression) as well as delusions of jealousy (including a preoccupation with the alleged perpetrator's footprints).

## CURRENT ISSUES

These reports of occasional mental illness in Aboriginal and Torres Strait Islander culture notwithstanding, the decimation of Aboriginal populations, destruction of Aboriginal culture and significant disempowerment and marginalisation of Aboriginal and Torres Strait Islander peoples following the British colonisation of Australia has resulted in what is widely regarded as 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.

The current significant disadvantage of Aboriginal health and social determinants is well recognised. Hospitalisation rates for cardiovascular disease in Aboriginal and Torres Strait Islander were 67% higher in 2004–06 than for other Australians (AHMAC, 2008). In 2006, rheumatic heart disease was nine times more common for Aboriginal and Torres Strait Islanders than for other Australians in the Top End of the Northern Territory and Central Australia (p. 34). 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 to other Australians (p. 38). Hospitalisation rates for Aboriginal and Torres Strait Islander people with diabetes are almost six times higher than for other Australians (p. 38). End stage renal disease, often the consequence of poorly controlled diabetes, was eight times higher for Aboriginal and Torres Strait Islander peoples than for other Australians (p. 40). Given these alarming statistics, it is not surprising that life expectancy for Aboriginal and Torres Strait Islander people is estimated to be 11.5 years for males and 9.7 years for females less than for other Australians (p. 7), an issue now well recognised in the Close the Gap agenda (AHMAC, 2008).

Aboriginal and Torres Strait Islander disadvantage is also apparent in other social indices. The 2008 National Aboriginal and Torres Strait Islander Social Survey estimated that 25% of the Aboriginal and Torres Strait Islander population over 15 were living in overcrowded housing. The overcrowding becomes more common/problematic in remote areas where it is estimated that 48% of Aboriginal and Torres Strait Islanders live in such housing (ABS, 2009). In respect to education, the National Schools Statistics Collection reported that the retention rate of Aboriginal and Torres Strait Islander students in Year 7/8 to Year 10 was 91% compared to 99% for other students. Unfortunately, the retention rate for Aboriginal and Torres Strait Islander students from Year 7/8 to Year 12 was only 43% compared to 76% for other students (AHMAC, 2008). Given this trend in education, the accompanying statistics of significant Aboriginal and Torres Strait Islander disadvantage in employment and income compared to the rest of Australia are no surprise; neither are data from the Australian criminal justice system which show that Aboriginal and Torres Strait Islander people are 13 times more likely to be in prison than other Australians (p. 110).

Poverty and racism also provide a framework for these statistics. Walter and Sagers (2007) point to the significant association between poverty and adverse health outcomes. They note that a significant proportion of Australia's Indigenous 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 diarrhea, are directly related to inadequate sanitation and living conditions (p. 101). The issues of Indigenous poverty appear particularly marked in rural 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. Welfare colonialism (Anderson, 1997) affects Aboriginal communities that rely heavily on the provision of public sector resources. Over time, the mechanisms to deliver these 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 (Paradies, 2007).

A perception of safety is also a crucial element of wellbeing. Surveys have shown that Aboriginal and Torres Strait Islander people aged over 18 are twice as likely to report being victims of violence or threatened violence than other Australians (AHMAC, 2008). A further alarming statistic in respect to child safety was that in 2006–07 the rate of substantiated child protection notifications per 1000 was 32 for Aboriginal and Torres Strait Islander children compared with six for other children (p. 112)

Given the above, it is not surprising that Aboriginal and Torres Strait Islander peoples report significantly higher levels of stress than the remainder of the 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 (AIHW 2009). 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 (p. 23–4). The significant effect of stress on Aboriginal children in Western Australia is also of concern. *The West 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 stress life events had occurred over the preceding 12 months (De Maio et al., 2005). Associate Professor Helen Milroy (personal communication) refers to the phenomenon of ‘malignant grief’ being the result of persistent stress experienced in Indigenous communities. Malignant grief is a process of irresolvable, collective and cumulative grief that affects Indigenous individuals and communities. The grief causes individuals and communities to lose function and become progressively worse; ultimately it leads to death. Milroy further comments that the grief has invasive properties, spreading throughout the body, and that many of Australia’s Indigenous people die of this grief.

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 substance abuse (p. 465).

Given this level of background stress, it is not surprising that substance abuse also figures prominently as a background factor to mental illness. It is well recognised that Aboriginal and Torres Strait Islander people experience harmful rates of alcohol and other substance use and that this tends to be more pronounced in rural communities (Trewin & Madden, 2005). It is also unfortunate that Aboriginal and Torres Strait Islander men are hospitalised at over four times the expected rate for population with severe mental illness related to substance abuse, and over double the expected rate for severe chronic mental illnesses such as schizophrenia (Pink & Allbon, 2008, p. 112). 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 (p. 112).

Death rates in the Aboriginal and Torres Strait Islander population secondary to substance abuse and mental illness are alarming. The death rate for Aboriginal and Torres Strait Islander people from mental and behavioural disorders due to psychoactive substance use is almost 12 times the rate for the Australian population in men and almost 20 times the rate of the Australian population for women (p. 161). In addition, the rates of death by suicide for Aboriginal and Torres Strait Islander men are almost three times the rate for the Australian population generally (p. 169).

## WAYS FORWARD

Evidence from overseas indicates that enlightened government policy and enhanced control of socioeconomic factors by Indigenous communities in respect to their health can lead to improved health outcomes including mental health. Recent 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 (Ratima et al., 2007). 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 (Kunitz & Brady, 1995). Ring and Brown (2003) note a recent reduction in overall death rates for Indigenous people in the USA and New Zealand. The reduction in First Nation mortality in the USA relates to injury prevention, while the reduction in Maori mortality relates to fewer deaths from circulatory conditions. While there does not appear to be a direct correlation between improved health services for Indigenous peoples in the two countries and improved mortality, the two appear to travel together well. In comparison, the 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 (Chandler & Lalonde, 1998).

Another example of an overseas innovative government program was the strategic leadership recently shown in Canada through the Canadian Aboriginal Horizontal Framework (Canada's Performance, 2005), a government policy 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.

In the context of this international emerging policy background, the approach of the broader Australian community to issues of Aboriginal and Torres Strait Islander mental health and illness is also of interest. Professor Ernest Hunter (1997) notes an evolutionary progression of thought from an ethnographic fascination with issues of mental illness in Aboriginal and Torres

Strait Islander people 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, the Commission into the Separation of Aboriginal and Torres Strait Islander Children from their Families and the establishment of National Aboriginal Community Controlled Health Organisation and the Office of Aboriginal and Torres Strait Islander Health also form a background framework for these and other developments. These developments are explored in more detail in Chapter 4.

It appears, therefore, that any way forward to better mental health for Aboriginal and Torres Strait Islander people will involve a general revision of government attitudes and policies towards Aboriginal and Torres Strait Islander welfare generally, in addition to specific programs to address improvements in services for Aboriginal and Torres Strait Islander social and emotional wellbeing and Aboriginal and Torres Strait Islander 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 (Veazie et al., 2001). There have been a number of recent successful examples of this for Aboriginal and Torres Strait Islander communities in the Australian context. The OXFAM family place projects in the Gulf of Carpentaria (OXFAM, 2007) looked to enhance community resilience against the effects of substance abuse by developing safe family place houses. A similar community project, Domestic Violence – It's Not Our Game, used local sportsmen as role models to reduce the incidence of domestic violence in the Gulf communities (p. 2). 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 (Norris et al., 2007).

The Australian policy environment has also recently produced a number of innovative solutions in government approaches to Aboriginal and Torres Strait Islander disadvantage. The recent paper by Ken Henry (2007) suggests a broad approach across Australian Government departments to address Aboriginal and Torres Strait Islander health disadvantage, similar in some ways to the Canadian Framework. Henry 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 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 Australians in the design of policy frameworks that might improve these incentives and capacities. 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 Indigenous people to be engaged in policy development.

Dillon and Westbury (2007) also look to a number of ways that government can rebuild capacity within Aboriginal and Torres Strait Islander communities. They look at seven directions for an enhanced government role. The first is an 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.

The second is investment in cross-cultural communication and governance capacity. The third is a rationalisation of short-term program delivery in Aboriginal and Torres Strait Islander communities through an increasing ‘connecting government’ approach. The fourth is 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. The fifth is 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. The sixth is a need to replace a myriad ‘small niche programs’ within Aboriginal and Torres Strait Islander communities with negotiated priorities for funding and support, and flexible program funding arrangements. Finally, the authors argue that mainstream programs retain (or build up) the inherent flexibility 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.

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 strategies specifically targeted to Aboriginal and Torres Strait Islander social and emotional wellbeing and services for those suffering from mental illness.

A major strategic direction for the progression of mental health services for Aboriginal and Torres Strait Islander people was the development of the *Ways Forward* document in 1995. Swan and Raphael (1995, p. 11) recommended a range of initiatives to deal with the major burden of mental illness within the Aboriginal and Torres Strait Islander population. Key initiatives included self-determination within Aboriginal and Torres Strait Islander mental health service development, a holistic approach to Aboriginal and Torres Strait Islander mental health, specific services for population sub-groups, improved coordination of service delivery for Aboriginal and Torres Strait Islander people within mainstream health services, Aboriginal and Torres Strait Islander mental health worker and other staff development, and improved research. Many of these themes are continued in the key strategic directions of more modern policy frameworks for Aboriginal and Torres Strait Islander mental health such as the *Social and Emotional Wellbeing Framework 2004–2009* (Social Health Reference Group, 2004). 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 credentialling of standards for health professionals working with Aboriginal and Torres Strait Islander people, as well as improved recognition of the role of Aboriginal and Torres Strait Islander Mental Health Workers (Parker, 2009).

From the preceding, it can be seen that Aboriginal and Torres Strait Islander peoples appeared to have had a particularly effective system of mental health in place for the 40,000 years before European contact. Chapter 3 describes pre-contact life as well as discussing some of the major impacts of colonisation on Aboriginal and Torres Strait Islander people. In the current policy environment, the way back to mental health for these people 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 social and emotional wellbeing, 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 Commonwealth Department of Health and Ageing and the National Aboriginal Community Controlled Health Organisation is working towards, a brighter future for mental health for Australia’s Aboriginal and Torres Strait Islander peoples appears probable.

## Reflective exercises

- 1 What are the features of 'mental health' in pre-contact Aboriginal society and how would the disruption or loss of these lead to 'mental illness'?
- 2 What are the features of Torres Strait Islander 'mental health'?
- 3 Identify a number of social issues underlying current Indigenous mental illness in Australia.
- 4 This chapter may present different information from other concepts of health and histories you have learnt about. What are those differences?

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