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7.2 Factors affecting the social and emotional wellbeing of Indigenous Australians

Social and emotional wellbeing is strongly linked to the welfare of the individual and community. Stressful life events, recent or past trauma, and experiences of discrimination, bullying or harassment can adversely affect a person's social and emotional wellbeing and contribute to higher levels of psychological distress and poor mental health (Ferdinand et al. 2012; Kelaher et al. 2014; Net Industries 2017). These experiences may reduce people's willingness to contact services, negatively affecting their health and welfare outcomes (Kelaher et al. 2014).

Poor social and emotional wellbeing is also linked to employment: it can be a barrier to finding or keeping a job, stressful events at work can affect mental health, and the loss of a job or inability to find work can cause or increase psychological distress (Harnois & Gabriel 2000; Krueger et al. 2011; Olesen et al. 2013). Problems with finding or keeping employment have broader impacts on income, living conditions and opportunities for the affected individual as well as their family and community (Belle & Bullock 2010).

Social and emotional wellbeing for Aboriginal and Torres Strait Islander Australians is a broad construct that includes mental health as well as factors such as connection to country, culture, spirituality, ancestry, family and community (Gee et al. 2014). Factors linked to poor social and emotional wellbeing among Indigenous Australians include discrimination, grief, past and ongoing child removals and unresolved trauma, social exclusion, economic and social disadvantage, incarceration, experiences of violence, substance use and poor physical health (Zubrick et al. 2014).

Mental and substance use disorders are the largest contributor to the burden of disease in Indigenous people, accounting for 19% of the total burden in 2011 (AIHW 2016). Suicide and self-inflicted injuries accounted for a further 4.5% of the burden. Dealing with the causes of poor social and emotional wellbeing, self-harm and suicide are therefore critical to improving both the health and welfare of Indigenous Australians.

The effects of stressful events on wellbeing are influenced by differences in resilience—that is, how people cope with stress and the resources they have available to make adjustments (Net Industries 2017). These resources may be physical (for example, health status), personal (such as values, self-control, and religious beliefs) or social (such as networks and supports). Resilience is strongly related to an individual's environment, and the ability of their family, community and culture to provide these resources in culturally meaningful ways (First Nations Information Governance Centre 2014; Ungar 2008).

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For Indigenous Australians, factors such as family and community connectedness, supportiveness, sharing and leadership have been found to be important in building resilience and strength, and in enhancing social and emotional wellbeing (McLennan 2015; Parker & Milroy 2014). This finding reinforces the importance of a well-functioning community as a key factor in improving the social and emotional wellbeing of Indigenous Australians. More information about community functioning is provided in Chapter 7.1 'Community factors and Indigenous wellbeing'.

This chapter looks at some of the key factors affecting and reflecting the social and emotional wellbeing of Indigenous Australians, including psychological distress and life stressors, experiences of discrimination, substance use, and self-harm and suicide.

Psychological distress and stressors

According to the Australian Bureau of Statistics (ABS) 2014–15 National Aboriginal and Torres Strait Islander Social Survey (NATSISS):

- more than two-thirds (68%) of Indigenous Australians aged 15 and over had experienced at least one personal stressor in the previous 12 months. The most commonly experienced stressors were the death of a family member or close friend (28%), not being able to get a job (19%), serious illness (12%) and work-related stressors (11%)

- more than one-quarter (28%) of Indigenous Australians aged 15 and over and almost one-third (32%) of Indigenous children aged 0–14 lived in a household where household members had run out of money for basic living expenses at least once in the previous 12 months

- one-third (33%) of Indigenous Australians aged 15 or over had experienced high or very high levels of psychological distress in the previous 4 weeks

- Indigenous adults were 2.6 times as likely as non-Indigenous adults to have high or very high levels of psychological distress (ABS 2016).

Experiences of discrimination

Racism and discrimination affect wellbeing in several ways, both directly and indirectly. They cause psychological distress and increase the risk of mental health issues, such as depression (Ferdinand et al. 2012; Priest et al. 2011). They are also associated with risky behaviours, such as substance use (Paradies 2008). Anticipation of being subject to racism may cause anxiety. Fear of discrimination may lead to avoidance of certain people, places or situations, which can have negative consequences—for example, not seeking health care when it is needed, poor school attendance, or social isolation. This avoidance can have profound effects on socioeconomic outcomes and health status.

A survey of Aboriginal people in Victoria found that the risk of high levels of psychological distress increased as the volume of racism experienced increased (Ferdinand et al. 2012). According to Reconciliation Australia, 46% of Indigenous respondents to its 2016 Reconciliation Barometer survey reported experiencing racial prejudice in the previous 6 months, compared with 18% of general community respondents (Reconciliation Australia 2017).
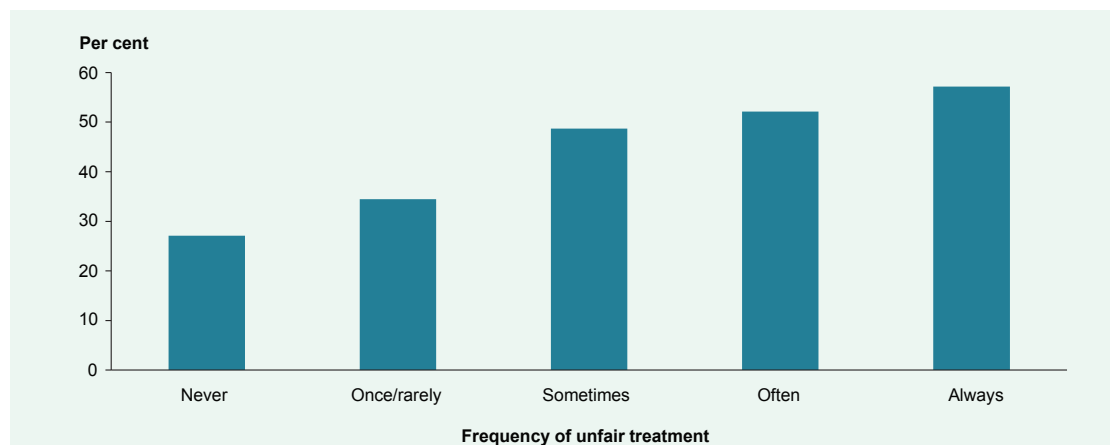
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According to the 2014–15 NATSISS, of Indigenous Australians aged 15 and over:

- one-third (33%, or about 148,400 people) felt that they had been treated unfairly in the previous 12 months because they were Indigenous. The most commonly reported form of unfair treatment was hearing racial comments or jokes (23%), followed by being called names, teased or sworn at (14%), and not being trusted (9.3%)

- 4.8% (21,100 people) reported that discrimination had been a stressor in their lives in the previous 12 months

- 14% (62,300 people) had avoided situations in the previous 12 months due to past unfair treatment (ABS 2016).

Among Indigenous people aged 15 and over who felt they had been treated unfairly in the previous 12 months because they were Indigenous (148,400 people), 44% had high or very high levels of psychological distress. This was 1.6 times the rate of high/very high psychological distress among Indigenous people who had not been treated unfairly in the previous 12 months (27%). The proportion of Indigenous Australians with high or very high levels of psychological distress increased with the frequency of unfair treatment experienced in the previous 12 months—from 34% of people who felt unfairly treated once or rarely to 57% of people who always felt unfairly treated (Figure 7.2.1).

Source: AIHW analysis of 2014–15 NATSISS (TableBuilder).

Figure 7.2.1: Proportion of Indigenous Australians aged 15 and over with high or very high levels of psychological distress, by frequency of unfair treatment in the previous 12 months, 2014–15

Use of alcohol and other drugs

Alcohol and other drugs are the cause of, or contribute to, a wide range of social problems among Indigenous Australians. These include violence, social disorder, family breakdown, child neglect, loss of income or diversion of income to purchase alcohol and other substances, and high levels of imprisonment (Wilkes et al. 2014). See also Chapter 7.3 'Community safety among Indigenous Australians' for information on contact with the criminal justice system and experiences of violence among Indigenous Australians.
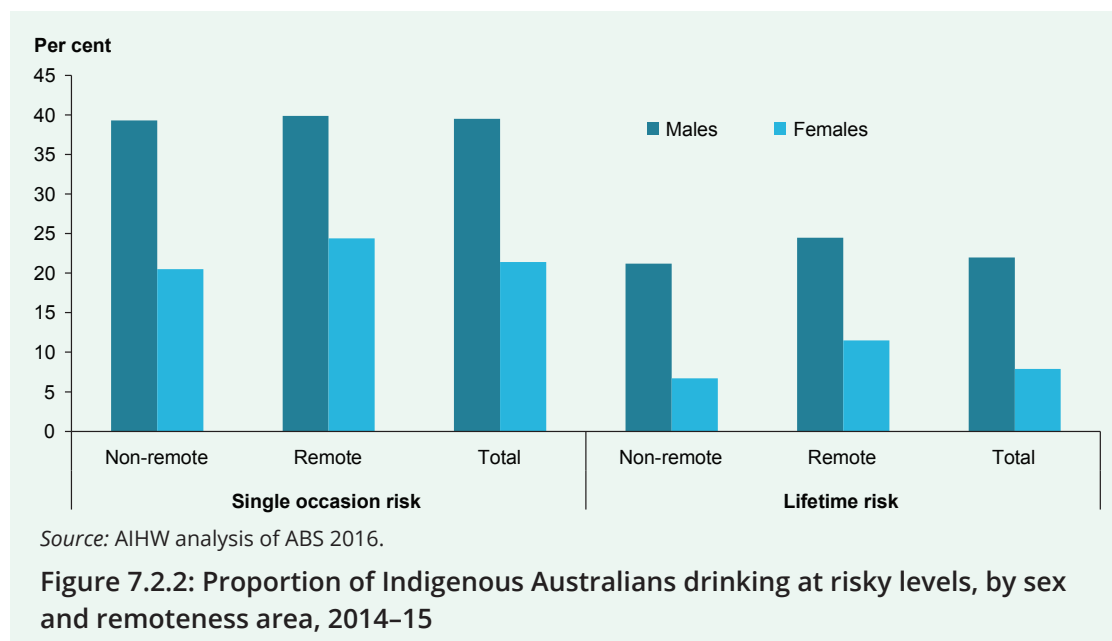
Alcohol

Most Australian adults drink alcohol, and do so at levels that cause few adverse effects. However, a substantial proportion of people drink at levels that increase the risk of alcohol-related harm to themselves and others. As well as the risks to an individual's physical health, harmful use of alcohol is associated with anti-social behaviour, violence, anxiety, depression, self-harm, road traffic accidents, and other unintentional injuries (NHMRC 2009).

According to the 2014–15 NATSISS, among Indigenous Australians aged 15 and over:

• 38% were abstainers (that is, they never consumed alcohol, or had consumed alcohol on 1 day or less in the previous 12 months)

• 15% drank at levels that exceeded the Australian guidelines for lifetime risk of long-term harm (more than 2 standard drinks per day, on average), a decrease from 19% in 2008

• 30% had consumed alcohol at a level that exceeded the Australian guidelines for single occasion risk of harm at least once (more than 4 standard drinks on a single occasion), a decrease from 38% in 2008

• drinking at risky levels was significantly more common among males than females (Figure 7.2.2).

Data from the 2011–12 Australian Health Survey and the 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey show that, after adjusting for age:

• Indigenous Australians aged 15 and over were 1.2 times as likely as non-Indigenous Australians of this age to abstain from alcohol

• the proportions of Indigenous and non-Indigenous people aged 15 and over drinking at levels that put them at risk of lifetime harm were similar

• Indigenous Australians aged 15 and over were 1.1 times as likely as non-Indigenous Australians of this age to drink at levels putting them at risk of short-term harm (ABS 2013).

Source: AIHW analysis of ABS 2016.

Figure 7.2.2: Proportion of Indigenous Australians drinking at risky levels, by sex and remoteness area, 2014–15

Other drug use

According to the 2014–15 NATSISS, 30% of Indigenous Australians aged 15 and over had used other drugs (drugs other than alcohol and tobacco) in the previous 12 months, an increase from 22% in 2008. The most commonly used substance was marijuana (19%), followed by analgesics or sedatives used for non-medical purposes (13%). About 1 in 20 (4.8%) Indigenous Australians aged 15 and over had used amphetamines in the previous 12 months. Amphetamines can be used in several forms (for example, powder, tablet or ice); survey data for the total Australian population suggest that the preferred form is ice (or crystal methamphetamine), with half (50%) of recent amphetamine users aged 14 and over in 2013 reporting that they mainly use ice (AIHW 2014).

Data from the 2013 National Drug Strategy Household Survey suggest that Indigenous Australians are more likely than non-Indigenous Australians to report using substances, particularly marijuana and pharmaceuticals used for non-medical purposes (AIHW 2014).

Self-harm and suicide

Suicide and self-harm cause great distress and grief in both Indigenous and non-Indigenous communities. Indigenous Australians experience higher rates of self-harm and death from suicide than non-Indigenous Australians. Underlying this is a complex set of factors, including the effects of past trauma; psychological distress; geographic and social isolation and marginalisation; socioeconomic disadvantage; substance abuse; and experiences of violence, abuse and neglect.
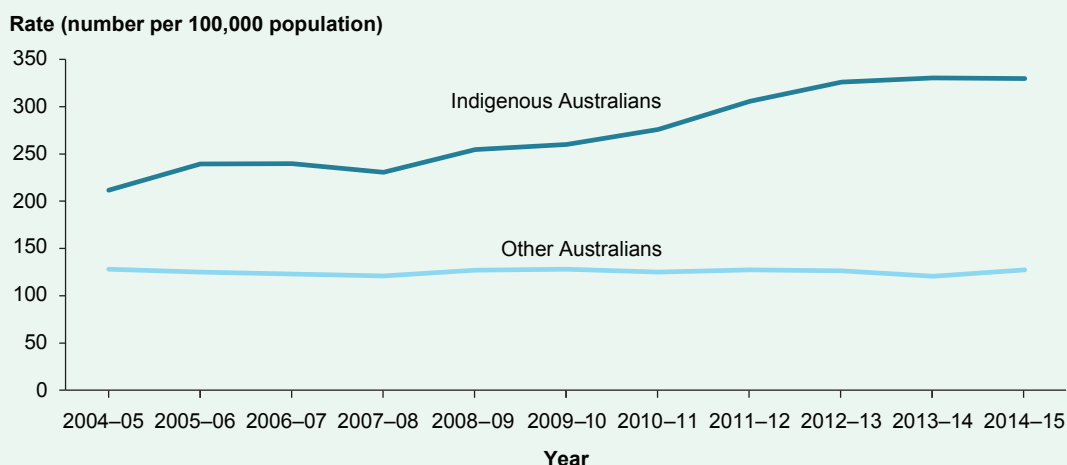
In 2014–15, there were more than 2,200 hospitalisations of Indigenous Australians for non-fatal self-harm (that is, a hospitalisation for self-inflicted injury where the patient was discharged alive)—an age-standardised rate of 315 per 100,000 population. This was 2.6 times the rate for non-Indigenous Australians.

- Among both Indigenous and non-Indigenous Australians, females were more likely than males to be hospitalised for non-fatal self-harm.
- The age-standardised rate of hospitalisations of Indigenous Australians for non-fatal self-harm increased by almost 60% between 2004–05 and 2014–15. By comparison, the rate for other Australians remained stable during this period (SCRGSP 2016) (Figure 7.2.3).

Between 2011 and 2015, there were 690 deaths due to suicide among Indigenous Australians in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory combined—an age-standardised rate of 23 per 100,000 population. This was 2.1 times the rate for non-Indigenous Australians in those jurisdictions.

- Among both Indigenous and non-Indigenous Australians, males were around 3 times as likely as females to die from suicide.
- The suicide death rate was greatest among Indigenous Australians aged 25–34, at 41 per 100,000 population (SCRGSP 2016).
- Between 2006 and 2015, the suicide death rate increased among both Indigenous (from 19 to 26 per 100,000 population) and non-Indigenous Australians (from 10 to 13 per 100,000 population) (Figure 7.2.4).
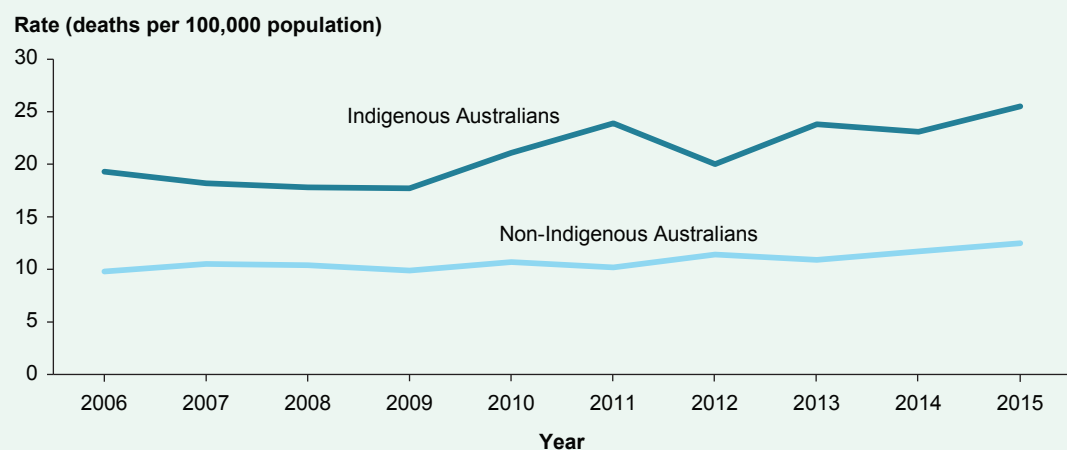
Rate (number per 100,000 population)

Notes

1. 'Non-fatal' refers to records where the patient was discharged alive. 'Intentional self-harm' refers to a principal diagnosis of injury and poisoning (ICD-10-AM codes S00–T98) and a first reported external cause reported for ICD-10AM codes X60–X84, based on the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification.

2. Rates have been directly age-standardised to the 2001 Australian standard population and are expressed per 100,000 population.

Source: SCRGSP 2016.

Figure 7.2.3: Rate of non-fatal hospitalisations for intentional self-harm, by Indigenous status, 2004–05 to 2014–15

Rate (deaths per 100,000 population)

Notes

1. Rates have been directly age-standardised to the 2001 Australian standard population and are expressed per 100,000 population.

2. Suicide includes ICD-10 codes X60–X84 and Y87.0. Causes of death data from 2006 onward are subject to a revisions process. The status of data in this figure is: 2006–2012 (final), 2013 (revised), 2014–2015 (preliminary).

Source: AIHW 2017.

Figure 7.2.4: Suicide rates, by Indigenous status, 2006 to 2015

Being part of a resilient, well-functioning community that includes strong family and community support networks, that minimises exposure to harm, and that provides opportunities for engagement can help to prevent suicide among Indigenous Australians (DoHA 2013). Access to culturally appropriate and coordinated support services, and the involvement of Elders in establishing suicide prevention activities at the community level, is also critical (Dudgeon et al. 2016). Research among First Nations people in Canada has also found that community empowerment, self-determination, and renewal and maintenance of culture protect against suicide (Chandler & Lalonde 2008).

If you or someone you know needs help:

Lifeline **13 11 14**   beyondblue **1300 22 4636**   Kids Helpline **1800 55 1800**

Where do I go for more information?

Relevant AIHW reports such as *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015* are available for free download from the AIHW website.

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) website contains a range of resources related to suicide prevention in Indigenous Australian communities.

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