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What works? A review of actions addressing the social and economic determinants of Indigenous health

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Summary

What we know

What works

There are significant health inequities between Indigenous and non-Indigenous Australians, and the health disadvantages experienced by Indigenous Australians are shaped by the broader social and economic conditions in which they live. In this paper, we review evidence relating to improving Indigenous outcomes and 'closing the gap' across a range of key social and economic determinants of health and wellbeing.

For each key determinant area, there are particular issues which contribute towards success, and we have identified these in the relevant chapters. Below are some general issues which are relevant across all determinant areas and characterise successful programs and interventions when taking a social determinants approach. A social determinants approach considers the broad social, political, economic, cultural and environmental context in which people live and the impact these contexts have on health and wellbeing. The causal pathways between social determinants and health are complex and multi-directional. For the programs we have reviewed in each determinant area, establishing direct causal relationships with health outcomes is not possible. It is possible, however, to make causal inferences by linking the program activity with other factors that are known to be associated with improved health. In identifying 'what works', we have identified successful (or unsuccessful) elements of programs which, if they improve outcomes for Indigenous people in that particular area, may be associated with long-term benefits for health and wellbeing.

Effective approaches are characterised by the following:

- holistic approaches which work with Indigenous people in ways which take into account the full cultural, social, emotional and economic context of their lives, including an awareness of the ongoing legacy of trauma, grief and loss associated with colonisation
- active involvement of Indigenous communities in every stage of program development and delivery, in order to build genuine, collaborative and sustainable partnerships with Indigenous peoples, and build capacity within Indigenous communities
- collaborative working relationships between government agencies and other relevant organisations in delivering services and programs, acknowledging the interrelatedness of key social and economic determinants across multiple life domains for Indigenous Australians
- valuing Indigenous knowledge and cultural beliefs and practices which are important for promoting positive cultural identity and social and emotional wellbeing for Indigenous Australians
- clear leadership and governance for programs, initiatives and interventions. This includes commitment from high level leadership of relevant organisations and agencies to the aims of reducing Indigenous disadvantage and addressing determinants of health and wellbeing
- employing Indigenous staff and involving them fully in program design, delivery and evaluation, and providing adequate training, where necessary, to build capacity of Indigenous staff
- developing committed, skilled staff (Indigenous and non-Indigenous) and providing diversity and cultural awareness training
- in cases where programs demonstrate success, it is important to provide adequate, sustainable resources for long-term, rather than short-term funding



- adopting a *strengths-based* perspective which builds and develops the existing strengths, skills and capacities of Indigenous people
- clear plans for research and evaluation to identify successful aspects of programs, provide a basis to amend and improve, demonstrate success and build an evidence base to justify allocation of ongoing resources.

What doesn't work

The evidence reviewed in the paper suggests the following aspects hinder the ability of programs and interventions to be successful in addressing the social determinants of health to reduce health inequities:

- not involving Indigenous communities in design, delivery and evaluation of programs, and limited consultation with, and opportunities for the participation of Indigenous representatives
- not training and employing Indigenous staff to contribute towards program implementation and delivery
- short-term funding and not continuing to fund programs which have demonstrated success – which can contribute towards Indigenous people feeling loss, disappointment and anger at being let down by the system
- ad-hoc approaches to implementation which may rely upon a handful of people but have no clear leadership or governance
- not having plans for built-in research, evaluation and monitoring which can build an evidence base and can be used as a basis for advocacy for good practice interventions.

What we don't know

The following points relate to information 'gaps' that restrict our ability to specifically identify 'what works' in relation to addressing the social determinants of Indigenous health:

- Across all of the key determinant areas, there is a lack of high quality, publicly available evaluation data regarding programs and interventions, which limits the ability to identify success associated with such programs.
- Because social and economic determinants of health are 'upstream' or distal causes of population health outcomes that are mediated through a variety of pathways, there are no clear causal links as the relationships are complex and multi-directional.
- Furthermore, it is difficult to identify *which* social and economic determinants contribute directly to cause particular health outcomes, or the *relative contribution* of different social determinants to different health outcomes. This would require extensive multivariate modelling of high quality longitudinal epidemiological data, and is beyond the scope of this issues paper.

Summaries from key sections

The following boxes contain summaries drawn from each section of this paper, which highlight the characteristics of successful programs and initiatives. These summaries are also reproduced in the relevant sections of the paper.



Summary 1: Educational attainment

There is evidence of an association between educational attainment and indicators of wellbeing for Indigenous Australians, although the causal pathways between educational attainment and improved health outcomes are not so clear. At all educational levels, factors identified with positive education outcomes for Indigenous Australians include:

- having high expectations of students and promoting a positive Indigenous identity
- adopting a community development focus which involves active collaboration with Indigenous communities
- having a 'whole of institution' (for example, school, university) approach to improving Indigenous outcomes, involving senior management
- well-trained, high quality teachers
- the inclusion of Indigenous culture and knowledge in educational curricula.

The two evaluated programs reviewed in this section contributed towards positive outcomes for Indigenous Australians, including positive attitudes towards education, improved confidence with school work, and increased self-efficacy as learners. However, links between program activities and improved educational attainment were not established. The programs have some shared characteristics that contributed towards the success they achieved:

- extensive involvement and consultation with local Indigenous communities
- highly skilled and committed staff who can build trusting relationships with students
- good connections with services and organisations in the local community
- flexibility to be adapted to the needs of the local community (especially where mainstream education programs are provided to Indigenous Australians).



Summary 2: Connection to family, community, culture and country

Evidence suggests that feeling connected to family, community and Indigenous culture is positive for Indigenous Australians' overall wellbeing, with some caveats. In relation to social connections with family and friends, evidence suggests that feelings of obligation to provide social support to others can be an emotional burden. Being connected with traditional culture is associated with positive wellbeing but has also been linked with psychological distress, particularly for Indigenous Australians living in non-remote settings. Research has demonstrated that maintaining a connection with traditional land and country is associated with benefits for the health and wellbeing of Indigenous Australians living in remote and non-remote contexts.

Evaluation data suggest that the initiatives reviewed in this section contributed towards positive social and emotional wellbeing for Indigenous Australians. It was not, however, possible to establish direct causal links between program activities and improved health outcomes on the basis of the available data. Characteristics of these programs include:

- delivery by organisations with clear direction, planning and vision
- locally driven programs led and owned by Indigenous communities that work in collaboration with community organisations
- building on traditional cultural approaches and activities as pathways to healing
- involvement of Elders in teaching of traditional culture and skills
- drawing on land and country as a means to heal
- building on the *strengths* of Indigenous Australians and cultures to enable healing
- working with women and supporting them to undertake leadership and governance roles
- having committed, trained and skilled staff
- having strategic, intersectoral partnerships.



Summary 3: Employment and income

The causal pathways between employment, income and health outcomes for Indigenous Australians are complex. However, enabling Indigenous Australians to participate in paid work leads to higher incomes which in turn, provide resources which are positive for health and wellbeing. In relation to employment service agencies supporting Indigenous Australians to secure work, evidence suggests the importance of the following:

- highly skilled, culturally competent staff, including Indigenous staff
- provision of cross-cultural training for all workers
- strong vision and commitment to supporting Indigenous job seekers and communities
- collaborative relationships with local communities and businesses
- collaborative partnerships with Indigenous leaders and communities
- holistic support provided to Indigenous job seekers.

Indigenous Australians are more likely than non-Indigenous Australians to be living on low incomes. Apart from increasing participation in paid employment, other interventions have focused on income, and particularly welfare benefits paid to Indigenous people, in order to reduce Indigenous disadvantage:

- Income management has been the subject of much debate and the evidence of its success is not clear. The Cape York Welfare Reform trial suggests that income management, when used as one of a number of strategies as part of the Families Reform Commission process, can promote positive behaviour change, school attendance, and improvements in financial management skills among families. The Cape York trial has been less successful in generating economic development which is related to the limited employment options and lack of economic opportunities in remote Australia.



Summary 4: Housing

The relationship between housing and health is complex and multi-directional, but living in poor quality, inadequate, insecure or unaffordable housing is associated with poor health. Inadequate health hardware can create risks to health and leads to problems for physical health such as infectious disease. Other housing issues, such as overcrowding and affordability, can increase stress and put negative pressures on health and wellbeing.

In remote areas, the evaluated program we have reviewed here was successful in regard to fixing houses to improve health hardware and bring them to adequate standards of safety and functioning. Although health outcomes were not examined, it can be assumed from previous research that improving the health hardware safety of houses would promote better health. Important aspects of this program included:

- focusing on improving health hardware, such as physical infrastructure relating to sanitation, food preparation and water supply, using a standardised methodology
- building community capacity through training of Indigenous community members to complete basic tasks and gain skills
- securing the collaboration and support of Indigenous communities and housing associations.

In a metropolitan area, the program we reviewed succeeded in preventing Indigenous families from becoming homeless and supporting Indigenous families to remain in their homes. Doing this is likely to promote wellbeing. Important aspects included:

- a collaborative working relationship between two Australian Government agencies and a local non-government organisation
- skilled staff (including Indigenous staff) who had knowledge of cultural issues and could build trust with Indigenous families
- using a strengths-based, holistic case management approach
- working with families *before* they became homeless
- linking families with other relevant services
- enabling the family to be self-managed.



Summary 5: Racism

Racism has a negative effect on the social and emotional wellbeing of Indigenous Australians. Racism is experienced by a significant proportion of Indigenous Australians, and operates through a number of pathways to affect health and wellbeing negatively. Despite limited Australian evidence on what works to reduce racism, that available suggests reducing racism should include: universal interventions, targeted interventions across different settings (such as schools, workplaces, public sector and sports/recreation organisations), organisational development, communications and social marketing, and direct participation programs. We reviewed evaluated examples of two anti-racism programs: a communications and social marketing campaign and a diversity training intervention. Data from these evaluations suggest the following success factors:

- targeting specific false beliefs, for example that all Indigenous people are unemployed or receive 'special treatment'
- well-designed and specific program content designed to challenge negative beliefs and specifically address behaviours
- provision of accurate information about Indigenous culture, and how racism affects Indigenous Australians
- having a focus on specific areas of discrimination – such as employment
- highlighting shared values between Indigenous and non-Indigenous Australians
- ensuring that Indigenous communities are involved in campaign design and development.

Summary 6: Interaction with government systems

There are significant inequities in access to health care between Indigenous and non-Indigenous Australians, and Indigenous Australians have high levels of contact with the criminal justice system. Both of these issues are intrinsically connected with other social and economic determinants (for example racism, connection to family, community, culture, education, income) and contribute significantly to the social and economic disadvantage experienced by Indigenous Australians. Inequities in access to adequate health care and higher levels of contact with the criminal justice system (such as higher levels of incarceration) have been clearly linked with negative health outcomes.

Among the programs designed to improve access to health services and prevent contact with the criminal justice system the evaluations suggested some common themes:

- having skilled, committed and culturally competent staff – including Indigenous staff
- culturally appropriate service delivery – facilitated by cultural competency training and collaboration between Indigenous and non-Indigenous staff
- training and support provided to Indigenous staff to enable them to gain professional skills
- collaborative relationships and partnerships between workers and across agencies that link Indigenous Australians with a range of support services in areas such as health care, education, housing, income and family support
- having a holistic, strengths-based focus
- in relation to health care: taking a primary health care approach
- in regard to prevention of contact with criminal justice system: taking a long-term 'whole of community approach' to community development and providing quality youth services which support young people and provide gender-specific activities.



Summary 7: Health behaviours

Negative health outcomes among Indigenous Australians can be linked with health behaviours such as poor nutrition, low physical activity, smoking and consumption of alcohol. All of these behaviours are influenced by the broader social, cultural and economic environment in which Indigenous Australians live. In this section, we reviewed evaluated programs which acknowledged the significance of broader social and economic determinants, and did not have a focus solely on lifestyle interventions or individual behaviour change. Evaluation data suggest that these programs had success in promoting positive health behaviours such as decreased smoking, petrol sniffing and increased self-management of chronic conditions (including physical activity and healthy eating), although health outcomes were not established. Characteristics of these programs which contributed towards success included:

- a community development approach, and investing in community capacity building
- well trained, community-based staff, including Indigenous staff
- commitment of health professionals and other staff to develop culturally appropriate health promotion services
- collaborative partnerships between health agencies and others—for example, outlets selling tobacco products and petrol
- community ownership, including the leadership and involvement of Indigenous Elders
- restricting the supply of harmful substances
- taking into account the history of colonialism in responses to risky behaviours
- youth services to support young people to engage in alternative behaviours and activities
- using strong relationships within the community to build on strengths.



Introduction

The purpose of this paper is to review evidence relating to ‘what works’ to influence the social and economic determinants of Indigenous health, in order to reduce health inequities, and ultimately contribute to closing the life expectancy gap between Indigenous and non-Indigenous Australians. We outline a conceptual framework for understanding how social and economic determinants influence health and wellbeing, and identify a number of key determinants of health. We review evidence relating to how each determinant is associated with Indigenous health and wellbeing, and then consider specific actions designed to improve Indigenous outcomes in each of these areas in order to determine the characteristics of successful initiatives. Based on our conceptual framework, we link successful actions which result in positive outcomes for Indigenous Australians in each of the key determinants to ultimately improving health and wellbeing and contributing towards ‘closing the gap’ in health and wellbeing. We note that many actions we consider only aim to improve the situation for Indigenous Australians in regard to that specific area (for example, education, housing) and were not devised to take direct action to improve health, even though the evidence indicates that those actions may be likely to contribute to improved health over the longer term.

Background

The social and economic determinants of health refer to the ‘conditions in which people are born, grow, live, work and age’ (WHO 2013). Social and economic determinants include factors such as education, employment and working conditions, housing, and access to and use of health services. It is these social and economic circumstances that largely account for health inequities, which refer to unfair and preventable differences in health within populations (CSDH 2008). Health inequities may occur because of the unequal economic and social conditions into which people are born and experience throughout their lives.

This paper views health as more than simply an absence of disease or illness, but rather as a multi-dimensional concept of *wellbeing*, referring to physical, social, emotional and cultural aspects. This is consistent with Indigenous understandings of health, which are holistic and multi-faceted:

Aboriginal health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community.

It is a whole of life view and includes the cyclical concept of life-death-life (NACCHO 2012).

This understanding represents a social model of health, which identifies that the health of individuals and communities is determined by the broader social, environmental, economic and cultural conditions in which people live (Saggers & Gray 2007). As such, it is consistent with taking a social determinants approach to understanding the factors that shape health.

Social determinants of health and health inequities have been the subject of international focus and action. In 2008, the international Commission on the Social Determinants of Health (CSDH) reported on a series of recommendations designed to reduce global health inequities. As part of its work, the Commission examined health inequities experienced by Indigenous peoples internationally and how their health is determined by the social, economic and cultural context in which they live. This work is recorded in the report of the International Symposium on the Social Determinants of Indigenous Health (CSDH 2007). Key determinants identified in this symposium include:



- the overarching role of *colonisation* as a fundamental determinant of poorer health outcomes among Indigenous people, and the significance of *self-determination* in empowering Indigenous people and undoing the adverse effects of colonisation
- the disruption of Indigenous peoples' ties to land and related issues such as land degradation and climate change
- poverty and economic inequality as fundamental drivers of poor health
- the adverse health effects of racism
- the impact of broader societal lack of understanding of Indigenous culture and world views on Indigenous peoples' wellbeing.

Social determinants of Indigenous health and health inequities

Indigenous Australians experience substantial social and economic disadvantages which are linked with poorer health. This is illustrated by the life expectancy gap between Indigenous and non-Indigenous men and women and their non-Indigenous counterparts/as compared with the population as a whole, which consists of 12 years and 10 years respectively (ABS 2012b). The shorter life expectancies reflect adverse health outcomes in a range of areas, for example, in chronic disease (cancer, circulatory disease, diabetes, kidney disease, respiratory disease), mental illness, disability and injury. These health inequities have been extensively documented (see, for example, ABS 2012b; AHMAC 2011; AIHW 2011a). These health outcomes are linked with increased health risk factors and lower levels of access to health services which are in turn shaped by interrelated social and economic disadvantages in such areas as education, employment and housing. The National Aboriginal and Torres Strait Islander Health Plan (Australian Government 2013) which was released just as this paper was being completed, acknowledges the significance of, and proposes some measures to address the social and economic determinants of health. The social and economic determinants of Indigenous health in Australia have been extensively reviewed by others, for example see Anderson et al. (2007), Carson et al. (2007), and the Australian Indigenous HealthInfoNet (2013).

Indigenous health is shaped throughout the life course. The health status of an adult can be viewed as a marker of their accumulated life history and social position at earlier points in their life (Blane 2006). Indigenous health disadvantage is shaped by the accumulated life experiences of social, economic and cultural inequality. Key periods in the life course are critical for determining future life opportunities and health and wellbeing. For example, evidence suggests that early childhood is crucial in terms of subsequent psychological, physiological and social development. If a child is exposed to stressors during this period, and lives in a context of social and economic deprivation, it is probable that this will have a long-lasting and profoundly negative impact throughout their whole life (Anderson et al. 2003; COAG 2009a; Duncan et al. 1994).

Furthermore, different patterns of health inequities are evident for Indigenous Australians depending upon life course position. Key health issues in adolescence and early adulthood include mental health and wellbeing, suicide, sexual and reproductive health and, for women, young motherhood. Later in adulthood, chronic disease – such as cancers, diabetes and heart disease – becomes more prominent. This represents the outcomes of 'lag effects': an accumulation of health behaviours (for example, smoking) over time which commenced earlier in life. Gender also shapes how Indigenous women and men experience their health throughout their lives. Indigenous women experience motherhood earlier on average than non-Indigenous women (AIHW 2011c) and these experiences of child birth and caring responsibilities have different implications for the health of young Indigenous women as compared to young Indigenous men. Young Indigenous men are more likely to die than young Indigenous women, as the death rate for young Indigenous males is twice as high as for females (AIHW 2011c). Both Indigenous men and women experience violence at greater rates than non-Indigenous Australians, but Indigenous women are more likely to be hospitalised than Indigenous men as a result of family violence-related assault (AIHW 2006). Thus social and economic determinants of health interact with both gender and life course experiences, and the resultant health outcomes reflect the interactions between these factors.



Another key factor that relates to different patterns of health inequities among Indigenous Australians is location, and whether Indigenous Australians live in remote, regional or urban Australia. The social and economic context of Indigenous Australians' lives is, on average, different depending on the location that they live in. Indigenous Australians are relatively more likely to live in remote areas than non-Indigenous Australians, and Indigenous Australians in remote areas typically face higher absolute levels of poverty and disadvantage in relation to access to health and other services, employment and education opportunities, and quality of housing. Improving outcomes for this population of Indigenous Australians with such 'visible' disadvantage has been the focus of much policy attention (Atkinson et al. 2010). However, in 2006, three quarters of the Indigenous population lived in regional or urban areas (Table 1), a population which is relatively more 'invisible' in Australian mainstream cultural and policy discourse (Atkinson et al. 2010; Scrimgeour & Scrimgeour 2008). Although similar figures are not yet available for 2011 census data, Biddle (2012b) analysed 2011 census data and identified that 28.8% of the Indigenous Australian population lived in the coastal region between Sydney and Brisbane, an area that consists of urban and regional, but not remote areas. This research also identified that, on current trends, the Indigenous population is likely to become increasingly urbanised over the next few decades (Biddle 2012b). While on average they may not experience the same levels of material poverty as Indigenous Australians in remote Australia, these Indigenous Australians nevertheless experience significant social and economic disadvantage in comparison to non-Indigenous residents of regional and urban Australia. In this paper, we have reviewed programs which take action to address the social determinants of health for Indigenous residents of remote, regional and urban Australia.

Table 1: Indigenous population at 30 June 2006

	Major cities	Inner regional	Outer regional	Remote	Very Remote
	Per cent				
Australia	31.8	20.9	21.9	9.6	15.8

Source: ABS 2008.

Australian policy context

A useful overview of Australian Indigenous policy since the 1960s is provided in the Strategic Review of Indigenous Expenditure (DFD 2010). A brief summary of some of the main policy developments in this period is detailed below:

- The 1967 referendum enabled Indigenous Australians to be counted in the census and is viewed as the symbolic recognition of Indigenous Australians as the first Australians.
- During the 1970s–80s, Australian Governments emphasised policies of self-determination and self-management which sought to end 'assimilationist' policies that had been prevalent since the 1920s. This was a significant period, as it saw the passing of the Racial Discrimination Act (1975), the Aboriginal Land Rights (Northern Territory) Act (1976), and the Human Rights and Equal Opportunity Commission Act (1986).
- The early 1990s saw the Mabo decision, in which the High Court ruled that Australian land was not 'Terra Nullius' (land belonging to no-one) at the time of European settlement. The Australian Government responded by passing the Native Title Act 1993. This Act serves a number of purposes. It recognises and protects native title, validates past land grants that may otherwise be invalid due to native title, establishes frameworks to determine where native title exists and who holds it, and determines compensation where native title is affected by other Acts (ABS 1995).



- The period from the mid-1990s onwards was characterised by significant adjustments in Indigenous policy, as it was perceived that persistent high levels of social, economic and health disadvantage among Indigenous Australians had not been adequately addressed by earlier policies. These changes included a focus on 'mainstreaming' Indigenous policy areas across Australian Government portfolios. The Aboriginal and Torres Strait Islander Commission (ATSIC) was abolished in 2004. Other policies focused on welfare, in particular concepts of 'mutual responsibility' and 'welfare to work' approaches.
- The late 2000s were characterised by some significant events in Indigenous policy, including the Northern Territory Emergency Response, in 2007 (see page 37) and the apology to Australia's Indigenous peoples in 2008 (see page 27) (DFD 2010).

Following the apology to Australia's Indigenous peoples in 2008, the Council of Australian Governments (COAG) set six targets relating to the social, economic and health disadvantages experienced by Indigenous Australians. These targets are:

- close the gap in life expectancy within a generation (by 2031)
- halve the gap in mortality rates for Indigenous children under 5 by 2018
- ensure access to early childhood education for all Indigenous four year olds in remote communities by 2013
- halve the gap in reading, writing and numeracy achievements for Indigenous students by 2018
- halve the gap for Indigenous students in Year 12 (or equivalent) attainment rates by 2020
- halve the gap in employment outcomes between Indigenous and other Australians by 2018.

These targets guide policy development to close the gap in Indigenous disadvantage across all Australian Governments, including the National Indigenous Reform Agreement (NIRA) and National Partnership agreements, which commit the Australian, state and territory governments to investing resources to reduce inequities in these areas. Two of these targets relate directly to health outcomes, and the remaining four relate to education and employment, both key social and economic determinants of health and wellbeing. It is worth noting that none of these overarching targets specifically address issues that were identified in the CSDH Indigenous Symposium (2007) as being social determinants relevant to Indigenous people, including cultural respect, access to land, self-determination, and racism (CSDH 2007), although these issues are addressed within the NIRA, and a number of strategies (such as those included in the Indigenous Economic Development Strategy) address areas such as self-determination and access to land.

Key social and economic determinants

On page 15, Figure 1 presents a conceptual framework which outlines how the social and economic determinants of health impact on health and wellbeing for Indigenous Australians and lead to health inequities. We present the historical context of colonisation (and related issues such as dispossession and removal from land and separation from family and community) as the overarching driver of social, economic and health inequities experienced by Indigenous Australians. The impact of colonisation has cascading effects which flow through to economic, material, social and cultural disadvantage.

The following social and economic determinants are relevant to understanding Indigenous health inequities and represent significant economic, material, social and cultural factors which comprise the context of everyday life for Indigenous Australians. We note the experience of these determinants differs depending on whether Indigenous Australians live in remote, rural or urban areas and on family and cultural backgrounds. The determinants are:



- educational attainment
- connection to family, community, country and culture
- employment
- housing
- racism
- interaction with government systems:
 - access and treatment within the health system
 - contact with the criminal justice system.

It is these determinants, and actions that have been taken to address them, which we focus on in the rest of the paper. This list was identified by examining previous publications relating to the social and economic determinants of Indigenous health, which have all identified the significance of the above issues (Anderson et al. 2007; Carson et al. 2007; VicHealth 2011). Furthermore, Indigenous people themselves identify the importance of determinants associated with ‘community functioning’, such as connectedness to family, community and culture and the relationships and social norms that operate within families and communities as particularly relevant for their wellbeing (AHMAC 2012). The relationships and interactions between social and economic determinants, health behaviours and health outcomes are complex and the causal mechanisms underpinning them are not clear.

In relation to interaction with government systems (including services, agencies and institutions), we have chosen to focus in this paper on two domains which are particularly relevant to Indigenous health and wellbeing—the health system and the criminal justice system. We consider health behaviours (smoking, physical activity, diet and nutrition, and alcohol and other drug use) as key areas for action when addressing Indigenous health disadvantage. We also examine how these behaviours are shaped by the determinants listed above, and review actions that seek to address these behaviours and promote health through addressing determinants.

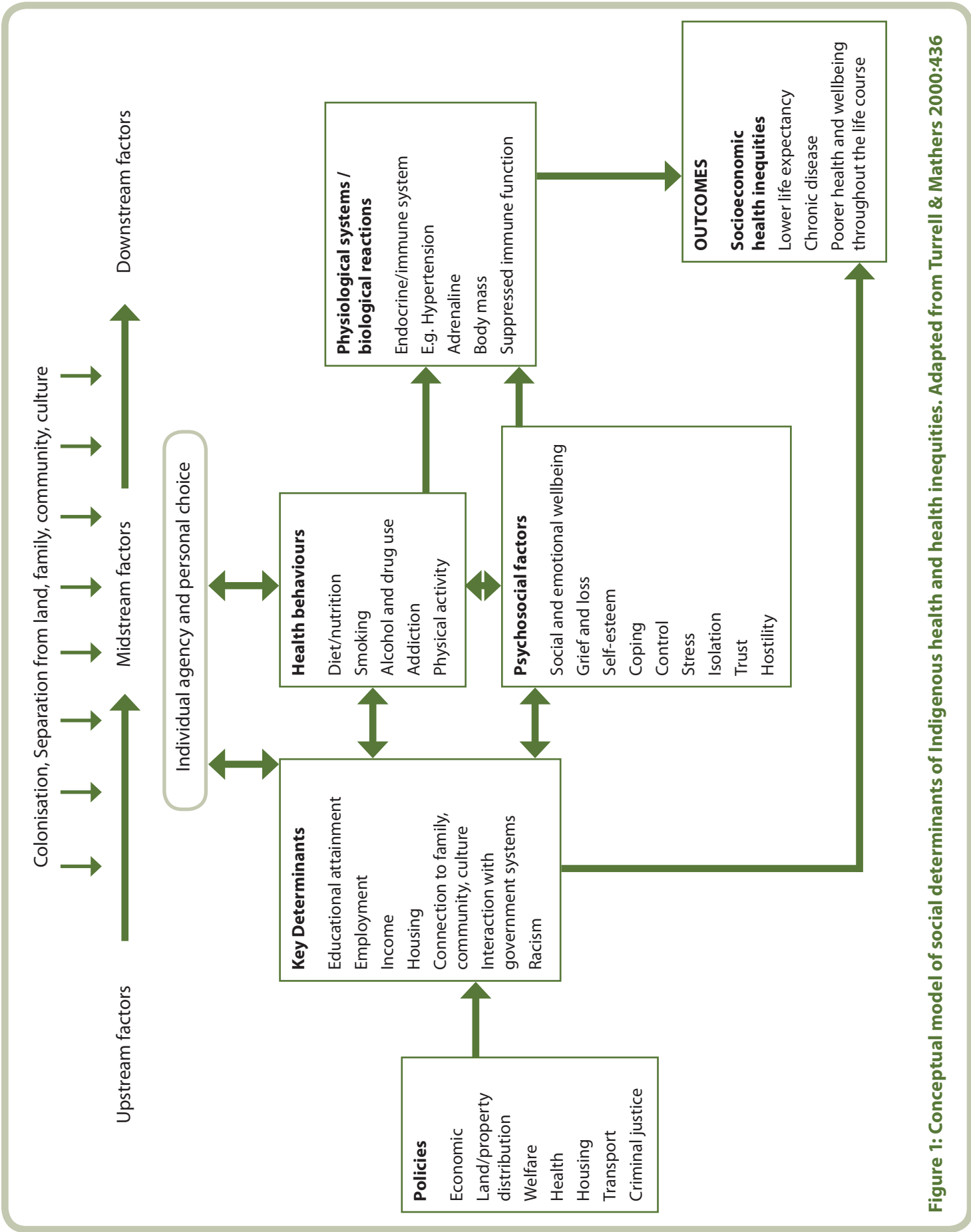


Figure 1: Conceptual model of social determinants of Indigenous health and health inequities. Adapted from Turrell & Mathers 2000:436



Methodology

Our search for ‘what works?’ focused on policies, programs and interventions designed to improve Indigenous Australians’ experiences and outcomes for each of the determinants listed in the previous section. We only selected programs for inclusion in the paper that had publicly available evaluation data which provided some information about effectiveness. We included evaluations of large and small scale programs, which used a range of methods including both qualitative and quantitative data. In regards to actions on health behaviours, we sought to identify programs that were designed to address at least one of the key social and economic determinants in order to change health behaviours and improve health, and excluded those which only used behaviour change strategies in isolation.

Initial literature searches were conducted for evidence relating to Indigenous health and each of the key determinants, to provide an overview of how each determinant was related to *Indigenous* health and wellbeing, as opposed to the health of non-Indigenous populations. We focused this searching on identifying *reviews* which would clearly summarise the existing evidence. The following databases were used in searching: the Australian Indigenous HealthInfoNet, Closing the Gap Clearinghouse, Informit (ATSI health and Indigenous Australia), CINAHL, CINCH, Web of Knowledge, Expanded Academic ASAP, Sociological Abstracts, Proquest, Medline and Google Scholar. We also searched government websites (for example, ABS, AIHW). Search years were limited to 2000–2013. Key search terms included each determinant, Indigenous and/or Aboriginal and Torres Strait Islander, review, and health/wellbeing.

We then undertook searching on the same databases for programs and interventions relevant to each of the determinants. We also obtained references listed in useful documents found through previous searching. The Australian Indigenous HealthInfoNet, in particular, was a useful source of information regarding programs, interventions and the availability of evaluation data. We utilised Google and Google Scholar to identify documents in the grey literature, in addition to sites such as the Centre for Aboriginal Economic Policy Research (CAEPR), and government websites (for example, the Departments of Education, Employment and Social Services). In searching for evaluations for each of the determinants, we largely identified government evaluation reports in the grey literature, although some were in peer reviewed articles.

Limitations of this paper

This paper has a number of limitations. It is not an exhaustive systematic review of either background literature or programs and interventions relevant to the social determinants of Indigenous health. Rather, we have focused on providing specific examples of initiatives relevant to each determinant which have some level of evaluation evidence that provides information about relative success or lack of success. As such, it is a ‘snapshot’ of action that has been taken in order to contribute towards knowledge about what characterises successful approaches. Undoubtedly, there are many other programs and interventions with evaluation data that have achieved levels of success which we have not included in this paper.

We have noted that gender, life course position and location of residence are key organising factors which shape Indigenous Australians’ health and their experiences of everyday life, but we have not had the scope to devote detailed attention to each of these issues separately. In addition, due to the amount of material found in our searching relevant to Australia, we have largely restricted the examples we have included to Australian programs and initiatives, which we viewed as most relevant for the purposes of this paper. Nevertheless, this has restricted us from including international examples of actions that have been taken to address the social determinants of Indigenous health. Given the number of countries that face similar issues in regard to Indigenous health inequities and the varied levels of achievement in reducing inequities in different countries, a review of international actions relating to the social determinants of Indigenous health would be a useful focus for future research.



A review of actions to address key determinants

Educational attainment

Improving educational attainment is the focus of three COAG closing the gap targets relating to early childhood education; reading, writing and numeracy; and Year 12 (or equivalent) attainment. In this section, our discussion of education and educational attainment relates to the mainstream Australian education system, as opposed to traditional Indigenous teachings, although we discuss the importance of integrating Indigenous teachings, values and knowledge within mainstream education curricula. Education has been the focus of two previous Closing the Gap Clearinghouse Issues papers: on school readiness (Dockett et al. 2010), and school attendance (Purdie & Buckley 2010), and as such, literature in these areas has been reviewed comprehensively. It is well established that educational attainment, as a key indicator of socio-economic status, is associated with health and wellbeing among general populations: high educational attainment is associated with better health (Ross & Wu 1995, Turrell et al. 2006). While the causal pathways underpinning this relationship are not clear, Ross and Wu (1995) identify these explanations:

- work and economic conditions: people who have higher levels of education are less likely to be unemployed, more likely to work full time, more likely to have fulfilling jobs, high incomes and lower economic hardship
- psychosocial resources: higher levels of education are likely to be linked with more sense of control over life and higher levels of social support
- healthier lifestyle: higher levels of education mean that people are less likely to smoke and more likely to exercise and drink moderately.

Education and wellbeing among Indigenous Australians

Indigenous Australians have lower rates of educational attainment than non-Indigenous Australians, although educational attainment has been increasing among Indigenous Australians in recent years. In 2008, 37% of Indigenous adults aged 18 years, and 22% of people aged 15 years and over had achieved a minimum of Year 12 or a vocational qualification, and 5% of adults had completed a bachelor degree (ABS 2012b). The rates of attainment of non-school qualifications, such as vocational and tertiary qualifications, have also increased so that, in 2008, 40% of Indigenous adults aged 25-64 achieved a non-school qualification, an increase from 32% in 2002 (ABS 2012b). Between 2006 and 2011, the rate of Indigenous Australians achieving Year 12 or equivalent increased by 6.5%, from 47.4% to 53.9% (COAG Reform Council 2013).

Dunbar and Scrimgeour (2007) note that, although evidence suggests poorer health among Indigenous children in particular (such as poor nutrition and hearing loss) has a negative effect on educational attainment, there is less evidence to suggest a causal link between higher levels of educational attainment and health. More recent data provides evidence on an association between educational attainment and wellbeing for Indigenous Australians. In an analysis of data from the 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and waves 1-4 of the Longitudinal Surveys of Australian Youth, Biddle and Cameron (2012) found that Indigenous Australians who have completed higher levels of education (completing Year 12 or equivalent as compared to finishing school at Year 9 or less; or Years 10 or 11, and a level of post-school qualification as compared to no post-school qualification) have better self-rated health, higher levels of happiness, lower sadness, better outcomes in regard to employment, income and financial security, and were more likely to engage in Indigenous cultural activities than those with lower levels of educational attainment. Engaging in Indigenous cultural activities is an indicator of positive cultural identity which is also associated with higher levels of happiness and better mental health among Indigenous Australians (Dockery 2011).



ABS data (2011) has identified that higher levels of educational attainment among Indigenous adults are associated with lower levels of economic and social disadvantage measured across a range of determinants, all of which are relevant for health and wellbeing. This includes higher rates of employment, lower likelihood of living in overcrowded housing and a higher likelihood of living in a house owned by a householder, and a lower likelihood of being arrested in the previous 5 years. All of these relationships were stronger in regard to Indigenous adults living in major cities compared to regional and remote areas. In regard to health behaviours, smoking and high alcohol consumption reduced with higher levels of educational attainment. However, across all levels of education, rates of smoking among Indigenous adults are twice as high as non-Indigenous adults.

In relation to all of these associations, the ABS cautions against the notion that education alone can close the gap between Indigenous and non-Indigenous Australians. The causal pathways are not clear, and other factors aside from education (such as living in a metropolitan or a rural/remote location, and access to services) have a role in maintaining the gaps between Indigenous and non-Indigenous Australians in employment, housing and health risk behaviours. However, these data support the view that, for Indigenous Australians, higher levels of educational attainment are associated with better social and economic outcomes, which are ultimately beneficial for health and wellbeing.

Good practice for supporting education participation of Indigenous Australians

The evidence described above suggests that education can have a positive impact on the wellbeing of Indigenous Australians. However, incidences of poor educational practice have also been documented, whereby participation in mainstream education can have a negative impact on the wellbeing of Indigenous students through socially exclusionary and discriminatory policies and practices (Boughton 2000; Dunbar & Scrimgeour 2007; Malin 2003). Boughton (2000) argues that historically, mainstream education has been implicated in the colonisation and dispossession of Indigenous Australians and this legacy remains in institutional practices. Researchers have identified connections between the cultural and linguistic alienation experienced by Indigenous youth as a result of participation in mainstream education and adverse outcomes such as contact with the criminal justice system and substance abuse (Dunbar & Scrimgeour 2007; Hunter 2001; Schwab 2006). More research is needed to explore Indigenous perspectives on education and educational achievement. As such, it is important to identify evidence relating to good practices which enable Indigenous students to have positive experiences of education and achieve good outcomes, which in turn can promote wellbeing.

Pre-school education in early childhood

There is considerable international evidence that education interventions in a child's pre-school years promote positive social, educational and health outcomes throughout life (COAG 2009a) and that quality, well-resourced pre-school and early learning programs are important to promote positive educational attainment and improved social outcomes (Black 2007). Evidence suggests such programs need well-trained staff, use a mix of home and childcare-centre-based activities, and have an explicit focus on child development (Black 2007).

In Australia, Black (2007) reviewed evidence from a limited number of pilot programs that have demonstrated the significance of preschool for Indigenous children. Successful Australian examples of preschool programs for Indigenous children were all underpinned by community involvement and a culturally appropriate approach, including consultation with local communities to ensure the acceptability of the programs (Black 2007).

Armstrong et al. (2012) identified factors associated with resilience among young Indigenous children, and found that family support, strong cultural identity, good health and positive self-identity are key strengths for Indigenous children transitioning to school.

In their review of school readiness for Indigenous children, Dockett et al. (2010) identify that high quality early childhood education helps prepare children for school. Schools that employ and value Indigenous staff, links between pre-school educators and school educators, and positive involvement of families and community members can all enhance children's transition and also support schools to be ready for Indigenous children.



School

In a study of schooling and Indigenous children's health, Malin (2003) examines contrasting case studies of classroom practices, including examples of socially exclusionary practices which have a negative impact on Indigenous students, and empowering, inclusive practices which have a positive influence on students' experiences of education. She concludes that the extent to which Indigenous students are 'culturally incorporated and socially supported' within the classroom can have long-term implications for their health. Schools that incorporate Indigenous leadership and community development may contribute to the health of both the child and the whole family (Malin 2003). As such, the extent to which school is *culturally appropriate* for Indigenous children affects how education impacts on the health and wellbeing of Indigenous students (Dunbar & Scrimgeour 2007).

Evidence suggests important factors for promoting positive education outcomes among Indigenous students include: having high expectations of students and challenging assumptions of Indigenous under-achievement; adopting a community development focus which involves and collaborates with community; promoting a sense of positive Indigenous identity; having a 'whole of school' approach to improving outcomes and involving senior management; high quality teachers; a positive school environment; and the inclusion of Indigenous culture and knowledge in the school curriculum (Black 2007, Sarra 2006; see also Malin 2003; Purdie & Buckley 2010). Education programs that increase the presence of Indigenous Australians within schools, including parents, family and community members, are positive for engaging Indigenous children in school (Black 2007).

In their issues paper regarding school attendance and retention of Indigenous students, Purdie and Buckley (2010) list key attendance and retention strategies identified in the literature, including: training for school staff to raise their awareness and sensitivity to Indigenous history, contemporary culture, language and lifestyle, respect for Indigenous languages, valuing the students' cultural background and the skills they bring to school, and using a whole of school approach to commit to improving education outcomes. Significantly, Purdie and Buckley (2010) also highlight a lack of supporting evidence about 'what works' in relation to school attendance and retention, particularly in regard to high quality evaluation research. Black (2007) has also highlighted a lack of Australian evidence in regard to both early childhood and schooling strategies for Indigenous children, with much of the evidence from individual case studies and a limited number of pilot studies.

Post-school further and tertiary education

In regards to post-school education pathways, the evidence is clear that achievements in further, and particularly higher, education are associated with lower levels of social and economic disadvantage for Indigenous Australians. A systematic review which examined how Vocational Education and Training (VET) and Adult and Community Education (ACE) can meet the aspirations and requirements of Indigenous Australians in remote, rural and urban environments was conducted by Miller (2005). It identifies seven key good practice factors associated with positive VET and ACE outcomes among Indigenous Australians: community ownership and involvement; inclusion of Indigenous identities, cultures, knowledge and values; establishment of true partnerships; flexibility in the design, content and delivery of courses; quality staff and committed advocacy; extensive student support services; and appropriate and sustainable funding. Stanwick et al. (2006) highlight qualitative data from an Indigenous community controlled VET provider that emphasise the importance of developing a sense of community and belonging among students, which promotes positive wellbeing. Clearly, there are shared themes between adult education and schools about what makes for good practice to enable Indigenous students to achieve positive outcomes.



In a review of higher education access and outcomes for Indigenous students, Behrendt et al. (2012) identify that Indigenous students require social, financial and academic support to do well at university. The authors make a number of recommendations to increase the rates of Indigenous students attending university and improve retention and outcomes. They state it is necessary to have a whole of university approach that is clearly led by vice-chancellors and involves all faculties, as opposed to wholly locating the responsibility for improving Indigenous outcomes within Indigenous education units. They also recommend developing Indigenous teaching and learning frameworks that involve the inclusion of Indigenous knowledge within curricula and teaching practices across all faculties, and efforts to increase numbers of Indigenous staff within universities. They identify examples of good practice within universities, including case management to support individual students to increase retention and achievement. Ultimately, they view increased participation in higher education and more Indigenous graduates as a way to develop Indigenous professional and academic leaders who can make a positive contribution towards closing the gap in Indigenous communities throughout Australia.

A review of the participation in higher education of Indigenous students and students from low socioeconomic backgrounds (CSHE 2008) made these recommendations: enable diverse pathways of entry through schools, TAFEs and other training organisations; increase Indigenous staff working in universities; improve status of Indigenous knowledge, culture and studies in universities; and improve the participation of Indigenous Australians in university governance and management.

Policy approaches and programs

Relevant policy initiatives in the area of education are the National Partnership Agreement on Early Childhood Education and the Smarter Schools National Partnership Agreements between the Australian Government and State and Territory Governments. The three Smarter Schools agreements provide resources to reform and improve schools which are 'falling behind', and address literacy and numeracy, improving teacher quality and reducing disadvantage in low socio-economic status schools. Although the Smarter Schools initiative is not specific to Indigenous students or schools, there is a clear expectation that there will be a positive impact on Indigenous students' education. Over half of Australia's Indigenous students attend schools that have participated in the Smarter Schools National Partnerships. The quality teaching and literacy and numeracy aspects of the Northern Territory Closing the Gap National Partnership (2009–2012) were being administered under Smarter Schools (Atelier Learning Solutions 2012). The first phase of the evaluation has been published (Atelier Learning Solutions 2012) and identified that a significant level of activity is required to improve student performance across all participating schools, including: improved school leadership, improved teacher practice and performance, and strengthened student engagement.

The Ministerial Council for Education, Early Childhood Development and Youth Affairs (MCEECDYA) Aboriginal and Torres Strait Islander Education Action Plan 2010–2014 (MCEECDYA 2010) identifies a number of key areas and strategies for improving education outcomes among Indigenous students. It highlights a number of commitments made in COAG reform agreements such as the National Indigenous Reform Agreement, Indigenous early childhood development National Partnership and the Smarter Schools National Partnerships, as described above. It also describes new measures designed to close the gap in education outcomes, including the Focus Schools Next Steps Initiative (for which evaluation data is not yet publicly available). The MCEECDYA report (2010) identifies six priority domains for improving education outcomes among Indigenous Australians: readiness for school; engagement and connections; attendance; literacy and numeracy; leadership, quality teaching and workforce development; and pathways to real post-school options. The Focus Schools Next Steps Initiative and Investing in Focus Schools Project were specifically designed to complement and accelerate implementation of local level actions in the 'engagement and connections', 'attendance' and 'literacy and numeracy' domains of the action plan, in state and territory-selected focus schools.

In the section below we review case studies of programs which can be viewed as taking a 'social determinants approach', have been evaluated and have demonstrated success in improving educational outcomes for Indigenous Australians.



Home Interaction Program for Parents and Youngsters (HIPPY)

The Home Interaction Program for Parents and Youngsters (HIPPY) is an early childhood education program. HIPPY is not specific to Indigenous Australians but is run in five areas with a high Indigenous population, including two Indigenous-specific pilot locations. In 2008, a five-year rollout of the program commenced, funded by the Australian Government. It aims to support children from disadvantaged backgrounds to have a successful transition to school and commence school on an equal footing with other children. It is described as 'a combined home and centre-based early childhood enrichment program that supports parents in their role as their child's first teacher' (Liddell et al. 2011:vi). It targets communities that experience social and economic disadvantage and enables home tutors to work with parents for two years to assist the child to have a successful transition to school. The evaluation of the program (Liddell et al. 2011) undertakes a detailed examination of HIPPY in Alice Springs, Inala, Pioneer in Mt Isa, Katherine and La Perouse. It concludes that HIPPY holds 'significant promise' as an early childhood program for Indigenous Australians and aligns with COAG targets relating to early childhood education. Significantly, the evaluation identifies that HIPPY had higher levels of success in sites where the local Indigenous leaders and community were closely involved and, furthermore, where there were strong relationships between the agency delivering HIPPY and other child and family services for Indigenous Australians.

The program was modified in sites with high Indigenous populations and the majority of these changes were made to improve engagement with Indigenous parents and children. Modifications were necessary relating to location (options for parents and tutors to meet away from home), providing transport, and ensuring materials were culturally appropriate and suitable for parents' literacy levels. Attracting and retaining high quality tutors and coordinators was important in building trusting relationships. Positive outcomes for Indigenous parents and families included: increased confidence to teach their child and talk to the child's teacher; improved parenting skills; better relationships between parents and children; social connectedness with other parents; increased knowledge about the school's requirements; improved awareness of the child's skills and abilities; and pride in the child's learning achievement. Benefits for the children included improved familiarity and confidence with school work.

Sporting Chance Program

The aim of the Sporting Chance Program is to improve educational outcomes for Indigenous school students using sport and recreation. Such outcomes include improved school attendance, engagement and attitudes towards school, better learning outcomes and increased retention of Indigenous students into Year 12. The program consists of two streams: School-Based Sports Academies (Academies) for secondary school students and Education Engagement Strategies (EES) for both primary and secondary school students (Lonsdale et al. 2011). Academies use sports and recreation activities as a means to engage students in school and offer sports-focused learning to improve education and career opportunities. They are intensive with contact between staff and students being maintained throughout the year. EES programs are less intensive and focus on engaging with primary and secondary students in regional and remote locations. EES staff visit locations and involve high profile athletes as role models for healthy lifestyles, life skills and improved self-esteem (Lonsdale et al. 2011).

Evaluation of this program finds positive results in relation to both the students' experiences and the teachers' and principals' evaluations of the students' progress from participating in Sporting Chance. In regard to student results, over 90% of students surveyed report positive attitudes towards school and their own self-identity, a sense of pride in being Indigenous and self-efficacy as learners. Data from teachers indicate moderate student improvements in relation to attendance, engagement, achievement, retention and parental/community involvement that can be specifically attributed to the program. Scope for further improvement is identified. Academies in particular are linked to improved attendance and engagement, but the evidence is not clear for educational attainment. However, despite the lack of clear connection between the program and educational attainment, it can be assumed that if a program contributes towards improved attendance and engagement, it is supporting students to have more positive experiences of education, which in itself is progress, and can



ultimately contribute towards improved educational achievement in the long term. The evaluation identifies that effective Academies were characterised by: skilled, enthusiastic and dedicated staff who could build trusting relationships with Indigenous students; involving local Indigenous communities in the planning and processes before implementing the program; support from school leadership; sufficient resources and funding; strong relationships with local community and business organisations; and a commitment to promoting Sporting Chance as both an education and sporting program.

Other positive outcomes include the families' pride in students' achievements in the program, and qualitative data suggests improvements in participating students' sense of self-esteem and self-confidence. However, negative aspects reported include a gender imbalance and a disproportionate number of boys as opposed to girls participating in academies. The evaluation concludes that overall, the program is meeting the objective of leading to positive educational outcomes for Indigenous students. This is most apparent in the areas of improving student engagement and attendance. The evidence is less clear in relation to improving retention, parental and community engagement, and it is difficult to establish a link between the program and improved learning achievements (Lonsdale et al. 2011).

Summary 1: Educational attainment

There is evidence of an association between educational attainment and indicators of wellbeing for Indigenous Australians, although the causal pathways between educational attainment and improved health outcomes are not so clear. At all educational levels, factors identified with positive education outcomes for Indigenous Australians include:

- having high expectations of students and promoting a positive Indigenous identity
- adopting a community development focus which involves active collaboration with Indigenous communities
- having a 'whole of institution' (for example, school, university) approach to improving Indigenous outcomes, involving senior management
- well-trained, high quality teachers
- the inclusion of Indigenous culture and knowledge in educational curricula.

The two evaluated programs reviewed in this section contributed towards positive outcomes for Indigenous Australians, including positive attitudes towards education, improved confidence with school work, and increased self-efficacy as learners. However, links between program activities and improved educational attainment were not established. The programs have some shared characteristics that contribute towards the success they achieved:

- extensive involvement and consultation with local Indigenous communities
- highly skilled and committed staff who can build trusting relationships with students
- good connections with services and organisations in the local community
- flexibility to be adapted to the needs of the local community (especially where mainstream education programs are provided to Indigenous Australians).



Connection to family, community, country and culture

Research suggests that a positive connection with family, Indigenous community, country, and culture, is associated with social and emotional wellbeing and health for Indigenous Australians (AHMAC 2012; Biddle 2011; Dockery 2011; Guerin et al. 2011; Kingsley et al. 2009, 2013). For Indigenous Australians, social and emotional wellbeing is a holistic concept which encompasses health and mental wellbeing, but furthermore acknowledges the central significance of connection to culture, family, community and land. It also acknowledges the impact of loss and trauma associated with the practices of colonisation, such as dispossession from land and separation from family and community (Nguyen & Cairney 2013).

Connectedness to family and community can include a shared sense of identity and belonging through positive social relationships and cultural practices (AHMAC 2012). The concept of social capital is relevant to this. Conceptualisations of social capital vary, but all include networks of social relationships and the benefits that accrue to members of these social networks (Baum & Ziersch 2003; Bourdieu 1986). Social capital has been linked with both physical (Kawachi et al. 2004) and mental health (McKenzie et al. 2002). For non-Indigenous populations, evidence suggests that strong, supportive relationships with family, friends and community members can provide psychosocial resources such as a sense of belonging and inclusion, instrumental benefits such as access to different forms of help and support from others, and can 'buffer' against the adverse effects of negative life events (Kawachi & Berkman 2000).

In relation to Indigenous Australians, social capital is embedded in cultural understandings and identity (Brough et al. 2006; Hunter 2004) including spoken languages, identification of family and clan groups, and connection with country (Dockery 2010). These issues vary between Indigenous Australians living in remote and non-remote settings. Indigenous Australians, particularly those living in urban areas, have to negotiate tensions between identities which emphasise connectedness to Indigenous culture and participation in 'mainstream' Australian culture (Fredericks et al. 2008).

A disconnection from family and community (as enforced by the state, for example among the Stolen Generations) or a negative connection with family and community – characterised by high levels of dysfunction, breakdown of social norms and abuse – is significantly related to negative health behaviours and poor health and social and emotional wellbeing among Indigenous Australians (AIHW 2006; CtGC 2013). The Aboriginal and Torres Strait Islander Social Justice Commissioner (2011) has drawn attention to 'internalised colonialism' or 'lateral violence', which has been defined as:

the organised, harmful behaviours that we do to each other collectively as part of an oppressed group: within our families; within our organisations and; within our communities. When we are consistently oppressed we live with great fear and great anger and we often turn on those who are closest to us. (Frankland & Lewis 2011 cited in ATSIJSJC 2011).

Lateral violence includes behaviours such as bullying, shaming, family feuding, organisational conflict, and, at the most extreme, physical and sexual violence and abuse (ATSIJSJC 2011). This does not simply refer to the behaviours of individuals, but can occur in situations where groups of people work together to undermine or attack other groups. It is important to emphasise that such actions result from sustained oppression and disadvantage, and from living within a society which does not adequately recognise or value Indigenous culture (ATSIJSJC 2011). Rather than anger being directed toward the oppressors, lateral violence results in anger and hostility being directed 'horizontally' at those in the same cultural group. In such situations, within a colonised society, connections with family and community can further exert a negative influence on health and wellbeing and not lead to positive identity, belonging or social capital resources that promote health.



Connection with family and friends

Some research has identified a positive connection between social capital, including measures of connection to family and friends, with health and wellbeing among Indigenous Australians. In an analysis of data from the 2008 NATSISS to examine how measures of social capital were associated with wellbeing for Indigenous Australians, Biddle (2011) considered self-reported happiness and sadness as indicators of wellbeing. This research found that face-to-face contact with family and friends was associated with a lower probability of reported sadness, and general support from outside the household was associated with a higher likelihood of happiness and lower likelihood of sadness. However, providing support was associated with a higher probability of sadness, possibly indicating the burden of supporting others can take a negative toll, a finding which is supported by other research (Ziersch et al. 2011a). An obligation to provide support to others may be particularly difficult when living in a context of social and economic disadvantage and limited resources. Perceptions of being able to have a say with family and friends or within the community were associated with higher happiness and lower sadness, as were levels of trust. Finally, having a diverse social network, with some but not all friends being Indigenous, was associated with higher levels of wellbeing than having a social network that was largely Indigenous or largely non-Indigenous (Biddle 2011).

A study of Indigenous residents living in an urban area revealed high levels of social connections, with the majority of participants seeing family and friends frequently and being regularly involved in community groups (Gallaher et al. 2009). The results also indicated that for this sample, higher levels of practical and emotional support were available than financial and information support (Gallaher et al. 2009). The relatively high level of social connectivity found in this study suggests the possibility that relationships with family, friends and community are a key strength among Indigenous Australians living in urban areas. Another study considering how satisfied Indigenous urban residents were living in their neighbourhood (which may be associated with more positive neighbourhood experiences and quality of life) indicated that perceived neighbourhood safety and trust in people living in the local neighbourhood were associated with neighbourhood satisfaction (Osborne et al. 2012).

Other research has identified that higher levels of social capital are associated with lower levels of mental distress among Indigenous Australians living in regional coastal communities (Berry 2009). In another study of urban Indigenous residents that considered aspects of social capital, it was found that involvement in Indigenous-specific community organisations was important for promoting health (Brough et al. 2004). Brough and colleagues have identified the significance of shared Indigenous identity as forming the basis for cohesive social ties between urban Indigenous Australians, and for facilitating community-based involvement (Brough et al. 2006).

Brough and colleagues (2006) also illustrated the significance of a wider context of racism, as it identified the difficulties faced by Indigenous Australians engaging in mainstream community organisations when their previous social interaction with non-Indigenous Australians had been influenced by racism and a resulting lack of trust. Similarly, in research undertaken in a rural Australian town, researchers found that participation in civic activities and attendance at community events was high among both Indigenous and non-Indigenous respondents (Gilles et al. 2004). However, the same research also indicated that Indigenous respondents experienced health problems resulting from unfair treatment on the basis of race, and had worse health than non-Indigenous respondents (Gilles et al. 2004).

In a study of responses to racism among urban Indigenous residents, it was found that gaining social support from others in a social network can be a coping strategy that is beneficial for health. However, it was also identified that the obligation to provide social support to other Indigenous Australians who experience racism can be an emotional burden which further damages health (Ziersch et al. 2011b). This indicates that in wider contexts of discrimination and disadvantage, social connections may not necessarily give rise to social capital which is beneficial for health (Ziersch et al. 2011b). In a quantitative study, Ziersch and colleagues considered whether variables relevant to social capital - including socialising, community group membership, and social support - ameliorated the negative mental health impacts of racism. It found that these social resources did not reduce the negative relationship between mental health and racism (Ziersch et al. 2011a).



Connection with culture and country

Indigenous Australians' attachment to traditional culture has been associated both with higher advantage on social and economic indicators, and better health and wellbeing (Dockery 2010, 2011). This association is supported by international evidence. Research conducted in Canada has found that youth suicide in First Nations communities is lower among communities which have taken steps to preserve and remain strongly connected to cultural practices, thereby offering adolescents and young adults 'cultural continuity' at a time of personal, social and cultural transition (Chandler & Lalonde 1998).

Dockery (2011) uses factor analysis of NATSISS data to derive four aspects of culture: participation (attending and participating in cultural events), identification (identifying with clan, tribal group and traditional country), language (speaking Indigenous languages) and traditional activities (such as fishing and hunter/gathering). The associations between these measures and two indicators of wellbeing—happiness and mental wellbeing—are then considered.

The results of this research suggest a complex picture. Dockery (2011) finds evidence that higher participation in cultural events and participation in traditional activities was associated with better mental wellbeing and happiness. It is also found that strong identification with Indigenous culture is associated with higher frequency of feeling happy and better mental wellbeing. However, those with strong, moderate and weak cultural identity have higher levels of psychological distress than those with 'minimal' identification with their culture. Speaking Indigenous languages is also associated with positive wellbeing and happiness, and yet also linked with higher psychological distress than reported by those who do not use Indigenous languages. This study also identifies that the positive associations between cultural identity, speaking Indigenous languages and undertaking traditional activities apply to a greater extent in remote areas. Conversely, associations between cultural identity and psychological distress occur more in non-remote areas. Dockery speculates that Indigenous Australians living in non-remote areas may be more likely to experience the negative effects of living 'between two cultures', and having to manage the conflict between connectedness to Indigenous culture and participating in mainstream Australian culture. The role of discrimination is also considered, and it is found that for Indigenous Australians living in non-remote areas, greater feelings of cultural identity are associated with higher levels of discrimination, whereas this does not apply in remote areas. It is suggested that Indigenous Australians in non-remote areas pay a 'high price', in terms of their experiences of discrimination and racism in exchange for a strong identification with Indigenous culture (Dockery 2011).

In traditional Indigenous cultures, country—or traditional land—refers to a place that gives and receives life, and Indigenous Australians talk about and regard country in the same way as they would a person (Rose 1996). Research suggests that connectedness to land and country has significant health and economic benefits (Burgess et al. 2009, Ganesharajah 2009, Guerin et al. 2011, Kingsley et al. 2009, 2013). In a study in the Northern Territory, Campbell et al. (2011) show that Indigenous Australians who participate in land management are less likely to have diabetes, renal disease or hypertension than those who are not involved in these activities, and estimate significant cost savings associated with these health benefits. Similarly, in another Northern Territory study, it was found that higher levels of participation in 'caring for country' among Indigenous Australians are associated with more frequent physical activity, lower levels of obesity, blood pressure and diabetes (Burgess et al. 2009). Indigenous natural land resource management has been linked with a wide range of health, cultural, emotional and social benefits, including improved social capital, and has been identified as offering economic potential for remote Indigenous communities in northern Australia (Burgess et al. 2009). International research also identifies the central role of land in Indigenous identity and wellbeing (Richmond et al. 2005). Victorian research suggests that connection to country is significant for Indigenous Australians who do not live in remote contexts (Kingsley et al. 2009). This qualitative study focused on three Indigenous communities, two in regional Victoria and one within a short distance of metropolitan Melbourne, and found that caring for country (including having knowledge, a sense of responsibility and an inherent right to be involved in the management of traditional land) was associated with positive self-esteem, self-identity, maintaining connection to culture and allowing for relaxation (Kingsley et al. 2009).



In a recent paper, Kingsley and colleagues (2013) develop a holistic conceptual model of the connection between Victorian Indigenous people's wellbeing and country. They argue that the interaction between wellbeing and country involves a number of forces which influence health and wellbeing in positive and negative ways. This framework depicts positive influences on wellbeing as parts of a tree: the roots being the fundamental components of wellbeing (biology, learnt experiences, country, partnerships, built environment) and the branches are forces which are linked to and build on these roots (ancestry; traditional knowledge; caring for country; consultation, respect, consistency and employment opportunities; and missions and urban spaces). The framework also highlights 'western/downward' forces which impact negatively on wellbeing, including colonisation, destruction of country, loss of traditional knowledge and racism.

Impact of loss and disconnection from family, community, country and culture

The impact of loss—including the loss of relationships to a person or people, disconnection from country and place, the loss of rights to access country, community or culture, and the destruction of areas of cultural significance—has a significant, enduring, and in many cases traumatic impact upon the social and emotional wellbeing of Indigenous Australians (Garvey 2008). The 'Bringing them home' National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families reports the negative impacts on mental and physical health including a loss of cultural heritage and broken families and communities (HREOC 1997).

Among Indigenous Australians, the experience of being stolen from natural family is associated with worse health, social and economic outcomes. In 2008, 8% of Indigenous Australians had been removed from their natural family (ABS 2012b). Higher proportions of Indigenous Australians who had been removed reported fair or poor health and experienced high or very high psychological distress (ABS 2012b), as compared to those who had not been removed. Furthermore, Dockery (2011) identifies that Indigenous Australians who had been removed were more likely to have been charged by the police and to consume alcohol at a risky level, and less likely to be employed. In regards to cultural identification, a higher proportion of Indigenous Australians who had experienced removal identified with a clan, tribal or language group, and recognised traditional country or homelands (ABS 2012b). This cultural identification, along with the poor health and levels of psychological distress experienced by this group suggests that the pressures of living in 'two worlds' and negotiating the tensions between Indigenous and mainstream culture may be particularly acute for these Indigenous Australians.

Family violence is a significant problem among Indigenous Australians, contributing towards poorer health and health inequities (AIHW 2006). Indigenous women are almost 40 times more likely to be a victim of violence than non-Indigenous women (Mouzos & Makkai 2004), and are 35 times more likely to be hospitalised for assaults relating to family violence than non-Indigenous women (AIHW 2006). The underlying causes of this have been attributed to the violent separation and dispossession from land and culture as a result of a history of colonisation in Australia (AIHW 2006; Memmott et al. 2001). Colonisation has been identified as an 'unresolved grief' which has led to 'multiple layers of trauma spanning many generations' (Gordon et al. 2002) including practices of genocide, experiences of racism, stolen generations, loss of languages, culture and spirituality. All of these have contributed towards the erosion of social norms, structures and values and have given rise to a range of problems in Indigenous communities, including family violence (AIHW 2006). This is compounded by a lack of economic and social resources and support services, and exacerbated by behaviours which may originate as a form of coping but contribute towards community dysfunction, such as alcohol and substance abuse.



Policy context

National apology to Australia's Indigenous people

In relation to addressing the pain and trauma caused by past policies and practices which removed people from their families, communities and country, the National Apology to Australia's Indigenous Peoples, in particular the Stolen Generations, in 2008 by the then Prime Minister Kevin Rudd, on behalf of the Parliament of Australia, was a significant event. It acknowledged, on a national scale, the profound and enduring negative legacy of these practices and effectively put to rest previous debates about the value of such an apology. This apology was viewed as having profound symbolic meaning in enabling healing and facilitating respectful relationships between Indigenous and non-Indigenous Australians (Reconciliation Australia 2010). Furthermore, acknowledging these issues of loss and trauma in an apology enabled the policy focus to move on from debates about whether claims about stolen generations were 'legitimate', and focus clearly on 'Closing the Gap' in a number of key social and economic areas, as indicated by the COAG closing the gap targets. The Closing the Gap strategy commits all governments to targets addressing Indigenous disadvantage, and associated building blocks – areas for action. This strategy also acknowledges the importance of engagement and positive relationships with Indigenous Australians. However, we have noted that these overarching COAG targets do not specifically address issues relating to dispossession of land, self-determination and loss of family, community and culture.

Programs and approaches

Below, we describe case studies of initiatives which have taken a social determinants approach to improving connection to family, community and culture for Indigenous Australians and have evaluation data which indicate aspects of success, in order to identify characteristics of such approaches.

The Aboriginal and Torres Strait Islander Healing Foundation

The Aboriginal and Torres Strait Islander Healing Foundation is a national independent organisation which aims to address 'the profound legacy of pain and hurt caused by colonisation, forced removals and other past government policies' (Healing Foundation 2012). It funds community-based healing programs across Australia run by Indigenous organisations and aims to contribute towards healing and improved social and emotional wellbeing for Indigenous Australians, in particular, members of the stolen generations. It also aims to document the importance of healing programs through research and evaluation, and build leadership, community and worker capacity to address trauma through education and training. All projects funded by the Healing Foundation are designed and implemented by Indigenous Australians, and projects operate across urban, regional and remote parts of Australia.

Themes identified that contribute towards success of Healing Foundation programs include: building on strengths of communities by delivering programs which build on culture and traditional ways of healing; drawing on country as a source of healing; enabling self-determination and stronger health, education and social services; strengthening identity through improving connection to culture; and supporting women to be involved in leadership and governance roles.

The Healing Foundation has funded a number of Indigenous organisations to deliver healing initiatives. These have included a wide range of activities which have focused on enhancing Indigenous Australians' connections with culture, family, community and country. Such initiatives include: healing camps on country; cultural renewal and revitalisation activities; men and women's gatherings; and life skills programs focusing on resilience and recovery from trauma (Healing Foundation 2012).



A recent report produced by the Healing Foundation, although not an external evaluation, provides preliminary evaluation data, with information and statistics about the programs the Foundation has funded (Healing Foundation 2012). It reports that, in the first half of 2012, 19 projects were funded which employed 137 Indigenous Australians. Large numbers of children, young people, families, men, women and Elders participated in healing activities.

The report indicates that 99% of participants reported improved physical, emotional, social, spiritual and cultural wellbeing as a result of participation in the healing projects. The report concludes that all programs have contributed towards closing the gap and addressing the social and economic determinants of Indigenous health, including early childhood and education; racism; employment; and culture, family and community functioning.

Given the positive reports of participants involved in Healing Foundation-funded projects, it appears the Foundation is making positive gains in promoting health by enabling healing and connecting people with family, community, culture and country. However, since the nature of the projects are so diverse and operate in different community contexts, more rigorous independent evaluation is necessary in clearly identifying the successful characteristics of healing initiatives and which initiatives may require further improvement.

Aboriginal Family and Community Healing program

The Aboriginal Family and Community Healing program, based in Adelaide, was designed to develop effective responses to family violence which take account of the complexities of Indigenous families and communities (Kowanko et al. 2009). The program included a range of activities, courses and group programs in four categories: work with women, work with young people, work with the community and work with men. Activities included a family wellbeing course; a women's healing group with art and narrative therapy; individual counselling; a peer-led weekly art group; a young people's drop-in; clinic services for adult and child health assessment; and men's groups. It was delivered by a program team of 25 staff. Staff were involved in clinical, health promotion and early intervention work. An evaluation of this program identified a number of strengths including: evidence-based design and an holistic approach; a clinical focus; committed staff; peer support; mentoring; Indigenous cultural focus; developing strategic partnerships and intersectoral linkages; and a creative use of resources (Kowanko et al. 2009). The evaluation found that the program was successful in achieving all of its objectives, and all clients and workers who spoke to evaluators were positive about the program. The evaluation concluded that the program was successful in addressing the social, cultural, spiritual, emotional and physical dimensions of wellbeing. Despite the positive evaluation of the program, it did not receive further funding, highlighting the short-term and tenuous nature of funding for Indigenous programs, and demonstrating that decisions to provide further funding are not solely based on evidence.

Yiriman project

The Yiriman project is a partnership between four language groups and an Indigenous law and cultural centre based in the western Kimberley in Western Australia. Qualitative evidence has been collected relating to the success of this project (see Taylor 2010). The project was initiated by Elders who had concerns for young people in their communities and wanted an opportunity to pass on cultural knowledge. It aims to pass on traditional culture, knowledge and healing to young people in order to reduce risk taking and self-harm behaviours and encourage them to enter meaningful employment. It involves young adults up to 30 years old (Taylor 2010). It consists of four main strategies:

- The young people take trips to country with Elders. The nature of each trip is determined according to traditional law, and during the trip, the Elders teach the young people in an informal way. Bush skills, culture, language and the right ways of being in the world are all passed on.



- Digital technology and music are used as tools to engage young people on the trips to country. Each trip is filmed, photographed and a story book is compiled. This type of ‘cultural mapping’ is a key aspect of the Yiriman project.
- The project promotes young leaders, or ‘young cultural bosses’. These young people bring their knowledge of the issues faced by youth in their communities, and are also in logistical support work for trips to country, and plan and facilitate structured activities during trips. This is important as a means to build the capacity, skills and leadership of young people.
- The project creates meaningful and culturally appropriate employment opportunities. This is achieved through providing young people with opportunities to develop work and life skills, and skills particularly relevant to ranger-type positions in areas such as coastal management, constructing interpretive materials, blocking off cultural sites and working on facility construction.

Taylor (2010) reported positive outcomes including: strengthening culture, tradition and identity among young people through their relationships with Elders; healing through connection to country; developing culture, language and bush skills among young people; nurturing respect for Elders; enabling traditional knowledge to be taught in a culturally appropriate manner; and providing young people with skills for sustainable employment. These outcomes are relevant to promoting social and emotional wellbeing among Indigenous youth in this remote area.

Key factors contributing to the success of this program have been identified as: community ownership and governance over the project; the significant involvement of the middle generation between Elders and young people, who act as a bridge between the two groups; and the importance of all participants gaining benefit from the project—including the Indigenous organisation, the Elders, young people, middle generation, and the community as a whole, particularly through working in partnership (Taylor 2010).

Social and Emotional Wellbeing program (Link Up and Bringing them Home)

The Social and Emotional Wellbeing (SEWB) program consolidates the ‘Link Up’ and ‘Bringing Them Home’ programs. It delivers a number of services, including: Link Up services which provide family tracing, reunions and counselling for members of the Stolen Generations (the Link Up program); and counselling support for Indigenous Australians (the Bringing Them Home program component). It also provides workforce support units to support the wellbeing workforce (the Social and Emotional Wellbeing Regional Centre program); funding for mental health service delivery projects (the Mental Health program); and support for the National Sorry Day Committee and National Stolen Generations Alliance.

An evaluation of the four key projects implemented as part of the SEWB program was conducted (Wilczynski et al. 2007). Main findings of this evaluation included evidence that Link Up and Bringing them Home provided services to a large number of Indigenous clients around Australia, as Link Up had over 35,000 client contacts, and Bringing them Home over 39,000. The programs were found to provide culturally appropriate services. The evaluation found high levels of client satisfaction and positive outcomes, particularly for the Link Up, Bringing Them Home and Mental Health program participants. Key themes in relation to ‘good practice’ in these programs were identified, including: clear directions; planning, leadership and vision; integrated and holistic approach to service delivery; flexibility and responsiveness to clients; and having a highly skilled and integrated workforce with established networks. A number of challenges of the programs were identified relating to a lack of focus on the first generation Stolen Generations members; variation in staff experience and training; a lack of adequate national guidelines; and limited geographical coverage. The administration and management of the programs was found to be effective.



Summary 2: Connection to family, community, culture and country

Evidence suggests that feeling connected to family, community and Indigenous culture is positive for Indigenous Australians' overall wellbeing, with some caveats. In relation to social connections with family and friends, evidence suggests that feelings of obligation to provide social support to others can be an emotional burden. Being connected with traditional culture is associated with positive wellbeing but has also been linked with psychological distress, particularly for Indigenous Australians living in non-remote settings. Research has demonstrated that maintaining a connection with traditional land and country is associated with benefits for the health and wellbeing of Indigenous Australians living in remote and non-remote contexts.

Evaluation data suggest that the initiatives reviewed in this section contributed towards positive social and emotional wellbeing for Indigenous Australians. It was not, however, possible to establish direct causal links between program activities and improved health outcomes on the basis of the available data. Characteristics of these programs include:

- delivery by organisations with clear direction, planning and vision
- locally driven programs led and owned by Indigenous communities that work in collaboration with community organisations
- building on traditional cultural approaches and activities as pathways to healing
- involvement of Elders in teaching of traditional culture and skills
- drawing on land and country as a means to heal
- building on the strengths of Indigenous Australians and cultures to enable healing.

Employment and income

Employment

Employment and working conditions are significant social determinants of health. In broader populations, unemployment has been linked with poor health outcomes, particularly psychosocial stress which has a direct negative impact on physical and mental health and wellbeing (Dooley et al. 1996). However, it has also been argued that much research applies western understandings of employment and its meaning, and more research is needed to explore Indigenous understandings of the meaning of work, employment and job seeking (Lowry & Moskos 2007). Employment, as a means of generating income, provides economic resources which are beneficial for health, such as the ability to access health services and being able to afford goods and services that can promote health. Employment undertaken in poor and hazardous conditions can harm health (Benach et al. 2010). Low levels of employment and exclusion from the labour market contribute towards the economic disadvantage experienced by many Indigenous Australians, and increasing employment is an important strategy for reducing disadvantage and ultimately promoting better health and wellbeing (Gray et al. 2012). The significance of employment in reducing Indigenous disadvantage is recognised in that employment is the focus of one of the COAG closing the gap targets. The causal relationship between employment and health is not clear, however. It can be assumed that increasing Indigenous participation in the labour market will contribute towards reducing economic disadvantage and that this will be associated with improved health outcomes. But the causal relationships underpinning these relationships are complex and multi-directional, as poor pre-existing health may limit Indigenous Australians' ability to participate in employment. Opportunities to participate in employment, and the nature of employment, also vary according to remoteness of location.



Indigenous Australians have lower levels of participation in the labour market than non-Indigenous Australians (Gray et al. 2012). Recent Australian figures (ABS 2012a) illustrate that the labour force participation rate of Indigenous Australians is 58% (52% for women and 63% for men) and for non-Indigenous Australians the rate is 77% (71% for women and 84% for men). Although the gap is evident, research has identified that employment among Indigenous Australians has grown steadily since 1994, particularly in the private sector (Gray et al. 2013). Indigenous workers are more likely than non-Indigenous workers to be employed in 'low status' occupations and to be more insecurely attached to the labour force (Gray et al. 2012).

In remote areas, lower participation in paid employment among Indigenous Australians relates, in part, to a lower demand for labour (Gray et al. 2013). Lowry and Moskos (2007) argue that, although the vast majority of Indigenous Australians desire to work in paid employment, there are legitimate reasons why some may choose not to participate that relate to both how employment is viewed in an Indigenous cultural context (particularly in remote settings), and a history of exploitation at work. Choosing not to participate in mainstream employment may enable Indigenous Australians to be fully involved in traditional cultural activities which are highly productive for their communities, including hunting, fishing, painting and participating in ceremonial activities. Paid work that requires temporary migration to other places may disconnect the worker from their communities. Furthermore, historically, Indigenous Australians were required to work in exploitative and poor quality employment, and knowledge of these experiences may influence some Indigenous Australians' choices in relation to paid work (Lowry & Moskos 2007).

Gray et al. (2012) summarise reasons for lower levels of Indigenous participation in the labour market, including: lower levels of education and skills; poorer health; higher levels of arrest rates and interaction with the criminal justice system (Borland & Hunter 2000); living in areas with fewer labour market opportunities, and discrimination (Gray et al. 2012). In areas of Australia with fewer job opportunities it is also likely that cultural factors may play a role, as Indigenous job seekers may be less willing to migrate due to family and community commitments (Lowry & Moskos 2007). Higher levels of education are associated with higher levels of full-time employment (ABS 2012b) and some research indicates that employment is associated with better health for Indigenous Australians. Lowry and Moskos (2007) found that unemployed Indigenous Australians and those not participating in the labour market are more likely to experience poor health than those who are employed, although this differs according to location (remote or non-remote). Drawing on NATSISS data from 2002, they found that Indigenous Australians in remote areas had better self-assessed health despite their lower levels of participation in employment. Hunter (2000) found that unemployment is associated with arrest and police harassment, low levels of social capital and high levels of offences related to drinking, but not with ill health. Ewald & Boughton (2002) found that mothers' employment was associated with better health of their children. Given these complex patterns, the health benefits of employment for Indigenous Australians are far from established.

Income

Indigenous Australians have lower levels of income and financial resources than non-Indigenous Australians, as significantly higher proportions of Indigenous Australians live with financial stress (ABS 2009). Indigenous Australians are also over-represented as recipients of welfare benefits (Walter & Mooney 2007), which contributes to their higher level of financial disadvantage since the level of income support payments currently offered is not compatible with living costs (ACOSS 2012). Lower incomes are associated with higher levels of health risk factors among Indigenous Australians, such as smoking; lower levels of physical activity and consumption of healthy food; and binge drinking (AHMAC 2012). In recent years in Australia there has been significant debate about the role of welfare in contributing to the social and economic disadvantage of Indigenous Australians. Noel Pearson has argued, particularly in relation to remote Indigenous communities in Cape York, Queensland, that a passive dependence upon welfare has developed which has acted like a disempowering 'poison' in Indigenous culture, creating dysfunctional communities which has limited people's capacity to have control over their lives and take responsibility for themselves and others (Pearson 2000). On this view, it is this welfare dependence which explains the breakdown in social norms in remote communities and associated problems with alcohol, substance



use and violence. These issues, and ideas for solutions to overcome them, have been the subject of much debate, with others arguing that although welfare dependence is problematic, it is a symptom rather than a cause of social and economic exclusion. Further, that reducing welfare dependence will not in itself lead to improvements in Indigenous wellbeing unless other social determinants are addressed (Walter & Mooney 2007).

One recent strategy designed to address the apparent breakdown in social norms in remote Indigenous communities is that of compulsory 'income management' (or income quarantining) which dispenses payments in ways which ensure that money cannot be spent on prohibited goods, such as alcohol or cigarettes. This is to enable money to be spent on items such as food, housing, clothing, utilities and education-related expenses (FaHCSIA 2012b). Income management is not solely an Indigenous-specific measure, but was first applied in Indigenous communities. Between 50% and 75% of welfare payments may be 'quarantined', and this approach, which has been applied in remote Indigenous communities in the Northern Territory as part of the Northern Territory Emergency Response (see page 37), has now been applied in Cape York Indigenous communities and in disadvantaged communities across Australia (remote and non-remote), the latter applying to both Indigenous and non-Indigenous welfare recipients. A full debate about the relative disadvantages and merits of this approach is beyond the scope of this paper (see Central Land Council 2008 for discussion on some of the advantages and disadvantages). It has been argued this is a paternalistic measure which is not consistent with basic human rights (Altman 2010). However, evidence suggests positive consequences of income management, such as reducing gambling, alcohol consumption, reduced occurrence of 'humbugging' (demands and harassment for cash), increased household expenditure on food and children, and improved wellbeing of families (AIHW 2010; Orima Research 2010). The difficulty in evaluating complex social policy such as income management has been noted, and the evidence of the benefits and disadvantages of this approach may be clearer after the policy has been in place for a longer period of time (Buckmaster & Ey 2012). From a social determinants perspective, when income management is compulsory, it is in tension with the need to fully involve Indigenous Australians as equal partners in taking action to improve their wellbeing, and the loss of personal agency and control can be viewed as potentially disempowering. An evaluation of six case study communities in Central Australia finds a mixed reaction to income management, with 51% in favour and 46% opposed (Central Land Council 2008). However, a health impact assessment of the Northern Territory Emergency Response, of which compulsory income management was part, concludes that the practice is very disempowering of the welfare recipients. The assessment finds it was likely to increase Indigenous Australians' distrust of the government and undermine their control over their lives, which is central to health and wellbeing (AIDA & CHETRE 2010).

Key factors associated with promoting positive employment and improved incomes

A number of researchers have reviewed employment programs for Indigenous Australians and strategies to increase employment rates (for example, Black 2007; Dockery & Milsom 2007; Giddy et al. 2009; Gray et al. 2012), and we used these to summarise key findings.

Increasing skill levels of Indigenous Australians through formal education and training is an important avenue for improving employment rates. Customising vocational training for Indigenous job seekers to enable them to be job-ready is also important (Gray et al. 2012). Intensive assistance for Indigenous job seekers who face multiple barriers is also a key strategy for enabling participation in employment. Employers can use a number of strategies to increase their Indigenous workforce, including: adopting non-standard recruitment strategies which give Indigenous job seekers opportunities for employment which they might otherwise be excluded from; ensuring that cross-cultural training is provided for all employees in the workplace; and putting in place multiple and complementary forms of support for Indigenous employees to ensure their employment is sustainable (Gray et al. 2012).



A review of successful employment service organisations which have achieved positive and sustainable employment for Indigenous Australians identifies a number of characteristics associated with success. They include: strong vision that related to the wellbeing of the local Indigenous community; maintaining strong relationships with community and business; collaborating with Indigenous leaders and the community; and offering holistic support to job seekers (Giddy et al. 2009). A review of Indigenous-specific employment programs finds those which involve wage subsidies or brokered placements, combined with support and mentoring for Indigenous employees, have been highly successful in achieving short-term employment outcomes (Dockery & Milsom 2007). Similarly, Gray et al. (2012) highlight that Indigenous-specific programs such as the Indigenous Employment Program (IEP)—which includes Indigenous wage subsidies, tailored assistance to employers, Indigenous cadetship programs and access to language, literacy and numeracy training—have been successful in achieving short-term employment outcomes (Gray et al. 2012). The IEP aims to enable Indigenous job seekers to become employed in the mainstream economy. This is, of course, a more achievable outcome for Indigenous Australians living in cities than for those in remote communities, although the Remote Jobs and Communities Program (RJCP) has been designed to assist Indigenous Australians in remote areas to participate in paid work. The RJCP commenced on 1 July 2013, and this has involved the transitioning of Job Services Australia (JSA), Disability Employment Services (DES), Community Development Employment Projects (CDEP) and IEP in remote areas to the RJCP (DEEWR 2013b).

The issues of welfare and employment are both relevant to considering the CDEP scheme, which was a significant initiative in Indigenous Employment Policy. First introduced in 1977, CDEP focused on community capacity building and self-determination, and was used as a means to provide training, enterprise support and income support to Indigenous participants. It paid individuals' unemployment benefits to Indigenous communities, and these communities then 'employed' Indigenous individuals on various local projects.

CDEP was initially conceived as a community development initiative with multiple goals, although as time progressed it became more narrowly defined as simply a labour market program and politically, came to be associated with 'passive welfare' (Altman 2007). Dockery and Milsom (2007) argue that although community capacity building and self-determination were original goals of the CDEP scheme, these areas were ignored in evaluations which had a more narrow focus on employment outcomes. The current policy goals guiding Indigenous employment initiatives are to enable Indigenous Australians to participate within the mainstream economy, rather than Indigenous-specific forms of employment (as was provided by CDEP).

From the mid-2000s, funding for CDEP in non-remote areas was no longer provided and Indigenous Australians received services mostly through mainstream employment programs. Since 2009 JSA has been the main provider of employment services for Indigenous Australians. DES, although not Indigenous-specific, is another service relevant for Indigenous Australians, given that Indigenous Australians experience disability at a higher rate than non-Indigenous Australians.

The focus of CDEP in remote areas changed from providing employment for income support to developing skills in order to assist people to find non-CDEP employment, and has recently been replaced by the RJCP. Black (2007) identified positive effects of CDEP, including improved self-esteem, self-discipline and work habits. It provided short-term training opportunities, such as enabling individuals to gain formal skills and licences, and created a pool of trained local people. Furthermore, Indigenous community leaders were generally supportive of CDEP schemes (Black 2007). Altman (2007) also documents many benefits of CDEP, including higher incomes for CDEP participants than those who are unemployed, enabling Indigenous Australians to participate in a range of traditional cultural activities, and supporting Indigenous enterprises in areas of remote Australia where mainstream employment is difficult to obtain (Walter & Mooney 2007). As such, from a social determinants perspective, CDEP offered significant individual and community benefits. The move away from CDEP has been criticised as bad policy, in that it resulted in higher unemployment and lower incomes for Indigenous Australians, and the demise of successful Indigenous organisations in remote Australia (Altman 2007; Altman & Jordan 2009). This policy shift was consistent with an approach which emphasises enabling Indigenous Australians to be employed in the mainstream economy.

Below, we discuss two significant services and initiatives which are designed to enable Indigenous Australians to participate in employment and economic development, and focus on welfare reform as a way to address Indigenous disadvantage.



Services and initiatives

Job Services Australia: servicing Indigenous job seekers

An evaluation of how Job Services Australia (JSA) supports Indigenous job seekers identified that JSA providers can improve the ways in which they engage with Indigenous job seekers and maintain their involvement over time (DEEWR 2012b). A large percentage, 12.5% of JSA clients are Indigenous, and these Indigenous job seekers are younger on average than non-Indigenous JSA clients. Indigenous job seekers are relatively more disadvantaged, as they have higher scores on the measure of severity of labour market disadvantage. Almost one-third of Indigenous job seekers serviced by JSA live in remote regions which presents considerable problems for the job seekers as they are remote from economic opportunities and live in communities where mainstream work practices may not be valued. Indigenous job seekers are less likely to attend their initial and ongoing appointments. They are therefore more likely to be subject to action under JSA compliance (DEEWR 2012b).

Indigenous job seekers have lower rates of employment, education and training outcomes. However, for some outcomes, Indigenous job seekers did better than non-Indigenous job seekers. Three months after leaving JSA assistance, Indigenous jobseekers: had higher rates of full-time employment in streams three and four, higher rates of education and training in streams one and two, but lower rates of education and training in streams three and four (JSA streams determine the level and intensity of assistance job seekers are entitled to from their JSA provider, with one being the lowest and four the highest), and were less likely to have left the labour force. Overall, the evaluation presents a mixed picture of how JSA is servicing Indigenous job seekers. Importantly, the evaluation report identifies some key factors associated with supporting the engagement and participation of Indigenous job seekers, including making job seekers feel welcome as Indigenous Australians, which can involve the display of stickers, posters or artwork visibly at the premises of JSA providers. The report also identified that staff at JSA providers who are well known and have good relationships with local Indigenous communities find it easier to engage with Indigenous job seekers. Where providers have links with local Indigenous communities and a level of cultural competency, which includes employing Indigenous staff, this is also helpful in engaging with Indigenous job seekers (DEEWR 2012b).

However, evidence suggests that these factors are not being addressed. The report identifies that in 2010, 62% of JSA providers did not employ Indigenous staff, and there was little evidence that staff were provided with cultural awareness training. The report identifies that JSA providers could better use their Indigenous Employment Strategy within their organisations. Other factors were identified as important in securing and maintaining the engagement of Indigenous job seekers, particularly relating to the type of training and work activities that are likely to attract and ensure the participation of Indigenous job seekers. They include:

- 'on-the job' training, including shadowing other employees and 'learning by doing'
- having a respected mentor or supervisor in a workplace
- activities which enable a sense of ownership for the job seeker, by connecting to their goals and aspirations, or to the priorities of the local community
- activities which are connected with maintaining cultural heritage through art, craft, music, working on country, or looking after culturally significant areas. Activities which involve 'import substitution' are also important, whereby goods that have previously been imported into the community are replaced by local production
- activities which are family or clan-based
- activities which lead to ongoing work
- activities which involve sport.



In order to engage well with Indigenous job seekers, mainstream service providers have to make an effort to ensure their services are culturally appropriate. Strategies to do this include: employing Indigenous staff, providing cultural awareness training, maintaining good relationships with local Indigenous communities, and exploring ways in which training, work placements or paid work can enable Indigenous job seekers to connect with their culture. The evaluation suggests significant progress needs to be made by many JSA providers in order to achieve this. Since this evaluation was completed, a number of changes and initiatives have taken place to improve services for Indigenous job seekers. One example is the Indigenous Opportunities Policy, which requires JSA providers (with contracts of \$5 million or more) in regions with significant Indigenous populations to detail plans of how the organisation intends to provide training and employment opportunities for local Indigenous Australians, and purchase goods and services from Indigenous businesses (DEEWR 2012a). Another example is the Indigenous mentoring pilot, which operates in non-remote areas with large numbers of Indigenous job seekers and provides pre-placement support and ongoing culturally appropriate mentoring for up to 26 weeks after an Indigenous job seeker begins work (DEEWR 2013a). These are new initiatives and evaluation data will be necessary to identify if they contribute towards improved outcomes for Indigenous job seekers.

Cape York Welfare Reform Trial

The Cape York Welfare Reform trial operates in four remote communities in the Cape York region: Aurukun, Coen, Hope Vale and Mossman Gorge. It is based upon the assumption that passive welfare dependence has led to a breakdown of social norms and community dysfunction, and aims to 'rebuild social norms, restore Indigenous authority and increase engagement in the 'real economy' (Limerick et al. 2012). The trial includes a wide range of activities which address a number of social determinants including employment, education, housing, economic development, and 'social responsibility' (which includes income management). All aspects of the trial are comprehensively explained in a recent evaluation report (FaHCSIA 2012a).

A central aspect of the trial is the Families Reform Commission (FRC) which consists of a commissioner and 19 local commissioners. The FRC has authority in relation to all community members (Indigenous or non-Indigenous) who are welfare recipients, or CDEP participants, and where the FRC has received a notice of a 'trigger event'. Trigger events relate to a child's absence from school, being the subject of a child safety report, convicted offences in the local magistrate's court, or a breach of a tenancy agreement (SPRC 2012). In cases involving these issues, the FRC holds a conference with a client, and aims to reach an agreement as to an appropriate course of action. The FRC can take a range of actions including case management and referral to support services; follow up monitoring; re-conferencing and intensive case management; and, as a last resort, income management. As such, the use of income management is accompanied by other strategies such as conferencing, case management and referral to support services. Furthermore, individuals who are participating in income management are offered referrals to financial management services, including financial counselling and training in money management skills.

An evaluation of the trial identified that, after community consultation over a period of 15 to 18 months, community support was gained for the trial in all communities except Hope Vale, where there remained vocal opposition (Limerick et al. 2012). The evaluation identified significant progress in relation to education and social responsibility (Limerick et al. 2012). Progress in behavioural changes has been made in regard to areas such as children's school attendance, caring for children and families, and accessing support to deal with problems, although no residents have been able to move from public housing to home ownership, which was one goal of the trial.

The successful establishment of the FRC is identified as a significant achievement, and survey responses and qualitative feedback identify income management as having positive outcomes, including improved financial management and increased capacity to meet the needs of families and children. Aurukun and Mossman Gorge recorded statistically significant improvements in school attendance. Progress is also identified in creating positive norms for responsibility and pride in housing, although no residents have been able to move from public housing to home ownership (Limerick et al. 2012).



Evidence in regard to income, employment and economic opportunity is mixed. The trial has 'converted' 103 former CDEP positions into jobs and created 118 new jobs in service delivery. However, many former CDEP participants have transitioned onto welfare payments, and the trial has not had a significant impact on the numbers of residents receiving welfare payments. Furthermore, no progress has been made in generating significant business development in the four communities (Limerick et al. 2012). The limited employment options and relative lack of economic opportunities in remote Australia more broadly may help explain why economic development has been difficult to achieve in these areas.

Summary 3: Employment and income

The causal pathways between employment, income and health outcomes for Indigenous Australians are complex. However, enabling Indigenous Australians to participate in paid work leads to higher incomes which in turn, provide resources which are positive for health and wellbeing. In relation to employment service agencies supporting Indigenous Australians to secure work, evidence suggests the importance of the following:

- highly skilled, culturally competent staff, including Indigenous staff
- provision of cross-cultural training for all workers
- strong vision and commitment to supporting Indigenous jobseekers and communities
- collaborative relationships with local community and businesses
- collaborative partnerships with Indigenous leaders and communities
- holistic support provided to Indigenous job seekers.

Indigenous Australians are more likely than non-Indigenous Australians to be living on low incomes. Apart from increasing participation in paid employment, other interventions have focused on income, and particularly welfare benefits paid to Indigenous Australians, in order to reduce Indigenous disadvantage:

- Income management has been the subject of much debate and the evidence is not clear. The Cape York Welfare Reform trial suggests that income management, when used as one of a number of strategies as part of the Families Reform Commission process, can promote positive behaviour change, school attendance, and improvements in financial management skills among families. The Cape York trial has been less successful in generating economic development which is related to the limited employment options and lack of economic opportunities in remote Australia.



Box 1: Place-based initiative - the Northern Territory Emergency Response

The Northern Territory Emergency Response (NTER) was a place-based intervention to reduce Indigenous disadvantage that has had a significant influence on recent Indigenous policy in Australia. It is relevant to this paper as it included strategies to take action on multiple social determinants of health, and so we have not located it under one specific key determinant. Below, we provide a brief overview of the NTER, including its main initiatives and evaluation findings. A full explanation of the NTER can be found in the evaluation report published in 2011 (FaHCSIA 2011), and directly through the FaHCSIA website (FaHCSIA 2012c). Critical accounts of the NTER can be found elsewhere (AIDA & CHETRE 2010; Altman & Russell 2012).

What did the NTER involve?

The NTER was introduced in 2007 after the release of *Ampe Akelyernemane Meke Mekarle 'Little Children are Sacred'* report (Wild & Anderson 2007), with the overarching aim of protecting children and making communities safer. The *'Little Children are Sacred'* report documented, as had many previous reports, evidence regarding the disproportionate levels of violence and abuse, including child abuse and neglect, in Indigenous communities in the Northern Territory. The report also identified the need for genuine consultation and partnership with Indigenous communities to design any initiatives to address these issues. The NTER was introduced by the Australian Government of the day in response to the *'Little Children are Sacred'* report. It aimed to address a range of social and economic factors which are associated with child abuse, neglect and poor health, including: poverty and economic disadvantage, mental illness, substance abuse, overcrowding, poor housing and unsafe communities (Higgins & Scott 2012).

The NTER operated in 'prescribed' Indigenous communities (including townships and town camps) across the Northern Territory. Activities it initially involved included:

- comprehensive health checks for Indigenous children under 16 years
- increased policing levels
- widespread alcohol restrictions
- banning possession of pornography
- the introduction of income management
- the provision of school meals
- the suspension of the Racial Discrimination Act in respect to the overall NTER legislation
- allowing the Australian Government to take leases over parcels of Indigenous-owned land, whereby ownership remained with Indigenous land owners, and the government paid rent to land owners for 5 year leases
- improvements to essential infrastructure
- the clean up and repair of communities.

The NTER was initially controversial for a number of reasons, including the speed with which it was introduced and the lack of consultation and involvement on the part of Indigenous communities. An independent review commissioned by the newly elected Australian Government in 2008 reported that Indigenous Australians felt humiliated and shamed by the introduction of the NTER, and many believed that the NTER measures were imposed on the basis of race, and felt a sense of being blamed for abuse, violence and neglect.

continued



Box 1 (continued): Place-based initiative - the Northern Territory Emergency Response

The Australian Government elected in 2007 retained the NTER, with a stronger focus on 'Closing the Gap', including the introduction of the Closing the Gap strategy in the Northern Territory National Partnership Agreement (NTNPA), and most recently, the 'Stronger Futures in the Northern Territory' package of services and programs, announced in 2012 (FaHCSIA 2013c). The legislative changes made to the NTER in 2010 are summarised in the policy statement: 'Landmark reform to the welfare system, reinstatement of the Racial Discrimination Act and strengthening of the Northern Territory Emergency Response' (Australian Government 2009). The NTNPA was structured around programs and initiatives in the following areas: income management and welfare reform; law and order; family support; early childhood; improving child and family health; enhancing education; remote service delivery; 'resetting the relationship' between Indigenous people and government; housing and land reform; and other activities (including related National Partnership Agreements in the Northern Territory and initiatives focusing on Closing the Gap) (FaHCSIA 2011). The Racial Discrimination Act was reinstated. Income management was retained in a substantially altered way (see Bray et al. 2012, for a full description of these changes). Other aspects of the NTER that were retained in modified ways included alcohol restrictions (which communities were able to tailor to their own circumstances) and alcohol management plans (FaHCSIA 2011).

What have been the outcomes of the NTER?

An evaluation of the NTER (FaHCSIA 2011) identified positive outcomes in relation to improving basic services, infrastructure and safety in communities. In a survey of over 1,300 Indigenous community members living in communities affected by the NTER, 58.7% reported that their lives had improved compared to three years before. A majority, 72.6%, also said their community was safer than three years ago. Although there is a lack of definitive data on the success of the NTER with respect to preventing and/or responding to child abuse and neglect, existing evidence suggests NTER measures have increased awareness of child safety issues in Indigenous communities and provided extra resources for reporting and investigation, which represents progress towards reducing child abuse and neglect (Higgins & Scott 2012).

The evaluation also identified that health, education, safety, housing and employment outcomes have improved since the start of the NTER (FaHCSIA 2011). However, school attendance has not improved, and most children do not meet minimum standards for reading, writing and numeracy. However, among Year 3 students, the percentage that were at or above national reading average increased from 18% at the start of the NTER to 41% at the time of the evaluation, indicating positive progress (FaHCSIA 2011).

Positive aspects of the NTER included additional policing, with 18 communities gaining a resident police presence. Improvements to the enforcement of alcohol restrictions were also identified. Benefits to children included the increased availability of food and that child health checks resulted in children receiving health treatment. Almost all (99%) children received treatment during their check, and 70% received referral for ongoing treatment (although the child health checks did identify a substantial unmet need in terms of health care).

Community members identified that it is easier to get help from police, Centrelink and health clinics than three years before. The evaluation also identified that income management is supported by many people in communities (FaHCSIA 2011). People participating in income management may be eligible for support in the form of Intensive Family Support Services (IFSS). Bray et al. (2012), in assessing the changes to income management introduced in 2010, highlight positive impacts of New Income Management including: improved ability to afford food, reduced negative outcomes of financial harassment or 'humbugging', and improved perceptions of children's wellbeing. More broadly though, this evaluation identified diverse outcomes, as some Indigenous participants identified both positive and negative aspects, and three quarters of participants surveyed who were subject to income management identified a sense of unfairness (Bray et al. 2012).

continued



Box 1 (continued): Place-based initiative - the Northern Territory Emergency Response

The evaluation identifies shortfalls in the health, education, police and governance workforces as a problem (FaHCSIA 2011). There is also low employment in NTER communities and further economic development is identified as essential. The rates of alcohol-related offences and violent crime remain high. The evaluation also identifies that income management is supported by many people in communities. This is reinforced by respondents from 17 remote Indigenous communities in the Community Safety and Wellbeing Research study who voted the basics card in the top five changes (Shaw & d'Abbs 2011). Nevertheless, many report problems with using their 'basics card' (a card supplied by Centrelink for individuals whose payments are managed, to spend their money on approved goods). Exploring the perspectives of Indigenous men and women in six Central Australian communities found a mixed reaction, with 51% of residents in favour of income management, and 46% opposed (Central Land Council 2008). The initial introduction of income management has not been evaluated as favourably by others, including the Health Impact Assessment undertaken by AIDA and CHETRE (2010), which concluded that compulsory income management is likely to have significant negative long-term implications for health, social and emotional wellbeing.

Housing

The relationship between housing and health is complex and bi-directional (Mallett et al. 2011). Australian research has demonstrated that poor health can lead to living in poor quality and precarious housing, and that multiple aspects of housing are associated with health and wellbeing (Mallett et al. 2011). Precarious housing refers to housing that is:

- unaffordable (high costs relative to income) and/or
- inadequate (poor dwelling condition, overcrowded, unsafe, poorly located) and/or
- insecure (insecure tenure type and subject to forced moves) (Mallett et al. 2011).

At the most extreme end of poor housing outcomes, in 2006, Indigenous Australians comprised 9% of the homeless population in Australia, despite only comprising 2.5% of the Australian population overall (AIHW 2011b). Housing may be related to health in different ways depending upon whether Indigenous Australians live in remote or non-remote parts of Australia.

Remote housing issues for Indigenous Australians

In remote areas, poor quality housing and inadequate health hardware can create serious health risks and adversely affect physical health through problems such as infectious and parasitic disease, eye and ear infections, skin conditions, and respiratory tract infections (Australian Indigenous Health *InfoNet* 2008). 'Health hardware' refers to a number of housing features that are significant for healthy living, including: access to adequate/safe water supply, access to electricity, sewerage, drainage and rubbish collection. A lack of access to clean water, and inadequacies in the disposal of human waste, rubbish removal and power supply are associated with a number of health problems.



Overcrowding is another housing issue which can put pressure on housing infrastructure and health hardware, and can be negative for social and emotional wellbeing (Australian Indigenous Health/InfoNet 2008). In relation to measuring overcrowding in Indigenous households, it should be noted that the use of the Canadian National Occupancy Standard (CNOS) as a measure of overcrowding in Australia by the ABS has been viewed as problematic. Memmott et al. (2012) acknowledge overcrowding as a significant problem for Indigenous households, but maintain that the CNOS measure is based upon certain cultural assumptions (including relationships and sleeping arrangements between genders) which do not necessarily apply to Indigenous Australians. They also argue that NATSISS, which has been used to collect housing data from Indigenous Australians, is flawed in terms of accurately measuring overcrowding, as it does not measure the dynamic flow of people in and out of Indigenous households, and the complexity of the culturally-specific drivers of overcrowding for Indigenous households (Memmott et al. 2012). On this account, NATSISS data should only be considered a 'first step' to decision-making about the allocation of resources to deal with housing problems, and should be complemented with consultation and in-depth community surveys (Memmott et al. 2012).

Issues of poor health hardware apply disproportionately to Indigenous Australians living in remote areas. For example, in NATSISS data from 2008, 28% of Indigenous Australians living in remote areas reported living in housing where one or more basic facilities (for washing people, clothes and bedding; safely removing waste; or safely storing and cooking food) were not available or did not work, as compared to 9% in regional areas and 8% in major cities (ABS 2009). Indigenous residents of remote areas were also more likely to live in rented households (Indigenous Australians living in major cities were much more likely to live in a house that was owned with a mortgage or outright, as compared to remote areas), overcrowded households (albeit with limitations in measurement described above) and houses with major structural problems (ABS 2009).

A recent large-scale initiative relevant to improving housing for Indigenous Australians in remote areas is the National Partnership Agreement on Remote Indigenous Housing (NPARIH). The NPARIH focuses effort on the 'healthy homes' building block, one priority action area that underpins the Closing the Gap strategy in remote Indigenous communities. It established the Australian Government as the major funder (\$5.5 billion) of remote Indigenous housing over the 10-year life of the strategy, with state and Northern Territory governments responsible for service delivery against a set of agreed objectives. Those objectives are:

- significantly reducing severe overcrowding in remote Indigenous communities
- increasing the supply of new houses and improving the condition of existing houses in remote Indigenous communities
- ensuring rental houses are well maintained and managed in remote Indigenous communities.

A recent review concluded that governments are making good progress and are 'on track' to deliver the intended outcomes of the NPARIH by 2018. Targets for capital works and Indigenous employment have been exceeded, and progress has been made to reducing overcrowding (FaHCSIA 2013a).

Regional and urban housing issues for Indigenous Australians

Housing stress, defined as low income households who spend 30% or above of their income on housing costs (Biddle 2012a), is a significant issue for Indigenous Australians. High housing costs relative to income reduces disposable incomes and the associated stress can affect health and wellbeing in both direct and indirect ways. In an Australian study not specific to Indigenous Australians, the unaffordability of housing was linked with poor mental health (Mallett et al. 2011). According to data from the 2011 Census, higher proportions of Indigenous households as compared to non-Indigenous households are in housing stress (Biddle 2012). This is particularly the case for non-remote regions outside of capital cities, which have the highest rates of Indigenous households in housing stress (for example, south-eastern New South Wales, New South Wales central and north coasts) (Biddle 2012a). Large capital cities also have rates of Indigenous households in housing stress which are significantly higher than non-Indigenous households (Biddle 2012a). In contrast, Indigenous households in remote areas have relatively lower levels of housing stress, in most cases similar to or lower than non-Indigenous households (Biddle 2012a).



Even though problems such as overcrowding, lack of basic facilities and major structural problems applied to higher proportions of remote Indigenous households, it is also important to note that it is in regional and urban areas where most Indigenous Australians live (Milligan et al. 2011), and that larger numbers of Indigenous Australians in these areas are affected by these issues. For example, Biddle (2012a) directs attention towards the large numbers of overcrowded Indigenous households in non-remote areas, and argues for directing policy attention towards urban and regional as well as rural areas.

Milligan et al. (2011) highlight that 3 in 10 Indigenous households live in social housing (including general public housing, public housing identified for Indigenous tenants, Indigenous-run community housing and mainstream community housing), and 80% of these live in urbanised areas (including capital cities and regional towns and centres). It is therefore likely that higher proportions of Indigenous residents of urbanised areas live in areas characterised by higher public housing and concentrated social and economic disadvantage. Milligan et al. (2011) identify that in urban contexts, mainstream housing policy approaches are undifferentiated and not adequately responsive to the needs of Indigenous clients. Social housing planning and resource allocation processes directed towards addressing Indigenous housing needs are also found to be 'weak or absent' (Milligan et al. 2011:4). This highlights the relative 'invisibility' of Indigenous residents of urbanised areas (Atkinson et al. 2010). Below, we discuss two programs relevant to improving housing for Indigenous Australians, one run in remote areas and one in an urban area.

Programs to promote positive housing outcomes

A remote initiative: Fixing Houses for Better Health

The Fixing Houses for Better Health (FHBH) ran (in four phases) from 1999–2011. The program focused on improving housing and household living conditions in rural and remote Indigenous communities. It assessed individual houses and made repairs using a standardised 'housing for health' methodology. Houses were fixed in order to support 'healthy living practices', which were deemed to include: the ability to wash people, particularly children; wash clothes and bedding; remove waste safely; store, prepare and cook food; reduce the negative effects of crowding; reduce negative contact between people and animals, insect and vermin; reduce dust; control temperature; and reduce trauma or injury by removing hazards (Pholeros et al. 1993). FHBH focused on improving these aspects by giving attention to the 'health hardware', the physical infrastructure relating to water supply, sanitation and food preparation.

An audit of the program (ANAO 2010) reported that, between 2005–2009, FHBH made health-related improvements to over 2,000 houses in remote areas of five states and the Northern Territory. It improved the functioning of health hardware in houses, and as such, the ability of houses to support healthy living practices. However, the report noted that data were not collected which allowed these improvements in housing to be linked to changes in health outcomes, and it is therefore not possible to identify a direct relationship between FHBH and health outcomes.

An evaluation of the program conducted in 2006 (SGS 2006) identified that the program was successful in improving the safety and functioning of houses in Indigenous communities. Furthermore, the program had the involvement and cooperation of Indigenous communities and Indigenous Community Housing Associations. Indigenous community members were trained to undertake maintenance and repairs, data entry and the assessment methodology, and were paid a market wage during their employment in FHBH projects. However, most of this training occurred in basic skills and techniques, while 'higher level' repair work was conducted by workers who were brought into communities. Nevertheless, the report identifies a number of successes of the FHBH program.



A non-remote initiative: Household Organisational Management Expenses (HOME) advice program, Indigenous-specific site—Wodli, South Australia

The HOME advice program focuses on early intervention to assist families at risk of homelessness to manage their financial and household demands to avert accommodation crises. It is a national program that operates in eight sites, one in each state/territory, although there is one Indigenous-specific site in South Australia. It is a holistic, strengths-based case management program that works across multiple issues that families may face which put them at risk of homelessness; actively maintains partnerships with other services; and provides financial assistance to families where other assistance is not available (Mackenzie et al. 2007).

The program is a partnership between the former FaHCSIA and Centrelink, and involves collaboration between dedicated Centrelink HOME advice workers and non-government organisations that deliver the program in each site. This program is not restricted to Indigenous families but in South Australia the program: 'Wodli' (previously 'Wodlitinattoai', meaning So As Not To Be Without A Home in Kurna language) was designed specifically to address the needs of Indigenous families. The South Australian site is located in Salisbury, a metropolitan suburb of Adelaide. The evaluation identified that, when working with many Indigenous families, one of the main goals is to build capacity in the family for strategies to deal with kinship obligations and demands that contribute towards financial and housing difficulties (Mackenzie et al. 2007). Other issues at the South Australian site include the need to engage Indigenous families' trust early in their involvement in the program. It was also viewed as important for Wodli staff to have knowledge of cultural issues, such as the kin group the family was affiliated with and the nature of relationships with the extended family and broader community. The importance of employing Indigenous staff on the Wodli program who are known within local Indigenous communities was highlighted. However, given their links to community, workers made a concerted effort to maintain confidentiality of their participating families (Mackenzie et al. 2007).

The evaluation identifies a number of overall strengths of the program, including: a focus on working with families *before* they became homeless, working holistically with all members of the family, focusing on family strengths, and the quality of the partnerships between Centrelink and the service provider delivering the program (Mackenzie et al. 2007). The evaluation also identifies how the Wodli program works effectively with Indigenous families to reduce the risk of homelessness using such strategies as: using brokerage to assist with paying rent and bills; linking with specialist services such as alcohol and drugs services, family violence and Aboriginal health services; providing counselling around grief and loss (both historically and in context of immediate family losses); and meeting with and providing support to extended family to enable them to provide support to the participating family. It was important for Wodli workers to maintain these links to extended family, as there is a risk that once a family becomes involved with Wodli, positive support networks in the extended family 'withdraw'. The focus on enabling families to be self-managed and to deal effectively with any burdens placed upon them by kinship obligations was also a key strength of the program (Mackenzie et al. 2007).



Summary 4: Housing

The relationship between housing and health is complex and multi-directional, but living in poor quality, inadequate, insecure or unaffordable housing is associated with poor health. Inadequate health hardware can create risks to health and leads to problems for physical health such as infectious disease. Other housing issues, such as overcrowding and affordability, can increase stress and put negative pressures on health and wellbeing.

In remote areas, the evaluated program we have reviewed here was successful in regard to fixing houses to improve health hardware and bring them to adequate standards of safety and functioning. Although health outcomes were not examined, it can be assumed from previous research (Pholeros et al. 1993) that improving the health hardware safety of houses would promote better health. Important aspects of this program included:

- focusing on improving health hardware, such as physical infrastructure relating to sanitation, food preparation and water supply, using a standardised methodology
- building community capacity through training of Indigenous community members to complete basic tasks and gain skills
- securing the collaboration and support of Indigenous communities and housing associations.

In a metropolitan area, the program we reviewed succeeded in preventing Indigenous families from becoming homeless and supporting Indigenous families to remain in their homes. Doing this is likely to promote wellbeing. Important aspects included:

- a collaborative working relationship between two Australian Government agencies and a local non-government organisation
- skilled staff (including Indigenous staff) who had knowledge of cultural issues and could build trust with Indigenous families
- using a strengths-based, holistic case management approach
- working with families *before* they become homeless
- linking families with other relevant services
- enabling the family to be self-managed.

Racism

Racism has been defined as: 'an organised system based on an ideology of inferiority that labels some ethnic/ racial groups as inferior to others and differentially allocates desirable societal resources to the superior racial/ ethnic groups' (Bonilla-Silva 1997). It is expressed through: stereotypes (beliefs), prejudice (emotions) and discrimination (behaviours and practices) (Paradies et al. 2008). Racism can be both direct and indirect, and can occur at both interpersonal levels (in interactions between individuals) and at an institutional/systematic level (through institutionalised policies and practices which systematically discriminate against certain groups on the basis of their race). It has also been noted that racism can be 'internalised', whereby members of oppressed groups accept beliefs and attitudes about the inferiority of their own ethnic group (Paradies et al. 2008).



Racism is a significant determinant of health, and self-reported racism has been clearly associated with poor health, particularly negative mental health, depressive symptoms and health-related behaviours (Paradies 2006; Paradies & Cunningham 2012; Ziersch et al. 2011a, 2011b). It accounts for a significant burden of ill-health among Indigenous Australians (Paradies et al. 2008). There are a number of pathways by which racism leads to poor health. This includes lower levels of access to health services, employment opportunities and other social and economic resources which can benefit health, as a result of direct and indirect discrimination. In addition, racism has a negative and enduring impact upon mental health and social and emotional wellbeing through experiences of distress, anxiety and symptoms of depression. The adoption of certain responses to cope with racism may not benefit physical or mental health in the long term, and the direct injury caused by racially motivated physical assaults has a very obvious negative affect upon health (AHMAC 2012; Krieger, 1999; Paradies et al. 2008). Figure 2 below, reproduced from Awofeso (2011), provides an illustration of the contextual, distal and proximal determinants of racism and the associated impact on health and wellbeing for Indigenous Australians.

Estimates of the prevalence of racism experienced by Indigenous Australians vary and depend upon how racism is measured. Data from NATSISS in 2008 found that 27% of respondents reported experiencing racism (AHMAC 2012), although other studies utilising multiple-item measures of racism have identified a prevalence of self-reported racism between 58-79% among Indigenous participants (see Paradies et al. 2008). Despite variations in measurement, it is clear that racism is experienced by a significant proportion of Indigenous Australians.

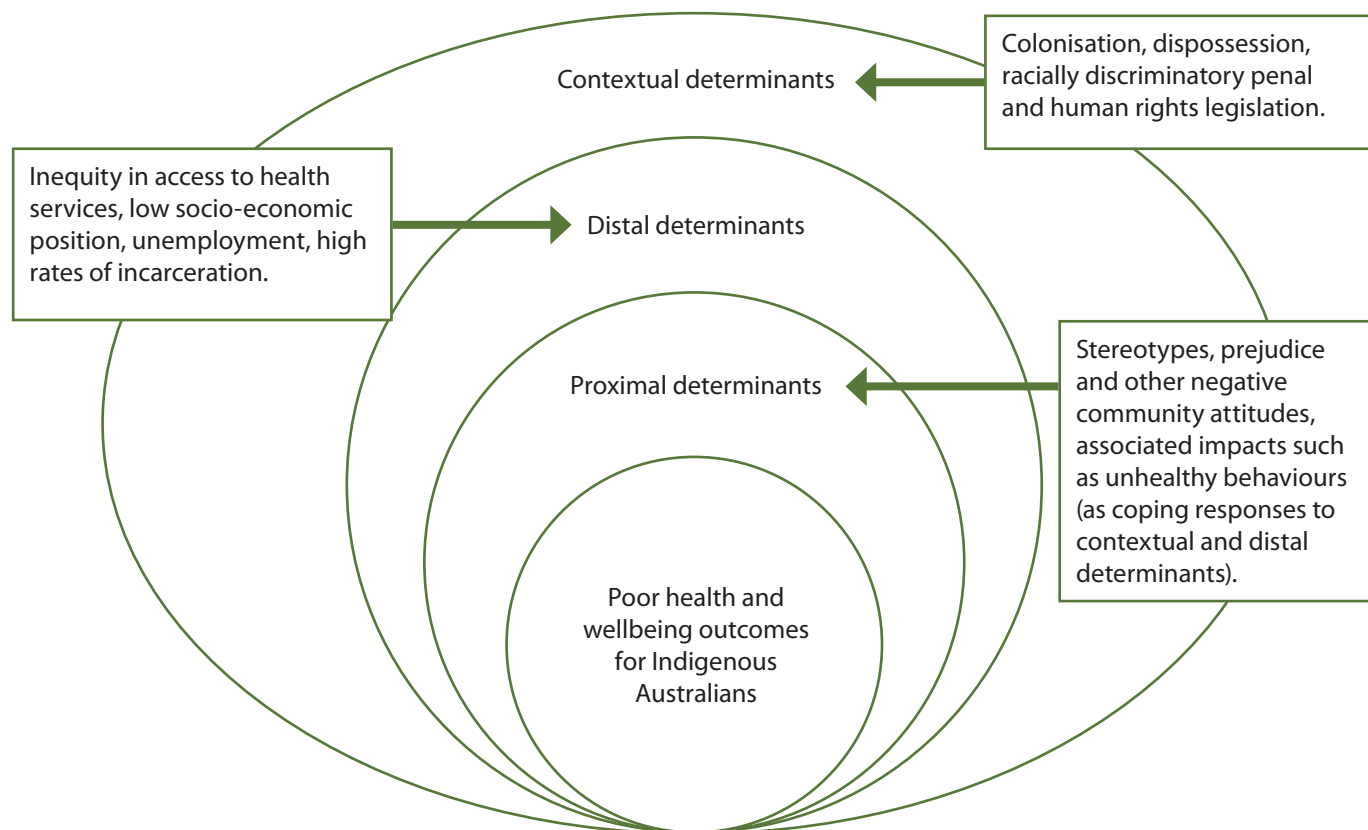


Figure 2: Determinants of racism among Indigenous Australians (Adapted from Awofeso 2011:6)



Racism is relevant to all of the previous determinants that affect Indigenous Australians, including access to: education, employment, housing, social connections and networks, and influences engagement in the health and criminal justice systems. Racism experienced by Indigenous Australians can be understood as a manifestation of colonisation and associated oppression of Indigenous people in Australia. Historically, past policies and practices, such as the removal of children from their families, were based on racist beliefs and values. The nature of contemporary social and economic disadvantage experienced by Indigenous Australians is intrinsically bound up with racism. Although racism is addressed by certain government policies (such as the National Anti-Racism Strategy), the overarching COAG targets do not include anything relating to racism even though it has been demonstrated to have a significant impact on physical and mental health and in adversely affecting access to other determinants of health.

How can racism be reduced?

Approaches, strategies, priority settings and actions to reduce racism are comprehensively reviewed in the VicHealth report prepared by Paradies and colleagues (2009). This report suggests comprehensive approaches and multiple strategies are needed to reduce racism. It identifies eight key themes for action: increasing empathy, raising awareness, providing accurate information, recognising incompatible beliefs, increasing personal accountability, breaking down barriers between groups, increasing organisational accountability, and promoting positive social norms. It also highlights that reducing racism requires universal interventions, local-level interventions coordinated by local government, multi-level and multi-strategy interventions in different 'priority settings' (including schools, workplaces, public sector, and sports and recreation). There should be a particular focus on reaching young people, organisational development strategies, engaging Indigenous community leadership, and ongoing research, evaluation and monitoring to identify what works (Paradies et al. 2009). Categories of actions to reduce discrimination include: whole of population communications and social marketing; organisational development; legislative and policy reform; direct participation programs; community strengthening; and advocacy. Among the categories listed above, Paradies et al. (2009) identify that strategies within the following areas have rigorous evaluation data which suggest their effectiveness: organisational development, communications and social marketing, and direct participation. But further research, evaluation and monitoring is necessary to build an evidence base about the experiences and outcomes of racism and discrimination for affected groups, which can be used as a basis for advocacy, to improve policy and practice and to design anti-racism interventions (Paradies et al. 2009).

A current example of an universal initiative to combat racism is the National Anti-Racism Strategy and 'Racism: it stops with me' campaign being led by the Australian Human Rights Commission in partnership with other Australian Government agencies, including the Attorney-General's Department, Department of Immigration and Citizenship, and the former FaHCSIA (AHRC 2013). This is an example of a 'whole of population' communications and awareness-raising campaign that provides information and advice, particularly to encourage 'bystanders' who observe racist behaviour to take action. It also provides information about action taken by a range of Australian organisations to reduce racism, campaign materials such as posters and leaflets, and links to external resources for individuals, schools, workplaces and communities. It promotes examples of celebrities who endorse the campaign and anti-racism events and activities. As yet, evaluation data are not available concerning the success of the campaign. Below, we discuss evaluated programs and interventions to reduce racism.

Programs to reduce racism

Australian intervention research aimed at identifying ways to reduce racism is extremely limited (Paradies et al. 2008). A range of options for initiatives to reduce racism are comprehensively reviewed in Paradies et al. (2009) and further information can be found in this document. Here we discuss two strategies for which there is evidence of effectiveness: anti-racism communication and social marketing, and diversity training.



Anti-racism communications and social marketing campaigns

Some strategies utilise a range of media for widespread promotion of anti-discrimination messages and the recent 'Racism: it stops with me' campaign described previously in this section, is an example of this approach. However, there is very limited research into the effectiveness of such strategies. More information about this particular approach to reducing racism can be found in Donovan and Vlasis (2006). They undertook an extensive review of Australian and international anti-racism communication and social marketing campaigns. In this report, they identify that there are very few examples of large-scale campaigns that have been evaluated, or where formative research is undertaken prior to running the campaign (Donovan & Vlasis 2006). They also highlight that communication campaigns are not often based upon attitude behaviour change models or communications principles, but are rather simplistic in seeking to portray different cultural and ethnic groups in a positive light and highlight that diversity is a good thing.

In a rare example of an Australian communications campaign that was evaluated, Donovan and Leivers (1993) reported on a study of an anti-racism campaign in Bunbury, Western Australia: 'All anybody wants is a fair go: Aboriginal Employment week', in 1985. This was a two week campaign that used television, print and radio advertising, and was commissioned by the Equal Opportunity Commission of Western Australia. This campaign is noteworthy because, in addition to being evaluated, it undertook formative qualitative research to guide campaign development, and used psychological concepts of attitude change (in particular, 'latitude of acceptance') in the design of the campaign (Donovan & Vlasis 2006). The campaign aimed to change attitudes underlying employment discrimination. The target groups were all non-Indigenous town residents, employers and employed residents. The aim of the campaign was for non-Indigenous Australians to reconsider their beliefs about Indigenous Australians and employment. The campaign also targeted Indigenous residents in order to increase their sense of pride by presenting positive portrayals of Indigenous employees in the local media. Local Indigenous community members were active partners in the campaign.

The evaluation of the campaign measured belief change among local residents, negative reactions to the campaign and whether it had any unintended consequences. In particular, the campaign aimed to increase residents' knowledge about the percentage of local Indigenous Australians in employment, the percentage who remained in jobs for long periods, and the percentage in skilled jobs, as, prior to the campaign, negative attitudes were based on false beliefs relating to these areas (Donovan & Vlasis 2006). The results of the evaluation, which involved pre and post-surveys, indicate that the campaign reached 90% of respondents, and the vast majority reported supporting the campaign and changing their mind about Indigenous employment in a positive way. The campaign also had a significant positive impact on respondents' knowledge in the three key areas. Donovan and Vlasis (2006) draw on the findings from this campaign to highlight a list of nine good practice principles to guide anti-racism campaigns, including: targeting objective, specific beliefs that underpin 'emotive' beliefs where possible; indicating shared values between Indigenous and non-Indigenous Australians in one key respect (for example, the importance of having a job); not using single celebrities, who can be viewed as exceptions to the rule; focusing on a specific area of discrimination (such as employment); and ensuring that the relevant ethnic or cultural groups (in this case, local Indigenous community groups) are involved in campaign development.



Diversity training

Diversity training aims to increase positive attitudes and behaviours towards other groups, and decrease negative attitudes, stereotypes and prejudices. Paradies et al. (2009) report that most diversity training programs reported in the academic literature refer to workplace initiatives, designed to train participants in their work roles. However these types of programs also apply in other settings, such as schools-based awareness training and more broadly in communities as part of community strengthening programs. Diversity training that relates to race, ethnicity, culture or religion can take the approach of *cultural awareness training* (designed to provide information and improve awareness of and communication between different cultures) or *anti-discrimination training* (which involves participants examining their own values and beliefs, and aims to increase participants' awareness of the discriminatory attitudes they may hold). Cultural awareness training for staff has already been highlighted in previous sections of this issues paper as a strategy for organisations that aim to effectively engage with and assist Indigenous Australians.

Diversity training can result in improved attitudes and behaviours towards other cultural groups and increased knowledge (Kulik & Roberson 2008). However, reviews also highlight the possibility that diversity training may *increase* negative attitudes and beliefs, and it is important for such training to be well-designed, based upon well-developed theory and best practice, and tested prior to being widely implemented (Paradies et al. 2009). Programs that feature both cross-cultural and anti-discrimination aspects are more likely to be successful (Buhin & Vera 2009). Elements that contribute towards success also include: having strong support from the organisation's leadership, trainers who are experienced in organisational change, training that specifically addresses behaviour, is designed for particular organisations, and is inclusive of a range of participants from different cultural and ethnic backgrounds.

An example of an evaluation of a diversity training intervention is described by Pedersen and Barlow (2008). They describe a university-based program whereby first year psychology students participated in an elective cultural psychology unit, and completed questionnaires at the commencement and conclusion of this course. The questionnaires measured prejudice, false beliefs, guilt and included a qualitative item relating to 'special treatment' of Indigenous Australians. Students were given a 6 week series of lectures which focused upon social inequality, with a particular focus on Indigenous Australians. The lectures were designed to challenge false beliefs, attitudes and assumptions about Indigenous Australians, including the idea that they receive 'special treatment', and provide accurate information about Indigenous culture, and how prejudice and racism affects Indigenous Australians. Students also participated in tutorials which complemented the content of lectures (Pedersen & Barlow 2008). The results indicated significant reduction in prejudice, acceptance of false beliefs, and perceptions that Indigenous Australians received 'special treatment'. Importantly, the training course was not designed to emphasise or increase guilt in participants, and levels of guilt in regard to the societal treatment of Indigenous Australians remained stable between the first and second measures. This intervention, whilst university-based and not specific to a workplace, demonstrates the value of diversity training, particularly with well-designed and specific content intended to challenge common negative attitudes and false beliefs. It also demonstrates the value of evaluation for measuring the success of such interventions. A limitation of the study was that it did not follow-up after conclusion of the course, which would have been valuable to measure whether changes in attitudes and beliefs remained.



Summary 5: Racism

Racism has a negative effect on the social and emotional wellbeing of Indigenous Australians. Racism is experienced by a significant proportion of Indigenous Australians, and operates through a number of pathways to affect health and wellbeing negatively. Despite limited Australian evidence on what works to reduce racism, that available suggests reducing racism should include: universal interventions, targeted interventions across different settings (such as schools, workplaces, public sector and sports/recreation organisations), organisational development, communications and social marketing, and direct participation programs. We reviewed evaluated examples of two anti-racism programs: a communications and social marketing campaign and a diversity training intervention. Data from these evaluations suggest the following success factors:

- targeting specific false beliefs, for example that all Indigenous Australians are unemployed or receive 'special treatment'
- well-designed and specific program content designed to challenge negative beliefs and specifically address behaviours
- provision of accurate information about Indigenous culture, and how racism affects Indigenous Australians
- having a focus on specific areas of discrimination – such as employment
- highlighting shared values between Indigenous and non-Indigenous Australians
- ensuring that Indigenous communities are involved in campaign design and development.

Interaction with government systems

In this section, we consider Indigenous Australians' access to and interaction with two institutional systems: the health care system and the criminal justice system. A social determinants approach identifies the key determinants of health and wellbeing as being *outside* of institutional systems. However, it is recognised that health care and other institutional systems, and the extent to which such services are equitably distributed and are accessible to people, make a substantial contribution to population health (Griew et al. 2008). In the case of the criminal justice system, the extent to which the police, courts and prisons come into contact with Indigenous Australians, and the types of treatment encountered by Indigenous Australians within this system, are associated with health and wellbeing (Kariminia et al. 2012; Krieg 2006).

Health care system

Access to health care is a crucial determinant of health. Health systems which are based on universal entitlement to publicly-funded services have been shown to promote equity of access (WHO 2008). In Australia, the provision of free-at-the-point-of-use public hospital services and bulk billing of General Practitioners' (GPs) services is important in assisting Indigenous access to health care. Even within universal systems, however, access is not guaranteed as other barriers such as culture, racism and non-transparent systems may impede access. Universality is hard to evaluate but is a fundamentally important aspect of promoting health equity. It is important for all Indigenous Australians to have access to appropriate documentation, for example Medicare cards, to ensure they have equal levels of access to universal health care.



Barriers to quality and appropriate health care services contribute towards the significant health inequities experienced by Indigenous Australians. The Aboriginal and Torres Strait Islander Health Performance Framework (AHMAC 2012) summarised recent data relating to health system performance for Indigenous Australians. Key points include evidence that in 2008, 26% of Indigenous Australians 15 years and over reported problems accessing health services (including dentists, doctors, hospitals, and Aboriginal and Torres Strait Islander Health Workers) with this rate being higher in remote areas (36%) than non-remote areas (23%). In regards to antenatal care, Indigenous women receive antenatal care later in their pregnancy and less frequently than non-Indigenous women, which in part is likely to reflect a lack of access to such care (AHMAC 2012). The proportion of perinatal deaths, preterm births and low birth weight babies increases with lower levels of antenatal care (SCRGSP 2009).

Potentially preventable hospitalisations for Indigenous Australians were five times the rate for non-Indigenous Australians between 2008 and 2010. Indigenous Australians also have longer waiting times than non-Indigenous Australians for public elective surgeries. In 2004-05, Indigenous Australians were twice as likely to visit casualty in a hospital, and they have higher rates of public hospital and community health services use and lower rates for GPs, dental services, and medications. The expenditure on pharmaceutical medications for Indigenous Australians compared to non-Indigenous Australians is significantly lower (AHMAC 2012).

In regard to health care models and approaches that effectively promote the health of Indigenous Australians and address health inequities, primary health care services are viewed as significant in addressing the health disadvantages faced by Indigenous Australians. NACCHO defines primary health care as:

‘Primary Health Care’ has always been a continuing integral aspect of our Aboriginal life, and is the collective effort of the local Aboriginal community to achieve and maintain its cultural wellbeing. Primary health care is a holistic approach which incorporates body, mind, spirit, land, environment, custom and socio-economic status.

Primary health care is an Aboriginal cultural construct that includes essential, integrated care based upon practical, scientifically sound and socially acceptable procedures and technology made accessible to Communities as close as possible to where they live through their full participation in the spirit of self-reliance and self-determination. The provision of this calibre of health care requires an intimate knowledge of the community and its health problems, with the community itself providing the most effective and appropriate way to address its main health problems, including promotive, preventative, curative and rehabilitative services...

Primary health care is all inclusive, integrated health care and refers to the quality of health services. It is a comprehensive approach to health in accordance with the Aboriginal holistic definition of health and arises out of the practical experience within the Aboriginal community itself having to provide effective and culturally appropriate health services to its communities (NACCHO 2012).

Evidence suggests that reductions in infant mortality and mortality due to infectious diseases among Indigenous Australians are linked to primary health care services (Griew et al. 2008). International evidence suggests that stronger primary health care is related to lower rates of infant mortality and lower national health costs, while weaker primary health care is associated with poorer results in relation to years of potential life lost (Starfield et al. 2005). As part of the National Partnership Agreement on Closing the Gap in Indigenous health outcomes, the Indigenous Chronic Disease Package has included measures to improve affordability and help increase the uptake of MBS-funded primary health care services among Indigenous Australians. Since this commenced in July 2009, there has been an increase in MBS-listed adult health assessments (AHMAC 2012).



Health services that are culturally appropriate and sensitive (in which beliefs and traditions are respected) employ Indigenous staff, are geographically accessible and are more likely to be accessed by Indigenous Australians. Racism and a history of dispossession have been identified as barriers to health care among Indigenous Australians (Liaw et al. 2011). Liaw et al. (2011) identified the importance of cultural competency for improving chronic disease care for Indigenous Australians, and highlighted the importance of six factors: Indigenous community engagement, drawing on local knowledge, strong leadership, shared responsibilities, sustainable resources and integrated data and systems. Improving cultural competency of mainstream health services is an essential aspect of enabling health services to be more accessible to Indigenous Australians. The Australian, State and Territory Governments have developed cultural competency frameworks (of which the AHMAC Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009 is one example) which have guided capacity building for cultural competency among all health sector staff, and involved Indigenous communities in health decisions.

Salaried GPs and health and medical staff, as opposed to the fee-for-service approach, has also been identified as more appropriate for meeting the needs of Indigenous Australians (Scrimgeour & Scrimgeour 2008). Aboriginal Community Controlled Health Services (ACCHSs) are primary health services which are operated and controlled by the local Indigenous community through a locally elected management board, and provide health services to the local Indigenous communities. The values and approach of these services are underpinned by an Indigenous holistic view of health and wellbeing, and they provide culturally sensitive health services which view the individual within their wider family, social, cultural and spiritual context. Community control is a significant element of empowering Indigenous communities to have control over their own affairs (NACCHO 2012). Research conducted in South Australia and the Northern Territory found that an Aboriginal-controlled health service was better able to address social determinants of health in its work than the other primary health care services in the study (Baum et al. 2013). This initial finding suggests the need for further research on the Aboriginal community-controlled model especially in terms of its ability to provide comprehensive care including curative, rehabilitative, preventive and promotive health care.

Research has identified the significant administrative and governance burdens placed on ACCHSs by a highly complex and fragmented funding system (Dwyer et al. 2009). Most funding for ACCHSs comes from the Australian Government, although State and Territory Governments do contribute smaller amounts. Significantly, Government funding comes from multiple program areas within different divisions of Government departments, each of which have specific guidelines and funding requirements. This entails significant effort and resources to acquire, manage and report against an array of different funding contracts (Dwyer et al. 2009).

Below, we provide an example of the way in which health services can be tailored to the needs of Indigenous Australians to improve both access to health services and health outcomes.

Programs to improve health access and outcomes for Indigenous Australians

Aboriginal Maternal and Infant Health Service

There are a number of specific maternity and infant health services operating across Australia, which are designed to improve health outcomes and provide culturally appropriate health care for Indigenous pregnant women and their babies (Rumbold & Cunningham 2008). Here we highlight an evaluation of one such service, the *Aboriginal Maternal and Infant Health service* (AMIHS) in New South Wales (Murphy & Best 2012). This service was established to decrease perinatal mortality and morbidity of Indigenous babies, and to improve the health of Indigenous women during pregnancy.



The service has a woman-centred approach and operates under a social model of health. It provides continuity of care to Indigenous women, with Indigenous health workers and midwives collaborating to provide a service that is culturally appropriate, based on primary health care principles and delivered in partnership with Indigenous Australians. AMIHS is linked with mainstream maternity services. Key aspects of the service include: a focus on community consultation, partnering with other services, transition of care for the infants after 8 weeks of age to child and family health services (so that they have continuity of care to school age for child health and development checks at key milestones) and the training and support provided to AHMIHS workers. An evaluation of the service showed that AMIHS had achieved the following outcomes: an increased proportion of women attending first antenatal visit before 20 weeks; decreased rates of low birth weight babies, preterm births, perinatal mortality; and improved breastfeeding rates (Murphy & Best 2012). The evaluation also found that Indigenous women trusted and supported the service, and identified home visiting, contact with Indigenous health workers, and reminders about and transport to antenatal appointments as key aspects they were satisfied with. Strengths of the program included the collaboration between Indigenous health workers and midwives using a primary health care approach and skilled and committed staff who had good relationships with Indigenous communities and health services (Murphy & Best 2012). The training and support provided to AHMIHS workers was also identified as a strength of the program, with a number of Indigenous health workers graduating from a training course and progressing to undertake Bachelor of Midwifery courses. Since the evaluation was conducted, the program has been expanded (Murphy & Best 2012).

A collaborative approach to improving Indigenous eye health in the Northern Territory

Keys and O'Hara (2009) describe a case study of a collaboration between an ACCHS in the Northern Territory - the Anyinginyi Health Aboriginal Corporation (AHAC), and an NGO—the International Centre for Eyecare education (ICEE), to improve access to eye care services and eye health for Indigenous Australians in the Tennant Creek and Barkly region of the Northern Territory. Eye health problems are significant for Indigenous Australians, as they comprise 30% of all long-term health conditions among Indigenous Australians (ABS 2006), and Indigenous Australians access eye care services at lower rates than the non-Indigenous population (Hecker 1998).

The Regional Eye Health Coordinator, based within AHAC, established a relationship with ICEE to provide assistance in providing regular optometry services, and to set up a spectacle scheme to provide low cost spectacles to local Indigenous communities. They also re-established a relationship with a visiting ophthalmologist from Alice Springs. Prior to this, eye care services had been extremely limited in this region. As a result of these partnerships, optometry services in the Barkly region expanded from seven days a year prior to the involvement of the NGO to 78 days in 2008. Professional relationships were established between the Regional Eye Health Coordinator, the NGO optometrist and the visiting ophthalmologist, and systems were established to improve continuity of care for patients, data collection and access to spectacles. During 2007–2008, 1,385 patients were seen by an eye health professional, with 734 being prescribed spectacles and 146 referred to specialist care. Furthermore, a low cost spectacle scheme was established, which provided affordable spectacles to community members, and could be paid for by centrepay, enabling patients to pay for their spectacles through instalments using their income from Centrelink.

Keys and O'Hara (2009) identify that culturally appropriate service provision is a key aspect of this program, and the NGO emphasises that all optometrists are well trained, familiar with local customs, and that they are accompanied by the Regional Eye Health Coordinator or an Indigenous ACCHS staff member on their visits. Other successful strategies include providing mobile optometric services to small, remote communities, and increased eye clinics at AHAC or the community health centre. The success of this partnership in improving eye care services to Indigenous Australians in the Barkly region is evidenced by the invitation by other Northern Territory ACCHSs to ICEE to expand its services Territory wide (Keys & O'Hara 2009).



Criminal justice system

A significant indicator of Indigenous Australians' social and health disadvantage is their levels of contact with the criminal justice system, as they are considerably over-represented compared to non-Indigenous Australians. Imprisonment rates of Indigenous Australians are approximately 12 times the rate of the non-Indigenous population, and Indigenous Australians comprise 40% of people imprisoned for assault offences (AIC 2013). Despite comprising less than 3% of the entire population, one quarter of the prison population in Australia is Indigenous (AIHW 2011c; SSCRRIC 2010). Indigenous Australians are also over-represented in juvenile detention, as Indigenous 10–17 year olds are 24 times more likely to be in detention (AIC 2013). Data from the 2008 NATSISS show that, of Indigenous Australians 15 and over, 15% have been arrested in the previous 5 years, 3.2% have been incarcerated in the previous 5 years, 17.5% have used legal services in previous 12 months, and 23.2% report being the victim of physical or threatened violence in the past 12 months (ABS 2009).

The Royal Commission into Aboriginal Deaths in Custody (1991) argued that custody should be 'a sanction of last resort', and yet since this enquiry, the incarceration of Indigenous Australians has risen (Heffernan et al. 2009). It is argued that the high rates of imprisonment of Indigenous Australians do not contribute towards safer communities (Krieg 2006) and that there is little evidence that incarceration is being used as a sanction of last resort, indicating that this over-representation of Indigenous Australians is a manifestation of institutionalised and systemic racism (Awofeso 2011). A Victorian study examined systemic racism as a contributing factor towards the over-representation of Indigenous Victorians in the criminal justice system (Blagg et al. 2005). Common serious offences with which Indigenous Australians are charged are property, violent and disorder offences, and drug and alcohol use has also been linked with Indigenous offending (Joudo 2008). Both criminal behaviour and substance use can be viewed as a consequence of the deep and enduring grief, pain and anger resulting from a history of colonisation and dispossession. Incarceration further exacerbates separation from community and contributes to the multiple disadvantages experienced by Indigenous Australians (Krieg 2006).

Imprisonment has a severe negative impact on the health, social and emotional wellbeing of Indigenous Australians (Krieg 2006). Rates of mental illness and mental health problems are high for Indigenous Australians in custody (Heffernan et al. 2009). In prison, Indigenous Australians have an increased risk of infectious disease and pre-existing chronic physical and mental health problems are less likely to be well managed (Awofeso 2011). The consequences upon release are significant: during 6–12 months following release, Indigenous Australians have a greater risk of death due to causes such as suicide, drug and alcohol-related incidents, and vehicle accidents (Krieg 2006). Research conducted in New South Wales has identified that the risk of death for Indigenous men and women during imprisonment and after release was 4.8 and 12.6 times more than that of men and women in the general population (Kariminia et al. 2012). This study identified higher risks among this population of Indigenous prisoners and ex-prisoners for many health conditions, with cardiovascular disease being the leading cause of death among men, and mental and behavioural disorders (including drug overdose) among women, and that the risk of death was highest following release (Kariminia et al. 2012). Problems faced upon release include a lack of appropriate housing and a lack of adequate income and identification documents, which has the consequence that it is difficult for individuals to attend counselling and medical appointments, obtain medication and pursue healthy lifestyles (Krieg 2006). The lack of continuity between prison and post-prison services can also mean that it is difficult to effectively coordinate services to meet the health needs of Indigenous prisoners, as described by Krieg (2006) using the example of Hepatitis C treatment programs.



The majority of Indigenous Australians in custody are men, however, data from New South Wales, the Northern Territory and South Australia indicate that Indigenous women are between nine and 16 times more likely to offend than non-Indigenous women, and this is a greater over-representation than for men (Bartels 2010). Indigenous women serve shorter sentences than non-Indigenous women, indicating that they are being incarcerated for minor offences (including public order offences) (Bartels 2010), again illustrating that the principle of 'sanction of last resort' is not necessarily being adhered to. In Western Australia, Indigenous women's mortality rates post-release are higher than those for men. The imprisonment of Indigenous women has severe negative consequences for not only them but their families and children, due to their roles as mothers and carers. Evidence suggests that Indigenous women in custody experience higher rates of substance use and mental health problems than men, and have experienced violence and childhood sexual and physical abuse, which is linked to their offending behaviours (Bartels 2010; Krieg 2006).

In a review of interventions to reduce Indigenous juvenile offending, Richards et al. (2011) identify three types of interventions: primary prevention measures, which aim to prevent offending before it begins; secondary prevention measures, which aim to address existing problem behaviour before it reaches the attention of authorities; and tertiary prevention, which intervenes with known offenders to reduce reoffending.

In terms of ways to reduce contact with the criminal justice system, one example of a 'tertiary' prevention measure is diversionary programs which aim to 'divert' individual offenders away from the criminal justice system or reduce progression through the criminal justice system (Joudo 2008). In addition to reducing future offending, diversionary programs seek to reduce: the labelling and stigma associated with contact with the criminal justice system, the number of people going through courts and prisons, unnecessary social controls, and aim to provide interventions to people who need treatment, for example, for substance use (Joudo 2008). Many diversionary programs operate across Australia and divert individuals at different points in the criminal justice system including pre-arrest, pre-trial, pre-sentence and post-sentence. Indigenous-specific diversionary programs are largely targeted towards offenders who have committed drug offences or whose offences are linked with substance use. There are also mainstream diversionary programs in which efforts have been made to be culturally appropriate for Indigenous Australians (Joudo 2008). In a review of diversion programs, Joudo (2008) summarises evidence which suggests that Indigenous participants in diversion programs are more likely to reoffend than non-Indigenous participants. Other evaluations of Indigenous-specific diversion programs in New South Wales and Queensland have found that Indigenous participants in diversion programs are equally as likely to reoffend as Indigenous offenders who have not been diverted, and participated in mainstream criminal justice processes (Fitzgerald 2008; Morgan & Louis 2010).

In regard to mainstream diversion programs, available evidence suggests Indigenous Australians are less likely to be referred and accepted into these programs (Joudo 2008). Indigenous offenders have complex needs: they are more likely to have multiple charges, previous criminal convictions, multiple drug misuse, and a co-existing mental illness (Joudo 2008). These factors may act as barriers which prevent them from accessing diversion programs. It has been argued that, as a strategy to reduce Indigenous over-representation in the criminal justice system, diversionary programs can only have a limited impact (Richards et al. 2011). There are multiple complex issues, influenced by other social and economic determinants, which impact upon offending behaviour, and programs need to take full account of these complexities (Allard et al. 2010). Interventions which focus on preventing contact with the criminal justice system before it occurs, particularly among young Indigenous Australians, would seem to be a worthy focus of effort, particularly if they take action on other social and economic determinants. Below, we review two examples of programs which take this approach, one delivered in an urban area and one that is run in remote communities.



Programs to prevent contact with the criminal justice system

Pathways to prevention

Pathways to prevention is a Queensland-based 'universal, early intervention' program which aims to enable the positive development of children and their families, and thereby prevent involvement in crime and related problems. It is not an Indigenous-specific program but was introduced in an ethnically diverse, socially disadvantaged area of Brisbane with a high proportion of Indigenous residents, in which local young people had a higher rate of court appearances than for the Brisbane area as a whole. The original focus of the program was to promote a positive transition to school for children using many strategies, including developing children's communication and social skills prior to school, behaviour management programs for families, family support groups and linking families with other health and support services. These activities were included in the 'Preschool Intervention Program' and the 'Family Independence Program'. In recent years the scheme has expanded to support a range of programs which emphasise family support and community development (Homel et al. 2006a). It is a broad-based program with a holistic focus which aims to engage with and link families to adequate and appropriate support in a range of areas such as education, housing, income, parenting skills and children's participation in education.

The program evaluation identified that a key strength of the program was the inclusion of highly skilled and committed staff who were representative of the ethnically diverse area, including Indigenous workers, who were able to build significant trust with Indigenous families (Homel et al. 2006b). Evaluation of the program has shown that it has achieved a range of positive outcomes, including developing connectedness within families and attachment between parents and children, which assisted parents to have greater understanding of their children's development. Participation in the program reduced children's levels of difficult behaviour, over and above their participation in the normal preschool curriculum (Homel et al. 2006a). Using a 'Juvenile justice simulation model' Homel et al. (2006a) found the reduction in the number of children displaying behavioural problems would result in a reduction of 21% of juvenile offending in the area where the program was run. Homel et al. (2006b) identify a number of positive benefits of the program specifically for Indigenous families, including tailored and culturally appropriate support provided to individual families. They also highlight the strength and resilience of Indigenous families, particularly as many live in contexts of disadvantage, with a lack of social and economic resources and support.

Youth in Communities

Youth in Communities is a remote, Northern Territory-based program funded by the former FaHCSIA initially under the Closing the Gap scheme in the Northern Territory National Partnership Agreement, and currently by the Stronger Futures in the Northern Territory Package. Stronger Futures in the Northern Territory aims to improve the lives of Aboriginal people in the Northern Territory, particularly those living in remote communities and town camps. As at June 2013, Youth in Communities is delivered by 19 not-for-profit organisations reaching approximately 60 communities across the Northern Territory. Approximately \$10 million will be provided each year from 2012–13 to 2021–22 for Youth in Communities under the Stronger Future for the Northern Territory package. Evaluation will need to examine the implications of the strategy to outsource these services to a range of non-government organisations and what this means for consistency of service delivery, and compare this with a strategy of using these funds to support ACCHS.

It is designed to deliver early intervention, prevention and diversionary initiatives in the Northern Territory for young people who are at risk of substance misuse, suicide or intentional self-harm entering or re-entering the criminal justice system and disengaging with education, training or employment. Services are directed towards improving life choices and outcomes for young people through engaging youth in positive activities that improve resilience and promote pathways to better health, wellbeing, education and employment (FaHCSIA 2013b).



The program sits under the broader goal of ‘creating safer communities’, and it is included in this section as an example of a program which aims to prevent offending by young people and contact with the criminal justice system, although it addresses health behaviours and other aspects of family and community life. The program is a ‘comprehensive youth strategy’ for young people aged 10-20 years living in remote communities. It provides funding for youth workers and Indigenous trainee youth workers, infrastructure for youth services and ‘diversionary’ activities that prevent young people from engaging in risky behaviours. The program aims to prevent involvement in violence, reduce incidences of arrest and detention, reduce petrol sniffing behaviour, other substance abuse, self-harm and suicide, and increase involvement in ‘daily routines’ (Courage Partners 2012). The program engages young people in actions and pursuits that promote wellbeing, community capacity and participation in school, social networks and paid work. As such, it diverts young people away from risky behaviours by taking relevant action to address other social determinants, such as social participation, education and paid work.

An evaluation of the program (Courage Partners 2012) identified that in 2012, 4,500 young people were participants in the program. It also highlighted strong support from local communities, with Youth in Communities services engaging well with local communities and Elders. The evaluation identified the development of gender-specific youth activities, particularly to address the problem in some communities of young men not participating once they had been through traditional initiation practices as an important aspect. It was also identified that in many sites the program needed to be flexible to include young people under the ages of 10 and over 20. Positive behavioural outcomes among young people were identified, including engaging in Youth in Community activities, attending or re-engaging in school, increasing self-care and self-esteem, participating in cultural activities and contributing to the resilience of peers.

However, areas identified for further attention include providing education, training and employment options for young people. The evaluation report identifies a need for a ‘whole of community’ approach to community development, highlighting the limit to what youth services alone can achieve. Furthermore, they argue that many young people have been part of ‘dysfunctional’ communities and families for many years and that as such, sustained positive outcomes will take a long time to achieve, longer than the program’s lifespan of three years. The evaluation recommends continued funding to maintain current infrastructure and consistent staffing levels (Courage Partners 2012).



Summary 6: Interaction with government systems

There are significant inequities in access to health care between Indigenous and non-Indigenous Australians, and Indigenous Australians have high levels of contact with the criminal justice system. Both of these issues are intrinsically connected with other social and economic determinants (for example racism, connection to family, community, culture, education, income) and contribute significantly to the social and economic disadvantage experienced by Indigenous Australians. Inequities in access to adequate health care and higher levels of contact with the criminal justice system (such as higher levels of incarceration) have been clearly linked with negative health outcomes.

Among the programs designed to improve access to health services and prevent contact with the criminal justice system, the evaluations suggested some common themes:

- having skilled, committed and culturally competent staff—including Indigenous staff
- culturally appropriate service delivery—facilitated by cultural competency training and collaboration between Indigenous and non-Indigenous staff
- training and support provided to Indigenous staff to enable them to gain professional skills
- collaborative relationships and partnerships between workers and across agencies that link Indigenous Australians with a range of support services in areas such as health care, education, housing, income and family support
- having a holistic, strengths-based focus
- in relation to health care: taking a primary health care approach
- in regard to prevention of contact with criminal justice system:
 - taking a long-term 'whole of community approach' to community development
 - providing quality youth services which support young people and provide gender-specific activities.

Health behaviours

Daily health-related behaviours relating to the consumption of food, substances such as alcohol, tobacco and other drugs, and physical activity have a significant impact on health outcomes. Health behaviours are a more 'proximal' determinant of health than some of the distal or 'upstream' social and economic determinants already discussed in this paper. The causal links between nutrition, smoking, physical activity, alcohol and substance use and specific health outcomes such as obesity and a range of chronic diseases, including heart disease and cancers, are well understood. Health behaviours are influenced by the broader social and economic determinants of health, for example, negative health behaviours can be a coping response to experiences of racism and discrimination (Paradies et al. 2008). In this section, we consider health promotion programs and interventions which take a social determinants approach to developing healthy behaviours and lifestyles among Indigenous Australians. Promoting positive health behaviours has been a significant area of investment of funding in recent years, for example, \$160.8 million over four years has been allocated to health promotion under the Indigenous Chronic Disease Package, as part of addressing the COAG commitment to closing the gap in life expectancy (DoHA 2010). We note, however, that these funds are primarily targeted at directly changing health behaviours rather than the underlying social determinants of health. Below, we provide a brief overview of patterns of health behaviours among Indigenous Australians.



In regard to healthy eating and nutrition, Indigenous Australians aged 12 and above are twice and seven times more likely than non-Indigenous Australians to report no daily fruit and vegetable intake (ABS 2006; AHMAC 2011). This differs by remote and non-remote areas: in remote areas 20% of Indigenous Australians report no daily fruit intake and 15% report no daily vegetable intake, whereas in non-remote areas these proportions were lower: 12% and 2% respectively (AHMAC 2011). In regard to children, data from the 2008 NATSISS identified that 59% of Indigenous children aged 1–14 reported eating fruit every day, with a lower proportion, 52% in remote areas. Fifty three per cent of Indigenous children in the same age group reported eating vegetables daily, which did not differ between remote and non-remote areas (ABS 2012b). The data suggest that the prevalence of eating fruit and vegetables daily was higher for younger children, and decreased in the 12–14 age range. Food insecurity (inadequate access and supply of food and inappropriate use of food) is a significant problem faced by Indigenous Australians, with rates of food insecurity being highest in remote communities, due to problems with the quality, affordability and availability of healthy food in these areas (Browne et al. 2009). Indigenous Australians in non-remote areas also experience food insecurity relating to poor income, inadequate household facilities for storage and cooking, and lack of access to transport (Rosier 2011). Food insecurity is connected with other social and economic determinants such as housing (including poor health hardware), income, education and the management of stores in remote communities.

In relation to physical activity, recent data have shown a decline in levels of physical activity among Indigenous Australians, as data from the 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) showed that 45% of Indigenous people aged 15 years and over in non-remote areas reported being sedentary (AHMAC 2011). This is an increase from 2001 and is one and a half times the rate for non-Indigenous Australians. Indigenous Australians are twice as likely as non-Indigenous Australians to smoke on a daily basis (ABS 2012b), and in 2008, 47% of Indigenous Australians aged 15 and over smoked. However, in proportional terms, this was a decline from 2002, when 51% smoked (AHMAC 2011). Indigenous Australians in remote areas have higher rates of smoking than in non-remote areas. The proportion of Indigenous children aged 0–14 years living in a household where people smoked inside declined from 29% in 2004–05 to 21% in 2008 (ABS 2012b). Social and economic disadvantage is linked with smoking, as levels of smoking increase with disadvantage. People living with disadvantage are more likely to experience social environments which normalise smoking (ANPHA 2013).

High levels of alcohol consumption among Indigenous Australians are associated with a range of poor social and health outcomes, and account for the largest burden of disease and injury for young men aged 15–34 and the second largest for young women (after intimate partner violence) (ABS 2012b). Data from the 2008 NATSISS also found that 20% of Indigenous Australians had used an illicit substance in the last 12 months. In regard to alcohol consumption, 46% of Indigenous Australians in 2008 reported drinking at low risk levels; 35% had abstained from drinking alcohol in the previous 12 months (AHMAC 2011); and 17% reported drinking at chronic/high risk levels. Data from 2004–05 identified that rates of chronic/high risk drinking are similar for both Indigenous and non-Indigenous Australians (ABS 2012b). It is worth noting, however, that alcohol consumption is a significant issue for Indigenous Australians in the Northern Territory, and contributes to the high levels of Indigenous disadvantage in this part of Australia. Indigenous Australians in the Northern Territory are more than twice as likely as non-Indigenous Territorians to have risky/high level drinking behaviours (AIHW 2011c). Rates of deaths attributable to alcohol occur at a rate 3.5 times higher in the Northern Territory than Australia as a whole. For non-Indigenous Territorians, the rate is double that of Australia, and for Indigenous Territorians, the rate is 9–10 times higher than the national rate (Skov et al. 2010). Brady (2004) has shown the clear links between the history of colonial dominance and the existence of alcohol abuse among Aboriginal people and this crucial social determinant needs to inform policy responses to alcohol use among Indigenous Australians.



Overall, these data suggest that Indigenous Australians' poorer health can be linked with health and lifestyle behaviours. Such behaviours are inextricably linked to the broader social, cultural and economic environment in which people live, and higher levels of behaviours detrimental to health can be understood as stemming from social and economic disadvantage. We consider that programs and interventions take a 'social determinants' approach to promoting positive health behaviours if they acknowledge the broader context of Indigenous Australians' lives, and also include actions to address broader social and economic determinants, rather than focusing solely on individual behaviour change. Below, we review some programs to address health behaviours which have taken a social determinants approach.

Programs to promote positive health behaviours

Anti-smoking programs: Maningrida Smoke-Busters

This pilot program was established in the remote Northern Territory community of Maningrida after high levels of smoking were identified by adult health checks. A program description and evaluation is reported by Burgess et al. (2008). The smoke-busters program aimed to: 'provide a supportive and culturally secure environment for families and individuals to develop the personal skills and motivation to stop smoking tobacco' (Burgess et al. 2008:8). The program took a community development approach and was based upon community control and ownership. It involved the establishment of a steering group of non-smoking Indigenous Elders; the appointment of a community-based public health officer and training a non-smoking community tobacco support worker; collaborative partnerships between community agencies selling tobacco products and education and health agencies; adapting mainstream anti-smoking messages to be acceptable for the local community; and monitoring local tobacco sales during the life of the program (Burgess et al. 2008). The program was guided by the steering group and a broader project reference group, which consisted of Indigenous representatives from different language groups, representatives of community organisations and youth representatives. The focus on community ownership and development, and the importance of a 'culturally secure' quitting environment highlight that this program incorporated a social determinants perspective.

Program activities involved the public health officer and tobacco support worker presenting to a range of local community organisations including schools, childcare, sports teams and remote homelands. The tobacco support worker provided direct support to people who wished to give up smoking. T-shirts were provided to local children to wear highlighting the importance of not smoking around children. Partnerships were developed with local agencies to promote smoke free public areas and workplaces, provide brief interventions to reduce smoking in routine health care, and to provide a smoking cessation service that accepted self or health centre referrals.

The program achieved significant outcomes. Local tobacco sales declined by 8% over the 6 month duration of the program. Community capacity was increased to: reduce smoking through the appointment of the public health officer and tobacco support worker, and to raise community awareness of the dangers of smoking, passive smoking, non-smokers' rights, and strategies to stop smoking. The program was evaluated through regular audits of tobacco outlets and monitoring of tobacco purchases, qualitative interviews, and feedback from participants after education sessions. Key contributors to success were identified as the role of community control, community ownership of the program and strategic community capacity building. Given the community development approach, the extent of community involvement and the ways in which cultural factors were taken into account in the design and running of the program, it can be viewed as taking a social determinants approach. Burgess and colleagues (2008) compare this to centralised, mainstream tobacco control programs administered in regional centres which they view as ineffective, particularly in small remote communities. Limited funding and accommodation for the public health officer meant the program did not continue, and Burgess et al. (2008) argue that if this program were funded in the future it would require more community-based tobacco support workers to adequately address the linguistic and cultural diversity of the local community.



Petrol sniffing prevention program: introduction of OPAL fuel

In 2006, a low aromatic fuel (OPAL, developed by BP) was introduced in the Northern Territory and Western Australia that has significantly lower levels of inhalants, and does not produce the 'high' when sniffed that is produced by traditional petrol. The aim of introducing OPAL to petrol stations is to reduce petrol sniffing. This initiative can be viewed as one which seeks to reduce harmful, risky health behaviours, particularly among Indigenous youth in remote communities. It is also an initiative to prevent offending and associated antisocial behaviour and in so doing, reduce Indigenous contact with the criminal justice system. Importantly, it does not seek to bring about such change by individual behaviour change, but rather by restricting supply of the harmful substance, which can be viewed as a higher level structural intervention. Furthermore, an evaluation of this program also had a focus on the availability of youth services, and as such, the focus was broader than individual behaviour change and emphasised the role of support services for young people to prevent sniffing (d'Abbs & Shaw 2008). The evaluation found that the prevalence of sniffing declined in 17 out of 20 sample communities in which OPAL had been introduced (d'Abbs & Shaw 2008). It concluded that decreased sniffing cannot be attributed to the introduction of OPAL alone, but many residents of sample communities believe it contributed significantly. Furthermore, the evaluators emphasise the role of access to youth services to support young people in engaging in alternative activities which promote wellbeing. They recommend that sites with no youth services have such services established (d'Abbs & Shaw 2008).

Aunty Jean's Good Health Team

This community capacity building program, delivered in the Illawarra, a region of New South Wales, was designed for Indigenous Australians with chronic and complex care needs. It aimed to develop a model of health promotion, education and self-management that could support good health behaviours (Illawarra Health 2004). It provided regular access to health care professionals and health support, and promoted health promoting activities such as regular physical activity and information about healthy eating. An evaluation identified the need for this program because Indigenous Australians with chronic conditions were not engaging with or utilising local mainstream health programs (Illawarra Health 2004). It involved 12 modules of one day a week in the local Aboriginal health centre, and a self-directed program of home activities over the same time period.

Program objectives included: improving self-management by Indigenous Australians with chronic and complex care needs (including heart disease, diabetes, stroke, kidney disease, arthritis and chronic airways disease); developing partnerships to promote Indigenous health; facilitating culturally appropriate information sharing, activity and self-management strategies; and creating an environment that is supportive of good health. The evaluation of this program identifies the success it achieved in meeting these objectives, and factors contributing towards this success included: the leadership and commitment of Indigenous Elders; the strength of the relationships within the community and between the community and health professionals; the commitment of specialists and allied health professionals to developing more culturally appropriate and effective health promotion strategies and behaviours; the program location in a safe community space; and the 'motivational power' of community aspirations to achieve better health (Illawarra Health 2004).



Summary 7: Health behaviours

Negative health outcomes among Indigenous Australians can be linked with health behaviours such as poor nutrition, low physical activity, smoking and consumption of alcohol. All of these behaviours are influenced by the broader social, cultural and economic environment in which Indigenous Australians live. In this section, we reviewed evaluated programs which acknowledged the significance of broader social and economic determinants, and did not have a focus solely on lifestyle interventions or individual behaviour change. Evaluation data suggest that these programs had success in promoting positive health behaviours such as decreased smoking, petrol sniffing and increased self-management of chronic conditions (including physical activity and healthy eating), although health outcomes were not established. Characteristics of these programs which contributed towards success included:

- a community development approach, and investing in community capacity building
- well trained, community-based staff, including Indigenous staff
- commitment of health professionals and other staff to develop culturally appropriate health promotion services
- collaborative partnerships between health agencies and others—for example, outlets selling tobacco products and petrol
- community ownership, including the leadership and involvement of Indigenous Elders
- restricting the supply of harmful substances
- taking into account the history of colonialism in responses to risky behaviours
- youth services to support young people to engage in alternative behaviours and activities
- utilising strong relationships within the community to build on strengths.

Conclusion

This paper has provided a brief overview of a number of evaluated initiatives which take action to address the social determinants of Indigenous health in order to improve Indigenous outcomes in the relevant determinant and ultimately, promote Indigenous wellbeing, health and improved quality of life. Based upon the evidence we have reviewed, we can conclude that there are certain qualities or 'good practice principles' which characterise successful programs and can lead to positive change. While acknowledging that the relationship between social determinants and health is complex and multi-directional, it is not possible to specify direct causal relationships. A social determinants approach recognises the social context of Indigenous Australians' lives and the impact of multiple and complex social, cultural, economic and personal issues on health and wellbeing. The evaluated programs reviewed in this paper do not provide direct evidence of associations with better health outcomes. However, we can assume that if a program contributes towards improving Indigenous Australians' outcomes in specific key determinants, that this in itself can improve wellbeing and quality of life which can contribute to improving health outcomes in the longer term. The conceptual model depicted on page 15 highlights the complex and multiple pathways by which social determinants impact upon the health and wellbeing of Indigenous Australians.



In a report produced by the Closing the Gap Clearinghouse (AIHW 2013) on the social and emotional wellbeing of Indigenous Australians, it was noted that 'programs are unlikely to be effective when: they are not culturally competent and do not have a high level of Indigenous ownership and community support; they operate in isolation from, or do not address the legacy of, past trauma, past and current racism and issues such as poverty and homelessness' (p. 2). This is supported by the initiatives we have reviewed in this paper. Broadly, as described at the outset of this paper, we have identified the following points as characteristics of success in programs and strategies to address key social and economic determinants of health for Indigenous Australians:

- holistic approaches which work with Indigenous Australians in ways which take into account the full cultural, social, emotional and economic context of their lives, including an awareness of the ongoing legacy of trauma, grief and loss associated with colonisation
- active involvement of Indigenous communities in every stage of program development and delivery, in order to build genuine, collaborative and sustainable partnerships with Indigenous Australians, and build capacity within Indigenous communities
- collaborative working relationships between government agencies and other relevant organisations in delivering services and programs, acknowledging the interrelatedness of key social and economic determinants across multiple life domains for Indigenous Australians
- valuing Indigenous knowledge and cultural beliefs and practices which are important for promoting positive cultural identity and social and emotional wellbeing for Indigenous Australians
- clear leadership and governance for programs, initiatives and interventions. This includes commitment from high level leadership of relevant organisations and agencies to the aims of reducing Indigenous disadvantage and addressing determinants of health and wellbeing
- employing Indigenous staff and involving them fully in program design, delivery and evaluation, and providing adequate training, where necessary, to build capacity of Indigenous staff
- developing committed, skilled staff (Indigenous and non-Indigenous) and providing diversity and cultural awareness training
- in cases where programs demonstrate success, it is important to provide adequate, sustainable resources for long-term, rather than short-term funding
- adopting a *strengths-based* perspective which builds and develops the existing strengths, skills and capacities of Indigenous Australians
- clear plans for research and evaluation to identify successful aspects of programs, provide a basis to amend and improve, demonstrate success, and build an evidence base to justify allocation of ongoing resources.

Some of the programs we have reviewed in this paper have been specific to Indigenous Australians, others are 'mainstream' programs which address the needs of Indigenous Australians as one part of their focus. The evidence reviewed in this paper suggests that where mainstream programs are designed to include Indigenous Australians, it is important that such programs are *flexible* and open to adaptation to be made culturally appropriate for Indigenous Australians. The good practice principles detailed above apply to both Indigenous-specific and mainstream programs. Evidence from evaluations of programs such as HIPPY and HOME advice indicates success where programs have been adaptable, and subject to consultation with local Indigenous communities. However, the evaluation of services provided by Job Services Australia (a mainstream organisation) to Indigenous job seekers suggests that not enough progress has been made in enabling Indigenous job seekers to feel comfortable using the service, by employing Indigenous staff and staff who have good relationships and networks with local Indigenous communities, for example.



Indigenous Australians are diverse in the contexts in which they live, their life experiences, values, beliefs, needs and requirements of health, social and community services. It is important that programs designed to address social determinants recognise this diversity. Key factors which differentiate among Indigenous Australians include whether they live in a remote, regional or urban setting, their gender and life course position. We have reviewed programs in this paper that have been focused towards both remote and urbanised populations, and some (such as HIPPY) have included both. But at each site a different approach has been taken depending upon the priorities identified by the local community. In programs which address family and community violence and some health programs (depending upon the health issue being addressed), it is important to focus on considering the needs of women and men separately. Other health programs address the needs of older Indigenous Australians. Many programs which aim to prevent offending and contact with the criminal justice system and promote positive health behaviours focus upon Indigenous youth, and the education programs we identified for this paper also focus upon the needs of Indigenous young people, in both early childhood and through the schooling years. Across all programs, a social determinants approach involves a holistic understanding of the full context of Indigenous Australians' lives, including cultural issues; grief and loss; social and emotional wellbeing; family and community dynamics; and economic situation. Programs which work across multiple life domains and acknowledge this complexity are more likely to be successful than a 'silo' approach which only takes a narrow approach to dealing with single issues without paying attention to the broader context.

In the process of searching for literature and reviewing programs to prepare this paper, we identified many programs and initiatives across all of the key determinant areas which had no publicly available evaluation data. We did not include such programs in this paper. This is a significant limitation in our knowledge of what works to address the social determinants of Indigenous health to reduce health inequities. The *types* of evaluation evidence we have reviewed in this paper have been mixed and vary according to the size and scale of the program and, we can speculate, the resources committed to evaluation. We consider that all the evaluated evidence (both qualitative and quantitative) we have reviewed in this paper is useful for contributing towards knowledge about addressing the social determinants of Indigenous health. However, it is important to note that very little 'high level' evaluation evidence exists as defined by the National Health and Medical Research Council; for example, randomised control trials or other research designs with an intervention and comparison 'control' group (Black 2007). In many circumstances, it is inappropriate, difficult and costly to design such evaluation research, however, where possible such research should be done, as it can contribute significantly to building an evidence base for what works. We also note that the Senate Community Affairs References Committee (2013) investigating Australia's response to the WHO's Commission on the Social Determinants of Health recommended the National Health and Medical Research Council give greater emphasis in its grant allocation priorities to research on public health and social determinants. We suggest this is particularly important regarding the full evaluation of initiatives addressing the social determinants of Indigenous health.

Given this lack of evaluation evidence, we conclude there is a lack of a comprehensive evidence base regarding successful strategies for taking action on the social determinants of Indigenous health. Programs need to have capacity and resources for evaluation included at the design stage, and an overarching cohesive evaluation framework with clear program logic. This is important, as Altman and Russell (2012) note, in regard to the NTER, high levels of monitoring and evaluation activity without an overarching evaluation framework to provide guidance can result in a 'fragmented and confused' approach.



Our review of the literature on what works to address the social determinants of Indigenous health reinforces that it is these determinants that are most powerful in influencing health outcomes and that the downstream behavioural risk factors largely reflect the power of the more upstream social determinants. The health of Indigenous Australians is affected by all the social determinants that affect the health of other Australians – including the quality of housing, level of income and education, opportunities for meaningful and productive work and rates of imprisonment. But we also identified a double burden whereby Indigenous Australians are disadvantaged in these shared social determinants but then also have to deal with specific social determinants including loss of culture and dispossession from land resulting from colonisation, racism and the impact of living in a society where Indigenous worldviews are undervalued. These latter factors reflect over two hundred years of colonial history yet still shape the lived experience of Indigenous Australians today. An effective response to the social determinants needs to deal with both sets of determinants to be effective in meeting the national target of closing the gap in life expectancy between Indigenous and non-Indigenous Australians over the coming decades.

Appendix 1

The Closing the Gap Clearinghouse Assessed collection includes summaries of research and evaluations that provide information on what works to overcome Indigenous disadvantage across the seven Council of Australian Governments building block topics.

Table A1 contains a list of selected research and evaluations that were the key pieces of evidence used in this issues paper. The major components are summarised in the Assessed collection.

To view the Assessed collection, visit <http://www.aihw.gov.au/closingthegap/collections/>.



Table A1: Assessed collection items for *What works? A review of actions addressing the social and economic determinants of Indigenous health*

Title	Year	Author(s)
Social capital	2003	Baum FE & Ziersch AM
Beyond Band-aids: Exploring the underlying social determinants of Aboriginal health	2007	Anderson I, Baum F & Bentley M
Evidence of effective interventions to improve the social and environmental factors impacting on health: Informing the development of Indigenous Community Agreements	2007	Black A
Social determinants of Indigenous health	2007	Carson B, Dunbar T, Chenhall R D & Bailie R
Interventions to halt child abuse in Aboriginal communities	2007	Ring IT & Wenitong M
Closing the gap in a generation: Health equity through action on the social determinants of health	2008	Commission on Social Determinants of Health
Health care access for Aboriginal and Torres Strait Islander people living in urban areas, and related research issues: A review of the literature	2008	Scrimgeour M & Scrimgeour D
Healthy country, healthy people: The relationship between Indigenous health status and "caring for country"	2009	Burgess CP, Johnston FH, Berry HL, McDonnell J, Yibarbuk D, Gunabarra C, Bailie RS
The overburden report: Contracting for Indigenous health services	2009	Dwyer J, O'Donnell K, Lavoie J, Marlina U & Sullivan P
Building on our strengths: A framework to reduce race-based discrimination and support diversity in Victoria	2009	Paradies YC, Chandrakumar L, Klocker N, Frere M, Webster K, Burrell M & McLean P
Health Impact Assessment of the Northern Territory Emergency Response	2010	Australian Indigenous Doctors' Association and Centre for Health Equity Training Research and Evaluation UNSW
Traditional culture and the wellbeing of Indigenous Australians: An analysis of the 2008 NATSISS	2011	Dockery AM
The health and welfare of Australia's Aboriginal and Torres Strait Islander people, an overview 2011	2011	AIHW
Racism: A major impediment to optimal Indigenous health and health care in Australia	2011	Awofeso N
Measures of Indigenous wellbeing and their determinants across the lifecourse: social capital and capabilities	2011	Biddle N
Responding to racism: Insights on how racism can damage health from an urban study of Australian Aboriginal people	2011	Ziersch AM, Gallaher G, Baum F & Bentley M
Life is health is life. Taking action to close the gap: Victorian Aboriginal evidence-based health promotion resource	2011	VicHealth
Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report	2012	AHMAC
The context of Indigenous Health	2013	Australian Indigenous Health InfoNet
Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people	2013	Closing the Gap Clearinghouse
Developing an exploratory framework linking Australian Aboriginal peoples' connection to country and concepts of wellbeing	2013	Kingsley J, Townsend M, Henderson-Wilson C & Bolam B



Table A2 contains a list of Closing the Gap Clearinghouse Issues papers and Resource sheets related to this issues paper.

To view the publications, visit <<http://www.aihw.gov.au/closingthegap/publications>>.

Table A2: Related Clearinghouse resource sheets and issues papers

Title	Year	Author
Engagement with Indigenous communities in key sectors	2013	Hunt J
Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people	2013	Closing the Gap Clearinghouse
Engaging Indigenous students through school-based health education	2012	McCuaig L & Nelson A
Healthy lifestyle programs for physical activity and nutrition	2012	Closing the Gap Clearinghouse
Anti-tobacco programs for Aboriginal and Torres Strait Islander people	2011	Ivers R
Reducing alcohol and other drug related harm	2010	Gray D & Wilkes E

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Terminology

Indigenous: 'Aboriginal and Torres Strait Islander' and 'Indigenous' are used interchangeably to refer to Australian Aboriginal and Torres Strait Islander people. The Closing the Gap Clearinghouse uses the term 'Indigenous Australians' to refer to Australia's first people.

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