Chapter 8

Social determinants of Australia's First Peoples' health: A multilevel empowerment perspective

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Topic covered

This chapter covers the following topics:

First Peoples' holistic health and wellbeing

Social and emotional wellbeing

The 'social' in social determinants from First Peoples' perspectives

Cultural, historical and political determinants of First Peoples' health

Structural determinants and racism

Multilevel empowerment and self-determination

Relationships, partnerships and accountability

The role of the reflective practitioner

Key terms

- Australia's First Peoples
- community engagement
- multilevel empowerment
- self-determination
- strengths-based approach
- socio-ecological model
- social support
- critical reflection

Key term definitions

Australia's First Peoples

Australia's First Peoples is the preferred term for referring to Aboriginal peoples. It is the collective term for the sovereign peoples of mainland Australia and Tasmania, as well as Torres Strait Islander peoples, the sovereign peoples of the islands between Cape York and Papua New Guinea. There are approximately 500 Aboriginal nations and 17 inhabited islands in the Torres Straits. The term 'Indigenous' can mean any person born in, or flora or fauna originating from a particular country, however is often used to refer to Aboriginal and Torres Strait Islander peoples. Many of Australia's First Peoples dislike the term Indigenous, and we use it here only in the international context.

Community engagement

The sustained process of creating meaningful relationships and developing empowering strategies with community members to participate in decision making, developmental actions and services that affect their lives, in order to create positive change. It includes the monitoring and evaluation of outcomes.

Critical reflection

The practice and process of developing awareness about oneself, examining experiences, ideologies, identity, social location, biases, motivations, contradictions and assumptions that might overtly or unconsciously influence one's behaviours, actions and ways of relating to and engaging with others. The purpose of critical reflection is to learn from and make meaning of one's position, to stimulate decision making and steps for self-improvement in personal and professional relationships with others, committed to the empowerment of others.

Multilevel empowerment

Empowerment is commonly understood as an enhanced sense of "control of destiny" with respect to forces that affect one's daily life (Syme 2004). Multilevel empowerment is the potential for and process of positive change at individual, family, community, services, system and environmental levels. Changes occur at these separate 'levels' and are interconnected and interactive.

Self-determination

Self-determination became a legal right for all peoples in 1960 (Mazel 2016, p. 327). Decades later the collective rights of Indigenous peoples to self-determination were articulated in Article 3 of the United Nations Declaration on the Rights of Indigenous Peoples, which stated 'Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and

freely pursue their economic, social and cultural development.' (United Nations 2008, p. 4).

Strengths-based approach

A commitment to actively identifying strengths of an individual, family, community and/or service, as well as assets and available resources, to build and invest in these, respecting and taking into account but choosing not to focus on or reinforce deficits, gaps, negatives or needs.

Social support

Social support is widely acknowledged as a determinant of health, and as having direct health-giving effects. It is the sense an individual has that their needs may be met with assistance and reinforcement from others, whether in practical, instrumental or emotional ways. There are many types of cultural and social influences on how needs and therefore assistance are defined, including who by, the timing of assistance and the evaluation of its effectiveness. Social support is a multilevel construct, required and experienced by individuals, families and communities, and involves the interplay between these domains.

Socio-ecological model

A perspective that respects the multiple interconnected relationships between a person and their social and environmental contexts. A socio-ecological model is often depicted as nested Venn diagram, onion rings or ripples in a pond. The centre depicts the individual, moving out to the 'microsystem' of family, peers, schools and community groups, extending to the 'exosystem' of social services and systems, to the 'macrosystem' of cultural, societal, economic, geographic and political factors. The socio-ecological model respects cumulative influences over the lifespan, as the underlying 'chronosystem' (Bronfenbrenner 1977; Santrock 2007).

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Introduction

We acknowledge the Traditional Owners on whose Lands, Waters and Skies the writing of this chapter took place, and we pay respects to Ancestors and Spirits of Nungeen-tya Mother Earth (In the language of the Wiradjuri peoples, from who authors Jackson Pulver and Williams are descended). We think of future generations and those who came before us; it is upon their shoulders we stand today.

There is no doubt that the work by Wilkinson and Marmot in the late 1990s drew attention to the role of social determinants in explaining inequities in life experience occurring between different groups of people (Wilkinson & Marmot 1998). These social determinants include: 1. The social gradient; 2. stress; 3. early life; 4. social exclusion; 5. work; 6. unemployment; 7. social support; 8. addiction; 9. food; and 10. Transport (**see also Chapters 1 & 2 in this volume**). This has had a profound influence on western notions of health and health promotion, and is the basis of much progressive health policy.

However, we argue that contemporary western understandings of social determinants of health need to be expanded and extended to more fully reflect the experiences of Aboriginal and Torres Strait Islander people, Australia's First Peoples. Australia's First Peoples are leading world citizens in the struggle for health equity and justice. They are leaders in culturally responsive, safe and respectful social support services, social and emotional well-being promotion and comprehensive primary health care practice. Even despite their wisdom and innovation, these services and practices are severely constrained by external, socially determined factors. Assumptions are too often made when applying a western framework to non-western cultures. We must question 'Who is the social in social determinants?' and 'What is the contemporary compared to the historical, social context?' Importantly, these questions must be asked from First Peoples' perspectives.

This chapter will explore three different yet interrelated sets of factors implicated in the health and well-being of Australia's First Peoples: cultural, historical, and structural determinants. We explore First Peoples' experience of determinants, and present examples of strengths-based, community-led services, programs and research. We then extend our understanding of determinants using a socio-ecological model of health that incorporates multilevel empowerment, with a particular focus on social support and the centrality of the value of relatedness. This provides a scaffold for our discussion about how all health and social care providers can develop confidence engaging with and providing support to First Peoples' families and communities, and be a good partner within and through their practice.

Laying claim to a future that embraces health for us all

> Australians are truly one of the world's great human populations and a very ancient one at that, with deep connections to the Australian continent and broader Asian region. About this now there can be no dispute (Curnoe, cited by Australian Geographic Staff & Australian Associated Press 2011; cf Rasmussen et al. 2011, pp. 96-98)

Evolving out of more than 65,000 years of intergenerational sharing of knowledges and practice, and a profound sense of belonging to this land, the First Peoples of Australia are the world's oldest, continuing cultures. The definition of health that First Peoples now share has social and emotional well-being and their determinants intertwined, being:

> **"Aboriginal health"** means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their Community. It is a whole of life view and includes the cyclical concept of life-death-life. (National Aboriginal Community Controlled Health Organisation (NACCHO) 2011, pp. 5-6; emphasis in original; cf National Aboriginal Health Strategy Working Party (NAHSWP) 1989, p. ix)

This understanding of health, in which the well-being of the individual is inextricably linked to that of the community, society and environment, and vice versa, is the basis of the comprehensive primary health care model that emerged early in the 1970s, led and still used today by Aboriginal Community Controlled Health Services (ACCHSs) (Grant, Wronski, Murray & Couzos 2008). This model preceded (Mazel 2016) yet has similarities with the Declaration of Alma-Ata (International Conference on Primary Health Care 1978) and Ottawa Charter (World Health Organization 1986), although those documents were developed largely from a western perspective and without the strategic inclusion of Indigenous peoples (McPhail-Bell, Fredericks & Brough 2013). Our conscious use of the Aboriginal definition of health acknowledges the pre-eminence of its relational model as cultural, as well as the importance of working to decolonise mainstream models by centring Aboriginal ways of being, doing and knowing (Smylie, Anderson, Ratima, Crengle & Anderson 2006; Mazel 2016), minimising the ongoing influence of colonisation and westernisation (Vickery, Faulkhead, Adams & Clarke 2004). The effect over time, 'to establish more equitable Indigenous – non-Indigenous relationships based on principles of **self-determination**, empowerment and coexistence' (Mazel 2016, pp. 325-326).

Self-determination definition is located here

For Australia's First Peoples to experience their holistic conceptualisation of health, several challenges must be addressed. These largely relate to 'the 97%'—the general Australian population who control, because of their overwhelming majority in numbers and as voting citizens (Mohamed & Sweet 2017), how governments plan for and respond to First Peoples, as well as how First Peoples are conceptualised and

treated, and the extent to which human rights abuses are allowed to occur. That is, Australia's First Peoples are a minority population, being 3% of all Australians, without formal political power through collective representation, and almost half not of voting age. Poor determinants of health have been, and continue to be, reinforced by the choices and ubiquity of the dominant Anglo cultures that have shaped contemporary Australia since invasion and colonisation by British forces.

Fuelled by imperialistic notions of racial supremacy and destiny, British colonisers were quick to judge Aboriginal people as uncivilised (Reynolds 1999) and closer to apes than humans (Wilkins 2009), and to deny citizenship rights (Chesterman & Galligan 1997). These assumptions persist in various forms today, with an 'historical emotionality … strongly tied to meanings of the past still existent within Australian society … [reinforcing] assimilative intent and subjugations' (Arbon 2008, p. 145). These politically and socially position First Peoples at the lowest rung on Australia's social ladder (Tripcony 2000; Danalis 2009). They also place all Australians as witness to and complicit in poor social determinants of health experienced by First Peoples, including social inequality and institutional and interpersonal racism. Contemporary Australia is a place of great wealth yet profound disparities exist. Opportunity is not equally shared and many First Peoples experience health and social lives similar to people in developing countries.

Further we agree with Arabana scholar, Veronica Arbon (2008 p. 145), that many in the wider Australian population also feel disempowered:

> All, including the invaded, are now expected to struggle to find their individual place along this road even if they are to be forced to transform, to exist within this created philosophical, scientific and ideological pathway. Individuality, subjugation and development for economic gains are all existent and central here.

The individuality and economic gains that Australians have benefited from come at great cost to First Peoples' families and communities. The forced removal of First Peoples from their homelands by colonisers, exacerbated then and now by social policies and economic development strategies that set in place a set of unequal power relations, perpetuate disadvantage among First Peoples. The dominant power of Anglo culture is now institutionalised through imported forms of governance, education systems and the narrative about the character of Australia and her citizens.

British colonisers have been described as unimaginative in their failure to recognise First Peoples as having highly developed legal, health, science, kinship, agriculture and land care systems (Pascoe 2014). The original and continued subjugation of First Peoples' knowledges from colonisation to now (Arbon 2008) is seen in persistent disregard for models of holistic health and social and environmental practices that First Peoples offer, based on their cultural ways of knowing, being and doing. These ways could enrich the lives of many. We are fortunate today that out-of-date methods of disempowerment are being circumvented and over-written by examples of positive

and progressive strategies with the potential to stabilise negative trajectories and promote First Peoples' health and well-being.

It is with a spirit of humility and respect for the strengths of First Peoples that we write this chapter, moving away from merely describing the problems, deficits, risks and gaps, and governments' imposed and ill-thought-out 'solutions' to health inequity. It is with utmost regard that we engage with First Peoples' ways of knowing, being and doing, including the intergenerational, relational and place-based values central to the Aboriginal definition of health. These have inherent value for everyone.

The shape of Australia: The *social* in social determinants

Australia is, according to the Australian Government, 'one of the most ethnically diverse societies in the world' (Australian Government, 2018, para 1). Of the estimated population of almost 25 million Australians (Australian Bureau of Statistics (ABS), 2018) 28% were born overseas, with 5.1% born in the United Kingdom (UK), followed by New Zealand (2.6%), China (2.0%), India (1.8%) and the Philippines and Vietnam (both 1.0%) (Australian Bureau of Statistics (ABS) 2017a). This is a profoundly different society to that of 1901, when Australia became a federation of states and territories. The population census then counted 3,773,801 people, with 18% born in the UK (ABS 2006). The vast majority of citizens were Caucasian and Christian immigrants or descendants of immigrants from Britain, Ireland, and central Europe. Chinese people made up the third largest immigrant group (Department of Immigration and Border Protection (DIBP) 2017, p. 4), and Australia's First Peoples were not reported in the counts (Madden & Jackson Pulver 2009). Soon after federation, the Australian parliament legislated to prevent further Chinese people and labourers from the Pacific Islands arriving, in what would become known as the 'White Australia Policy' (DIBP 2017).

By 1950, Australia had welcomed over a million additional post-war immigrants, particularly from central and western Europe. By 1961, nine per cent of the 10.5 million Australians were from countries other than Britain, predominantly Italy, Germany, Netherlands, Greece and Poland (DIBP 2017, p. 36). Many brought cultural practices from their own homelands, including Indigenous peoples' cultures and practices. Further changes in migration policies that welcomed people from all over the world have now created a potent, multidimensional 'intercultural space' (Yunkaporta & McGinty 2009). If nurtured, this rich mixing of cultures and insights could provide a dynamic position from which solutions to the exclusion and disadvantage of Australia's First Peoples could be realised, particularly if led by younger Australians growing up among multiple cultures, and their unique intergenerational weaving together of historical narratives and values systems.

Australia's First Peoples on average are young, too. There are 500-plus clans with an estimated 649,171 people, making up approximately 3% of the Australian population

(ABS 2017b), of whom one in three are under the age of 25. A third (34%) are under 15 (2017b), and there is a fertility rate that remains higher than that of the whole Australian community (ABS 2017c). There is an opportunity for major social change by developing the strengths of young people early, preventing ill health before it begins, and investing in supports to maintain well-being and its determinants.

The reality more broadly, however, is that Australia has an ageing population, with its average age being 37.2, and its birth rate declining (ABS 2017d). Very different health and social policies are required to serve this majority, ageing population, rather than the young population of First Peoples. It is this demographic profile of Australians overall, the 97%, and its overwhelming dominance that very much shapes the 'social' in social determinants of health, including of First Peoples. That is, current social policies, health systems and societal expectations are geared towards the mainstream Australian population's needs, needs that are at times very different to the needs of the country's First Peoples.

There is also the well-publicised worsening in well-being and determinants of health for many First Peoples (Markham & Biddle 2018; Seccombe 2018). Efforts over the past decade at 'closing the gap' in health inequality are 'not on track' (Department of Prime Minister & Cabinet 2018, p. 9). Targeted strategies self-determined by First Peoples have not been invested in; and government directives for First Peoples' access to mainstream services have not worked, nor have these been given ample time or resources to work.

Now on almost every indicator of health and well-being Australia's First Peoples fare worse than other Australians. The overall burden of disease is 2.3 times greater (Australian Institute of Health and Welfare (AIHW) 2016), and First Peoples born between 2010-2012 can expect to live approximately 10-11 years less than other Australians (AIHW 2018, p. 29).

This 'gap' has often been blamed on First Peoples with assertions made they are genetically predisposed, negligent or apathetic (Saggers & Gray 1991, p. 6). There has been a continuing focus on 'deficits' in the planning and delivery of services; that positions First Peoples as 'too sick' and 'the problem' rather than as having solutions to invest in (Anderson 1988, pp. 134-139; Fogarty, Bulloch, McDonnell & Davis 2018). Despite better education among the millennial generation and abundant contemporary evidence to the contrary, these are prevailing beliefs that remain privileged in the mainstream health and policy environment.

Social determinants: Expanding to understand First Peoples' views

A holistic, multilevel view

Peter Moodie was among the first researchers of the health gap between First Peoples and other Australians. He aimed to set a baseline from which to observe future progress (Moodie 1973, p. 2), and rejected common theories behind the gap. He questioned the assumption that Aboriginal people 'have—or should have—the same "health values" as white Australians' (Moodie 1973, p. 18). Moodie took what is akin to a social-ecological approach to health, identifying five categories of factors determining Aboriginal health status: demographics, environment, diet, economy and contact with health and medical services (Saggers & Gray 1991, p. 6). Moodie was clear that Aboriginal health status was not due to failings of Aboriginal people in these five categories, and located causes of ill-health in socioeconomic factors. He called for strategies that solved economic and social problems in concert with medical improvements, and pointed out that participation by Aboriginal people was 'essential to any efforts to improve their health status' (1973, p. 8).

Almost 50 years later, First Peoples and their allies continue to advocate for change, including for a paradigm shift to understand and address the particular social determinants of First Peoples' health. This means especially highlighting the impact of past and current processes and effects of colonisation and racism, and the importance of a human rights framework, strengths-based approaches and cultural understandings of health (Fisher, Battams, McDermott, Baum & Macdougall 2018).

These more nuanced social determinants are best understood as 'multiple, interconnected [factors that] develop and act across the lifecourse from conception to late life' (Zubrick et al. 2014, p. 93). Importantly these factors may differ between population groups, given the diversity of Aboriginal and Torres Strait Islander communities across Australia (Moodie 1973, p. 22; Carson, Dunbar, Chenhall & Bailie 2007).

The diversity of Australia's First Peoples

How different are determinants from First Peoples' perspectives from those described by Wilkinson and Marmot? Let's consider the value of work as an organising principle, which features in the famous Whitehall Studies renowned for demonstrating the impact on wellbeing of power and control (Marmot et al. 1991). How relevant work status is, across different First Peoples' communities, was questioned by Palawa academic Ian Anderson (2007, p. 26). Anderson noted that one's sense of purpose is constituted by a variety of roles, only one of which is work.

What if we were to consider culture instead of work? For example, in remote areas of Australia, positive impacts on social emotional well-being have been shown to accrue from a strong cultural identity (Dockery 2011, p. 14). Aboriginal people living in remote areas have higher self-rated sense of social and emotional well-being than Aboriginal people in urban areas, despite often having extremely limited health care access, relatively high unemployment and poorer living conditions (ABS 2011). For

those whose cultural identity is less strong or experience the cultural dissonance of 'living between two worlds', there is the potential for higher levels of psychological stress and anxiety, possibly associated with a sense of doubt over the persistence or survival of valued aspects of one's culture, or a person asking themselves 'what their role would be should their connection with that culture be severed' (Dockery, 2011, pp. 13-14).

More favourable socio-economic outcomes have been shown among those with stronger attachment to or engagement with their traditional culture, with higher educational attainment and probability of being employed associated with stronger cultural identity (Dockery 2011, p. 10). Further, the responsibilities and obligations held between some Aboriginal families can mean that family members are required to relocate in order to fulfil intergenerational caring roles, maintain connections and obligations to family, and also access seasonal work, health care and educational opportunities (Memmott, Long, & Thomson 2006). Burbank (2011, p. 136), in her study of stress, conveys the tensions experienced by her participants when their relationships, needs and emotions 'about getting on with life' in the intercultural setting of Numbulwar in the Northern Territory were at odds with the different value hierarchies of westerners who live there. Anderson (2007, p. 26) writes:

> In this light, it is not unreasonable to hypothesise that Indigenous extended families continue to have a relatively more significant influence on Indigenous sociality (compared with the social world of work) as people continue to negotiate social relationships within a system of reciprocity.

Anderson is referring to values inherent in the holistic worldview suggested by the Aboriginal definition of health and well-being. These values of relatedness and locatedness (Arbon 2008) are shared by Indigenous peoples around the world. For Australia's First Peoples, identity is fundamentally tied to Country and the obligations within the web of relationships associated with that connection to Country. One's fulfilment of these obligations is through reciprocity. This is the purpose to which Anderson alludes. As Arbon (2008, p. 34) reflects, 'becoming who you are is accomplished by knowing your reciprocal relationships'. This is the same whether living on Country or for the many people living in the city, away from Country and kin, 'strong cultural determinants of health can still be enabled and maintained through languages, relationships, customs and community networks' (Department of Health, 2017, p. 7). However, embedding these values into mainstream health systems is the challenge with which 'the social' is currently grappling.

A particular area of difficulty is achieving the human rights principle of effective participation (**see also Chapter 6**). We often hear about this in terms of **community engagement** and the struggle by Aboriginal and Torres Strait Islander peak organisations in having their voices heard (Thorpe, Arabena, Sullivan, Silburn & Rowley 2016).

Community engagement definition is located here

It is of 'deep concern' that 'Federal Government policies continue to be made for and to, rather than with, Aboriginal and Torres Strait Islander people', and opportunities for reform, reconciliation and renewal are ignored (National Congress of Australia's First Peoples 2016, p. 2).

The following case study highlights strong engagement and leadership by First Peoples, and their community and cultural strengths, in the urban community of Inala, in the city of Brisbane, Queensland. 'Strong in the City' was among the first Aboriginal and Torres Strait Islander health promotion projects to document a **strengths-based** health promotion framework, which ensured that community members were adequately involved in decisions that affected their well-being (Vignette 1), helping inform the successful development of a government health service (Vignette 2).

Strengths-based definition is located here

Case study 8.1: An urban Aboriginal community showcasing its strengths

Vignette 1: *Strong in the City*

The aim of Inala's *Strong in the City* was to identify participating community strengths through the eyes of community members themselves. Using participatory action research led by First Peoples, five key strengths identified were (Brough, Bond & Hunt 2004, p. 217-218):

- Strength 1: Extended family
- Strength 2: Commitment to community
- Strength 3: Neighbourhood networks
- Strength 4: Community organisations
- Strength 5: Community events.

Then, in order to establish and provide a basis for supporting community-initiated ideas and problem-solving strategies, the *Strong in the City* team developed working partnerships with a range of Aboriginal and Torres Strait Islander agencies. More than 50 ideas and strategies were put forward over a period of two years, and they were considered on the basis of how they engaged with the five strength themes (p. 218).

The *Strong in the City* collaboration identified the important enabling resources as:

- professional support and development
- networking resources
- management support
- specialist support

- financial support (pp. 218-219).

The research identified that rather than 'a passive community "waiting" for top-down public health interventions', it found 'a community already working hard towards health improvement goals' (p. 219). Nevertheless, people were usually working within limited resources, and in unsupported roles. These constraints were not only financial but in the 'connections and commitments made by mainstream structures to support the efforts of Indigenous communities to create their own mix of strategies and solutions' (p. 219).

Vignette 2: Connectedness and cultural richness

Also in Inala, local non-Indigenous general practitioner Dr Geoff Spurling's research found that the Aboriginal and Torres Strait Islander community had a keen awareness of and sought active engagement in breaking the cycle of 'complex, interrelated, intergenerational' social, cultural and environmental determinants of health such as 'poverty, racism, housing, mental health, grief, loss, education, and employment' (2017, p. 102).

Spurling's interviewees described how they were able to negotiate the social, cultural and environmental challenges of their youth with the support of parents, family members and positive peer groups. The local community-based health service was also seen as a trusted part of participants' lives. Overwhelmingly, its collective strength 'owing to its connectedness and cultural richness' sustained the Inala community (Spurling 2017, p. 110).

In a presentation to the Research Translation Conference co-hosted by Australia's National Health and Medical Research Council and the Lowitja Institute (2017), Spurling acknowledged how hard it is for practitioners trained in western models of health care, research and support to transform their practices to be able to support the design and delivery of First Peoples' collective, family and community-based models of healthcare. He highlights the need for non-Indigenous people to be honest about what they do not know, to commit to developing relationships with First Peoples, to be a resource rather than lead, and also to commit to ongoing learning about First Peoples' historical and contemporary experiences, needs and aspirations (McInerney 2017).

Cultural determinants of health

First Peoples' cultural determinants connect sense of identity with purpose and practices. The My Life My Lead report (Department of Health 2017, p. 7) states that cultural determinants:

> encompass the cultural factors that promote resilience, foster a sense of identity and support good mental and physical health and wellbeing for individuals, families and communities … [They] are enabled, supported and

> protected through traditional cultural practice, kinship, connection to land and Country, art, song and ceremony, dance, healing, spirituality, empowerment, ancestry, belonging and self-determination.

Cultural determinants also connect individuals to their environment:

> Cultural determinants originate from and promote a strength-based perspective, acknowledging that stronger connections to culture and Country build stronger individual and collective identities, a sense of self-esteem, resilience and improved outcomes across the other determinants of health including education, economic stability and community safety (Brown, cited in Department of Health 2017, p. 7).

Further to the connection between the individual and environment, cultural determinants reinforce a way of being, knowing and doing:

> The accepted and traditionally patterned ways of behaving and a set of common understandings shared by members of a group or community. Includes land, language, ways of living and working artistic expression, relationships and identity (Australian Museum 2017).

These perspectives on culture and cultural determinants and their relationship to health and well-being must be contrasted with behaviours that are manifestations of poor health, intergenerational trauma, social marginalisation and poverty. Trans- and inter-generational trauma and poverty have accumulated among Australia's First Peoples as a result of decades of systematic oppression and disempowerment.

My Life My Lead affirms overwhelmingly that for First Peoples:

> … strong connections to culture and family are vital for good health and wellbeing … The best results are achieved through genuine partnerships with communities … The impacts of trauma on poor health outcomes cannot be ignored … [and that] systemic racism and a lack of cultural capability, cultural safety and cultural security remain barriers to health system access. (Department of Health 2017, pp. 7-8)

These points highlight determinants that have a particular influence on the lives of First Peoples—including historical factors, policy and related structural issues. These are explored further below (see also Culture as a social determinant of health in Chapter 4).

Historical and political determinants of First Peoples' health

Prior to colonisation, people 'were able to determine their "very-being", the nature of which ensured their psychological fulfilment and incorporated the cultural, social and

spiritual sense. (NAHSWP 1989, p. ix). This was permanently disrupted by British colonial forces in 1788 and the subsequent resistance and warfare (Gapps 2018), which spread throughout Australia and continued well into the 20th century (cf Stanner 1969; Jackson Pulver 2003). The trauma of 1788 and colonisation did not disappear—the late Australian ethnographer and anthropologist, Patrick Wolfe (2006) has argued that invasion is a structure and not merely an event, and the same can be said for settler colonisation.

The roots of colonial society were steeped in disrespect borne of the invaders' sense of entitlement and desire to profit, which rested on the settler-colonial 'logic of elimination' (Wolfe 2006). This is 'premised on the securing—the obtaining and the maintaining—of territory. This logic certainly requires the elimination of the owners of that territory, but not in any particular way' (2006, p. 402). It includes disempowering First Peoples through oppressive government regulation, disparaging their cultures, social exclusion, not bringing to account perpetrators of frontier violence and Stolen Generations. Wolfe (2006, p. 403) describes their collective impact as 'structural genocide', which continues into the present.

It was the creation of a 'free market' that was paramount (Havemann 2001). In this new economy, Aboriginal families actively participated despite the disruption. They worked as shepherds, labourers and farmers, while at the same time maintaining fundamentals of their social behaviours and belief (Elkin 1951). Massacres, introduced diseases and the introduction and abuse of alcohol contributed to high death rates and lower birth rates (Jackson Pulver 2003). As early as the 1860s commentators were expecting Aboriginal people to become extinct (Reynolds 2001).

Segregationist government policies of the 1890-1950s rounded up Aboriginal people and forced them to live on small government reserves of land and church missions. Here biological and social factors were set in motion that profoundly influence health today, including oppression and disempowerment, profound grief and loss, the premature death of loved ones, sedentary and institutionalised lifestyles, malnourishment and trauma (Saggers & Gray 1991; Jackson Pulver 2003).

The assimilationist policy era of the 1950s-1960s reinforced the devaluing of First Peoples' cultures and humanity by the settler state. Wolfe (2006, p. 402) argues that:

> … depending on the historical conjuncture, assimilation can be a more effective mode of elimination that conventional forms of killing, since it does not involve such a disruptive affront to the rule of law that is ideologically central to the cohesion of society.

The high rates of government-enforced child removals that characterised this period and were enforced by policy and practice into the 1970s resulted in multiple 'Stolen Generations'. It is suggested that no Aboriginal family has been unaffected by the forcible removal of children. Trauma, grief and loss arising from these policies

impacts communities today (Human Rights and Equal Opportunity Commission 1997).

While the overarching intent was assimilation, restrictions remained, for example, on access to social security until 1966. A successful referendum in 1967 meant the Commonwealth could make laws for Aboriginal people and include them when enumerating the Australian population (Madden & Jackson Pulver 2009). The new short-lived policy era of integration (1967-1972) lifted hope, but threw up other challenges arising from Australia's federated political system. Aboriginal people led a growing civil rights movement that advocated for land rights, self-determination and for an end to racism, particularly in the health system, yet little attention was paid to the poor health and social conditions produced by generations of oppression (Eckermann et al. 2010).

Community frustration with inaction by the Commonwealth lead to the development of Aboriginal community-controlled housing, legal and health services, such as the Redfern Aboriginal Medical Service in 1971. Community controlled health organisations were organised locally, regionally and nationally as a response to racism and exclusion within the mainstream health system (NAHSWP 1989; Foley 1991; Mazel 2016). They embodied a social health model that also sought to address factors such as cultural connections and access to housing (NAHSWP 1989; Gillor 2012).

However, with the dismissal of the Whitlam Labor government, a short-lived policy period of self-determination (1972-1975) was wound back to a more conservative policy of self-management (Sullivan 2011). Nevertheless, this phase ushered in a period (1989-2005) of political participation through the Aboriginal and Torres Strait Islander Commission, a statutory authority that was directly elected by First Peoples, important because it not only recognised First Peoples' unique place in 'the Australian social and political system … it also legitimized an approach that acknowledged difference on the basis of equality' (Mazel 2016, p. 341-342). Self-management lasted into the 1990s and was overlapped by a formal decade of attempts at reconciliation (1991-2000) (Australians for Native Title and Reconciliation 2010). The current policy period of normalisation is marked by a shift toward mainstreaming, and interventions designed to enforce western cultural norms (Sullivan 2011). The logic of elimination of First Peoples continues in the fact that the property right of native title has rarely been experienced by Australia's First Peoples; their rights to land presumed to have been swept aside by the tide of history (Olney, cited in Wolfe 2006, p. 393). Top down, disempowering policies derived from the 2007 Northern Territory Emergency Response have resulted in deepening poverty, particularly in very remote communities (Altman 2017; Markham & Biddle 2018); over policing; 50% of pensions and other welfare payments being quarantined, and only able to be spent in government-prescribed ways; forced participation in work for the dole schemes; and the perpetuation of stigma (National Congress of Australia's First Peoples 2018).

It is important to note here that all these policies towards First Peoples are produced by people and thus are socially produced. Hence, whether historical, political or structural, they are social determinants.

Structural determinants of health: 'Institutional racism'

As well as at times being in conflict with each other (Sanders 2013), the overwhelming influence of the policies described above has been the manifestation of forms of institutional racism that, for example, restricts First Peoples from 'receiving better healthcare outcomes, securing long-term employment or gaining meaningful and appropriate education' (Holland 2018, p. 12). Effectively, such inequality of opportunity breaches human rights principles, and the Australian government is obligated to quantify and remedy such inequalities progressively over a reasonable period of time (**see also Chapter 6 for more information about human rights and social justice**).

The wide range of material discussed earlier particularly demonstrates deeply entrenched 'othering' of Australia's First Peoples as separate to the general population (Smith 2012; Quayle, Sonn & van den Eynde 2016). One of the most important questions to ask here is 'What is the link between First Peoples not achieving their self-determined strategies to improve social determinants of health, and racism?'

Firstly, racism occurs at the levels of 'interpersonal racism, internalised racism and systemic or institutional racism', all of which are interrelated (Kelaher, Ferdinand & Paradies 2014, p. 44).

At the interpersonal level, First Peoples report they frequently experience racism in health care, education, employment and the criminal justice system (Australian Human Rights Commission 2015). This exposure to racism is associated with psychological distress, depression, poor quality of life, and substance misuse, all of which contribute significantly to the overall ill-health experienced by Aboriginal and Torres Strait Islander people. Prolonged experience of stress can also have physical health effects, such as on the immune, endocrine and cardiovascular systems. (Anderson 2013, p. 7)

Stop and think

- Have you experienced racism? Why or why not?
- Have you experienced stigma? Why or why not?
- How have you been disempowered by institutions?

Think about the different ways racism might impact on your willingness to access health and other welfare services.

Poor health, depression, disempowerment and victimhood are visible manifestations of internalised racism and oppression (Fanon 1967; Paradies 2007) that in turn disempowers communities to exert their own local norms and caregiving mechanisms (Gooda 2014). This is made even more complicated when First Peoples are blamed for their situation and discourses of fairness and human rights struggle to find traction or be addressed (Australian Human Rights Commission 2015). Jiman-Bundjalung scholar, Judy Atkinson (2002), has shown how the impact of such trauma is cumulative and compounding and has impacts across the life course. First Peoples are not alone here. For example, the breakdown of Canadian Aboriginal families and loss of traditions, custom and culture has had a cumulative effect on future generations of residential school survivors, with many turning to 'alcohol and other drugs … as a means to cope with the complex effects of poverty, despair, discrimination, loss of language and traditional territories and the erosion of culture' (Craib et al., cited in Treloar et al. 2016, p. 19-20).

Such manifestations of trauma in turn fuel inappropriate assumptions and lack of empathy for First Peoples, which become 'embedded' into health and social care, policy and planning mechanisms and governance systems (Anderson 2013, p. 7).

Historically, there have been poor strategies to engage First Peoples in government policy and programming, and lack of trust to allow First Peoples' solutions to flourish. Quayle et al. (2016) discuss a perceived social distance that is perpetuated between First Peoples and the broader population. Paradoxically, while there is an absence or disregard for First Peoples' interests in so many spheres of influence, at the same time they are hypervisible, either as Australia's cultural icons, or as social problems perpetuated through racial profiling in mainstream media (Quayle et al. 2016, p. 81; see also Paradies 2007; Sweet et al. 2017). Stereotypes abound, intensifying the lack of trust felt between both groups and First Peoples quickly become disenchanted with the consultation and program planning process. Lack of good processes around participation contribute to service inaccessibility, to the extent that First Peoples:

> … may be reluctant to seek much-needed health, housing, welfare or other services from providers whom they perceive to be unwelcoming or who they feel may hold negative stereotypes about them (Anderson, 2013, p. 7).

Stop and think

- Describe Aboriginal and Torres Strait Islander peoples, Australia's First Peoples, in your own words (even things you would not tell other people).
- What is your experience engaging with Aboriginal and Torres Strait Islander peoples?
- How did you learn about Aboriginal and Torres Strait Islander peoples?
- What of this information did you seek out for yourself?

While it is one step to identify racism at individual and interpersonal levels, many Australians find it difficult to identify structural racism, let alone identify strategies to dismantle it (Dwyer, O'Donnell, Willis & Kelly 2016; Soutphommasane 2017). Alyawarre Elder Pat Anderson AO (Anderson, 2013, p. 7) understands this is not necessarily the result of individual ill-will by health practitioners, for example, but a reflection of how systems for health care are designed and implemented.

We see three implications for care providers arising from this dynamic:

> (1) The dominance of the western biomedical paradigm and its neoliberal emphasis on the individual limits holistic care that could ameliorate the impact of negative determinants (Baum, Laris, Fisher, Newman & MacDougall 2013), for example, through family-centred care and by strengthening First Peoples' cultures.
>
> (2) Social inequality reinforces inequality in the relationships between the professional support providers and service users (Sheaff 2005) that are so essential to breaking the trauma cycle.
>
> (3) We are 'unlikely to accommodate the provision of programs designed to assist Aboriginal groups pass on their culture to the next generation' (Spurling 2017, p. 180).

These statements highlight how institutional and interpersonal racism are linked. In practical terms, assumptions influence the design of whole programs of health interventions, as well as decisions about resource allocation, staffing, delivery and evaluation. They are made based on the worldview, power and values of the 97% of Australians who are not First Peoples, and thus rarely reflect First Peoples' perspectives and practices, and are rarely self-determined by ACCHSs (Blignault & Williams 2017).

This is despite Australia becoming party to the United Nations Declaration of the Rights of Indigenous Peoples, which recognises self-determination as a special and collective right of First Peoples (Mazel 2016). First Peoples have remained vulnerable, highly politicised and without collective representation in governments. A recent example of the denial of this right is the Australian Government's rejection of

First Peoples' recommendations for future directions outlined in the Uluru Statement from the Heart (First Nations National Constitutional Convention 2017).

Once again this places us at the interface between social and structural determinants. It is 'political will' that shapes determination to reform entrenched structural barriers to creating change (Mazel 2016). More often however, development and assimilative intentions take precedence over First Peoples' aspirations, contributing to a 'status quo that is not of an Indigenous definition' (Arbon 2008, p. 86).

The powerful forces of oppression and history cannot be overlooked (Fanon 1967), including the 'depth at which colonialism can submerse itself in a society' (Hilton 2011, p. 51), whether this is intentional, hidden or unintentional. Lasting change at interpersonal and structural levels and relatively peaceful coexistence between First Peoples and the new arrivals will ideally come about by recasting relationships through a peace-building process (Fitzpatrick 2003). Strategies for this will include the ongoing promotion of anti-racist values and beliefs with government leadership (Paradies 2007), a national truth telling process, a voice in the Australian parliament, and treaty frameworks (National Congress of Australia's First Peoples 2016; First Nations National Constitutional Convention 2017). Also vital is workforce development and strategies to enable parity in workforce participation by First Peoples (Department of Health 2015; Australian Indigenous Doctors' Association 2016).

While these important proposals are being discussed and nationally debated, excellent exemplars of leadership based on the experiences of health and social care professionals, themselves grappling with their own position, privilege, confusion, and strategies for inspiring change in others, suggest a shift in the 'social' is happening.

Multilevel empowerment

The importance of relationships and collective healing for all

There is an axiom however, that there can be no self-determination without healing. Healing for First Peoples 'is a holistic process which addresses mental, physical, emotional and spiritual needs and involves connections to culture, family, community and land' (Muru Marri with Blignault & Arkles 2015, p. 4). Collective healing is of particular relevance to First Peoples as a culturally-informed, strengths-based process that encompasses how issues, responsibilities and opportunities for change exist within and between personal, cultural and structural domains. In this way, collective healing reflects a socio-ecological model of health, incorporating the processes of **multilevel empowerment**.

Multilevel empowerment definition is located here

Research into multilevel empowerment among First Peoples affirms an enhanced sense of personal empowerment that flows from participation in and having influence

over activities at the community or organisational level, for example through volunteering or political action (Tsey et al. 2010). This can be through either a sense of direct control or influence or a sense of perceived control, for example through participating in organisations (Shulz, Israel, Zimmerman & Checkoway 1995, p. 312).

Another way of thinking about multilevel empowerment is to consider how it can be promoted and nurtured. Research amongst First Peoples shows how the dynamic interaction between collective and personal empowerment 'encompasses the extent that a person can live a life that honours their identity, values and abilities in harmony with others' (Haswell et al. 2010, p. 798).

An empowered community of First Peoples in Australia cannot grow nor flourish unless awareness, understanding, engagement and respect by all Australians also grow, and the value of First Peoples' cultures are embraced. For example, studies of social capital and Indigenous people from around the world have found their health and well-being is dependent on connections with communities (Richmond, Ross & Egeland 2007). This connection is not only within First Peoples' communities but also with the general community. This was affirmed by Sir Michael Marmot (2011, p. 21), who pointed out that in addition to addressing social disadvantage, attention was needed with respect to 'the particular relationship with Indigenous Australians to mainstream society'.

A multilevel empowerment perspective therefore requires us to understand that Australian society as a whole has an important role in bringing about improved health equity, making it 'everyone's business' (cf Virdun et al. 2013). Relationship—our basic need to be connected socially and to belong—along with the need for freedom to live autonomously and the need for competence to be effective in life are theorised as essential to the well-being of everyone (Deci & Ryan, 2000; Deci & Ryan, 2008).

Figure 1 illustrates the multiple levels of relationships significant to the well-being of First Peoples, from self to family, Aboriginal community, general community, health and other services, government (policy, bureaucracy, politics), and environment (Country, world, biosphere, universe and time) and back again: a dynamic ripple effect. As the model shows there are also cross-cutting factors (adapted from Anderson 1988, pp. 127-139):

- Socio-cultural (identity, inclusivity, intercultural space, colonisation)
- Socio-economic (access to employment, income, health and education, goods and services)
- Physical environment (place, demographics, climate and living conditions, food sovereignty)
- Political environment (control, self-determination, participation, coexistence and economy).

For each of these factors there is the potential for both positive empowerment and on the other hand negative stressors; it is a continuum and within a context of constant change.

Socio-ecological model of health definition is located here

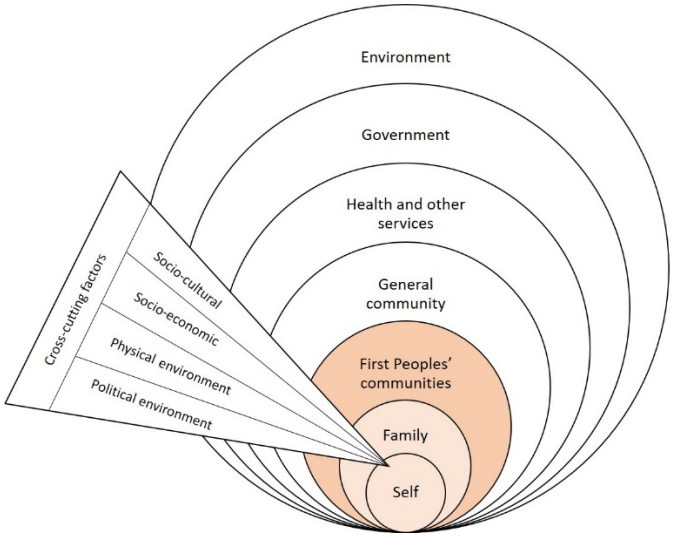

Figure 1: Socio-ecological empowerment model for First Peoples' health and wellbeing

Multilevel empowerment is the social action process that occurs within and between the levels and domains of a **socio-ecological model** (Wallerstein 1992). Positive collective identity, social support and enhanced confidence are all possible here, particularly for example when "individuals and organizations participate in processes which enable the community to meet the needs of its constituents" (Schulz, Israel, Zimmerman & Checkoway 1995, p. 311).

Collective healing is an example of this process, in that it 'broadens the scope for *who* does healing and *who* healing is for' (Muru Marri with Blignault et al. 2014, p. 14, emphasis in original).

> It means moving from a model where expert professionals work with individuals to a model where individuals develop their own skills and capacities to empower healing in themselves and their families and communities.

Further, collective healing engages participants 'as workers for healing so that working together we grow the wider circles of relationships necessary to develop healing communities' (Sheehan 2012, p. 108). Included here are psychosocial determinants such as cultural identity, which may be considered a mediator, such as in relation to social inequality (Saggers & Gray 2007, p. 15).

Being part of the solution: social support

As we have considered, Aboriginal social structures are based on kinship systems (Anderson 1988). The collecti-vist or communi-vist worldview held by First Peoples allows people to know who they are in terms of their affiliations, kin relations, social standing, roles, responsibilities and obligations to each other and to society as a whole (cf Secretariat of National Aboriginal and Islander Child Care 2011). Relationships and reciprocal responsibilities and obligations that flow from these are highly valued. This network of relationships sustained Aboriginal society since time immemorial, by locating people in a collective network of cultures, where reciprocity and mutuality are the norm, and reinforce the role and purpose of the individual as well as their health and well-being. In this way, we can see how relationships between individuals are the logical site of caregiving and **social support**, which in turn influence multiple other levels.

Social support definition is located here

Individual-level social support is well identified as a significant independent determinant of health (Bloom 1990; Schwarzer & Leppin 1991; Uchino, Uno & Holt-Lunstad 1999; Schwarzer & Knoll 2007; Taylor, Welch, Kim & Sherman 2007). Further, social support includes several 'entwined dimensions' of interpersonal relationship mechanisms, which protect people from stress (Cohen, Gottlieb, & Underwood 2000; Ball & Elliot 2005); and resources that people can give, and others can receive, to reduce stress (Stansfeld 2006). Social support can be tangible such as provision of financial resources, or intangible such as reassurance (Weber 1998). Social support can also be experienced as a belief that a person perceives they are loved, valued and cared for because they are in relationships with others who can provide this (Cobb 1976, cited in Stansfeld 2006, p. 148). The main effect of social support on health occurs when an individual's sense of wellbeing increases as a result of being part of a supportive network (Cohen & Syme 1985; Cohen 1988). That is, the health-giving effects of social support arise from interactions and transactions with others (Stansfeld 2006, p. 150).

So what is the health and social care practitioner's role? Clarifying this is essential for psychosocial empowerment, as it provides insights into relevant steps for action and for self-care. To paraphrase Quayle et al. (2016, p. 81), for practitioners to work in solidarity means centring and listening to First Peoples' voices, to critically discern power relations, to revise meanings attributed to experience, and to affirm identities and communities. Understanding history and context is key as this stimulates critical reflection, which we discuss below. Once we begin to reflect, critically heightened self-awareness becomes possible, providing a clarity that reduces fear of saying or doing the 'wrong thing' or being overwhelmed at the complexity of issues. This also serves to prevent resentment when positive change does not occur at a broader level—and helps to appreciate the small shifts that may have occurred in one's immediate sphere of influence.

Relating well and being critically reflective

> Social justice is what faces you in the morning ... a life of choices and opportunity, free from discrimination. (Dodson, cited by National Congress of Australia's First Peoples 2016, para 1)

When 'realities' in one culture are out of sight from another, there develops a gulf in understanding, which can be easily racialised; and characteristics of difference magnify (**see also Chapter 4**). Commitment to health equity and addressing social determinants of First Peoples' health means being confident to challenge racialisation, and instead develop and participate in meaningful relationships with each other at the 'cultural interface' (Nakata 2007). This means stepping into a relational domain in which one has a strong sense of the influence of one's own culture, privilege and bias, and where a reflexive sense of one's role can be developed and provide a solid basis for learning.

Developing this relational domain is not just about, for example, meeting the needs of First Peoples. As we have mentioned, it is also about truth telling, recognising the history of Australia, and embracing First Peoples' cultures towards forging a new national identity. This can stimulate re/connection with deeper ways of being often overlooked by western society, including, for example Europeans' tendency in recent generations to see themselves as separate from nature (Anderson 2011). It is also important for moving beyond learning about, to *learning with*, and *learning from* First Peoples. There is much to learn, particularly because of the great diversity amongst First Peoples that existed both pre-colonisation and that is now a result of colonisation. Each community has its own and multiple protocols for engaging, relating and working together. And as stated earlier, the holistic conceptualisation of health, intergenerational care and relational and place-based values have inherent value for everyone.

To know what and how we can contribute, and meet the needs and aspirations of First Peoples' communities requires ongoing, critical reflection. **Critical reflection** offers the chance and means by which to identify 'inconsistencies between formal theories and practice theories' (Bennett, Power, Thomson, Mason & Bartleet 2016, p. 2). Critical reflection values 'practical wisdom' because, by reflecting on an incident or text, we may gain new insights in relation to a situation that are potentially generalisable. Critical reflection opens up the potential to question actions, strategies and assumptions that render us as professionals complicit in maintaining an established order. Critical reflection is a key tool in self-care as well. It helps in knowing our role and setting our boundaries. It helps us to be discerning and not dominating as advocates.

Critical reflection definition is located here

The final Stop and Think includes some useful critical reflection questions. These are adapted from the work of social work scholar Jan Fook (2009) and Fitzpatrick (2011):

Stop and think

- How do I influence what I see?
- How does what I look for influence what I find?
- How could I learn directly from Aboriginal and Torres Strait Islander peoples?
- What holds me back?
- What steps can I take to overcome these, and make connections?

Community-empowered approaches

The model of multilevel empowerment is embodied in Aboriginal community controlled health organisations (Mazel 2016). As well as delivering a world-leading comprehensive primary health care model, these organisations are the largest employer of Aboriginal people, and they provide a benchmark for culturally safe care and self-determination through locally elected boards of management (NACCHO 2013; Mazel 2016). Their sector peak bodies advocate and mobilise other service providers, parliamentarians and community members to demand structural change (National Congress of First Peoples 2016), and extend the example of multilevel empowerment. An indicator of the success of the sector and its constituents is the successful embedding of social and cultural determinants at the centre of the national implementation plan for Aboriginal and Torres Strait Islander health (Fisher et al. 2018).

From an intervention perspective, we can understand multilevel empowerment through the factors and conditions required for a program to enable participants to achieve their full potential, as proposed in the Aboriginal definition of health. Case Study 8.2 summarises four sets of critical success factors that were found to influence the ability of a program or service to do so at service provider, organisational and system levels. These factors were elicited from case studies of social and emotional well-being programs for Aboriginal and Torres Strait Islander young people (Haswell, Blignault, Fitzpatrick & Jackson Pulver 2013) and women leaving prison (Haswell, Williams, Blignault, Grand Ortega & Jackson Pulver 2014, pp. 89-92).

Case study 8.2: Critical success factors in First Peoples' programs

Effectiveness factors

To be 'effective', programs work from strengths, are relational, model reliability and consistency, facilitate connection to culture, are non-judgemental, have rules and boundaries, model openness, honesty and trust, enable choice, and celebrate achievement.

Sustainability factors

To be 'sustainable' program establishment processes are inclusive, embed Aboriginal ways of being and doing, engage with the community and strengthen the local knowledge base,

reflect a shared vision with participants and workers, foster innovation and collaboration, have accountability and monitoring processes, demonstrate value through achievements, have emotionally-safe working environments, manage change respectfully and put time into relationships with stakeholders.

Resourcing factors

Critical 'resourcing' factors involve flexible funding attuned to local circumstances, connections with other services, pre-program grassroots consultation, culturally-informed evaluation processes and tools, realistic funder and community expectations, support by continuous funding strategies that facilitate growth, strengthen the workforce and accommodate flexible internally-relevant accountability.

Landscape factors

Within the wider 'landscape', critical factors include cross-sectoral alliances, avoiding competitive funding processes, the capacity to demonstrate meaningful accountability, systematic mechanisms to share information among stakeholders, clearly articulated roles, responsibilities and expectations across sectors, leadership and management by experienced, skilled and empowered Aboriginal people and recognised professional and community allies, extensive Aboriginal and Torres Strait Islander community networks and mechanisms that support the collection of culturally informed data on program performance.

(Haswell, Williams, Blignault, Grand Ortega & Jackson Pulver 2014, pp 89-92; cf Haswell, Blignault, Fitzpatrick & Jackson Pulver 2013)

Engaging multilevel empowerment and holistic health perspectives requires relating with a wide range of stakeholders at individual, service, community and policy levels. For decades, there have been calls for governments to break down silos in policy development and program delivery. For example, in 2008 the Close the Gap Statement of Intent, instigated by a First Peoples'-led coalition of national health sector peak bodies and social justice organisations, has been described as a compact between Australian governments and Australia's First Peoples (Holland 2018, p. 3). Included among its aims is 'working collectively to systematically address the social determinants that impact on achieving health equality for Aboriginal and Torres Strait Islander peoples' (Indigenous Health Equality Summit, cited in Holland 2018, p. 13). This must be in tandem with financial and other resource inputs that address for example infant and maternal health, chronic and communicable diseases, social and emotional wellbeing, along with strategies that reduce health system discrimination and racism (Mazel 2016; Holland 2018).

Kungarakan Elder Tom Calma AO (Calma, 2008) provides the crucial elements for interaction and partnership across the multiple domains:

> To me, these principles reflect what social workers are striving for and of course, [what] many social workers are actually practicing already:

1. People are recognised as key actors in their own development, rather than passive recipients of commodities and services.
2. Participation is both a means and a goal.
3. Strategies are empowering, not disempowering.
4. Both outcomes and processes are monitored and evaluated.
5. Analysis includes all stakeholders.
6. Programmes focus on marginalized, disadvantaged, and excluded groups.
7. The development process is locally owned.
8. Programmes aim to reduce disparity.
9. Both top-down and bottom-up approaches are used in synergy.
10. Situation analysis is used to identity immediate, underlying, and basic causes of development problems.
11. Measurable goals and targets are important in programming.
12. Strategic partnerships are developed and sustained.
13. Programmes support accountability to all stakeholders.

These elements represent ways of working together that protect trust, respect and integrity while moving towards common goals. In essence — how to be a good partner. Further, Marmot has suggested 'that both material or physical needs and capability, spiritual, or psychosocial needs are important to the gradient in health' (2005, p. 1102).

One important example aligned with this approach is First 1000 Days, based on a global initiative to reduce undernutrition in low and middle-income countries (Arabena, Ritte, Panozzo, Johnston & Rowley 2016). First 1000 Days Australia is an early childhood development intervention lead by First Peoples working with a multidisciplinary team of experts. In introducing the internationally-developed concept, the First Peoples-led Australian team conducted a year-long engagement process:

> … linking early-life researchers, research institutions, policy makers, professional associations and human rights activists with Australian Indigenous organisations and families. The resultant model, First 1000 Days Australia, broadened the international concept beyond improving nutrition (Ritte et al. 2016, p. 1).

First 1000 Days Australia focuses on 'bringing together disparate programs — home nursing, child protection and fathering support — with evidence-based very early learning programs' (Arabena 2014, p. 442). Together the partners are committed to developing an enabling environment, by building on strengths and reinforcing resilience.

This approach, while not yet fully evaluated, is critical to respecting community needs and values, overcoming service fragmentation and building practice-based evidence of programs that address the 'complex effects of social and community environments on children's development' (Arabena 2014, p. 442). Drawing from this program, case study 8.3 talks about the role of family, and the aspirations of family and therefore the types of supports, healing and development required.

Case study 8.3: First 1000 Days Australia

> The focus on the First 1000 Days is important because while the family life of Aboriginal and Torres Strait Islander people is predominantly centred around complex kinship systems and clan structures, with clear lines of rights and obligations to others, an increasing number of our children are vulnerable and at risk. We recognise that, until recently, the education and socialisation of young children took place within the rhythms of family life, the extended family and their Country. We also recognise the intrinsic value of children within our communities.
>
> However, we also acknowledge that these ideals have been radically disrupted for some families, particularly those who have suffered the separation of their children, the destruction of extended family networks, and decades of living in oppressive circumstances—as evidenced by poor health and early deaths, sub-standard housing, poor educational outcomes, high unemployment and large numbers of Aboriginal and Torres Strait Islander people in custody.
>
> Despite these hardships, family remains the primary and preferred site for developing and protecting culture and identity in our children. We also acknowledge, then, the importance of family-strengthening initiatives, the crucial role played by men in raising children and the importance of the First 1000 Days to the future prosperity of Aboriginal and Torres Strait Islander societies. By initiating an early and continued investment in the next generation, we can mitigate connections between adverse early experiences and a wide range of costly problems, such as lower educational achievement and higher rates of criminal behaviour and chronic disease. The First 1000 Days focuses on reducing the burdens of significant adversity on families with young children (Arabena, Panozzo, & Ritte 2015, p. 1).

The family-strengthening, transgenerational care and complex issues identified in Case Study 8.3 require efforts to be made across multiple domains of the community,

including, as we have mentioned, government departments, community organisations, community members and families and individuals. The diverse, transdisciplinary teams necessary for this work call for much care to be taken by individuals and the organisations and interest groups they represent, given the potential for professional differences, cultural differences and inevitable power differentials (Whiteside, Tsey & Cadet-James 2011, p. 228).

We suggest the article by Whiteside, Tsey and Cadet-James (2011) as further reading because it provides an example of a theoretical, multilevel empowerment framework, which can be applied to a range of contexts. Further, this type of framework is valuable as an evaluative and critical reflection tool:

> When used in a critically reflective way [a multilevel empowerment framework can help make sense of complexity and allow] the practitioner to place values at the forefront of any engagement and assist people to envision how things could be different (Whiteside et al. 2011, pp. 228-229)

A multilevel empowerment framework is also useful in monitoring and evaluation of processes and programs. The critical success factors identified in Case Study 8.2 include factors at each of the individual, family, community, service and policy levels of a multilevel empowerment framework. To genuinely understand processes, outcomes and impacts of projects and programs with, by or for First Peoples, evaluations and research must adhere to ethical guidelines (National Health and Medical Research Council 2003) and be led by, or at the very least, involve First Peoples, and ideally, from the decision to do the evaluation or research, through to the translation of the results (Williams 2018). Evaluation and research require critical engagement with socially- and culturally-relevant questions, and agreement by local First Peoples about data and indicators of success to be used. The misuse of simple demographics, such as nationally-aggregated data rather than local data, can have major implications in research, particularly when recommendations for the design and delivery of health and social support programs, addressing social determinants and prevention, and training of future generations of support providers are being made. It is an imperative to ask ‘who is doing the measurement, and why?’ (Walter & Andersen 2013). These questions are not culturally neutral.

There are also ethical concerns and implications of research. Too often evaluations are executed to satisfy conditions of a grant, yet programs shown to be successful are not supported or do not survive changes in government (Blignault & Williams 2017). The end-users of evaluation and research are critical to also engage, to ensure that outputs and recommendations are well-translated, as practically and realistically as possible, to meet the needs of all stakeholders, and confidently address complexity, such that multilevel empowerment frameworks enable the user to achieve.

Reflection exercise

Given that 3% of the population is of Aboriginal and Torres Strait Islander heritage, 97% is not. If you are one of the 97% majority, your norms, practices, expectations, biases and judgements affect the 3%. While the social determinants of health described by Wilkinson and Marmot (1998) relate to food, transport, education and more, they are all mediated through and controlled by the dominant culture.

Accessing support as a determinant of health is also socially mediated. Australia's First Peoples have a clear vision of what good support strategies are, and how to ensure they are accessible. This is through mainstream services such as hospitals that are respectful, culturally safe and meet the needs of all Australians, as well as through locally-oriented Aboriginal and Torres Strait Islander community controlled services.

Now that you have had a chance to reflect we ask you to consider, how will you advocate for, respect and enact Aboriginal and Torres Strait Islander peoples' solutions?

Will you make the effort to better understand your own culture, critically reflecting on what motivates your own actions, inactions and assumptions? Will you read the world through your cultural lens or open up to the lenses of others?

Will you consciously and deliberately take up opportunities to establish good relationships with Aboriginal and Torres Strait Islander services?

Will you learn from, not only about, Aboriginal and Torres Strait Islander peoples and share what you learn with others?

Summary

As we began this journey we sought to extend and expand our understanding of the social determinants of First Peoples' health and well-being. We have outlined the following propositions:

- The social is dominated by the 97% who determine; and who should and could move to embrace First Peoples' cultures, including holistic approaches to health.
- This social is made up of multiple cultures and values to be embraced with respect for all.
- Racism is a grave legal, health and wellbeing concern.
- Solutions involve partnerships, with strategies for multilevel empowerment and self-determination to occur.
- Accountability is paramount, and must include community.
- Be critically reflective. It will enable progress in providing social support.

Wisdom, particularly practical wisdom grounded in a sound moral and ethical framework, is at the core of effective Aboriginal and Torres Strait Islander social work. Emergent wisdom is when we recognise that the whole is greater than the sum

of its parts — a shift from independence and individualism to interdependence (Bassett 2005). It involves a shift in standpoint from 'I am a good person' to 'I am complicit'. This means that a person recognises himself or herself as part of the larger whole, participating in it willingly or not. Thus even if we are not working directly with Aboriginal and Torres Strait Islander people, we can still be working to effect change in prevailing structures and systems of oppression. We can call out racism wherever we see it. We can respect all life forms and contribute to the common good of this planet.

There is great potential for a mutually beneficial future; where one culture's aspirations and needs are not in competition to another's, where 'others' are not seen as a threat, but as an opportunity for enrichment and improvement.

The key step in achieving health equity is to learn to relate well with Aboriginal and Torres Strait Islander people, based on knowing oneself, one's position and bias, one's strengths and what one has to offer in supporting the Aboriginal and Torres Strait Islander leaders to meet their self-determined aspirations and needs. Learning to be reflective, in order to become more critically self-aware and able to understand one's own biases is the first crucial step.

Without such a shift in mainstream Australia, there is the potential for ever-widening health and social inequality. Unless humans can self-determine responses to their own issues, at individual and community levels, growth and empowerment is slow or impossible. Given the minority population and relative powerlessness of Australia's First Peoples, this requires the efforts of everyone. The effort must be to work with, rather than for or against First Peoples, supporting rather than rescuing, affirming rather than vilifying. Not only problem-focussed, but also strengths-based. Learning about empowerment in ourselves first, in order to be empowering of others.

If there is no critically-informed, inclusive action at all levels, there is no doubt health inequity will widen.

It is an ethical decision for mainstream Australia—will we watch health inequity widen, or challenge ourselves critically on how we work together with and respect First Peoples' knowledges and experiences for the good of the whole?

Tutorial exercises

1. Mad Bastards feature film

Watch the Australian feature film 'Mad Bastards', which is accessible in most university libraries or streaming services. The film has multiple narratives to help makes sense of concepts included in this chapter, and has been described as a rare

resource reflecting the lives of Aboriginal families. As you watch the film, ask yourself:

- What intergenerational transmission of the social determinants of First Peoples' health do you see?
- What factors are at play in TJ's life?
- What factors are working positively or negatively on TJs sense of being able to parent?
- What is the influence of cultural determinants of health?
- What strengths do you see for Bullet, to build on?
- What is the role of health and social support services to help improve Bullet's options in the future?

2. Using diagrams to explain interactions

The following model is informed by interviews with 13 Indigenous and 16 non-Indigenous people with extensive experience supporting Aboriginal groups, including in education, community development, health promotion, counselling, community management and health across remote, regional and metropolitan communities in Western Australia (Waterworth, Pescud, Braham, Dimmock & Rosenberg 2015).

- Describe this diagram in your own words—what is going on?

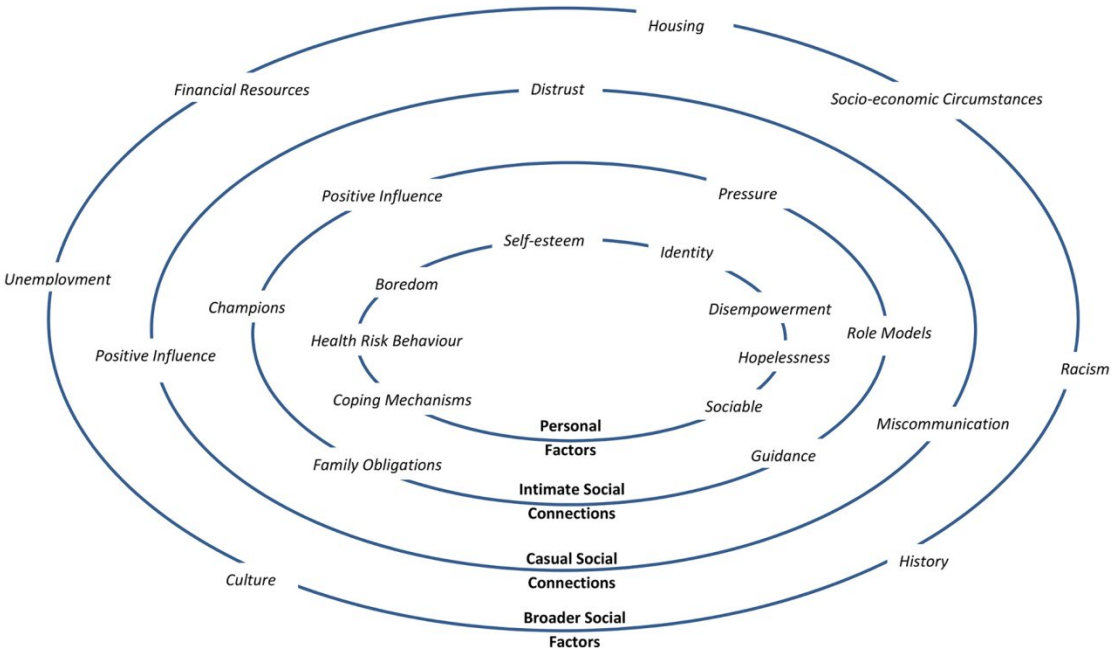

Figure 1: Factors influencing the health behaviour of Indigenous Australians from the perspective of people who support Indigenous groups (Waterworth, Pescud, Braham, Dimmock & Rosenberg 2015, p. 6)

3. Accessing First Peoples' media

- How would you characterise mainstream media discourse regarding Aboriginal and Torres Strait Islander peoples?
- Reflect on how many times you have accessed material from social media platform @IndigenousX? How often do you watch NITV?
- What are some of the main themes you hear and see?
- What have you learned that is applicable for other parts of your life?

4. Sector leadership

Apply for a copy of Indigenous Allied Health Association's *Cultural Responsiveness in Action: An IAHA Framework* through the online inquiry form http://iaha.com.au/policy/cultural-responsiveness/

- What does Indigenous Allied Health Australia seek to do?
- What is culturally responsive health care'?
- As a small group activity, take time to discuss one of the six key capability statements in the Framework. Share your thoughts with others about these leadership statements.

5. The Redfern Statement

In June 2016 all First Peoples' Peak Bodies and their supporters met and released *The Redfern Statement* https://nationalcongress.com.au/redfern-statement/

It calls on all Australian governments to genuinely engage with Aboriginal and Torres Strait Islander peoples, to meaningfully address generations of disadvantage

Access the Redfern Statement at: https://nationalcongress.com.au/redfern-statement/

- What commitments does *The Redfern Statement* ask for, to ensure First Peoples' self-determined solutions to health and social issues occur?
- What do they say is the role of partnerships in this?
- What would your role be, if you found yourself working in a mainstream health or social support role?

- Identify what holds you back from supporting and enacting the commitments that leaders of Australia's First Peoples ask?

Further reading

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Websites

Australian Indigenous Health*InfoNet*
http://www.healthinfonet.ecu.edu.au/

Fair Australia: Social Justice and the Health Gap: The 2016 Boyer Lectures by Professor Sir Michael Marmot
http://www.abc.net.au/radionational/programs/boyerlectures/series/2016-boyer-lectures/7802472

First 1000 Days Australia
http://www.first1000daysaustralia.org.au/

Healing Foundation
www.healingfoundation.org.au

Indigenous Allied Health Australia
http://iaha.com.au/

Lowitja Institute
https://www.lowitja.org.au/

National Aboriginal Community Controlled Health Organisation
www.naccho.org.au/

SNAICC – National Voice for Our Children
http://www.snaicc.org.au

Stronger safer together: A reflective practice resource and toolkit for services providing intensive and targeted support for Aboriginal and Torres Strait Islander families
https://aifs.gov.au/cfca/2017/07/27/stronger-safer-together

Western Australian Aboriginal Child Health Study
https://www.telethonkids.org.au/our-research/aboriginal-health/waachs/

Working Together
https://www.telethonkids.org.au/our-research/early-environment/developmental-origins-of-child-health/aboriginal-maternal-health-and-child-development/working-together-second-edition/. There are many other useful chapters in this resource in addition to the one we suggest, as well as maps of Aboriginal Australia and useful glossaries.

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