

Evidence Check

Improving social and emotional wellbeing for Aboriginal and Torres Strait Islander people

An **Evidence Check** rapid review brokered by the Sax Institute for Beyond Blue.
December 2018.

This report was prepared by:

This report was prepared by Roxanne Bainbridge, Janya McCalman, Crystal Jongen, Sandy Campbell, Irina Kinchin, Erika Langham, Tessa Benveniste, Ros Calder, Christopher Doran.

December 2018
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Suggested Citation:

Bainbridge R, McCalman J, Jongen C, Campbell S, Kinchin I et al. Improving social and emotional wellbeing for Aboriginal and Torres Strait Islander people: an Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for Beyond Blue, 2018.

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Executive summary

Background

Mental health is “a state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (World Health Organization 2001, p1). It is integral to good physical health and quality of life. ‘Social and emotional wellbeing’ (SEWB) is a term preferred by many Aboriginal and Torres Strait Islander Australians and other global Indigenous nations because it gives prominence to a descriptor that captures ‘understandings of themselves and their experiences as they relate to mental health’.¹ SEWB manifests in how Aboriginal and Torres Strait Islander Australians (hereafter respectfully termed Indigenous while acknowledging cultural and historical diversity) view the world, are affected by the networks of relationships and power in which they live, their histories and their embodiment of connections to land or ‘country’, culture, spirituality, ancestry, family and community.²⁻⁴ It focuses on a strengths-based approach and is based on evidence that, regardless of the number of risk factors, the presence and strength of protective factors has been shown to lower the level of risk.⁵ However, life histories and challenges present risks to the strengths and outcomes that come from good mental health and a positive sense of wellbeing.⁶ For Indigenous people, mental health issues and loss of social and emotional wellbeing are reflected in a range of indicators, including emotional, physical and sexual abuse, neglect, stress/distress, anxiety, depression, social exclusion, problem gambling, grief and trauma, removal from family, high-risk alcohol consumption (including during pregnancy), alcohol-related injury, recreational drug use, grief and trauma, suicide, family breakdowns, cultural disconnection, racism, discrimination, violence, victimisation, offending and social disadvantage.^{6,7} There also needs to be a focus on reducing these stressors (risks) and improving the capacity of community members and service staff to cope with these. Thus, the concept provides a holistic perspective on what are commonly understood as mental health concerns, and acknowledges the impact of the social and cultural determinants of health.

Indigenous SEWB is firmly established as a national strategic priority.⁸ Beyond Blue is considering where to invest its policy advocacy efforts to prevent suicide and improve mental health for all people in Australia. To bolster its advocacy efforts, Beyond Blue constructed the policy reform agenda project. In the project, a suite of compelling policy propositions will be developed that are then used for advocacy purposes. Currently, Beyond Blue is commissioning a series of evidence reviews, the utility of which will contribute to advocacy for change in the next wave of Australia’s mental health and suicide prevention policies. As one of a series of five reviews to identify evidence for reform of mental health and suicide prevention approaches, an Evidence Check was conducted to identify promising policies, programs and services that can underwrite transformational policy reform as an important contribution to strengthening the social and emotional wellbeing of Indigenous Australians. This activity was conducted alongside a series of consultations with Indigenous communities over the past five years, which is outlined in more detail later.

Review questions

This review aimed to address the following overarching question:

What policies, programs or services have been effective in improving social and emotional wellbeing for Indigenous Australians?

Question 1:

What is the quantity and nature of available literature aimed at improving social and emotional wellbeing for Indigenous Australians?

Question 2:

What are the components; workforce requirements (e.g. skills, qualifications, training, cultural awareness); location; target audience and reach; cost; outcomes; cost-effectiveness; and referral pathways of the policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians?

Question 3:

What are the barriers and enablers to effective implementation of policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians?

Summary of methods

This literature review provides the most up-to-date evidence on policies, programs and services aimed at improving social and emotional wellbeing for Indigenous people. The peer-reviewed literature was searched for relevant documents published between January 2013 and September 2018. An accredited librarian working at a leading Australian university assisted in identifying the search strings for review of both peer-reviewed and grey literature across seven countries: Canada, Australia, New Zealand and the US (CANZUS nations) and three Nordic countries – Finland, Norway and Sweden. Specific search strings were developed and applied to 12 electronic databases: MEDLINE/Ovid; Embase/Ovid; PsycINFO/Ovid; EBM Reviews – Cochrane Database of Systematic Reviews/Ovid; CINAHL/EBSCO; Global Health/Ovid; ATSIHealth/Informit; AIATSIS: Indigenous Studies Bibliography/Informit; FAMILY-ATSI/Informit; Indigenous Collection/Informit; Sociological Abstracts/ProQuest; and the Campbell Collaboration Library database.

Reviewers conducted a desktop search for relevant grey literature. Adapted search strings that accounted for the various search facilities were used to search the grey literature. Relevant websites searched were:

- Google Scholar and Google
- Australia: Indigenous HealthInfoNet; Closing the Gap Clearinghouse
- Canada: The National Collaborating Centre for Aboriginal Health; (National Aboriginal Health Organisation was closed); Health Council of Canada: Aboriginal Health
- New Zealand: Maori Health; Whakauae: Research for Maori Health and Development; MAI: A New Zealand Journal for Maori Health and Development
- US: American Indian Health; National Indian Health Board; Centers for American Indian and Alaska Native Health
- Norway, Finland and Sweden: No search sites.

Evidence grading

We assessed the quality of evidence using the Canadian Hierarchy of Evidence for Promising Practices. The hierarchy outlines three categories (and four levels) of evidence ranging from best to emerging practice. Best practice (levels 1 and 2) is an intervention, method or technique that has consistently been proved to be effective through the most rigorous scientific research. An intervention is considered a promising practice (level 3) when there is sufficient evidence to claim that the practice has been proved to be effective at achieving a specific aim or outcome, consistent with the goals and objectives of the activity or program. Emerging practices (level 4) are interventions that are new, innovative and which hold promise based on

some level of evidence of effectiveness or change that is not research-based and/or sufficient to be deemed a 'promising' or 'best' practice.

Key findings

Overall review question: What policies, programs or services have been effective in improving social and emotional wellbeing for Indigenous Australians?

We found no publications that provided best-practice evidence of policies, programs or services that have been effective in improving social and emotional wellbeing for Indigenous people. Twelve peer-reviewed literature sources and two grey literature sources provided evidence of promising practice, and 17 peer-reviewed and six grey literature sources provided evidence of emerging practice. Of the promising practices, 15 peer-reviewed and two grey literature publications described Australian policies, programs or services.

Only two (grey literature) publications described a promising Australian policy or policy framework – the Australian Health Ministers' Advisory Council's (2017) National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023, and the Victorian Government's Balit Murrup: Aboriginal social emotional wellbeing framework 2017–2027. Ten peer-reviewed publications described five promising Australian programs – SAM Our Way⁹, Yarning about Indigenous Mental Health using the AIMHI Stay Strong App¹⁰, Ngala Nanga Mai (We Dream) Parent Group Program¹¹, the Family Wellbeing Program (Kinchin et al. 2015, Kinchin et al. 2017, Whiteside et al. 2014)^{12–14}, and Voices United for Harmony singing program.^{15–17} Two of these programs (SAM Our Way and Family Wellbeing Program) are national programs; one has been delivered in urban, rural and remote sites in Queensland (Voices United for Harmony singing program), one in remote Northern Territory sites (the AIMHI Stay Strong App) and the other in urban Sydney (Ngala Nanga Mai (We Dream) Parent Group Program). No publications described promising SEWB services.

The other two promising programs evaluated in peer publications were from the US; these were the Living in 2 Worlds substance abuse prevention program for middle school students¹⁸ and the Healthy and Empowered Youth (HEY) sexual and reproductive health youth development program.¹⁹

Question 1: What is the quantity and nature of available literature aimed at improving social and emotional wellbeing for Indigenous Australians?

Thirty-seven studies were included in the synthesis of the literature – 29 from the peer-reviewed (Appendices 2 and 3) and eight from the grey literature (Appendix 4). The largest proportion of the peer-reviewed studies was from Australia (n=21); five were Canadian and three were from the US. No papers were found from New Zealand or the Nordic countries, or from Australia in 2018. Of the peer-reviewed studies, none included best-practice evidence (levels 1 and 2), 12 showed evidence of promising practice and 17 of emerging practice. Of the 29 peer-reviewed documents, all were journal articles. There was no increase in the quantity of literature found across the past five years (2013–2018), with no documents at all found from 2018.

The review identified 29 original research studies. Of these, 11 were evaluation studies; six were measurement studies; and 12 were descriptive studies. The target populations in the studies were children and youth (n=12); community members (n=7); parents and children (n=2); men (n=5); women (n=1); and service providers (n=1). No study was considered to provide evidence of best practice.

Question 2: What are the components of the policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians?

The policies, programs and services that aimed to improve the social and emotional wellbeing of Indigenous people required a skilled, motivated and stable workforce.⁹ Development took many forms, however. Many

of the programs and services were either developed by (e.g. Whiteside et al. 2016)²⁰ or culturally adapted for implementation with Indigenous people (e.g. Dingwall et al. 2015).¹⁰ The locations of the policies, programs and services encompassed urban^{9, 11, 15-17}, regional^{9, 15-17} and remote geographical settings.^{9, 10} They were located within primary healthcare services (including Aboriginal Community Controlled Health Organisations)^{10, 15-17, 21}, schools and tertiary education institutions⁹, community support groups²⁰ and other human service providers.^{10, 20} Client outcomes were vast and generally aligned with the specific activities and issues targeted through the programs. However, these were at times difficult to identify because of the gaps in the evidence.

Question 3: What are the barriers and enablers to effective implementation of policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians?

Enablers of SEWB implementation fell under four key categories: 1) respecting culture; 2) relationships and Indigenous leadership; 3) service/program delivery; and 4) embedded research and evaluation. Six conditions that constrained the implementation of SEWB programs and services were: 1) staff capacity; 2) geographical environment; 3) cultural diversity; 4) limited evidence base for programs and services; 5) late intervention; and 6) research. Staff recruitment and high turnover were particularly detrimental to the delivery of SEWB programs and services.

Gaps in the evidence

Several key gaps in the evidence were apparent in the review. Studies focused primarily on qualitative methods. There is an imperative to continue to enhance the evidence base by incorporating quantitative components in more compelling evaluation designs. More rigorous designs will help raise the quality of extant evidence. It should be noted, however, that enhanced methodological approaches are difficult to implement where sample sizes are small, as was the case in many studies.

The review analysis highlighted other methodological gaps: 1) lack of consistency across programs; 2) the need to standardise and develop culturally appropriate screening tools and outcome measures; and 3) the need to conduct economic analyses.

The largest proportion of SEWB programs and services focused on children and youth. More methodologically rigorous evaluations will ideally target Indigenous people across the life-course as per the calls for this approach in existing evidence (South Australian Aboriginal Health Partnership, 2015).

Only one study (Kinchin et al. 2017) reported the costs or cost-effectiveness of the policies, programs or services aimed at improving social and emotional wellbeing for Indigenous people.

Discussion of key findings

The review revealed a lack of evidence for policies, programs or services that are effective in improving SEWB for Indigenous Australians. We found no best-practice evidence and only 12 papers that had promising-practice evidence. Further, there were evidence gaps in many of the studies, and extrapolation of various elements necessary to assess effectiveness was absent or poorly articulated. This made it difficult to synthesise and formulate what is most useful or promising for improving SEWB.

Question 1: What is the quantity and nature of available literature aimed at improving social and emotional wellbeing for Indigenous Australians?

The final synthesis and analysis included 37 publications – 29 peer-reviewed papers and eight grey literature publications. SEWB literature on global Indigenous nations across seven countries revealed that the volume of original research publications was randomly dispersed and has not increased from 2013 to 2018. In fact, there were no publications in 2018 and only two in 2014. Of the 29 peer-reviewed publications, 11 were

evaluation studies, six were measurement studies and 12 were descriptive studies. Across time, numbers of publications in these categories can provide some indication of whether research efforts have progressed beyond describing the problem of Indigenous SEWB to demonstrating how to implement change in the field.²² Findings therefore suggest the current state of SEWB research is in its exploratory phase. The nature of the SEWB publications also shows that little research has explored the effectiveness of SEWB policies, programs and services; captured its impact qualitatively or quantitatively; developed appropriate measures; or assessed its cost-effectiveness. However, while the review found a stronger focus on descriptive publications, there is value in extrapolating the components and characteristics of these studies and they can provide valuable evidence and lessons for developing the field of SEWB further. We identified two key policy documents addressing the SEWB of Indigenous people in Australia: the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023⁸; and the Aboriginal Social and Emotional Wellbeing Framework 2017–2027.²³ While these guiding policies were robust, there were no best-practice models to guide service and program development and implementation.

Question 2: What are the components of the policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians?

No best-practice evidence was found in the review of SEWB literature. However, there was promising practice evidence in 12 papers. The number and heterogeneity of conditions, activities, outcomes and measures identified through the analysis made engaging in meaningful synthesis difficult. However, it was evident that SEWB is a missing link in efforts to improve health and other outcomes both for Indigenous Australians and other global Indigenous peoples. Promising practice evidence signalled that comprehensive and culturally sensitive strengths-based approaches show potential for success. The concept elements consistently found across this evidence were: cultural embeddedness; Indigenous engagement, partnerships and leadership; service integration; incorporating and accounting for the social determinants of health; workforce development; program adaptation; multi-level program components; targeted issues; accounting for holistic views of health and wellbeing; brief interventions and short-term education components; and consistent and reliable service delivery.

Staff trained in this specialised area of SEWB, and dedicated funding for such initiatives, were both largely absent. Demonstrated client outcomes indicate that SEWB programs and services are much needed as a targeted strategy to improve the health and wellbeing of Indigenous peoples. Most often SEWB initiatives were implemented to address an entrenched problem such as disengagement from school, psychological distress or substance abuse. SEWB programs and services are likely to produce the best outcomes through prevention and early intervention strategies. However, there is a pressing need for staff training and culturally competent service delivery, and culturally tailored locally developed programs.

Question 3: What are the barriers and enablers to effective implementation of policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians?

Twelve publications demonstrated promising evidence for improving social and emotional wellbeing for Indigenous Australians. The shared themes that reinforce promising practice require solutions that take an ecological, strengths-based life-course perspective that includes the social and cultural determinants of health. These solutions include: co-development with communities; strong community interest and engagement; Indigenous leadership; sustainable funding; workforce development including culturally competent practice; improved service access; continuity of care and improved infrastructure; coordinated/integrated care; and embedded research and evaluation. The conditions or environments that facilitated or constrained the implementation of policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians are listed in Table 2.

Conclusion

This review of extant SEWB literature sought to distil the evidence of what works most effectively, under what conditions, through which mechanisms and activities, and with what outcomes in efforts to improve SEWB for Indigenous Australian in particular, and global Indigenous populations more broadly. The Evidence Check review found no publications that provided best-practice evidence of policies, programs or services that have been effective in improving social and emotional wellbeing for Indigenous people. However, it did identify the key elements of two promising SEWB policy frameworks, five promising programs for Indigenous Australians and two promising programs from the US. The Australian policy frameworks were the national and Victorian Government Indigenous mental health and social and emotional wellbeing frameworks. The Australian programs were the SAM Our Way, Yarning about Indigenous Mental Health using the AIMHI Stay Strong App, Ngala Nanga Mai (We Dream) Parent Group Program, the Family Wellbeing Program, and the Voices United for Harmony singing programs. The US programs were the Living in 2 Worlds substance abuse prevention program and the Healthy and Empowered Youth (HEY) sexual and reproductive health youth development program. The review identified the enablers and barriers to program and service implementation and the gaps in the evidence. While Australia leads the way in terms of volume in SEWB research, the review team identified no best-practice examples. Much work remains to be done in this area to ensure progression in developing effective meaningful policies, programs and services that work to address the unique needs of Indigenous Australians. Many of the challenges experienced by those who promote SEWB are evidenced in the Indigenous health domain more broadly. However, the outcomes and benefits that were documented as a result of engagement in SEWB programs and services, and their potential flow-on effects, are worthy of further exploration and investment in research and evaluation.

Background

Mental health is “a state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community”.²⁴ It is integral to good physical health. However, life histories and challenges present risks to the strengths and outcomes that flow from good mental health and a positive sense of wellbeing.⁶ For Indigenous Australian populations, mental health issues and loss of social and emotional wellbeing are reflected in a range of indicators in health, education, employment and contact with the justice system.⁹ These indicators include emotional, physical and sexual abuse, neglect, stress/distress, anxiety, depression, social exclusion, problem gambling, grief and trauma, removal from family, high-risk alcohol consumption (including during pregnancy), alcohol-related injury, recreational drug use, suicide, family breakdowns, cultural disconnection, racism, discrimination, violence, victimisation, offending and social disadvantage.⁶

The concept of social and emotional wellbeing (SEWB) represents a decolonising approach to understanding mental health and wellbeing for Indigenous peoples.²⁵ It focuses on a strengths-based approach and is founded on evidence that critically asserts that regardless of the number of risk factors present in people’s lives, the existence and strength of protective factors has been shown to lower their level of risk.⁵ Inferences drawn from this point to several practice and policy implications. There needs to be a simultaneous focus on 1) reducing stressors (risks); 2) a move towards constructive behaviours and life-enhancing competencies aimed at improving the capacity of individual community members to cope with risk; 3) enhancing the capacity of service staff to respond to risk (i.e. understanding risk and mental health promotion, and developing tailored early intervention and prevention strategies); and 4) establishing improved engagement, screening, management and referral pathways. The latter is critically important: 80% of adolescents (10–24 years) from 114 primary healthcare services were not screened for social and emotional wellbeing concerns. Of those screened, no further action was taken for 14% of all clients for whom concerns were identified; and there was no follow-up for 33% of those for whom action was taken.²⁶

The term SEWB captures the holistic nature of health that encompasses mental health and physical, cultural and spiritual health and connectedness to land that holds unique meaning for Indigenous Australians.²⁷ SEWB manifests in how Indigenous people are affected by the networks of relationships and power in which they live, their histories and their embodiment of connections to land, culture, family, community, spirituality and ancestry.^{4, 28} SEWB is a prominent term used in Australian mental health policy and practice discourses to describe health and wellbeing for Indigenous Australian nations. Gee et al. (2014, p55) defined SEWB as “a multidimensional concept of health that includes mental health, but which also encompasses domains of health and wellbeing such as connection to land or ‘country’, culture, spirituality, ancestry, family and community”.³ These six domains that typically characterise SEWB are situated within a framework that places Indigenous world views and culture as ‘central’. Although this is a term commonly used in Australia, it is also relevant to other global Indigenous peoples, and indeed all humanity, because it takes a holistic perspective on what are commonly understood as mental health concerns, and acknowledges the impact of the social and cultural determinants of health. The World Health Organization (2018, p1) advocates that because mental health is “fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life ... the promotion, protection and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world”.²⁴

Indigenous SEWB is firmly established as a national strategic priority.²⁸ Beyond Blue is considering where it can have the greatest impact through its policy advocacy efforts to prevent suicide and improve mental

health for all people in Australia. To bolster its advocacy efforts, Beyond Blue constructed the policy reform agenda project. In the project, a suite of compelling policy propositions will be developed that will then be used for advocacy purposes. Currently, Beyond Blue is commissioning a series of evidence reviews that will contribute to advocacy for change in the next wave of Australia's mental health and suicide prevention policies. As one of a series of five reviews to identify evidence for reform of mental health and suicide prevention approaches, this Evidence Check was conducted to identify promising policies, programs and services that can underwrite transformational policy reform as an important contribution to strengthening the social and emotional wellbeing of Indigenous Australians. This has been conducted alongside a series of consultations with Indigenous communities over the past five years. Significant examples of consultation include Beyond Blue's consultations with Indigenous Advisory Groups, discussions with members of the Close the Gap Steering Committee, consultations with Aboriginal Community Controlled Health Organisations, and community consultation activities.

Evidence Check questions

The Evidence Check aimed to conduct a review of existing peer-reviewed literature, grey literature and policies to identify and evaluate the conditions, strategies, enabling and constraining factors and outcomes of effective and promising policies, programs and services to improve SEWB and mental health for Indigenous nations in Canada, Australia, New Zealand, the US and Norway, Finland and Sweden.

The review aimed to address the following overarching question:

What policies, programs or services have been effective in improving social and emotional wellbeing for Indigenous Australians?

Question 1:

What is the quantity and nature of available literature aimed at improving social and emotional wellbeing for Indigenous Australians?

Question 2:

What are the components; workforce requirements (e.g. skills, qualifications, training, cultural awareness); location; target audience and reach; cost; outcomes; cost-effectiveness; and referral pathways of the policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians?

Question 3:

What are the barriers and enablers to effective implementation of policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians?

Definitions and boundaries

Social and emotional wellbeing (SEWB): We understand that SEWB manifests in how Indigenous people are affected by the networks of relationships and power in which they live, their histories and their embodiment of connections to land, culture, family, community, spirituality and ancestry".^{28, 29} We define social and emotional wellbeing as *"a positive state of mental health and happiness associated with a strong and sustaining cultural identity, community, and family life that provides a source of strength against adversity, poverty, neglect, and other challenges of life"*.³⁰

Policies, programs or services: are those aimed at improving the social and emotional wellbeing of Indigenous Australians. Policies, programs or services can be delivered or accessed at an individual, family, community or system level.

Effective: refers to policies, programs or services that have achieved their stated aim of improving social and emotional wellbeing for Indigenous people, using culturally appropriate measures. Outcome measures could include (but are not limited to): social/community connectivity; improved empowerment and decision making; improved individual, family and/or community social and emotional wellbeing; reduced psychological distress; better connection to culture; better connection to country.

Promising: refers to other key policies, programs or services that have not yet been evaluated, or where the evidence base is not yet known or is not strong, but where there is weak evidence for its effectiveness or community support, or the program or service has been developed by or in conjunction with Indigenous communities and peoples.

Methods

Peer-reviewed literature

This Evidence Check provides the most up-to-date evidence on policies, programs and services aimed at improving social and emotional wellbeing for Indigenous people. We searched the peer-reviewed literature for relevant documents published between January 2013 and September 2018. An accredited librarian working at a leading Australian university assisted in identifying the search strings for review of both peer-reviewed and grey literature across seven countries: Canada, Australia, New Zealand and the US (CANZUS nations) and three Nordic countries – Finland, Norway and Sweden. We developed specific search strings that were applied to 17 electronic databases.

We completed searches on 12–13, 24–25 and 27–29 September 2018.

An exploratory search was carried out in the Scopus/Elsevier and PubMed Clinical Queries databases, and selected references were downloaded.

Then a comprehensive search was completed in: MEDLINE/Ovid; Embase/Ovid; PsycINFO/Ovid; EBM Reviews — Cochrane Database of Systematic Reviews/Ovid; CINAHL/EBSCO; Global Health/Ovid; ATSIHealth/Informit; AIATSIS: Indigenous Studies Bibliography/Informit; FAMILY-ATSIS/Informit; Indigenous Collection/Informit; Sociological Abstracts/ProQuest; and the Campbell Collaboration Library database.

Search strategy

We searched the databases with the terms below, and their corresponding subject headings in each database where specialised thesauri existed:

1. Indigenous OR First Nation* OR Aborigin* OR Torres Strait Island* OR Inuit OR Maori OR Iwi OR Tangata Whenua OR Metis OR Native American* OR American Indian* OR Native Hawaiian OR tribal OR Sami OR Saami OR Sámi
2. policy or policies OR programs OR services OR digital technologies OR software applications OR online services OR peer support OR consumer champions OR non-clinical support OR psychosocial support OR psychological interventions OR primary health care OR Indigenous health services OR mental health services OR low intensity mental health services OR psychological services OR suicide prevention OR stress assessment OR psychological wellbeing assessment
3. control OR empowerment OR resilience OR decision making OR choice OR social connectivity OR family connectivity OR community connectivity OR connection to (spirit or spirituality or ancestors) OR social and emotional wellbeing OR wellbeing OR wellness OR happiness OR connection to culture OR connection to country OR mental health OR psychosocial distress OR psychosocial distress OR stress* OR depression OR anxiety OR suicide OR poverty
4. Australia OR Canada OR USA OR New Zealand OR Norway OR Finland OR Sweden
5. AND/1-4.

After 556 duplicates were excluded, the searches retrieved 2214 studies for review.

We contacted experts in the field for advice on key documents and scrutinised references from key articles. The search was limited to literature:

- Published in English
- Targeting any Indigenous population in Canada, Australia, New Zealand, the US, Norway, Sweden or Finland
- Focused on documenting or evaluating SEWB and mental health policies, programs or services.

The search excluded literature:

- Published pre-2013
- Outside the Indigenous context and not from Australia, Canada, New Zealand, the US, Norway, Sweden or Finland
- Not focused on documenting or evaluating SEWB and mental health policies, programs or services
- Focused on public health campaigns, clinical treatments such as medication, or one-on-one therapeutic interventions provided by a clinician (e.g. psychologist, psychiatrist, GP)
- Published in languages other than English.

A flowchart of the literature selection process is included as Appendix 1.

Evidence grading

The quality of evidence was assessed using the Canadian Hierarchy of Promising Practices Evidence. The hierarchy outlines three categories (and four levels) of evidence ranging from best practice to emerging practice. Best practice (levels 1 and 2) is an intervention, method or technique that has consistently been proven effective through the most rigorous scientific research. To be a best practice, there must be a sufficient body of evidence to allow us to say confidently that the described practice is a generalisable example of something that works. It should be noted that some interventions might demonstrate scientific rigour, but never be generalisable in other contexts. An intervention that is generalisable within a specific context should also have merit as a best practice.

An intervention is considered a promising practice (level 3) when there is sufficient evidence to claim the practice has proven effective at achieving a specific aim or outcome, consistent with the goals and objectives of the activity or program. Ideally, promising practices demonstrate their effectiveness through the most rigorous scientific research, but there is not enough generalisable evidence to label them best practices. They do, however, hold promise for other organisations and entities that wish to adapt the approaches based on the soundness of the evidence.

Emerging practices (level 4) are interventions that are new, innovative and that hold promise based on some level of evidence of effectiveness or change that is not research-based and/or sufficient to be deemed a promising or best practice. In some cases, this is because an intervention is new and there has not been sufficient time to generate convincing results. Nevertheless, information about such interventions is important because it highlights innovation and emerging practices worthy of more rigorous research.

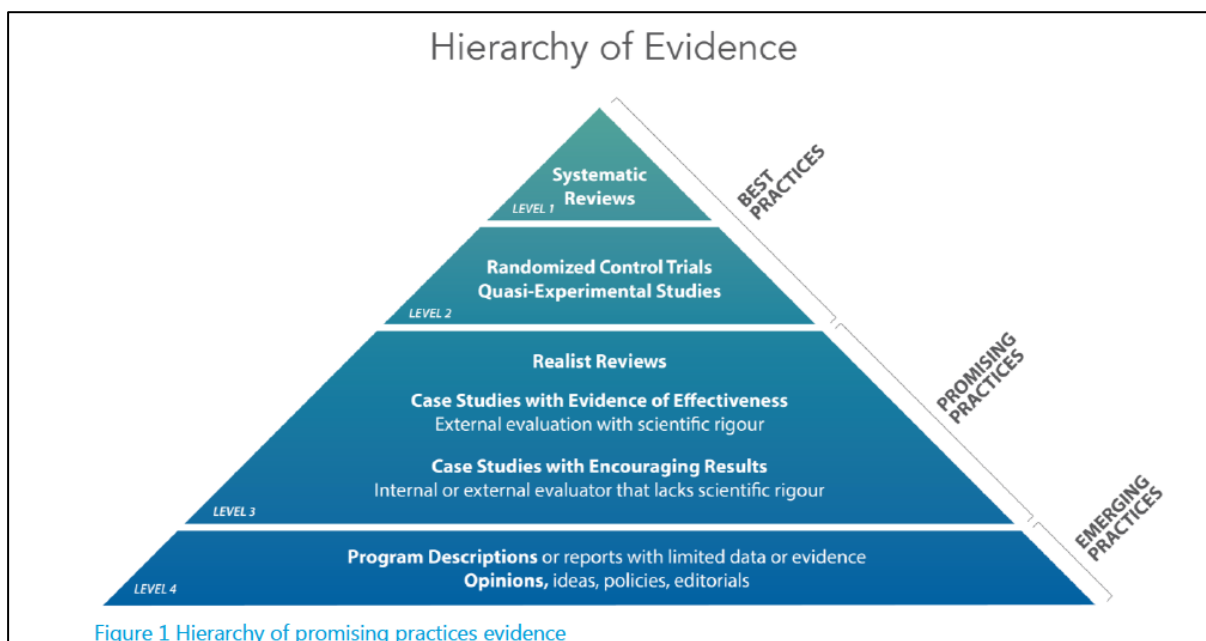


Figure 1 Hierarchy of promising practices evidence Source: Canadian Homelessness Research Network (2013)

We included evidence that is medium or weak in relation to the review questions (e.g. evidence that suggests an association but requires more rigorous research); and collated promising evidence and listed this evidence.

Included studies

Twenty-nine peer-reviewed papers met the criteria for inclusion in the review. Of these, 12 were considered promising practices with moderate quality evidence and 17 were emerging practices with a low quality of evidence.

Original research publications were classified under three categories: measurement, descriptive and intervention research:

Measurement research: Publications that developed or tested a measure of SEWB for use in Indigenous Australian populations, or a measure concerned with Indigenous Australian issues

Descriptive research: Publications where the primary aim was to explore issues, processes/models or attributes related to SEWB

Intervention research: Publications in which the aim was to test the effectiveness of an intervention implemented with Indigenous Australians. This category included research where the aim was to examine the impact of interventions designed to alter knowledge, attitudes or behaviours or to improve program delivery.

We identified the characteristics of the documents by conceptually mining the 29 resultant publications under the following components: study aims; location; target audience and reach; workforce requirements (e.g. skills, qualifications, training, cultural awareness); cost; outcomes; cost-effectiveness; referral pathways; and barriers and enablers to effective implementation of the policies, programs or services.

A summary table of the included studies is attached as Appendix 2.

Grey literature

In addition to searching the peer-reviewed literature, we conducted a desktop search of 14 websites and clearinghouses for reports and other documents. Adapted search strings that accounted for the various search facilities were used to search the grey literature. Relevant websites searched included:

- Google Scholar and Google
- Australia: Indigenous HealthInfoNet; Closing the Gap Clearinghouse
- Canada: The National Collaborating Centre for Aboriginal Health; (National Aboriginal Health Organisation was closed); Health Council of Canada: Aboriginal Health
- New Zealand: Maori Health; Whakauae: Research for Maori Health and Development; MAI: A New Zealand Journal for Maori Health and Development
- US: American Indian Health; National Indian Health Board; Centers for American and Alaska Native Health
- Norway, Finland and Sweden: No literature search sites.

53 relevant documents were found.

Findings

Overall research question:

What policies, programs or services have been effective in improving social and emotional wellbeing for Indigenous Australians?

We found no publications that provided best-practice evidence of policies, programs or services that have been effective in improving social and emotional wellbeing for global Indigenous peoples. Twelve peer-reviewed literature sources and two grey literature sources provided evidence of promising practice, and 17 peer-reviewed and six grey literature sources provided evidence of emerging practice. Of the promising practices, 10 peer-reviewed and two grey literature publications described Australian policies, programs or services.

Only two publications described a promising Australian policy or policy framework – the Australian Health Ministers' Advisory Council's (2017) National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023, and the Victorian Government's Balit Murrup: Aboriginal social emotional wellbeing framework 2017–2027. These were both grey literature reports.

Ten peer-reviewed publications described five promising Australian programs — SAM Our Way⁹, Yarning about Indigenous Mental Health using the AIMHI Stay Strong App¹⁰, Ngala Nanga Mai (We Dream) Parent Group Program¹¹, the Family Wellbeing Program^{12–14} and Voices United for Harmony singing program (Sun and Buys 2013a,b,c; 2016).^{15–17, 21} Two of these programs (SAM Our Way and Family Wellbeing Program) are national programs; one has been delivered in urban, rural and remote sites in Queensland (Voices United for Harmony singing program), one in remote Northern Territory sites (the AIMHI Stay Strong App) and the other in urban Sydney (Ngala Nanga Mai (We Dream) Parent Group Program). No publications described promising SEWB services.

The other two of the promising programs evaluated in peer publications were from the US; these were the Living in 2 Worlds substance abuse prevention program for middle school students¹⁸ and Healthy and Empowered Youth (HEY) sexual and reproductive health youth development program.¹⁹

Question 1:

What is the quantity and nature of available literature?

Quantity of identified literature

In total, 2868 references were identified: 2775 peer-reviewed documents, 53 grey literature references and 42 relevant references from 16 reviews. Documents were excluded if they: a) were duplicates (n=559); or b) did not pertain to SEWB policies, programs or services in the abstract of journal articles (n=2200). In all, 2756 references were excluded, leaving 112 references for full-text assessment (57 peer-reviewed; 27 grey; 28 references from reviews). Out of 112 full-text articles, 75 were excluded because they: did not pertain to Indigenous populations; were not concerned with improving SEWB; involved a public health campaign, clinical treatments or one-on-one therapeutic interventions by a clinician; did not include a description that is tangible with real-world information on implementation; or were deficit-focused e.g. suicide. The latter are listed at Appendix 5. The final peer-reviewed synthesis and analysis included 37 publications – 29 peer-reviewed papers and eight grey literature publications. Please see Appendix 1 for PRISMA Flow Chart.

Nature of identified literature

Peer-reviewed literature

Twenty-nine peer-reviewed documents were identified for analysis and synthesis. The largest proportion of these were from Australia (n=21); five were Canadian and three were from the US. No papers were found from New Zealand or the Nordic countries. Of the peer-reviewed studies, none included best-practice evidence (levels 1 and 2), 12 showed evidence of promising practice and 17 of emerging practice. Of the 29 peer-reviewed documents, all were journal articles. No documents were found from 2018.

Table 1 Distribution of peer-reviewed publications across time

2013	2014	2015	2016	2017	2018
6	2	5	9	5	0

Twenty-seven original research studies were identified. Of these, 11 were evaluation studies^{9, 11-13, 19, 21, 31-35}; six were measurement studies^{10, 15, 17, 18, 20, 36}; and 12 were descriptive studies.^{15, 37-46}

The target populations in the studies were children and youth (n=10); community members (n=7); parents and children (n=2); men (n=5); women (n=1); and service providers (n=1).

Promising practices

Appendix 2 provides an overview of the 12 studies that met the criteria for promising-practice evidence (level 3). Ten of these publications, reporting five promising programs, were from Australia. The other two were from the US. For each study, Appendix 2 provides information on the objective, method and key findings. In addition, a brief summary of each study of promising interventions is provided below in response to review Question 1.

Australian promising programs

Blignault et al. (2016)⁹ evaluated the first three years of the national Australian SAM Our Way program to improve the SEWB of Indigenous youth, with a focus on early intervention, prevention and community education. The SAM Our Way program targeted Indigenous youth aged 16–24 in five sites in remote and regional Australia. Activities included collaboration with secondary and tertiary education institutions; art, music and sports; bush camps; promotion of culture and identity; building individual, organisational and community capacity; collaborative, community-driven initiatives; education sessions on alcohol and other drugs, mental health and violence; drawing on content from Save-a-Mate and other evaluated programs, and Beyond Blue fact sheets on depression and anxiety. Outcomes for participants included: increased self-esteem and ability to speak up, learning how to deal with painful emotions without resorting to alcohol and drugs, making friends, improved relationships, increased confidence at school and in life generally, and a new sense of Aboriginal identity, employment and leadership. Outcomes for the local Aboriginal staff included increased knowledge, skills and confidence.

Dingwall et al. (2015)¹⁰ reported the impact of the Indigenous e-mental health training course Yarning about Indigenous Mental Health using the AIMhi Stay Strong App delivered to Northern Territory service providers in Darwin, Alice Springs and remote NT communities. On average, 80% of the service providers' clients were Indigenous. The Yarning about Indigenous Mental Health course is embedded within a consumer empowerment and recovery approach and provides culturally appropriate strategies and tools for understanding mental health, promoting wellbeing and delivering brief interventions for mental illness,

substance misuse and physical illness. Participants are introduced to e-mental health and are trained in the use of the culturally adapted AIMhi Stay Strong app.

Pre- and post- mean ratings were measured for knowledge and confidence questions, developed by combining prior evaluation forms from the Yarning about Mental Health training course with new questions developed through collaboration with other e-Mental Health in Practice (e-MHPrac) primary healthcare provider sites across Australia (identified as part of the Australian Government's National e-Mental Health Strategy to promote Indigenous e-mental health treatment and support through electronic formats as a key priority) to examine current use and changes in perceived knowledge and confidence in e-mental health. The outcomes of the training were significant improvements across all measures of skill and knowledge except for confidence in using computers. Outcomes included confidence in using e-mental health tools with Indigenous clients. It cannot be assumed that this improvement will translate to use of learned skills in the workplace. Levels of implementation and uptake following training are being measured, with results forthcoming. Overall, the paper found that culturally adapted e-mental health approaches have the potential to improve access to culturally appropriate mental health care for Indigenous people with minimal training required.

Jersky et al. (2016)¹¹ evaluated an Australian urban art-based community health program (Ngala Nanga Mai; We Dream) that seeks to improve the health, education, empowerment and connectedness of Aboriginal parents by describing paediatric health service attendance, maternal educational engagement, participant growth and empowerment, and worker and participant experiences. The Ngala Nanga Mai (We Dream) Parent Group Program (NNM) was delivered to 92 young Aboriginal parents of 133 children in Sydney. The program sought to improve participant health outcomes by simultaneously enhancing early healthcare service access, education and social connectedness. Key program elements were twice-weekly art sessions, regular health talks, cultural events, exhibiting artwork, childcare and transport, and TAFE enrolment and tutoring services, hosted within the local community health facility.

The Growth and Empowerment Measure (GEM) was used to measure participant changes in empowerment; additionally, 17 participants were interviewed and seven attended focus groups.⁴⁷ A Critical Effectiveness Factor framework that measures factors necessary for success, effectiveness and sustainability was used to assess program quality.⁴⁸ Factors used to assess program quality included working from strengths, focusing on empowerment, emphasising relationship development, demonstrating Aboriginal leadership, providing reliable and consistent services, facilitating connection to culture, fostering connections to other services, maximising opportunities for choice and enabling creative pathways for growth. The study found that outcomes included: the engagement of children of 93.5% of regular participants at least once with paediatric health services; and 27.1% undertook further education. Empowerment scores significantly improved despite little change in psychological distress. The program operationalised all 10 Critical Effectiveness Factors for youth wellbeing. Ngala Nanga Mai creates an environment of social connectedness and strengthens parenting, maternal and child wellbeing and empowerment. It supports increased use of health, education and support services, and early detection of treatable child health issues. There was clear evidence of an improvement in maternal and child wellbeing, as well as parenting confidence.

Sun & Buys (2013a, 2013b, 2013c, 2016)^{15-17, 21} all reported an evaluation of an Australian community-based singing activity intervention for improving social and emotional wellbeing among Indigenous Australians. The 2013 publications reported a study of Indigenous adults aged 18–78 years recruited through Aboriginal and Torres Strait Islander Community Controlled Health Services (CCHSs) in two urban, two regional and one rural location. There were 114 participants at baseline, and 56 participants stayed in the intervention group until 12 months. There were 127 participants in the control group at baseline, and 54 participants remained until 12 months. Ninety per cent of participants had chronic conditions such as heart disease,

diabetes, hypertension, stroke, depression and schizophrenia. The singing programs ran for 12 months, from June 2010 to June 2011. Within each community, these programs included group rehearsal sessions for two hours per week with a 15-minute break for social interaction and encouragement to individually rehearse at home.

Outcomes included a statistically significant difference between pre- and post-intervention phases in the three stressors: death of family member or close friend (12%), job loss (10.2%), seeing fights or people beaten up (9.5%). At 12 months, those who participated in the singing program showed a significant increase in singing-related mental and physical health aspects of QoL and positive affect ($p < 0.001$ and $p < 0.001$, respectively) compared with patients in the control group. There were significant differences between the singing and the control groups in the reduction of alcohol and drug use and criminal events. The 2016 publication reported results from 210 participants in singing groups across six Aboriginal CCHS locations and found a significant reduction in the proportion of adults in the singing group classified as depressed and a concomitant significant increase in resilience levels, quality of life, sense of connectedness and social support among this group. There were no significant changes for these variables in the comparison group.

Kinchin et al. (2015, 2017)^{12, 13} assessed the effect sizes and economic cost of delivering the Indigenous-developed Australian Family Wellbeing program (FWB) as empowerment training intervention for a child safety workforce in five remote north Queensland remote Indigenous communities. FWB empowerment training was offered to Act for Kids staff to enhance their social and emotional capacity to better support and provide care to the families and children in their charge. Act for Kids is an Australian not-for-profit organisation that provides services to prevent and treat child abuse and neglect. The foundation stage of the accredited FWB was delivered to 66 staff of a child protection agency; it included topics of group agreement, human qualities, basic human needs, understanding relationships, life journey, loss and grief, and beliefs and attitudes. The study extended previous qualitative research (e.g. Tsey et al. 2010, Whiteside et al. 2014)^{14, 49} and identified the best measurement tool for detecting outcomes of empowerment programs. The Growth Empowerment Measure (GEM) was found to be the most sensitive and most tangible measure that captures improvements in communication, conflict resolution, decision-making and life-skill development⁴⁸, and the research recorded a 17% effect size in the sample of child protection agency staff between pre- and post- surveys. In the Kinchin et al. (2017) study¹², retrospective cost descriptions were then taken to measure the economic cost required to deliver the FWB program from the perspective of the non-government child safety agency. The total cost of delivering the FWB program for the 66 participants was \$182,588 (\$2766 per participant) with 45% (\$82,995) of costs classified as indirect (i.e. opportunity cost of participants' time). Training costs could be further mitigated (~30%) if offered on-site, in the community. The costs for offering the FWB program to a remotely located workforce were high, but not substantial when compared with the recruitment cost required to substitute a worker in a remote setting.

Whiteside et al. (2016)²⁰ used both quantitative and qualitative methods to: a) determine the appropriateness of FWB as a tool to connect, and enhance the SEWB of, young Aboriginal men; and b) identify and test quantitative measures for routine FWB implementation and evaluation in similar situations. FWB was delivered to four consecutive groups of young Aboriginal men over a 10-week period per group; three of the groups were run in the community and one was held in a juvenile justice centre. Study participants comprised: six program organisers (the mental health program manager responsible for the overall implementation of FWB plus two FWB facilitators and three members of the project steering committee) and 30 male FWB program participants aged 16–25. FWB is a well-documented tool for engaging Aboriginal Australian adults in developing greater awareness of their emotional, spiritual, mental and physical needs and strengthening personal and community capacity to meet these needs.

In the sessions the 10 core FWB topics were integrated with physical and cultural activities such as swimming, football, basketball and visiting cultural sites with a local elder. A private Facebook page was set up as a means of communication. The young men were encouraged to write and play 'rap' songs. Where possible, the facilitators linked the young men into services that supported them to access education, work experience opportunities and employment, and ensured they had safe accommodation. Efforts were then made to reinforce change and to provide follow-up support through closing ceremonies, certificates and ongoing communication and mentorship through Facebook. Outcomes included completion of the program by 20 of the 30 initial participants; however, only 16 matched pre-post questionnaires were available. Participants experienced strong improvement in capacity to manage relationships, engagement in education and employment, and mental and physical health. A paired t-test of the Kessler K5 total score post-intervention (K5 items assess the frequency of negative feelings such as feeling without hope, or feeling restless or jumpy) showed a highly significant reduction in psychological distress across the time of the study ($t(12)=3.67$ $p=.003$) with a very strong effect size ($d=1.02$). Almost 50% of respondents, identified a major difference (i.e. four or five out of five) in behaviour on all the aspects associated with participating in the FWB program; 75% of participants indicated a major improvement and 20% a minor improvement in their ability to manage their relationships; 65% indicated a major improvement and 30% a minor improvement in their ability to deal with emotions. Participants indicated positive improvements in their attitudes to work, work-related learning, ability to lead, to cope, and to deal positively with mental health, as well as feelings of safety and positive physical health. These positive results were supported by qualitative data from program facilitators.

US programs

From the US, Kulis et al. (2017)¹⁸ tested the efficacy of the Living in 2 Worlds (L2W) substance use prevention curriculum with American Indian (AI) middle school students (aged 12–13). L2W was delivered to 107 AI youth in 7th and 8th grade in three schools in Phoenix, Arizona. The L2W curriculum is a culturally adapted version of keepin' it REAL (kiR), redesigned for urban American Indian (AI) middle school students. L2W is focused on strengthening resiliency and AI cultural engagement, and teaches drug resistance skills, decision-making, and culturally grounded prevention messages drawing on the potentially protective nature of connection to AI cultures. Outcomes included statistically significant thresholds in differences for youth receiving L2W, compared with kiR, for four outcomes: less growth in cigarette use from pre-test to post-test, less frequent use of the Leave drug resistance strategy, and less loss of connections to AI spirituality and cultural traditions. For other substance-use behaviours and antecedents, the direction of the non-significant effects in small sample tests was towards more positive outcomes in L2W and small-to-medium effect sizes.

Results suggest evidence-based substance use prevention programs that are culturally adapted for urban AI adolescents, such as L2W, can be a foundation for prevention approaches to help delay initiation and slow increases in substance use. For L2W participants, marijuana use increased in frequency ($p=.06$) but agreement that substance use is harmless decreased ($p=.04$). In contrast, despite a smaller sample size, kiR participants reported increases in five substance use outcomes that reached or neared statistical significance, including alcohol frequency ($p=.02$), cigarette frequency ($p=.01$) and amount ($p=.08$), and marijuana frequency ($p=.07$) and amount ($p=.07$).

Also from the US, Rushing et al. (2017)¹⁹ evaluated the Healthy & Empowered Youth (HEY) Project, a school- and community-based positive youth development program for 117 American Indian and Alaska Native junior and senior high school students in one Northwest tribal school. The HEY program encompassed the Native STAND (Students Together Against Negative Decisions) curriculum, which was enhanced with hands-on learning activities in media design to engage students in sexual and reproductive health topics covered by the curriculum. Guest speakers, field trips and extracurricular activities were added to provide academic enrichment, engage students in cultural activities and offer opportunities for career development. Students

also created more than 89 videos, 75 posters, two public billboards and a mural addressing health topics (e.g. drug and alcohol use, suicide, bullying, dating, violence). Outcomes included the education of tribal teens in a variety of sensitive health topics while remaining socially and culturally relevant. Students gained leadership and life skills, increased their confidence and self-esteem, and became more involved in their culture and community. Positive shifts were observed in key measures, e.g. behaviours associated with physical and mental health and protective sexual health behaviours.

Emerging practices

Appendix 3 provides details of the 17 publications that reported emerging practices (level 4); that is, interventions that are new, innovative and/or hold promise but that have not been rigorously evaluated. Of these studies, 11 were from Australia, five from Canada and one was from the US. The Australian studies were:

Australian emerging programs

Bockxmeer et al. (2015)³¹ evaluated a six-week local language yoga program aimed at improving social and emotional wellbeing in a pilot group of Australian Aboriginal children. Twenty-four Aboriginal Year 3 and 4 students aged between seven and eight years from Derby District High School in remote Western Australia participated in Wellness Walkabout Yoga exercises integrated into a structured teaching program using culturally relevant storytelling sessions from a freestanding flipbook using local language. The Strengths and Difficulties Questionnaire was administered pre- and post-intervention to participants, finding that mean total SDQ scores decreased significantly over the course of the study (difference -1.94; 95%CI -3.64, -0.24; $p=0.028$).

Carey (2013)³⁷ explored the impact of a social and emotional wellbeing service (SEWBS) in remote Australia, including issues of effectiveness and sustainability, from the experiences of people involved in the development and delivery of the service. The SEWBS comprised a suite of activities conducted on an individual, family and large group basis, including individual counselling, family therapy, narrative therapy, play therapy, sand play, traditional healing, cultural activities such as men's dancing, community engagement activities and community education. Twenty-one people with different involvement in the service, such as service providers, service participants and referrers, were interviewed. Findings indicated that the service had been experienced as an effective local response to serious problems. Implementation entailed: 1) 'The Big Picture', which included getting started, organisational factors, funding, the future, and operational problems; and 2) 'On the Ground', which entailed personal struggles, program activities, measuring outcomes, and results. Issues highlighted included appropriate staffing, localising decision-making, identifying priorities and how they would be evaluated, and developing flexibility in terms of job descriptions and qualifications.

Day et al. (2016)³² presented a case study of the Seasons for Healing Program that was piloted in five Aboriginal schools and communities, three metropolitan and two regional. The program was adapted from the mainstream Seasons for Growth program and entailed training two Aboriginal Family Support Services staff members from each community as companions to facilitate the program, with members of each community then invited to participate. Program activities were designed to help participants acknowledge hurt, name their feelings and find constructive ways to respond by focusing on those issues and concerns that they were able to influence. A process evaluation of program implementation noted a strengthening of participants' social, spiritual and emotional wellbeing. Some changes to program content were recommended before further implementation. To date, there has been no attempt to assess program outcomes.

Fletcher et al. (2017)³⁸ tested the acceptability and feasibility of developing a website offering tailored support and information to young Aboriginal fathers; and adapted and tested a mobile phone-based text-messaging and mood-tracker program that provided ongoing social, cultural and emotional support to the fathers to address issues in relation to mental health and wellbeing. Twenty young Aboriginal fathers (18–25 years, with all fathers having at least one young child at the time of enrolment) were recruited as co-investigators to develop the Stayin' on Track internet and mobile app across three Aboriginal Community Controlled Health Services (ACCHS) in one regional city and two rural towns in NSW. 'Yarn up' discussions with the fathers and community members were held at the three locations. Young fathers were filmed talking about their experiences of fatherhood. *SMS4dads* messages were reviewed and modified by the two Aboriginal mentors. Participants were also asked to monitor their mood on a weekly basis. The young fathers' films were presented at community events, and approximately 170 people viewed them. Outcomes included effective engagement of young Aboriginal fathers through participatory approaches using a strengths approach and investing time and resources in community consultations, and preliminary evidence for the feasibility and acceptability of providing support to young Aboriginal fathers through mobile phone-based text-messaging and mood-tracking programs to assist them in the transition to fatherhood. Young Aboriginal fathers and community members expressed unanimous support and pride in the project outcomes.

Henwood et al. (2017)³⁹ undertook five case studies of Men's Groups/Sheds across urban, regional and remote areas of Australia to examine the social opportunities they created for Indigenous men. Men's Sheds are a safe space, resembling a workshop setting or backyard shed, where men are encouraged to socialise and participate in health promotion, informal learning and engage in meaningful tasks both individually and at the community level. Sixty-one Indigenous men participated in interviews/focus groups. The study found the effective development of social relations and socially designed programs through Men's Groups, operating as communities of practice, may contribute to overcoming many social and health wellbeing concerns. Men's Sheds are a safe environment for Indigenous men to seek refuge in. In each of the five sheds there was overwhelming support for the Men's Shed as the catalyst to enhance social opportunities and bring men together in a safe place where they can pursue positive changes to their lives.

Isaacs & Lampitt (2014)⁴¹ described the design, implementation and outcomes of an innovative model for the early detection of mental illness among rural Aboriginal men (aged 18+) in Central Gippsland, Victoria. Twenty men participated in a Koori Men's Health Day, where an assembly line technique was used to provide a complete medical examination, a blood test for diabetes and a psychological assessment using the Kessler-10 schedule. The term 'mental' was avoided. The study used data from 17 participants and concluded that the Koori Men's Health Day, when conducted on a regular basis, has potential as a useful method for the early detection of mental illness among rural Aboriginal men in Australia.

Lee et al. (2013)⁴² provided a profile of Aboriginal women attending an inner-city outpatient alcohol and other drug (AOD) treatment service, and insight into how effective women and staff perceived the support group to be at meeting their needs and suggestions for improvements. The Aboriginal women's group was offered one morning a week for three hours, facilitated by two females — one Indigenous AOD worker and a non-Indigenous counsellor. The group format included informal conversation, art and craft, and recreational and educational activities (e.g. on treatment options, parenting, first aid or financial management). Children were welcome, with childcare and lunch provided. Clients reported social and health indicators illustrating disadvantage and complex needs. Most clients and staff perceived the group to be useful and easily accessible. The participants discussed positive elements including opportunities for shared experience in a non-judgemental environment, practical support and health education. Staff reported how the safe, relaxed environment of the group helped with early identification of issues and user-friendly

pathways for treatment access. Suggested improvements included greater involvement from Aboriginal staff and community members and enhanced communication with other staff.

Robinson et al. (2016)⁴⁴ described the process of developing and piloting Skills for Life (SFL), the Indigenous Youth Life Skills Development program (a preventive life skills curriculum) to 51 Indigenous middle school students (Years 7–9) in a very remote community college in the West Arnhem region of northern Australia. The aims of the pilot implementation project were to develop a 12-week curriculum and resources that could address both general promotion of resilience and the need for specific prevention relevant to known risks in Indigenous communities, to trial a collaborative process for joint delivery in middle school classes and to gauge student responses to content and the program delivery process. The Skills for Life (SFL) curriculum integrates proven educational and psychological techniques with culturally informed notions of relatedness. In total, 11 lessons were developed on the following themes: strengths in the community; character strengths; emotional literacy and managing strong emotions; positive thinking and problem solving; passive, aggressive and assertive communication; dealing with grief and loss; saying 'no' to alcohol; and help-seeking and working together with friends. Indigenous co-facilitators were involved in program delivery to help make it more culturally safe for young people and to help with youth engagement. The pilot program confirmed the need to adjust both the pedagogical approach and the curriculum content for young people with low English literacy levels and with variable school attendance patterns, for this cultural context, and for the students' varying levels of exposure to multiple stressors in disadvantaged community settings.

Southcombe et al. (2015)⁴⁶ investigated management capacity building approaches at the community level in Indigenous Men's Groups and Sheds. Three key research questions were examined: 1) what are the needs of Indigenous men in Men's Groups and Sheds? 2) how does community capacity building, as a management practice, work in Indigenous Groups and Sheds? and 3) in what ways does capacity building impact on Indigenous men's health and wellbeing outcomes? Fifteen Men's Groups/Sheds from urban, regional and remote communities were included and the study involved 45 men. Themes in the data revealed: 1) the need for men to connect and engage with community groups; 2) the main issues that impact on Indigenous men and the support groups can provide; 3) how Men's Groups and Sheds are pivotal avenues for capacity building; and 4) the ways in which Men's Groups and Sheds provide opportunities to make a difference to men's overall health and wellbeing. The study found capacity building is primarily about securing relationships between Group leaders/Shed co-ordinators and government services. Capacity building establishes links to services such as Centrelink, Medicare, Department of Housing, Probation and Control, and positive outcomes such as Indigenous men securing housing and Centrelink payments. Capacity building results in better health outcomes and educates and empowers men to improve their social, cultural, emotional and economic wellbeing. It helps men to better connect with family and community.

Togni (2017)⁴⁵ described the Uti Kulintjaku Project, which took an innovative approach to developing a process to strengthen a shared understanding of mental health between Anangu people from Central Australia and non-Aboriginal health professionals, with the long-term aims of increasing help-seeking and strengthening health services' cultural competency and Aboriginal leadership. A series of 10 three-to-four-day workshops over three years has been a key mechanism of the project. Evaluation of the project used reflective practice, participant observation, focused discussion groups with Aboriginal participants, and 21 semi-structured, in-depth key stakeholder interviews.

The project resulted in a model to facilitate clear thinking, enable safe ways to talk about difficult issues, foster healing and empowerment, and explore new ways to enhance mental health and wellbeing. It achieved a range of outcomes at a personal, group and project level: capacity development of the team of

senior Aboriginal women; increased bi-cultural understanding of mental health; and emphasis on the importance of culture in enhancing Aboriginal mental health and wellbeing. A multilingual compendium of words and phrases was created and innovative resources were produced. The poster — or 'words for feelings map' — is the most widely known resource produced to date. It contains Pitjantjatjara/Ngaanyatjarra and English words for feelings and emotions and includes drawings of people expressing these feelings and emotions within a community setting. Partnerships with mental health services were also strengthened.

Canadian emerging programs

Fanian et al. (2015)³³ evaluated a creative arts workshop for Th̓cho̓ youth in Behchoko̓, North West Territory, Canada, where young people explored critical community issues and found solutions together using the arts. Ultimately, the goal was to develop a community-led youth-driven model to strengthen resiliency through youth engagement in the arts in circumpolar regions. Nine youths participated in the Ko̓ts'i'ht̓la ('We Light the Fire') project to explore critical issues in their communities and lives and to find solutions together using creative arts (art as vehicle for social change), and to build resiliency among young people and promote healthy minds, bodies and spirits through the arts (art as vehicle for promoting healthier youth and communities). The objectives included: a) building confidence and personal/artistic skills among youth participants; b) connecting youth with one another and to positive role models; and c) demonstrating to youth how art can be a way to express oneself and to deal with various issues in our lives and communities. The study found the young people reported gaining confidence and new skills, both artistic and personal, and many found the workshop to be engaging, enjoyable and culturally relevant. They expressed an interest in continuing their involvement with the arts and spreading their messages through art to other youth and others in their communities.

Healey et al. (2016)⁵⁰ responded to a community-identified need to form an evidence base for interventions to promote mental health and wellness among youth in Nunavut. The Eight Ujarait (Rocks) Model was implemented as a camp program in six pilots in five communities, with 37 participants involved in community consultations, and 48 youth participants, eight youth peer leaders, and 15 facilitators participating in the camps. Core concepts from the literature and community dialogue sessions were incorporated into a model for wellness interventions focusing on Nunavut youth. The model was piloted as a youth camp program to validate the core concepts of the model. The Eight Ujarait (Rocks) Model highlights eight core constructs, which symbolise the formation of a solid stone foundation comprising skills and knowledge upon which young people build their lives. The modules/ujarait promote positive social interactions; opportunities for self-reflection and self-expression; cultural skill-building; and exploring the relationship between healthy minds and bodies. The evaluation found the program fostered physical, mental, emotional and spiritual wellness among youth. Parent observations of participants included an improvement in behaviour and attitude, stronger cultural pride, greater confidence in identity, and improved family and community relationships. The application of one such model through a camp program had a lasting impact on the individuals involved, beyond their immediate participation. The evaluation concluded that evidence-based community-driven models for youth mental health interventions in the North thus hold extraordinary promise.

Hirsch et al. (2016)⁴⁰ provided an interpretive description drawing from autobiographical accounts of the development of the innovative Going Off, Growing Strong resilience program for at-risk Inuit youth in Nain, Nunatsiavut. Ten participants (aged 14–21) were selected for this program by the steering committee. Priority was given to youth who were most at risk (suicidal ideation and substance abuse at home) and who had the least access to healthy adults who could take them off on the land. The program entailed a community freezer youth outreach program to: 1) enhance the mental, physical and spiritual health of a group of at-risk youth; 2) build social connections between the youth and other community members; and

3) transmit environmental knowledge, skills and values from experienced harvesters to the youth. Experienced and trusted harvesters were recruited to take the youth out on the land, in small and large groups, to teach them how to hunt, fish, collect firewood, navigate on the land, and prepare country foods. Community-based activities aimed to build connections among the youth, between participants and program staff, and between the youth and other community members such as elders. The study found that a multifaceted approach to relationship and skill-building can help communities respond to change and adversity through individual and collective resilience.

Malone and Stanley (2013)⁴³ described first-person accounts by a psychologist and a social worker of their experiences developing and piloting community-based mental health programs for a rural Albertan Cree community, and provided an overview of two pilots, the Family Wellness Program and the community-based Anger Management Workshops, reflecting on attempts to integrate mental, physical, emotional and spiritual considerations consistent with the community cultural context. The community-based Anger Management Program was developed in collaboration with the local National Native Alcohol and Drug Abuse Program, as a two-day program that included prayer, art therapy, cultural teachings, psycho-education, group sharing circles and relaxation training. The focus is on identity, multigenerational trauma, power and control, and developing support networks. This ongoing development sequence included planning meetings, debriefings, and direct collaboration with program participants. Community elders were frequently consulted and periodically attended the program. Core aspects of the program integrate physical, mental, emotional and spiritual aspects of anger with a focus on wellness rather than pathology, consistent with understandings of local Cree cultural teachings. Transportation and food are provided and the training takes place at a neutral community location with time balanced between indoors and out, in conversation and in activity, in sharing and in teachings. Other professionals are invited to attend, both to participate and to provide consultative evaluations on the program itself.

The Family Wellness Program included workshops, crisis intervention and support to single mothers, and developed to include a family wellness component that incorporated cultural teachings, elder support, psycho-education, group sharing circles, and regular home visits and individual counselling sessions. There was more focus on identity, self-care and relational health rather than strictly parenting. The program's aim evolved to empower rather than to teach. The maternal health coordinator focused her individual and group efforts on the mothers in the program; the male coordinator included individual and group work with the fathers in an attempt to engage them in family processes as fathers and men. Outcomes included anecdotal evidence of strong community support and demand for the program, as well as positive, healing and empowering experiences for those attending the group.

Ritchie et al. (2014)³⁴ evaluated the impact of an outdoor adventure leadership experience (OALE) on the resilience and wellbeing of 73 First Nations adolescents (12–18 years) from the Wikwemikong Unceded Indian Reserve in northern Ontario, Canada. The secondary purposes were to explore whether this impact was sustainable, and whether there were any intervening factors that may have influenced the impact. The OALE is a 10-day intensive program involving a wilderness canoe expedition homeward through the traditional territory of Wikwemikong. Participants were assigned day leadership responsibilities, and the experience included a half-day solo component. Group discussions and talking circles occurred each night around a campfire. Program staff and guides from Wikwemikong facilitated the experience, mentored the youth participants, and implemented program elements as needed and when appropriate. Over two years, 73 youth participated, representing 15% of the on-reserve adolescent population. Survey responses from 80.8% of participants were available at T1, 64.4% at T2 and 45.2% at T3. The mean RS-14 improved between T1 and T2 but returned back to pre-OALE levels at T3. Intervening factors reported at T3 included changes in family living situation, death in the family, and other life stressors that occurred over the course of the year and may have influenced the decrease in resilience scores from T2–T3.

US emerging program

Lee & Gobert (2015)³⁶ engaged in adaptation/translation of a mindfulness curriculum for cultural relevancy with Native American traditions and spiritual practices, and tested the feasibility of translating and implementing a culturally adapted mindfulness-based prevention curriculum with a sample of Native American youth from a Native American school in a reservation located in rural northwestern Montana. Eight youth (mean=17 years old, range= 5–20; five males) signed up for the class and participated in the pilot study. The school-based, culturally adapted mindfulness curriculum provided tools for Native American youth to recognise and manage self-destructive thoughts and emotions along with developing the capacity 'to be' with difficult thoughts and emotions (distress tolerance). The authors argue mindfulness is consistent with important aspects of Native American spirituality such as being virtuous, righteous and balanced, and incorporating the theme of interconnectedness and inter-being.

There were nine modules in the culturally adapted version including mindful breathing, mindful listening, mindfulness of nature, mindfulness of body, mindfulness of thoughts, mindfulness of emotions, cultivating compassion and empathy, judgement and forgiveness, and aligning with vision. The class was conducted in council style, a Native American practice whereby everyone sits together in a circle to encourage and practise speaking and listening from the heart. The mindfulness class was offered as an elective class at a Native American school that was run four times per week, 55 minutes per session, over 10 weeks. It was part of a larger comprehensive suicide prevention strategy called the Circle of Trust Suicide Prevention Program, which included coordination of suicide prevention services, gate-keeping activities and a social media campaign. The evaluation found the intervention was acceptable to Native American youth, with positive indications in terms of better self-regulation, less mind-wandering and decreased suicidal thoughts. There was a slight trend towards lower impulsivity. The young people self-reported that they gained useful skills to help them deal with stress and made new friendships and strong connections.

Grey literature

Appendix 4 provides details of the eight grey literature documents found and included for review. These included two reports of promising policies / policy frameworks and six studies of emerging practices. The promising policies / policy frameworks included the Australian National Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023 (Commonwealth of Australia, 2017) and a framework to inform and provide strategic direction to improve the mental health service system's capacity to support and improve the social and emotional wellbeing and mental health of Victorian Aboriginal people, families and communities (Victorian Government, 2017). The emerging practices were from Australia (n=5) and Canada (n=1).

Studies focused on suicide prevention and treatment of mental illness

Appendix 5 lists the 16 studies that focused primarily on suicide prevention and/or treatment of mental illness, but also had a SEWB component. These studies were excluded from the Evidence Check but are provided here as supplementary information.

Question 2:

What are the components; workforce requirements (e.g. skills, qualifications, training, cultural awareness); location; target audience and reach; cost; outcomes; cost-effectiveness; and referral pathways of the policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians?

The social and emotional wellbeing programs encompassed multiple components. They included art sessions^{9, 11}; music/singing^{9, 15-17, 21}; sports⁹; bush camps⁹; promotion of culture and identity^{9, 11 9}; building

individual, organisational and community capacity⁹; education sessions on alcohol and other drugs, mental health, health and violence^{9, 11}; referral to medical and other services^{11, 15-17, 20, 21}; training courses in e-mental health¹⁰; delivery of empowerment training integrated with physical and cultural activities²⁰; support to access education, work experience opportunities, employment, and safe accommodation (Whiteside et al. 2016); childcare and transport¹¹; and TAFE enrolment and tutoring services.¹¹ Programs were either developed by, (e.g. Kinchin et al. 2015, 2017; Whiteside et al. 2016)^{12, 13, 20} or culturally adapted for, Indigenous people e.g. (Dingwall et al. 2015).¹⁰

The workforce requirements for the policies, programs or services aimed at improving social and emotional wellbeing for Indigenous Australians entailed the need for a skilled, motivated and stable workforce⁹; staff based on-site⁹; employment, training and mentoring of local Aboriginal staff^{9, 11, 15-17, 20, 21}; training in the program^{9, 20}; co-facilitation by a local Aboriginal person and trained expert, e.g. psychiatrist, musician, researcher.^{10, 15-17, 20, 21}

The locations of the policies, programs or services aimed at improving social and emotional wellbeing for Indigenous people encompassed urban^{9, 11, 15-17, 21} and remote geographical settings.^{9, 10} They were located within primary healthcare services (including ACCHS)^{10, 15-17, 21}; schools and tertiary education institutions⁹; community support groups²⁰; and other human service providers.^{10, 20}

The target audiences and reach of the policies, programs or services aimed at improving social and emotional wellbeing for Indigenous people included youth⁵¹; young parents and their children¹¹; young men²⁰; adults^{15-17, 21}; and service providers.¹⁰

The client outcomes of the policies, programs or services aimed at improving social and emotional wellbeing for Indigenous people included increased self-esteem, empowerment, resilience and/or the ability to speak up^{9, 11, 15-17, 21}; learning how to deal with painful emotions without resorting to alcohol and drugs^{9, 20}; making friends and improved relationships^{9, 20}; increased confidence at school and in life generally⁹; a new sense of Aboriginal identity⁹; positive improvements in their attitudes to work and work-related learning²⁰; leadership^{9, 20}; improved parenting confidence¹¹; quality of life^{15-17, 21}; social support^{15-17, 21}; and improved ability to cope and to deal positively with mental health, as well as feelings of safety and positive physical health.²⁰ Additionally, clients experienced health and social outcomes such as a reduction in psychological distress²⁰; improvement in maternal and child wellbeing¹¹; engagement in further education and employment^{9, 11, 20}; and a reduction in alcohol and drug use and criminal events.^{15-17, 21}

Staff outcomes included increased knowledge, skills and confidence of local Aboriginal staff⁹ and skill and knowledge in using e-mental health tools with Indigenous clients.¹⁰ Broader community outcomes included increased use of health, education and support services¹¹; and an environment of social connectedness.^{11, 15-17, 21} One Australian study reported the costs and cost-effectiveness of the policies, programs and services aimed at improving social and emotional wellbeing for Indigenous people.¹²

The referral pathways for clients of the policies, programs and services aimed at improving social and emotional wellbeing for Indigenous people included self-selection¹⁰ and selection by their organisation.¹⁰ For example, some organisations selected participants through active recruitment by the early childhood and midwifery team, based on vulnerability or risk factors such as teenage parenthood and lack of social support,¹¹ or perceptions of risk of self-harm, most often because they had been suspended from school for lengthy periods²⁰ or incarcerated in the juvenile justice system.²⁰

Question 3:

What are the barriers and enablers to effective implementation of policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians?

Conditions were defined as the environments that facilitate or constrain the implementation of policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians. We applied a social ecological perspective to the definition of conditions, acknowledging that SEWB is influenced and impacted at multiple levels by individual, family, community, culture, geographical, economic, institutional and policy factors. The studies reported individual-level conditions that affected SEWB as self-esteem, self-efficacy, confidence and purposefulness;^{15-17, 21} being male;²⁰ and young, with young people constituting a considerable proportion of the Indigenous population and being an important group in realising community visions and strengthening community capacity.⁹ Reported family conditions included family-level warmth, affection, cohesion, commitment, coherence and emotional support;^{15-17, 21} and family difficulties.²⁰ Community conditions included high levels of mental health disorders, chronic disease and maternal and child health and associated lower quality of life in Indigenous populations;^{10, 11, 15-17, 21} mental health issues and loss of social and emotional wellbeing among young people across most measures of health, education, employment, and involvement in the justice system;⁹ and community social support.^{15, 16}

Broader conditions were associated with: 1) culture: cultural difference can create distance within mental health settings¹⁰; 2) economic factors: lower socioeconomic circumstances, higher unemployment, higher representation in the criminal justice system²⁰; 3) geography: geographical remoteness means, for some Indigenous communities, mental health care needs are often addressed by primary care workers who are frequently overworked and untrained in mental health assessment and care¹⁰; 4) institutional factors: poor health service access^{10, 17}; perceived cultural inappropriateness of services¹⁰; some services may lack the capacity to take account of Indigenous conceptualisations of health and wellbeing;¹⁰ schools and services are not engaging a growing number of young people²⁰; consequences of disengagement are linked to higher rates of social and mental health problems, including alcohol and drug use²⁰; 5) programs: the evidence base to inform initiatives to improve the social and emotional wellbeing of Indigenous people is limited^{9, 16}; and 6) policy: the Australian Government's National e-Mental Health Strategy identifies promotion of Indigenous e-mental health services as a key priority¹⁰; primary health networks were established by the Australian Government to coordinate primary healthcare delivery and tackle local healthcare needs and service gaps²⁰; and funding to pilot programs.²⁰

Enablers are the factors that facilitate the effective implementation of policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians. Program-related enablers identified were: cultural adaptation of the program for Indigenous people⁹⁻¹¹; cultural expression through arts and/or music¹¹ and building on the strengths of Indigenous culture, community and family⁹; targeted support for program implementation⁹; clarity about program purpose, objectives, requirements and ways of working⁹; longer, more intensive activities and multifaceted events⁹; differentiation of client need/support⁹; training to facilitate translation of the skills learned into practice¹⁰; post-training follow-up support¹⁰; Aboriginal workers who can improve cultural security, act as role models and establish relationships based on trust¹¹; and continuing quality improvement processes and evaluation.⁹

Enablers of implementation at community or broader levels included community partnerships^{9, 11, 16}; community consent from the boards of participating Community Controlled Health Services²¹; being led and controlled by local people^{9, 11}; engaging the broader community^{9, 11}; exerting an impact at multiple levels⁹; and addressing upstream social determinants of wellbeing as well as current issues.^{9, 11}

Barriers are the factors that hinder the effective implementation of policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians. Barriers included recruitment and staff turnover⁹; staff based off-site⁹; the limited availability of technology for e-mental health implementation in remote sites¹⁰; and the limited impact of mainstream interventions due to reduced

access and engagement, later presentation, failure to address social determinants affecting healthy behaviours, and lack of Aboriginal staff.¹¹ Barriers that affected program evaluations included small sample sizes that decreased the power to detect the effect of the program¹⁶ and relatively high dropout rates of participants.¹⁶

Gaps in the evidence

Several key gaps in the evidence were apparent in the review. The most prominent was the absence of best-practice evidence; there were no documents assessed as best practice for improving SEWB. Our finding that studies focused primarily on qualitative methods suggests an imperative to continue to enhance the evidence base by incorporating quantitative components in more compelling evaluation designs. More rigorous designs will help raise the lower quality of extant evidence. It should be noted, however, that enhanced methodological approaches are difficult to implement where sample sizes are small, as was the case in many studies.

Other methodological gaps included: 1) lack of consistency across programs; 2) a need to standardise and develop culturally appropriate screening tools and outcome measures; and 3) a need to conduct economic analyses.

Because the largest proportion of SEWB programs and services focused on children and youth, more methodologically rigorous evaluations will ideally target Indigenous people across the life-course as per the calls for this approach in existing evidence.⁵²

Discussion

SEWB is culturally embedded for Indigenous people, and critical to good physical health, mental health, sense of self and relationships, life purpose and cultural continuity. It includes *“not just the physical wellbeing of the individual but the social, emotional and cultural wellbeing of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life”*.⁵² Particularly important in achieving this state of wellness are *“connectedness to family and community, control over one’s environment and exercising power of choice”* (South Australian Aboriginal Health Partnership 2005, p6).⁵² The connection to land is also a critical factor for many Indigenous Australians because it *“constitutes one’s sense of individual and social identity and responsibility”*.¹ With these boundary definitions in mind, this Evidence Check sought to respond to the overarching question: What policies, programs or services have been effective in improving social and emotional wellbeing for Indigenous Australians?

The review revealed a lack of evidence for policies, programs or services that are effective in improving SEWB for Indigenous nations. We found no best-practice evidence and identified only 10 papers as promising-practice evidence. Further, there were evidence gaps in many of the studies, and extrapolation of various elements necessary to assess effectiveness was absent or poorly articulated. This made it difficult to synthesise and formulate what is most useful or promising to improve SEWB. However, services and programs that showed potential had a number of redeeming elements. These included: cultural embeddedness of initiatives; Indigenous engagement, partnerships and leadership; service integration; incorporating and accounting for the social determinants of health; workforce development; program adaptation; multi-level program components; targeted specific issues; accounting for holistic views of health and wellbeing; incorporating brief interventions and short-term education components; and consistent and reliable service delivery.

Three key sub-questions elaborated on the detail of the evidence:

Question 1:

What is the quantity and nature of available literature?

The final synthesis and analysis included 37 publications – 29 peer-reviewed papers and eight grey literature publications. The SEWB literature for Indigenous nations across seven countries revealed that the volume of original research publications was randomly dispersed and has not increased from 2013 to 2018. In fact, there were no publications in 2018 and only two in 2014. This finding suggests SEWB is being paid minimal attention by health professionals, policy makers and researchers, despite its significance as a moderator of good physical and mental health and an essential for Indigenous Australians.²⁸

Of the 29 peer-reviewed publications, 11 were evaluation studies, six were measurement studies and 12 were descriptive studies. Across time, numbers of publications in these categories can provide some indication of whether research efforts have progressed beyond describing the problem of Indigenous SEWB to demonstrating how to implement change in the field.²² Findings therefore suggest that SEWB research is currently in its exploratory phase. The nature of the SEWB publications also shows that little research has explored the effectiveness of SEWB policies, programs and services, captured its impact qualitatively or quantitatively, developed appropriate measures or assessed its cost-effectiveness. This finding is consistent with numerous reviews conducted across a number of specialisations in Indigenous health including health, program transfer and implementation, mentoring, sexual assault, cultural competency, child and maternal

health and suicide prevention⁵³⁻⁵⁷ However, while there was a stronger focus on descriptive publications, there is value in extrapolating their components and characteristics, which can provide valuable evidence and lessons for developing the field of SEWB further.

There are two key national policy documents addressing SEWB for Indigenous people in Australia. The first, the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023, complements the Fifth National Mental Health and Suicide Prevention Plan and contributes to the vision of the National Aboriginal and Torres Strait Islander Health Plan 2012–2023.^{2,8} This framework notes, importantly, that the inclusion of culture in promoting health and social and emotional wellbeing is central to the health and wellbeing of global Indigenous nations. Similarly, the second policy document, the Aboriginal Social and Emotional Wellbeing Framework 2017–2027²³ detailed similar recommendations for working to improve the SEWB of Aboriginal people in Victoria.

Question 2:

What are the components; workforce requirements (e.g. skills, qualifications, training, cultural awareness); location; target audience and reach; cost; outcomes; cost-effectiveness; referral pathways of the policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians?

Question 2 considers the key components and attributes of SEWB policies, programs and services in improving social and emotional wellbeing for Indigenous Australians. Of the 29 peer-reviewed publications, none comprised best-practice evidence and only 12 were identified as having promising-practice evidence. The number and heterogeneity of conditions, activities, outcomes and measures identified through the analysis made engaging in meaningful synthesis difficult. What was evident is that SEWB is a missing link in efforts to improve health and other outcomes for global Indigenous nations. It is the soft capacities that service providers, other health professionals and governments overlook. It appears to be an afterthought, with few staff trained in this specialised area and insufficient dedicated funding. Demonstrated client outcomes indicate SEWB programs and services are much needed as a targeted strategy to improve the health and wellbeing of Indigenous people. Outcomes of the SEWB programs and initiatives reported were very much aligned with the nature of the issue being addressed and/or the strategies implemented.

Only 12 of the 37 publications identified provided any direction on the value of policies, programs or services to improve SEWB. The combination of elements was dependent on the issue being addressed. The most common themes for promising directions in service delivery and program implementation included promotion of culture and identity; collaborative community-driven initiatives; collaborative partnerships with education institutions; education sessions on mental health and SEWB risk factors such as alcohol and drugs; building individual, organisational and community capacity; program adaptation for targeted issues; and creative programs such as arts and music.⁹ Jersky et al. (2016) found that a parental SEWB program combined culturally embedded approaches and community engagement with education programs and culturally appropriate activities such as artwork.¹¹ This was similar to the findings of Blignault et al. (2016).⁹ Additionally, program implementers sought to offset social disadvantage by providing childcare and transport so participants could attend the program. Other success factors included relationships and Aboriginal leadership; providing reliable and consistent service; fostering connections to other services; maximising opportunities and empowerment. Whiteside et al. (2016) integrated Family Wellbeing program topics such as leadership and understanding basic human needs into physical and cultural activities.²⁰ Sun & Buys (2013a,b,c, 2016) reported the evaluation of a singing program that involved regular two-hour rehearsals across a 12-month period.^{15-17, 21} The program targeted clients with chronic physical and mental health conditions. Kulis et al. (2017) evaluated a culturally adapted program that focused on building resilience, cultural connectedness and engagement and developing skills for youth¹⁸; and Rushing et al.

(2017) followed other implementation processes with promising outcomes by delivering a culturally developed curriculum targeting health-related topics.¹⁹ A combination of engagement and academic enrichment activities was embedded in cultural activities.

Taking a different approach, the study by Dingwall et al. (2015) focused on developing staff capacity to improve the uptake and delivery of a SEWB program.¹⁰ It identified the success of an embedded client empowerment and recovery approach in an e-mental health training course. Like Blignault et al. (2016), the approach promoted wellbeing through clients using an adapted program and delivery of brief interventions. The course also provided a 'toolbox' of culturally appropriate strategies and tools to clients.⁹

Most often SEWB initiatives were implemented to address an entrenched problem such as disengagement from school, parenting concerns, psychological distress or substance abuse issues. However, SEWB programs and services are likely to produce the best outcomes through prevention and early intervention strategies. A pressing point was the need for staff training and culturally competent service delivery and culturally tailored locally developed programs. The evidence suggested there was very little understanding of current trajectories of Indigenous people through the mental health care system and/or referral pathways.

Workforce requirements were primarily addressed in terms of barriers, e.g. where inadequate skills, qualifications, training, or cultural awareness impeded good implementation of services and programs. They included a need for staff stability; staff who are based on-site; dedicated staff training in SEWB and mental health; training in cultural competence and/or a culturally competent workforce; and strategies that address staff wellbeing.

Question 3:

What are the barriers and enablers to effective implementation of policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians?

Twelve publications demonstrated promising evidence for improving social and emotional wellbeing for Indigenous Australians, the details of which can be found in previous sections. The shared themes reinforcing promising practice require solutions that take an ecological, strengths-based, life-course perspective that includes the social and cultural determinants of health and comprises: co-development with communities and strong community interest and engagement; Indigenous leadership; sustainable funding; workforce development including culturally competent practice; improved service access; continuity of care and improved infrastructure such as primary health networks; coordinated/integrated care; and embedded research and evaluation.

The necessary conditions or environments that either facilitated or constrained the implementation of policies, programs or services that show promise in improving social and emotional wellbeing for Indigenous Australians are listed in Table 2. Enablers of SEWB implementation fit easily under four key categories: 1) respecting culture; 2) relationships and Indigenous leadership; 3) service/program delivery; and 4) embedded research and evaluation.

Six conditions that constrained the implementation of SEWB programs and services as outlined in Table 2 are: 1) staff capacity; 2) geographical environment; 3) cultural diversity; 4) programs and services; 5) late intervention; and 6) research. Staff recruitment and high turnover was particularly detrimental to the delivery of SEWB programs and services.

Table 2 Enablers and barriers to improving SEWB

Enablers	Barriers
<p>Respecting culture</p> <ul style="list-style-type: none"> • Building the strengths of Indigenous culture, community and family • Cultural adaptation of programs • Cultural expression through arts/music • Cultural security <p>Relationships and Indigenous leadership</p> <ul style="list-style-type: none"> • Community partnerships • Community consent • Control and leadership of Aboriginal people • Engaging the broader community • Trusting relationships • Role models <p>Service/Program delivery</p> <ul style="list-style-type: none"> • Addressing upstream social determinants and current issues • Continuity of care — post-training follow-up support • Funding • Good co-ordination of service delivery in primary healthcare • Meeting local service gaps • Exerting impact at multiple levels • Longer, more intense, multifaceted events • Implementation of e-health • Aboriginal workers • Targeted support for program implementation • Differentiation of clients' needs/support • Training to facilitate translations of skills into practice • Policy alignment <p>Embedded research</p> <ul style="list-style-type: none"> • Embedding continuous quality improvement processes and evaluation 	<p>Staff capacity</p> <ul style="list-style-type: none"> • Staff recruitment and turnover • Staff based off-site • Lack of staff training in SEWB and mental health • Staff cultural competence • Overworked staff <p>Geographical environment</p> <ul style="list-style-type: none"> • Limited technology • Remoteness • Lower socioeconomic circumstances <p>Cultural diversity</p> <ul style="list-style-type: none"> • Implementing mainstream interventions • Failure to recognise cultural difference <p>Programs and services</p> <ul style="list-style-type: none"> • Failure to address the social determinants of health • Failure to engage young people <p>Late intervention</p> <ul style="list-style-type: none"> • Late presentation • Poor access to services <p>Research</p> <ul style="list-style-type: none"> • Methodological rigour • Poor SEWB evidence base

Recommendations

Promising-practice evidence identified comprehensive and culturally sensitive strengths-based approaches as showing potential for success. The concept elements that were consistent across this evidence were: cultural embeddedness; Indigenous engagement, partnerships and leadership; service integration; incorporating and accounting for the social determinants of health; workforce development; program adaptation; multi-level program components; targeted issues; accounting for holistic views of health and wellbeing; brief interventions and short-term education components; and consistent and reliable service delivery. The Evidence Check found two key policy documents in the grey literature. One was a national policy that aimed to “*respond to the high incidence of social and emotional wellbeing problems and mental ill-health, by providing a Framework for action ... [and] to shape reform at the national level*” (p7).²⁸ The other was an Australian state policy document from Victoria that aimed to inform and provide strategic direction to improve mental health service systems’ capacity to support and improve SEWB and mental health: the Aboriginal Social and Emotional Wellbeing Framework 2017–2027.²³ The underpinning principles in both policy documents encouraged a comprehensive and culturally sensitive stepped-care model that embeds service integration and advocates for systems strengthening.

Recommendations

A key finding of the review was that no papers met the criteria for best-practice evidence. There were, however, 12 papers that demonstrated evidence of promising practices. In the absence of best-practice evidence, we synthesised the findings from the two policy documents and the 12 studies to develop the following themes in the form of recommendations for Beyond Blue. The recommendations are underpinned by the methodological inadequacies identified in the papers providing promising evidence; the enablers of service delivery and interventions aimed at improving SEWB; and the barriers that prevented the successful implementation of such. Similar statements of recommendation can be found in most reviews where policy, program and service delivery and implementation for Indigenous people are the focus of the research questions. One plausible explanation for repeated recommendations is that these are never taken up, and/or, where they are, the interpretation and implementation of these are problematic.

We recommend that Beyond Blue take a comprehensive multi-level approach at a systems/service level, a community level and an individual level in its efforts to advocate for policy, program and service-level change. We propose five key recommendations that can be activated through focused efforts that align planned activities with current promising-practice evidence from this Evidence Check to optimise Beyond Blue’s investments to improve SEWB across the life-course for Aboriginal and Torres Strait Islander Australians.

Recommendation 1: Embrace a strengths-based perspective and practice in a culturally inclusive approach

Health, for Indigenous Australians, is viewed as holistic and encompassing mental health and physical, cultural and spiritual health. Concordance between these elements must be observed for good health and wellbeing. Importantly, this must be underpinned by a recognition of the strengths of culturally oriented knowledge and practices that can, in turn, shape the provision of services and guide assessment, care and management alongside Western knowledge and systems.^{9, 28, 48}

Efforts to improve SEWB should engage with, and seek to activate change in the following areas:

- Ensure cultural respect through promoting practitioners’ and researchers’ self-awareness of their beliefs, attitudes and behaviours and acknowledgment and support for Indigenous people’s rights

to hold and express different values, norms and aspirations.⁵⁸ We have conducted extensive work on cultural competency. The most recent evidence for what works at multiple levels is collated in our book published in 2018⁵⁹

- Build the strengths of Indigenous culture, community and family across the life-course
- Ensure the cultural adaptation of programs and services — ‘one size fits all’ approaches do not work
- Enable cultural expression through arts/music and the like
- Ensure cultural security for participants and cultural competence of service staff
- Account for the culturally diverse and dynamic nature of environments in the development and implementation of policies, programs and services
- Foster trusting relationships and ensure Indigenous control and leadership
- Engage in community partnerships
- Ensure that conditions for community consent are satisfied, i.e. that community members participate, are fully informed, understand and voluntarily decide to engage in the program and associated research
- Promote Indigenous role models.

Recommendation 2: Ensure concordance between mental health and physical, cultural and spiritual health for good health and wellbeing

Indigenous Australians have a holistic view of health, their environments and the world at large. The interconnectedness of these various domains must be recognised and acted upon to achieve good health and wellbeing outcomes. This approach is especially important for Indigenous Australians, who often experience complex health and social and emotional concerns and difficulties engaging with the social determinants of health.

Change efforts should focus on systems and service-level change and consider the following:

- Healthcare systems and services must lead in providing care that aligns with clients’ ways of viewing and being in the world
- Comprehensive integrated stepped-care approaches are strongly recommended as a way of meeting this challenge. There is currently a strong move towards system-level strengthening and measures that ensure service integration. Integration of healthcare, public health and social services systems enable people to receive more timely, better quality care
- The design and implementation of integrated care is not done well in Australia and requires further investigation.

Recommendation 3: workforce capacity development

While workforce development was the explicit focus of only one paper,¹⁰ it was correspondingly nominated by others as a critical barrier to the development and implementation of services and programs.

Services should ensure that:

- Staff recruitment and turnover is minimised
- Staff are based on-site
- There is dedicated staff training in SEWB and mental health
- There is promotion of staff cultural competence in both mainstream and Indigenous-led services

- Staff wellbeing activities are encouraged.

Recommendation 4 Service program development and implementation

The development and implementation of a range of services/programs targeting different groups of Indigenous Australians is appropriate. As demonstrated in this Evidence Check, a range of different programs was identified in the literature, but the limited funding will be most effective if it focuses on programs that target a defined population and issue, but that have an impact at multiple levels, e.g. as in a stepped-care approach. The promising programs and services had strong community interest/investment/ownership, engagement, leadership and sustainable funding. It would be a more efficient and sustainable use of funds to support programs with existing community support and operational budgets.

Ideally, services should:

- Ensure policy alignment with key guiding documents
- Ensure that there is strong community support for services/programs
- Address upstream social determinants and current issues
- Consider the immediate environment in which the service/program is embedded
- Ensure continuity of care — including follow-up, support and referral pathways
- Meet local service gaps
- Have good co-ordination of service delivery in primary healthcare settings
- Employ Aboriginal workers
- Employ culturally competent staff
- Provide targeted support for program implementation
- Differentiate clients' needs/support
- Deploy training to facilitate translation of skills into practice
- Incorporate implementation of e-health strategies, particularly for remote locations
- Improve access to services
- Dedicate adequate SEWB funding.

Ideally, programs should:

- Take a trauma-informed approach to care. Colonisation led to the disruption of social and cultural wellbeing and has intergenerational effects. This should be considered in any approach to any type of healthcare for Aboriginal and Torres Strait people
- Account for cultural diversity and need
- Have multi-level program components and target specific issues as identified and valued by clients
- Engage in longer, more intense, multifaceted events with integrated academic enrichment and learning opportunities
- Incorporate brief interventions and short-term education components
- Be open to the adaptation of programs according to community-identified local priority or need
- Address the social determinants of health
- Engage young people in SEWB programs with an early intervention/prevention focus.

Recommendation 5: Embedded research

As previously noted, a key finding was that no best-practice evidence was identified in the Evidence Check. There is a critical need to support more rigorous evaluation of programs. More rigorous evaluations would

address the current limitations identified by the gap analysis. Given that SEWB evidence is developing, embedding continuous quality improvement processes and evaluation into the development and implementation of services and programs is an important part of better understanding what works for whom, under what circumstances, through what mechanisms, and with what outcomes in the promotion of SEWB for Indigenous people.

Ideally, the following actions should be considered:

- Improve the SEWB evidence base through rigorous research and evaluation
- Develop an evidence-based assessment process that could be used routinely by service providers to both define the promotive and risk factors for Indigenous people more precisely and standardise outcome measures
- Ensure that services have dedicated funding for research evaluation and development
- Achieve greater consistency across SEWB programs and measures
- Undertake process, impact and economic analyses that are consistent with known approaches such as Britain's Medical Research Council Framework for the Development and Evaluation of Complex Interventions⁶⁰ or the NSW Government Program Evaluation Guidelines⁵¹
- Identify researchers and/or evaluators with relevant and demonstrated expertise in conducting rigorous process, impact and economic evaluations in real-world settings with service providers. This could be a transparent Expression of Interest process.

Conclusion

This review of extant SEWB literature sought to distil the evidence of what works most effectively, under what conditions, through which mechanisms and activities and with what outcomes, in efforts to improve SEWB for Indigenous Australians in particular, and global Indigenous populations more broadly. It identified the enablers and barriers to program and service implementation and the gaps in the evidence.

The most significant finding of the Evidence Check was that while Australia leads the way in terms of volume in SEWB research, no best-practice examples were found and only 12 papers reported promising-practice evidence.

Much work remains to be done in this area to ensure progression in developing effective meaningful policies, programs and services that work to address the unique needs of Indigenous Australians. Many of the challenges experienced by those who promote SEWB are evidenced in the Indigenous health domain more broadly. However, the outcomes and benefits, and the potential flow-on effects that were documented as a result of engagement in SEWB programs and services are worthy of further exploration and investment in research and evaluation. The findings suggest that a comprehensive multi-level approach is needed at a systems / service level, community level and at an individual level to advocate for policy, program and service-level change.

The five key recommendations are that SEWB policies, programs, services and research should:

- 1) Embrace a strengths-based perspective and a culturally-inclusive approach
- 2) Ensure concordance between mental health and physical, cultural and spiritual health by focusing on systems and service-level change
- 3) Strengthen the capacity of the workforce
- 4) Support the development and implementation of services and programs with strong community interest/investment/ownership, engagement, leadership and sustainable funding
- 5) Embed continuous quality improvement processes and evaluation into the development and implementation of SEWB services and programs.

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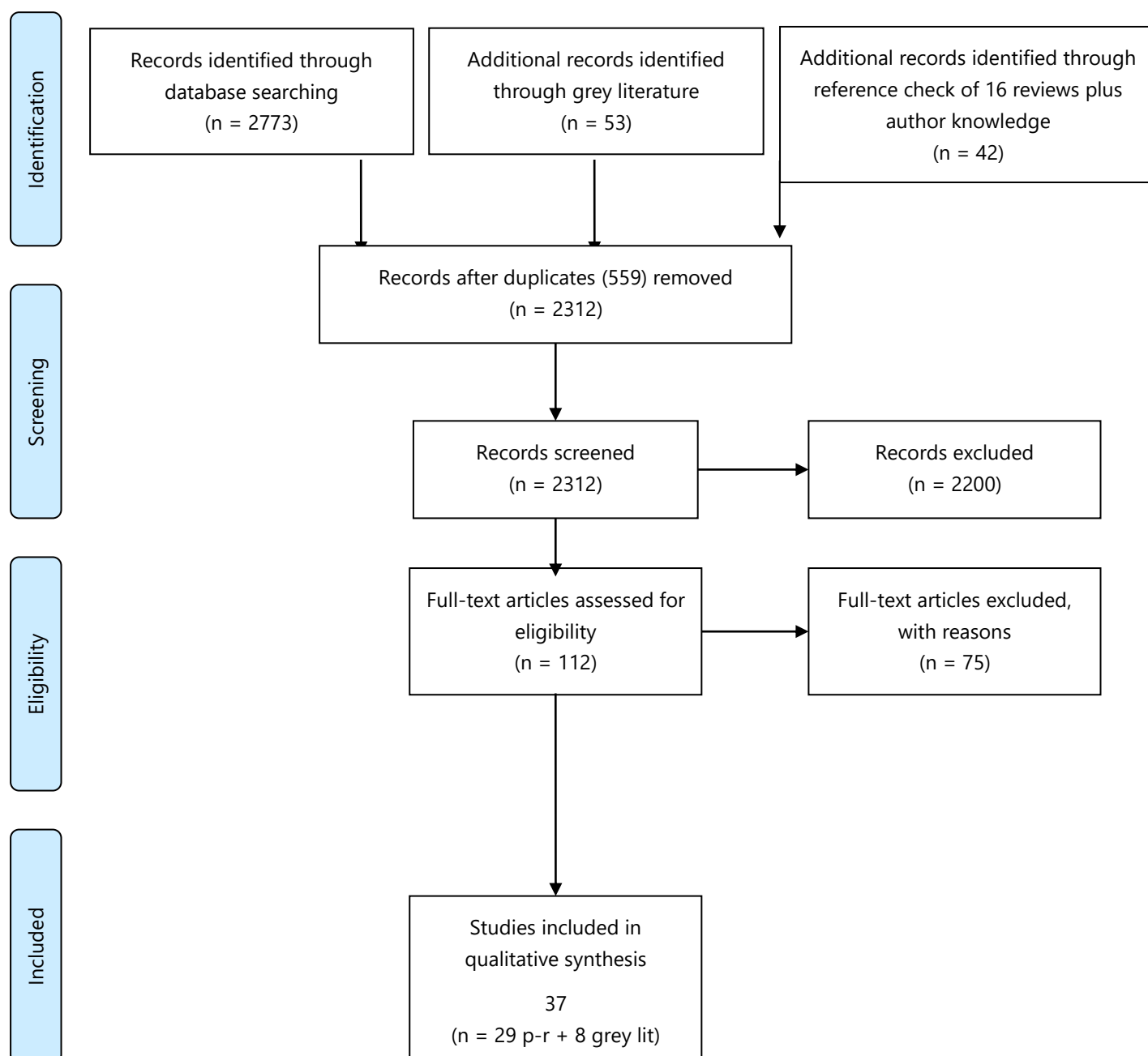
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Appendix 1

PRISMA flow diagram of search strategy



Appendix 2

Peer-reviewed literature: Promising practices

1 st author/ publication year/ publication type	Study aims/ brief description	Study setting/ target group	Policy/program/ intervention/ service	Components: strategies/ activities, conditions, enablers & barriers to effective implementation of the policy, program or services	Outcomes: outcome measures/ screening/ measurement tools	Workforce requirements (e.g. skills, qualifications, training, cultural awareness)	Cost: cost- effectiveness/ referral pathways	Level of evidence
1. Blignault et al. (2016)	Study aims: Evaluate the first three years of a national program to improve the social and emotional wellbeing (SEWB) of Indigenous youth with a focus on early intervention, prevention and community education.	Study setting: Remote and regional Australia. Target group: Indigenous youth in remote and regional Australia aged 16–24.	Policy/ program/ intervention/ service: National SEWB program SAM Our Way. Sample size: 5 sites.	Strategies/activities: Collaboration secondary and tertiary education institutions; art, music and sports; bush camps; promotion of culture and identity; building individual, organisational and community capacity; collaborative, community-driven initiatives; education sessions on alcohol and other drugs, mental health and violence, drawing on content from save-a-mate and other evaluated programs, and Beyond Blue fact sheets on depression and anxiety. Conditions: Mental health and social and emotional wellbeing issues among Indigenous young people; lack of evidence to inform initiatives to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander youth. Enablers: Targeted support for program implementation; clarity about program purpose,	Outcomes: <i>Personal outcomes:</i> Increased self-esteem and ability to speak up, learning how to deal with painful emotions without resorting to alcohol and drugs, making friends, improved relationships, increased confidence at school and in life generally, and a new sense of Aboriginal identity; employment; leadership. <i>Staff:</i> Knowledge, skills and confidence of the local Aboriginal staff. Outcome measures: Psychosocial wellbeing; empowerment; emotional wellbeing; and social connectedness; increased knowledge, improved health promotion skills, additional resources, greater community and stakeholder capacity, and increased	Workforce requirements: Skilled, motivated and stable workforce is vital for continued growth and development and an important indicator of sustainability. Staff based on-site. Employing, training and mentoring local Aboriginal staff. <i>Training:</i> Save-a-mate Alcohol and Other Drugs Emergencies Program.	Cost/ referral pathways: Not Available (N/A).	Level of evidence: Promising practice – Level 3.

1 st author/ publication year/ publication type	Study aims/ brief description	Study setting/ target group	Policy/program/ intervention/ service	Components: strategies/ activities, conditions, enablers & barriers to effective implementation of the policy, program or services	Outcomes: outcome measures/ screening/ measurement tools	Workforce requirements (e.g. skills, qualifications, training, cultural awareness)	Cost: cost- effectiveness/ referral pathways	Level of evidence
				objectives, requirements and ways of working; community partnerships; longer, more intensive activities and multifaceted events, e.g. festivals; accounting for gender and cultural norms; differentiation of need/support. Continuing quality improvement processes and evaluation. Barriers: Recruitment and staff turnover; staff based off-site.	avenues for Aboriginal young people to exercise their autonomy and power. Screening/ measurement tools: Growth and Empowerment Measure (GEM).			
2. Dingwall et al. (2015)	Study aims: To report the impact of the Indigenous e-mental health training course 'Yarning about Indigenous Mental Health using the AIMhi Stay Strong App'.	Study setting: Ten training courses held in Darwin, Alice Springs or remote NT communities. Target group: Northern Territory service providers. Participants reported that, on average, 80% of their clients were Indigenous.	Policy/ program/ intervention/ service: Indigenous e-mental health training course 'Yarning about Indigenous Mental Health using the AIMhi Stay Strong App'. Sample size: 138 participants completed the 'Yarning about Indigenous Mental Health using the AIMhi Stay Strong App' training course and 130 completed pre- and post-training questionnaires to explore knowledge and confidence in a number of areas trained. 35% were Indigenous.	Strategies/ activities: Draws on the original AIMhi training program 'Yarning about Indigenous Mental Health', which is embedded within a consumer empowerment and recovery approach and provides culturally appropriate strategies and tools for understanding mental health, promoting wellbeing and delivering brief interventions in the setting of mental illness, substance misuse and physical illness. Participants are introduced to e-mental health and are trained to use the culturally adapted AIMhi Stay Strong App. Conditions: The successful transfer of training to the workplace is dependent on a number of factors including characteristics of the training	Outcomes: Significant improvements across all measures of skill and knowledge except for confidence in using computers. Included confidence in using e-mental health tools with Indigenous clients. Cannot assume that this improvement will translate to use of learnt skills in the workplace. Levels of implementation and uptake following training are being measured, with results forthcoming. Culturally adapted e-mental health approaches have the potential to improve access to culturally appropriate mental health care for	Workforce requirements: Aboriginal co-trainers (including a Larrakeyah traditional owner involved in AIMhi since its inception) co-facilitate the training with a psychiatrist with more than 20 years' experience in the NT.	Cost/Referral Pathways: Participants either self-selected or were selected by their organisation to attend the training.	Level of evidence: Promising practice.

1 st author/ publication year/ publication type	Study aims/ brief description	Study setting/ target group	Policy/program/ intervention/ service	Components: strategies/ activities, conditions, enablers & barriers to effective implementation of the policy, program or services	Outcomes: outcome measures/ screening/ measurement tools	Workforce requirements (e.g. skills, qualifications, training, cultural awareness)	Cost: cost- effectiveness/ referral pathways	Level of evidence
				<p>course, the trainee and the workplace environment.</p> <p>Enablers: Program culturally adapted for Indigenous people. Following training, follow-up support is offered to all organisations trained to facilitate translation of the skills learnt into practice.</p> <p>Barriers: Technology availability will also influence e-mental health implementation.</p>	<p>Indigenous people, with minimal training required.</p> <p>Outcome measures: Pre- and post- mean ratings for knowledge and confidence questions.</p> <p>Screening/ measurement tools: The questionnaires were developed by combining prior evaluation forms from the 'Yarning about Mental Health' training course with new questions developed through collaboration with other e-MHPPrac sites to examine current use and changes in perceived knowledge and confidence in e-mental health.</p>			
3. Jersky et al. (2016)	Study aims: To evaluate an urban art-based community health program (Ngala Nanga Mai; We Dream) that seeks to improve the health, education, empowerment and connectedness of Aboriginal	Study setting: Urban: Sydney, Australia. Target group: Young Aboriginal parents and their children.	Policy/ program/ intervention/ service: Ngala Nanga Mai ('We Dream') Parent Group Program (NNM) is an arts-based program. Sample size: 92 Aboriginal parents of 133 children participated; 17 were interviewed; 7 attended focus groups.	Strategies/ activities: Program seeks to impact participant health outcomes by simultaneously enhancing early healthcare service access, education and social connectedness. Key program elements are twice-weekly art sessions, regular health talks, cultural events, exhibiting artwork, childcare and transport, and TAFE enrolment and tutoring services, hosted within the local community health facility. Conditions: Historical and ongoing disempowerment and	Outcomes: 93.5% of regular participants engaged their children at least once with paediatric health services and 27.1% undertook further education. Empowerment scores significantly improved, despite little change in psychological distress. The program operationalised all 10 Critical Effectiveness Factors for youth wellbeing. Ngala Nanga Mai creates an environment of social	Workforce requirements: Supported by an Aboriginal health education officer, early childhood nurse, social worker and paediatric doctors. Young parents are actively recruited by the early childhood and midwifery team,	Cost/ referral pathways: N/A.	Level of evidence: Promising practice.

1 st author/ publication year/ publication type	Study aims/ brief description	Study setting/ target group	Policy/program/ intervention/ service	Components: strategies/ activities, conditions, enablers & barriers to effective implementation of the policy, program or services	Outcomes: outcome measures/ screening/ measurement tools	Workforce requirements (e.g. skills, qualifications, training, cultural awareness)	Cost: cost- effectiveness/ referral pathways	Level of evidence
	parents by describing paediatric health service attendance, maternal educational engagement, participant growth and empowerment, and worker and participant experiences.			<p>disadvantage experienced by Aboriginal communities; inequitable health outcomes; social determinants of health; evidence indicating the positive effect of maternal education on birth outcomes and health in childhood; evidence linking engagement with cultural and art-based programs to improved mental health and wellbeing; identified social isolation, anxiety and depression experienced by young Aboriginal mothers.</p> <p>Enablers: Community control of Aboriginal services; Aboriginal workers/support staff; collaboration with local pediatric clinicians and services; support from local Aboriginal Advisory Health Link Committee and community members; co-location of the program with health centre services; the presence of health and social service providers during program activities.</p> <p>Barriers: Low numbers of participants completed the Growth and Empowerment Measure (GEM); funding challenges and uncertainties; dealing with</p>	<p>connectedness, strengthened parenting, maternal and child wellbeing and empowerment. It supports increased use of health, education and support services, and early detection of treatable child health issues. There was clear evidence of an improvement in maternal and child wellbeing, as well as parenting confidence.</p> <p>Outcome measures: A Critical Effectiveness Factor framework that measures factors necessary for success, effectiveness and sustainability was used to assess program quality. Factors used to assess program quality included working from strengths, focusing on empowerment, emphasising relationship development, demonstrating Aboriginal leadership, providing reliable and consistent services, facilitating connection to culture, fostering connections to other services, maximising opportunities for choice-</p>	based on vulnerability factors such as teenage parenthood and lack of social support.		

1 st author/ publication year/ publication type	Study aims/ brief description	Study setting/ target group	Policy/program/ intervention/ service	Components: strategies/ activities, conditions, enablers & barriers to effective implementation of the policy, program or services	Outcomes: outcome measures/ screening/ measurement tools	Workforce requirements (e.g. skills, qualifications, training, cultural awareness)	Cost: cost- effectiveness/ referral pathways	Level of evidence
				challenging incidents; limited group space restricted growth in participant numbers; use of a single open room may have restricted age and interest diversity and male participation; lack of long-term commitment through policy and resource allocation; lack of baseline data to measure program impact; short study timeframe.	making and enabling creative pathways for growth. Screening/ measurement tools: Growth and Empowerment Measure (GEM).			
4. Kinchin et al. (2015)	Study aims: To assess the Indigenous-developed Family Wellbeing (FWB) program as empowerment intervention for a child safety workforce in remote Indigenous communities by measuring effect sizes. The study also assessed the value of measurement tools for future impact evaluations.	Study setting: Five remote north Queensland Indigenous communities. Target group: Child protection staff.	Policy/ program/ intervention/ service: Indigenous- developed Family Wellbeing (FWB) program. Sample size: N=66 staff of a child protection agency.	Strategies/ activities: FWB is a program delivered in workshops. Workshops provided the foundational stage of the FWB program including topics of: group agreement; human qualities; basic human needs; understanding relationships; life journey; loss and grief; and beliefs and attitudes. Conditions: Enhance workers' self-esteem, interaction at the family and community levels, reduce social alienation and increase opportunities for self-development. Enablers: Community wide capacity can enable wider issues to be addressed (e.g. poor school attendance, interpersonal violence, drug and alcohol misuse, chronic disease management). Barriers: Processes take many years to achieve change beyond the individual level.	Outcomes: The study extended qualitative research and identified the best measurement tool for detecting outcomes of empowerment programs. The research recorded a 17% effect size in the sample of child protection agency staff. The GEM was found the most sensitive and most tangible measure to capture improvements in communication, conflict resolution, decision-making and life-skill development. The effect size for the K10 was small and not significant. The effect size for the Australian Unity Wellbeing Index was double the effect size of the Workforce engagement survey.	Workforce requirements: N/A.	Cost/ referral pathways: N/A in this study (discussed in Kinchin 2017).	Level of evidence: Promising practice.

1 st author/ publication year/ publication type	Study aims/ brief description	Study setting/ target group	Policy/program/ intervention/ service	Components: strategies/ activities, conditions, enablers & barriers to effective implementation of the policy, program or services	Outcomes: outcome measures/ screening/ measurement tools	Workforce requirements (e.g. skills, qualifications, training, cultural awareness)	Cost: cost- effectiveness/ referral pathways	Level of evidence
					<p>Outcome measures: Analysis was conducted to examine effect sizes between pre- and post-surveys. Based on comparisons of participants' mean responses before and after participation in the workshops, results indicated variation in the effect sizes for the four subscales of the FWB questionnaire, with stronger effect sizes indicated by larger gaps between pre- versus post-mean responses.</p> <p>Screening/ measurement tool: A questionnaire using a set of validated surveys administered at the beginning and three months after the FWB program delivery consisted of the: Validated Growth and Empowerment Measure (GEM) survey (14-item empowerment scale); Australian Unity Wellbeing Index; Kessler psychological distress scale (K10); Workforce Engagement survey.</p>			
5. Kinchin et al. (2017)	Study aims: This study sought to	Study setting: Retrospective	Policy/ program/ intervention/ service:	Strategies/ activities: Act for Kids is an Australian not-for-profit	Outcomes: The total cost of delivering the FWB program	Workforce requirements:	Cost/ referral pathways: The	Level of evidence:

1 st author/ publication year/ publication type	Study aims/ brief description	Study setting/ target group	Policy/program/ intervention/ service	Components: strategies/ activities, conditions, enablers & barriers to effective implementation of the policy, program or services	Outcomes: outcome measures/ screening/ measurement tools	Workforce requirements (e.g. skills, qualifications, training, cultural awareness)	Cost: cost- effectiveness/ referral pathways	Level of evidence
	estimate the economic cost required to deliver the FWB program to a child safety workforce in remote Australian communities.	cost description taken from the perspective of a non-government child safety agency. Target group: Child protection residential care workers aged 24 or older, who worked in safe houses in five remote Indigenous communities and a regional office during the study year (2013).	Family Wellbeing (FWB). Sample size: 66 Act for Kids residential support workers.	organisation that provides services to prevent and treat child abuse and neglect. FWB empowerment training was offered to Act for Kids staff to enhance their social and emotional capacity to better support and provide care to families and children in their charge. FWB is an Aboriginal-developed program that enables people to develop greater awareness of their emotional, spiritual, mental and physical needs and to strengthen personal and community capacity; 'safe space' workshops. Conditions: Enables participants to develop greater awareness of their emotional, spiritual, mental and physical needs and to strengthen personal and community capacity to meet those needs Enablers: Aboriginal-developed program <ul style="list-style-type: none"> • Program delivered in workshops where participants in small interactive groups explore multiple issues • Enables Indigenous people to develop greater awareness of their emotional, spiritual, mental and physical needs • The study estimates the resources required to deliver the 	for 66 participants was \$182,588 (\$2,766 per participant) with 45% (\$82,995) of costs classified as indirect (i.e. opportunity cost of participants' time). Training cost could be further mitigated (~30%) if offered on-site, in the community. The costs for offering the FWB program to a remotely located workforce were high, but not substantial when compared with the recruitment cost required to substitute a worker in remote settings. The cost study provided policy-relevant information by identifying the resources required to transfer the FWB program to other remote locations. Outcome measures: If FWB can contribute to circumventing the long-term consequences of social behavioural problems, the benefit to the society and cost-savings to tax payers will be considerable. This study has calculated valuable cost information that can assist planning of emotional wellbeing programs to	FWB empowerment training was offered to Act for Kids staff to enhance their social and emotional capacity to better support and provide care to families and children in charge. FWB was developed by the Aboriginal Employment Development Branch of the South Australian Department of Education, Employment and Training which makes it a culturally appropriate program.	total program cost for a cohort of 66 workers was \$182,588, or \$2766 per participant. The FWB program costs were found to vary across workshops due to two factors: 1) the travel cost of running the training outside of the home community; and 2) the number of participants (Table 4). The cost per participant could be reduced on average by 30%, if the program were to be delivered locally, that is, without requiring air travel for the participants (p < 0.05).	Promising practice.

1 st author/ publication year/ publication type	Study aims/ brief description	Study setting/ target group	Policy/program/ intervention/ service	Components: strategies/ activities, conditions, enablers & barriers to effective implementation of the policy, program or services	Outcomes: outcome measures/ screening/ measurement tools	Workforce requirements (e.g. skills, qualifications, training, cultural awareness)	Cost: cost- effectiveness/ referral pathways	Level of evidence
				<p>training at a similar scale and includes the direct and indirect costs of travel and workshop participation.</p> <p>Barriers: Disturbances and disruptions from family and other community responsibilities, which may reduce program attendance and, hence, lessen benefits to participants.</p>	<p>improve social outcomes in remote Indigenous communities.</p> <p>Screening/ measurement tool: To estimate the resources required to deliver the FWB program, the costing applied a 3-step procedure: Identify resource items, measure resource quantities; and assign unit costs to resources.</p>			
6. Kulis et al. (2017)	Study aims: To test the efficacy of the Living in 2 Worlds (L2W) substance use prevention curriculum with American Indian (AI) middle school students.	<p>Country: US.</p> <p>Study setting: Three urban middle schools in Phoenix, Arizona.</p> <p>Target group: AI middle school students aged 12–13 across three schools.</p>	<p>Policy/ program/ intervention/ service: Living in 2 Worlds (L2W) substance use prevention curriculum.</p> <p>Sample size: 107 AI youth in 7th and 8th grade.</p>	<p>Strategies/ activities: A culturally adapted version of keepin' it REAL (kiR) redesigned for urban American Indian (AI) middle school students. L2W is focused on strengthening resiliency and AI cultural engagement, and teaches drug resistance skills, decision-making and culturally grounded prevention messages that draw on the potentially protective nature of connection to AI cultures. This is achieved by engaging students in exploration of their heritage and integrating elements of AI culture that illustrate the curriculum's key components.</p> <p>Conditions: Health disparities related to substance abuse; higher prevalence, earlier onset, more severe consequences and less</p>	<p>Outcomes: Youth receiving L2W, compared with kiR, reported less growth in cigarette use from pre-test to post-test, less frequent use of the Leave drug resistance strategy, and less loss of connection to AI spirituality and cultural traditions. For other substance use behaviours and antecedents, the direction of the non-significant effects in small sample tests was towards more positive outcomes in L2W and small-to-medium effect sizes. Results suggest that evidence-based substance use prevention programs that are culturally</p>	<p>Workforce requirements: Highly experienced curriculum trainers from the research team led a day-long teacher training in kiR or L2W. Regular AI teachers delivered the L2W and kiR lessons. Teachers were rated by researchers on the quality of instruction and fidelity to the</p>	<p>Cost/ referral pathways: No information on costs or cost-effectiveness. School-based program, so no formal referral pathways. Participation was voluntary and based on parent identification of AI identity in schools.</p>	<p>Level of evidence: Promising practice</p> <p>Some evidence of efficacy, but limited. This is in the context of the control condition being an efficacious intervention.</p>

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				<p>perceived risk of harm from substance use by native youth; social and cultural stressors linked to substance use, including acculturation, urbanisation, ethnic isolation, cultural disruptions, marginalisation, invisibility and discrimination; and connection to tribal culture and identity.</p> <p>Enablers: Evidence of the importance of cultural connection for protecting youth; collaboration with schools; participation of AI youth, parents, professionals and prevention curriculum specialists in the curriculum development; previous pilot test of the curriculum; parental consent and student assent from all participants; AI staff (teachers and researchers).</p> <p>Barriers: Limited effect sizes due to the normal trend of increased substance use in adolescence; small AI student populations in urban schools; variations across schools in terms of intervention duration and requirements for participation complicating program delivery and retention; time required for L2W implementation; use of small, non-population-based sample; lack of generalisability of results; potential unknown selection bias in</p>	<p>adapted for urban AI adolescents, like L2W, can be a foundation for prevention approaches to help delay initiation and slow increases in substance use.</p> <p>Outcome measures: Study outcomes were measures of substance use, other risk behaviours, and an array of antecedents of substance use that the prevention curricula targeted. These included: the frequency and amount of recent (last 30 days) drug use; risk behaviours other than substance use (e.g. fighting, stealing or carrying a weapon); key antecedents or predictors of youth substance use initiation, such as substance use intentions, permissive drug norms, vulnerability to drug offers, perceived harmlessness of substance use, positive substance use expectancies (perceived benefits), and exposure to substance use offers.</p> <p>AI cultural identification and engagement was also assessed using measures of: (1) the overall strength of AI</p>	<p>curriculum manuals. Instructional quality (organisation, preparation, developmentally appropriate content, student participation, and positive student response) was scored and researchers measured how faithfully the teachers followed the lesson plans, including the instructions, videos, practice and homework.</p>		

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				recruitment favouring AI students whose families actively embrace their Native heritage; limited ability to investigate social contexts.	ethnic identity, (2) AI spirituality; and (3) engagement with AI cultural traditions. Screening/ measurement tools: Pre-and post-test multi-item questionnaire with items taken from numerous sources. Items include: alcohol, cigarette, marijuana & inhalants frequency (4 items); alcohol, cigarette, marijuana amount (1 item); other risk behaviours (5 items); substance use intentions (3 items); permissive drug use norms (3 items); vulnerability to drug offers (3 items); perceived harmlessness of substance use (3 items); positive substance use expectancies (3 items); exposure to substance offers (4 items); drug resistance strategies (12 items); American Indian (AI) ethnic identity (11 items); American Indian spirituality (4 items); American Indian cultural traditions (10 items).			
7. Rushing et al. (2017)	Study aims: To evaluate the Healthy &	Country: US.	Policy/ program/ intervention/ service:	Strategies/ activities: The Native STAND curriculum consists of 27 sessions that are each 90 minutes;	Outcomes: Although some positive changes in outcomes were reported,	Workforce requirements: The class was	Cost/ referral pathways: N/A.	Level of evidence:

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	Empowered Youth (HEY) Project, a school- and community-based positive youth development program for American Indian and Alaska Native high school students.	<p>Study setting: A Northwest tribal school.</p> <p>Target group: Students at the tribe's junior/senior high school.</p> <p>Sample size: 117 students participated in one or more trimesters of the HEY class; 27 students (23.1%) dropped out of the curriculum before finishing.</p>	Healthy & Empowered Youth (HEY) Project, a multimedia school- and community-based positive youth development program that emphasised sexual and reproductive health. Students received an enhanced version of the Native STAND (Students Together Against Negative Decisions) a culturally relevant curriculum that draws on teachings and values from across Indian Country.	<p>employs active learning methods; and holistically addresses healthy relationships, self-esteem, preventing STIs and early pregnancy, and avoiding substance abuse. The curriculum was enhanced with hands-on training in video production and media literacy to engage students in sexual and reproductive health topics covered by the curriculum. Guest speakers, field trips and extracurricular activities were added to provide academic enrichment, engage students in cultural activities, and offer opportunities for career development.</p> <p>Conditions: AI/AN youth are disproportionately affected by drug and alcohol use, violence and self-harm, teen pregnancy and sexually transmitted infections. Structural and environmental factors contribute to these health disparities, including rural geography, high poverty rates, poor access to health services, stigma and historical trauma. Despite the immense need, few culturally relevant interventions have been designed for, or rigorously evaluated among, American Indian and Alaska Native youth.</p>	pre-post differences were not statistically significant. Behaviours associated with STI risk generally improved, although were not statistically significant. Students created more than 89 videos, 75 posters, two public billboards, and a mural addressing health topics (e.g. drug and alcohol use, suicide, bullying, dating, violence). The project educated tribal teens on a variety of sensitive health topics while remaining socially and culturally relevant. Students gained life skills, increased their confidence and self-esteem, and became more involved in their culture and community. Positive shifts were observed in key measures, e.g. behaviours associated with STI risk. In focus groups, students reported that the hands-on training in filmmaking and media development were critical components, improving retention, self-esteem and self-confidence. In general, students favourably evaluated the	taught by two trained facilitators (one male, one female), who were employed as teachers at the school, and who received training from professional filmmakers.		Promising practice.

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				<p>Enablers: Culturally relevant curriculum that draws on teachings and values from across Indian Country.</p> <p>The filmmaking activities reinforced classroom lessons and generated health-related media that resonated with family and community, suggesting that training youth to create media messages has the potential to influence not only individual behaviour and peer norms, but also the social ecologic factors that contribute to community-level health.</p> <p>Barriers: N/A.</p>	<p>HEY Project as acceptable, relevant and valued.</p> <p>Outcome measures: Measures included (1) demographics; (2) self-esteem; (3) cultural identity; (4) aspirations and hopefulness; (5) cultural activities and interests; (6) relationships with caring adults; (7) feelings about school; (8) friends and community; (9) physical and mental health, alcohol and drug use, and sexual activity; and (10) feelings about the project.</p> <p>To assess protective/ resiliency factors, the analysis included composite measures of 'positive emotions and self-worth', 'cultural pride and identity', feelings of 'hopeful future', 'parent/family engagement' and 'community engagement'.</p> <p>Screening/ measurement tools: A 10-section survey, drawn and adapted from the Native Survey Youth and other questionnaires validated with Native youth, was administered pre- and</p>			

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					post-intervention. 33 focus groups with a total of 129 students were conducted. Interviews with the two teachers were conducted by phone at the end of each school year, and there were seven key informant interviews with community leaders, school administrators and parents at the end of the project.			
8. Sun & Buys (2013a)	Study aims: To examine the development of five Indigenous singing groups and the benefits related to promoting resilience and ultimately preventing chronic disease in this population.	Country: Australia. Study setting: Aboriginal and Torres Strait Islander Community Controlled Health Services (CCHSs), two urban, two regional and one rural location. Target group: Indigenous adults aged 18 years and older. Sample size: Five groups were established, consisting of adults aged 18–78 years. There	Policy/ program/ intervention/ service: Voices United for Harmony (VUFH) program was a 12-month participatory community singing intervention.	Strategies/ activities: Each group met weekly under the direction of musicians employed by Griffith University. Transport was supported by each community's CCHS. The singing programs included weekly group rehearsal sessions for 2h per week with a 15-min break for social interaction, as well as individual rehearsal at home. CCHSs conducted and coordinated the intervention programs, organising intervention activities, weekly rehearsals, testing and singing performances. Conditions: Increasing international interest in and evidence supporting the connection between resilience and increased wellbeing and health; emerging evidence of the positive impact of social support on	Outcomes: Intervention impacts included those related to individual resilience, social interaction and social capital, and increasing usage of CCHSs. Significant post-intervention impacts for singing group participants included: reductions in the number of stressful life events reported compared with the control group; increased reports of no stressful events; increased feelings of connectedness to their community in comparison with pre-intervention and the control group; improvement in quality of life, reported ability to manage social and emotional wellbeing, and	Workforce requirements: Each group singing activity session was organised by a CCHS Aboriginal community member who had attended leader training sessions prior to the program's implementation, and the sessions were led by professional musicians.	Cost/ referral pathways: Participants were recruited through Aboriginal Community-Controlled Health Services (CCHSs) when they attended health check consultation. Individuals presenting with severe medical conditions were referred for medical examination prior to commencing singing	Level of evidence: Promising practice.

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		<p>were 114 participants at baseline, and 56 stayed in the intervention group until 12 months. There were 127 participants in the control group at baseline, and 54 participants remained until 12 months. Ninety per cent of participants had chronic conditions such as heart disease, diabetes, hypertension, stroke, depression and schizophrenia.</p>		<p>individual health and wellbeing; growing interest in culture and arts-based interventions, such as community singing, to promote resilience and associated increasing evidence base of its efficacy; social and health inequities and disadvantage experienced by Indigenous peoples; limited research on the relationship between the effects of arts-based interventions and the prevention of chronic disease in Indigenous populations; cultural appropriateness of creative/arts-based interventions for Indigenous peoples.</p> <p>Enablers: Local Aboriginal community leaders played central roles in the design and implementation of the study; collaboration with local CCHSs; successful initial 'taster sessions' demonstrating strong community interest.</p> <p>Barriers: One choir group experienced retention problems; less participation from males than females.</p>	<p>sense of emotional and esteem support from social support; and increase in access to CCHS medical centre services. Structural equation modelling analysis results indicated a relationship between individual- and community-level responses to chronic disease and a relationship between individual-level characteristics and community-level support from family, friends and community, ultimately leading to reduced levels of chronic conditions.</p> <p>Outcome measures: Pre- and post-intervention questionnaires were administered to collect data on chronic life stresses, resilience, social support and social connectedness. Focus group interviews were conducted to obtain data on the participants' and stakeholders' perceptions of the impact of the singing groups. Multivariate analysis of variance was used to test effectiveness of the program</p>		intervention activities.	

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					<p>in improving resilience at both the individual and community levels.</p> <p>Screening/ measurement tools: Singing-related quality of life was measured using the Singing Activity Participation Questionnaire, which assesses perceived benefits to psychological health, physical health and spiritual health on a Likert scale. A resilience questionnaire included: 1. Individual resilience characteristics: self-esteem, ability to cope and bounce back (6 items); 2. Sense of belonging (10 items); 3. Support from family (10 items); 4. Perceptions of neighbourhoods (4 items: liking/disliking, feeling safe, having friends nearby and things to do); 5. Relationships with friends (8 items: perceived quality and quantity of friendship networks); 6. Social connectedness (21 items: sense of connections to the community). Lifetime stresses were estimated from two variables: (a) the total</p>			

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					number of stressful events and (b) the number of stresses on the following scale: no stress, one stress, two stresses and three or more stresses.			
9. Sun & Buys (2013b)	Study aims: To examine the health benefits of a community-based singing activity intervention on improving social and emotional wellbeing among Indigenous Australians.	Country: Australia. Study setting: Local Aboriginal Community Controlled Health Services (CCHSs). Target group: Indigenous people.	Policy/ program/ intervention/ service: The singing programs were of 12 months' duration, from June 2010 to June 2011. Within each community, these programs included weekly group rehearsal sessions for 2 hours per week with a 15-minute break for social interaction, and encouragement to individually rehearse at home. Sample size: 117 participants included both healthy individuals and those with chronic conditions such as heart disease, diabetes, hypertension, stroke, depression and schizophrenia.	Strategies/ activities: Programs included weekly group rehearsal sessions for 2 hours per week with a 15-minute break for social interaction, and encouragement to individually rehearse at home. Individuals presenting with medical conditions were referred for medical examination prior to commencing singing intervention activities. Conditions: High rates of social and emotional difficulties, and high levels of stress/stressful experiences, experienced by Indigenous peoples; social determinants of health/social economic disadvantage; the need for holistic, culturally appropriate approaches to improving Indigenous health and social and emotional wellbeing; lack of research on the effects of a singing program on the mental health of Indigenous people in Australia. Enablers: Local Aboriginal community leaders played central roles in the recruitment of	Outcomes: Participants self-reported reductions in the following stressors: death of family member or close friend, job loss, seeing fights or people beaten up, trouble with the police, discrimination or racism, abuse or violent crime, alcohol-related problems, and a family member being sent to jail. At post-intervention, there was a significant reduction in all stressors relative to the proportion of people who experienced stresses except for serious accident, experiencing divorce or separation, or not being able to get job. Among these stressors, there was a statistically significant difference between pre- and post-intervention phases in the three stressors: death of family member or close friend (12%), job loss	Workforce requirements: Each group singing activity session was organised by a CCHSs Aboriginal community member who had attended leader training sessions prior to the program's implementation, and the singing activity was led by a professional musician.	Cost/ referral pathways: Participants were recruited through five communities to participate in a one-year community singing program.	Level of evidence: Promising practice.

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				participants, study design and implementation of the study; collaboration with local Aboriginal Community Controlled Health Services (CCHSs), who assisted with intervention activities, weekly rehearsals, testing, and organisation of performances. Barriers: N/A.	(10.2%), seeing fights or people beaten up (9.5%). Outcome measures: Negative life events. Screening/ measurement tools: Negative Life Events Scale (NLES). NLES has demonstrated an excellent reliability and validity with Indigenous Australians.			
10. Sun & Buys (2016)	Study aims: To evaluate the impact of a meditative singing program on the health outcomes of Indigenous people. In particular, to examine its impact on improving mental health through building resilience, social connectedness and social support; reducing psychological distress; and encouraging access to	Country: Australia. Study setting: Six Indigenous communities and Community Controlled Health Services in Queensland, Australia. Target group: Australian Indigenous adults aged 1–71 years with an identified mental health problem, chronic risk factor (e.g. overweight or obesity, chronic conditions), or who have presented frequently to the	Policy/ program/ intervention/ service: A participatory community-based community singing program involving weekly singing rehearsals was conducted over an 18-month period.	Strategies/ activities: The community participatory singing intervention program consisted of 2-hour, weekly singing rehearsals. Singing rehearsals included physical warm-up exercises, breathing and tension-releasing techniques, and social interaction. Participants were encouraged to practise at home between rehearsals. Conditions: Limited evidence on the impact of community singing programs among Indigenous populations. Enablers: Community consent from the boards of the five participating Community Controlled Health Services. Barriers: N/A.	Outcomes: Results revealed a significant reduction in the proportion of adults in the singing group classified as depressed and a concomitant significant increase in resilience levels, quality of life, sense of connectedness and social support among this group. There were no significant changes for these variables in the comparison group. Structural equation modelling indicated that singing did not reduce psychological stress directly, but did so indirectly by improving resilience, a sense of social connectedness and social support. The total effect was significantly related to the reduction of psychological stress.	Workforce requirements: N/A.	Cost/ referral pathways: Recruitment occurred through the CCHSs.	Level of evidence: Promising practice.

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	primary health services.	health service with episodes of mental illness. Sample size: 210, of whom 108 were in a singing intervention group and 102 in a comparison group.			Outcome measures: Depression, resilience, sense of connectedness, social support and singing-related quality of life. Screening/ measurement tools: The Mental Health and Psychological Distress scale; the Resilience scale; Social Connectedness scale; social support was measured by eight items; and The Singing Related Quality of Life scale.			
11. Sun & Buys (2013c)	Study aims: To assess the effectiveness of a 12-month community singing program on quality of life (QoL) using survey methods. To compare the differences in QoL pre- intervention and post- intervention in Indigenous populations and determine the relationship between QoL	Country: Australia. Study setting: Aboriginal Community Controlled Health Services (ACCHSs) across 5 Aboriginal communities. Target group: Indigenous people with chronic diseases involved in a participatory community singing program.	Policy/ program/ intervention/ service: A 12-month community singing program.	Strategies/ activities: The program consisted of 2h group singing classes held weekly with a monthly performance. Classes included warm-up exercises of the body, breathing techniques, and releasing tension, which were then followed by singing rehearsals. Patients were encouraged to practise at home. Strategies included: aerobic exercise through singing, which incorporates heart and lung muscle exercise and gentle physical activity with relaxation and deep breathing; building social support through the singing program. Conditions: High levels of chronic disease and associated lower quality of life in Indigenous	Outcomes: At 12 months, those who participated in the singing program showed a significant increase in singing-related mental and physical health aspects of QoL and positive affect ($p < 0.001$ and $p < 0.001$, respectively) compared with patients in the control group. There were also overall reductions in stressful events, depression level, sense of social isolation and loneliness, as compared with the control group, although this difference did not reach statistical significance. There were significant differences between the singing and	Workforce requirements: N/A.	Cost/ referral pathways: Participants were recruited through Aboriginal CCHSs when they attended health check consultations.	Level of evidence: Promising practice.

1 st author/ publication year/ publication type	Study aims/ brief description	Study setting/ target group	Policy/program/ intervention/ service	Components: strategies/ activities, conditions, enablers & barriers to effective implementation of the policy, program or services	Outcomes: outcome measures/ screening/ measurement tools	Workforce requirements (e.g. skills, qualifications, training, cultural awareness)	Cost: cost- effectiveness/ referral pathways	Level of evidence
	and depression, social and emotional wellbeing, resilience, social isolation and loneliness.	Sample size: 45 Indigenous adults aged 18–85, with 27 people in the control group.		populations; evidence base on the effectiveness of singing programs on mental and physical health and wellbeing. Enablers: Collaboration and partnership with communities and CCHSs. Barriers: Small sample size decreased the power to detect the effect of the singing program on improvements in depression; relatively high dropout rates.	control groups in the reduction of alcohol and drug use and criminal events in the intervention group. There were marginally statistically significant reductions in the overall stress score and death of family member events in the singing group, as compared with the control group. Outcome measures: Quality of life (QoL); stressful life events; social and emotional wellbeing; and social isolation and loneliness. Screening/ measurement tools: Singing-related QoL questionnaire consisting of 21 items covering physical, psychological, and positive affect. Stressful life events scale; social and emotional wellbeing scale; and a social isolation and loneliness scale.			
12. Whiteside et al. (2016)	Study aims: To use both quantitative and qualitative methods to: (a) determine the appropriateness of the Family Wellbeing	Country: Australia. Study setting: FWB was delivered to four consecutive groups of young men over a 10-week period per	Policy/ program/ intervention/ service: The Family Wellbeing empowerment program (FWB) is well documented as a tool for engaging Aboriginal Australian adults to take greater control of and	Strategies/ activities: The program enables people to develop greater awareness of their emotional, spiritual, mental and physical needs and to strengthen personal and community capacity to meet these needs. In the sessions the 10 core FWB topics were integrated with	Outcomes: Completion of the program by 20 of the 30 initial participants; however, only 16 matched pre–post questionnaires were available. Participants experienced strong improvement in capacity to manage relationships,	Workforce requirements: An external researcher with lengthy experience in delivering and evaluating FWB was invited to	Cost/ referral pathways: FWB program participants in three of the four groups had been referred to the program by local schools	Level of evidence: Promising practice.

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	empowerment program (FWB) as a tool to connect and enhance the SEWB of young Aboriginal men; and (b) identify and test quantitative measures for routine FWB implementation and evaluation in similar situations.	group. Three of the groups were run in the community and one was held in a juvenile justice centre. Target group: Young Aboriginal men. Sample size: Study participants were: 6 program organisers consisting of the mental health program manager responsible for the overall implementation of FWB, two FWB facilitators, and three members of the project steering committee; and 30 male FWB program participants aged 16–25.	responsibility for their health and social and emotional wellbeing. The program was adapted for use with young Aboriginal men at risk.	physical and cultural activities such as swimming, football, basketball and visiting cultural sites with a local elder. A private Facebook page was set up as a means of communication. The young men were encouraged to write and play 'rap' songs. Where possible, the facilitators linked the young men into services that supported them to access education, work experience opportunities and employment, and ensured they had safe accommodation. Efforts were then made to reinforce change and to provide follow-up support through closing ceremonies, certificates, and ongoing communication and mentorship through Facebook. Conditions: Effects of the social determinants of health; high levels of social and health disadvantage; lack of engagement in school and other social systems by Indigenous youth; concern from local services about these issues; strong evidence base for the effectiveness and cultural appropriateness of the FWB program; gaps in the evidence base on the effectiveness of the FWB program with youth and quantitative evaluation.	engagement in education and employment, and mental and physical health. A paired t-test of the Kessler K5 total score post-intervention showed a highly significant reduction in psychological distress across the time of the study ($t(12)=3.67$ $p=.003$) with a very strong effect size ($d = 1.02$). Almost 50% of respondents identified a major difference (i.e. 4 or 5 out of 5) in behaviour on all the aspects associated with participating in the FWB program. 75% of participants indicated a major improvement and 20% a minor difference in their ability to manage their relationships better; 65% indicated a major difference and 30% a minor difference in their ability to deal with emotions. Participants indicated positive improvements in their attitudes to work, work-related learnings, ability to be a leader, to cope, and to deal positively with mental health, as well as feelings of	the region to train the two workers and the steering group in the program and to provide ongoing mentoring to the local facilitators including evaluation support.	and service providers because they were perceived to be at risk of self-harm, most often because they had been suspended from school for lengthy periods. The remaining participant group was incarcerated in the juvenile justice system.	

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				<p>Enablers: Collaboration between a primary healthcare network of local health services; funding to pilot the program; involvement by Aboriginal representatives from key local agencies including Aboriginal health, drug and alcohol services; the police; housing; education; child protection; and the youth sector.</p> <p>Barriers: High program drop-out rates.</p>	<p>safety and positive physical health. These positive results were supported by qualitative data from program facilitators.</p> <p>Outcome measures: Psychological distress such as feeling without hope, or feeling restless or jumpy. Participants were also asked about the difference made by their involvement in FWB with regard to attitudes to work, further learning, and leadership (three items); general coping and mental health (three items); relationships (two items); and physical health (one item).</p> <p>Screening/ measurement tools: 9-item version of the Kessler Psychological Distress Scale (K10).</p>			

Appendix 3

Peer-reviewed literature: Emerging practices

1 st Author/ publication year/ publication type	Study aims/ brief description	Study setting/ target group	Policy/ program/ intervention/ service	Components: Strategies/ activities, conditions, enablers & barriers to effective implementation of the policy, program or services	Outcomes: Outcome measures/ measurement tools	Workforce requirements (e.g. skills, qualifications, training, cultural awareness)	Cost: Cost- effectiveness/ referral pathways	Level of evidence
1. Bockxmeer et al. (2015)	Study aims: To determine whether a 6-week local language yoga program improved social and emotional wellbeing in a pilot group of Australian Aboriginal children.	Study setting: Remote Western Australia. Target group: Year 3 and 4 students of Derby District High School.	Policy/ program/ intervention/ service: Wellness Walkabout Yoga Program using yoga poses incorporated into culturally relevant storytelling sessions. Sample size: 24 Aboriginal children (9 female, 8 male) aged 7–8 years.	Strategies/ activities: Wellness Walkabout Yoga exercises integrated into a structured teaching program using a freestanding flipbook using local language. Conditions: N/A. Enablers: N/A. Barriers: N/A.	Outcomes: Mean total SDQ scores were found to decrease significantly over the course of the study (difference -1.94; 95%CI -3.64, -0.24; p=0.028) Outcome measures: Social and emotional outcomes. Screening/ measurement tools: Strengths and Difficulties (SDQ): emotional symptoms, pro-social behaviour, peer problems, hyperactivity and conduct problems.	Workforce requirements: Seven remote teachers were trained in the delivery of the Wellness Walkabout Yoga Program and 30 flipbooks were distributed to schools across six language areas of Western Australia.	Cost/ referral pathways: N/A.	Level of evidence: Emerging practice – Level 4.
2. Carey (2013)	Study aims: To explore the impact of a social and emotional wellbeing service (SEWBS), including issues of effectiveness and	Study setting: Remote Australia. Target group: Indigenous people in remote communities.	Policy/ program/ intervention/ service: Social and emotional wellbeing service (SEWBS). Sample size: 21 people with different involvement in the service such as service providers, service	Strategies/ activities: SEWBS comprises a suite of activities conducted on an individual, family and large group basis that are responsive to the needs of the community and its members. Activities include individual counselling, family therapy, narrative therapy, play therapy, sand play, traditional healing,	Outcomes: The service had been experienced as an effective local response to serious problems. Implementation entailed 1) 'The Big Picture', which included: getting started; organisational factors; funding; the future; and operational problems; and 2)	Workforce requirements: Activities developed emerged from existing skills of the service providers and the needs and	Cost/ referral pathways: N/A.	Level of evidence: Emerging practice.

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	sustainability, from the experiences of people involved in the development and delivery of the service.		participants, and referrers.	cultural activities such as men's dancing, community engagement activities, and community education. Conditions: SEWBS service providers work with other health and allied health professionals from the Health Service and also from other organisations who visit the community. Enablers: Working flexibly in the program. Barriers: Problems in establishing, maintaining and promoting access to the service, e.g. recruitment; scope of the work required given the time available; demands of the position could leave the service providers feeling exhausted and overwhelmed; communication barriers.	'On the Ground', which entailed: personal struggles; program activities; measuring outcomes; and results. Issues such as appropriate staffing, localising decision-making, identifying priorities and how they will be evaluated, and developing flexibility in terms of job descriptions and qualifications were highlighted. Outcome measures: What was the perceived impact of SEWBS in terms of effectiveness and sustainability. Screening/ measurement tools: N/A.	interests of the community. Two Aboriginal Family Workers (AFWs; one male and one female) and two non- Indigenous (one male and one female) counsellors. The two AFWs live in the community and the two non- Indigenous counsellors spend between four and six nights a week living in the community. The female AFW is also a traditional healer.		
3. Day et al. (2016)	Study aims: Seasons for Healing focuses on understanding the effects of change, loss and grief. It provides prevention through education and	Study setting Schools and communities. Target group: Piloted in five different Aboriginal communities: three metropolitan	Policy/ program/ intervention/ service: Seasons for Healing. Adapted from mainstream 'Seasons for growth' program. Sample size: Not provided.	Strategies/ activities: Two Aboriginal Family Support Services staff members from each community are trained as companions to facilitate the program, with members of each community then invited to participate. Program activities have been designed to help participants acknowledge hurt, name their feelings, and find constructive	Outcomes: Process evaluation noted a strengthening of social, spiritual and emotional wellbeing. Some changes to program content were recommended before further implementation. To date, no attempt to assess program outcomes. Outcome measures: N/A.	Workforce requirements: N/A.	Cost/ referral pathways: N/A.	Level of evidence: Emerging practice.

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	skills building, delivered through a model of 'companion training', in which community members deliver the program to their peers.	and two regional.		<p>ways to respond by focusing on those issues and concerns that they can influence.</p> <p>Conditions: Poor health and wellbeing outcomes experienced by Indigenous peoples; poor documentation and evaluation of programs to improve Indigenous social and emotional wellbeing; lack of information about program outcomes; government prioritisation of strategies to improve SEWB; issues and concerns about measurement of SEWB for Indigenous adults.</p> <p>Enablers: Carefully adapted following extensive consultation with a range of different stakeholders, with strong community representation. Acceptance and sustainability assured by delivery through a model of 'companion training' in which community members deliver the program to their peers. Designed to enable older participants to mentor younger participants. Made available to communities at low cost.</p> <p>Barriers: Impact should be in terms of empowerment, self-esteem and sense of identity: these are difficult constructs to define let alone reliably assess. Some self-report measures</p>	Screening/ measurement tools: N/A.			

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				developed but applicability in the local contexts is unclear. Links between personal and community-level change are even less easy to assess. Need to establish that any improvement does actually occur as a result of program participation.				
4. Fanian et al. (2015)	Study aims: To evaluate a creative arts workshop for Th̓cho̓ youth where youth explored critical community issues and found solutions together using the arts. The study sought to identify the workshop's areas of success and challenge. Ultimately, the goal is to develop a community-led, youth-driven model to strengthen resiliency through youth engagement in	Study setting: Behchoko̓, North West Territory, Canada. Target group: Th̓cho̓ youth.	Policy/ program/ intervention/ service: The Ko̓, ts'ii'htla ('We Light the Fire') Project. To engage and empower youth to explore critical issues in their communities and lives and to find solutions together using creative arts (art as vehicle for social change), and to build resiliency among youth and promote healthy minds, bodies and spirits through the arts (art as vehicle for promoting healthier youth and communities). The objectives included: (a) building confidence and personal/ artistic skills among youth participants; (b) connecting youth with one another and to positive role models; and	Strategies/ activities: Provide a mentorship opportunity for youth to learn artistic and personal skills from local Indigenous artists and from their peers. To develop youths' resiliency, confidence, self-expression and skill-set through music and creative arts. To provide resources and a safe space for youth to discuss pertinent issues in their communities and lives and to find solutions together using the arts. To share youth participants' artwork and messages with other youth in their community and around the world, if they desired. To develop a community-led, youth-driven model for continued youth engagement in the arts in Behchoko̓, and explore implications for circumpolar regions. Conditions: The dearth of prevention and early intervention programs targeting children and	Outcomes: The youth reported gaining confidence and new skills, both artistic and personal. Many found the workshop to be engaging, enjoyable and culturally relevant. Youth expressed an interest in continuing their involvement with the arts and spreading their messages through art to other youth, and others in their communities. Outcome measures: Observational data: youth attendance numbers, different activities and comments from facilitators and research staff about their art and the art media. At the end of each day, a focus group was conducted to explore youths' and facilitators' impressions about the day and their experiences. Field notes and facilitators' reflections.	Workforce requirements: N/A.	Cost/ referral pathways: N/A.	Level of evidence: Emerging practice.

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	the arts in circumpolar regions.		(c) demonstrating to youth how art can be a way to express oneself and to deal with various issues in our lives and communities. Sample size: Nine youths participated.	youth mental health and addiction issues was identified as one of the most critical and persistent service gaps in the NWT. Enablers: Four youths and five facilitators participated in the evaluation. Facilitators grounded their workshops on the principal of reciprocity and shared learning and dedicated time to share their personal stories with the participants. In doing so, this workshop created an open and safe space to share stories and promoted cultural relevancy. Ko` ts'i'htla responded to the need to improve availability, access, cultural safety, quality and continuity of mental wellness and addiction programming. Barriers: Having more young participants in attendance and a balanced student: facilitator ratio would have strengthened the success of the workshop. Flexibility is essential.	Screening/ measurement tools: The youth questionnaire assessed 6 main areas: (a) recruitment; (b) satisfaction; (c) areas of success and areas in need of improvement; (d) cultural relevancy and appropriateness; (e) personal impact; and (f) desire to continue engaging in the arts. The facilitator questionnaire assessed 6 main areas: (a) satisfaction; (b) areas of success and areas in need of improvement; (c) challenges encountered; (d) experience working with youth; (e) overall impressions; and (f) continuing youth engagement and capacity- building in the arts.			
5. Fletcher et al. (2017)	Study aims: To: (1) test the acceptability and feasibility of developing a website (that included short films) offering	Study setting: Aboriginal Community Controlled Health Services (ACCHS) in one regional city and	Policy/ program/ intervention/ service: Stayin' on Track internet and mobile app. Sample size: 20 young Aboriginal fathers were recruited as co- investigators.	Strategies/ activities: 'Yarn up' discussions with the fathers and community members were held at the three locations. Young fathers were filmed talking about their experiences of fatherhood. <i>SMS4dads</i> messages were reviewed and modified by the two	Outcomes: Participatory approaches using a strengths approach and investing time and resources in community consultations can be effective in engaging Aboriginal young people. Responses to the website	Workforce requirements: N/A.	Cost/ referral pathways: N/A.	Level of evidence: Emerging practice.

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	tailored support and information to young Aboriginal fathers; and (2) to adapt and test a mobile phone-based text-messaging and mood-tracker program that provided ongoing social, cultural and emotional support to the fathers to address issues in relation to mental health and wellbeing.	two rural towns in NSW. Target group: Young Aboriginal fathers (18–25 years), with all fathers having at least one young child at the time of enrolment.	Approximately 170 people viewed the films across the three locations.	Aboriginal mentors. On a weekly basis, participants were also asked to monitor their mood. The young fathers' films were presented at community events in each of the three locations. Conditions: Health promotion programs and initiatives developed for the general population may lack relevance for Indigenous people. Enablers: Fathers were integral in the development of web-based resources and testing of mobile phone-based text messaging and mood-tracking programs tailored to provide fathering and mental health support. Key to the success of the project was the close research partnership that was developed with the Aboriginal communities, and the involvement of the two Aboriginal mentors who supported the young Aboriginal fathers. Barriers: N/A.	and video presentations provide promising evidence of the feasibility and acceptability of providing tailored online resources to support young Aboriginal men in their fathering role. Young Aboriginal fathers and community members expressed unanimous support and pride in the project outcomes. Preliminary support for the feasibility of providing support to young Aboriginal fathers through mobile phone-based text-messaging and mood-tracking programs to assist them in the transition to fatherhood. Outcome measures: N/A. Screening/ measurement tools: N/A.			
6. Healey et al. (2016)	Study aims: This study responded to a community-identified need to form an evidence base for interventions to promote	Study setting: 5 Nunavut communities, Canada. Target group: Youth in Nunavut.	Policy/ program/ intervention/ service: The Eight Ujarait (Rocks) Model implemented as a camp program in six pilots in five communities. Sample size: 37 participants in	Strategies/ activities: Themes from a review of the literature were presented to Nunavut community members for comment. Core concepts from the literature and community dialogue sessions were incorporated into a model for wellness interventions focusing on Nunavut youth. The	Outcomes: The program fostered physical, mental, emotional and spiritual wellness among youth. Parent observations of participants included an improvement in behaviour and attitude, strong cultural pride, greater confidence in	Workforce requirements: N/A.	Cost/ referral pathways: N/A.	Level of evidence: Emerging practice.

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	mental health and wellness among youth in Nunavut.		community consultations. Forty-eight youth participants, eight youth peer leaders and 15 facilitators participated in the camps.	<p>model was piloted as a youth camp program to validate the core concepts of the model. The Eight Ujarait (Rocks) Model highlights eight core constructs, which symbolise the formation of a solid stone foundation comprising skills and knowledge upon which young people build their lives. The modules/ujarait promote positive social interactions; opportunities for self-reflection and self-expression; cultural skill-building; and exploring the relationship between healthy minds and bodies.</p> <p>Conditions: Trauma experienced during and after the settlement and resettlement era in the eastern Arctic and the loss of accumulated Inuit wisdom, knowledge, teachings and practices that occurred as a result are factors contributing to the mental health challenges in today's communities. Previous research has indicated that many young Inuit today do not feel a connection to or sense of stewardship for the land or knowledge of harvesting skills and practices that are highly regarded in Inuit society.</p>	<p>identity and improved family and community relationships. The application of one such model through a camp program had a lasting impact on the individuals involved, beyond their immediate participation. The study found evidence-based, community-driven models for youth mental health interventions in the North held extraordinary promise.</p> <p>Outcome measures: N/A. Screening/ measurement tools: N/A.</p>			

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				Enablers: Modules are delivered in a positive, respectful, strengths-based, solution-oriented space. Barriers: N/A.				
7. Henwood et al. (2017)	Study aims: To examine the social opportunities for Aboriginal and Torres Strait Islander men created through Men's Groups/ Sheds across urban, regional and remote areas of Australia.	Study setting: Five urban, regional and remote case studies. Target group: Indigenous men.	Policy/ program/ intervention/ service: Men's Groups/Sheds. Sample size: 61 Indigenous men.	Strategies/ activities: Men's Sheds are a safe space, resembling a workshop setting or backyard shed, where men are encouraged to socialise and participate in health promotion, informal learning and engage in meaningful tasks both individually and at the community level. Conditions: Three themes were the 'Need for Shared Social Spaces', 'Sharing Stories of Trauma, Grief, Incarceration' and 'Social Programs in the Sheds'. High levels of trauma and grief are prevalent among Indigenous men and contribute to mental health concerns. Social issues that men confront in their everyday lives including discrimination, racism, unemployment and violence can contribute to individual actions that result in AVOs and incarceration. High levels of unemployment result in increased violence and/or substance abuse as the men are not afforded the opportunity to participate in a meaningful sense in society. Adult literacy and education is an area of concern among Indigenous men,	Outcomes: The effective development of social relations and socially designed programs through Men's Groups, operating as communities of practice, may contribute to overcoming many social and health wellbeing concerns. Men's Sheds as a safe environment for Indigenous men to seek refuge. In each of the five sheds there was overwhelming support for the Men's Shed as the catalyst to enhance social opportunities and bring men together in a safe place where they pursue positive changes to their lives. Outcome measures: N/A. Screening/ measurement tools: N/A.	Workforce requirements: N/A.	Cost/ referral pathways: N/A.	Level of evidence: Emerging practice.

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				<p>with employment, income and literacy levels acting as potential factors impacting on Indigenous health. Mixed responses suggest education is viewed as unobtainable for the improvement of health and wellbeing among men. There is little understanding in the broader society about Indigenous approaches, with one participant noting that we 'can't fix all communities the same way [...] our needs vary'.</p> <p>Enablers: The men indicated that they want to yarn about the trauma that has happened throughout their lives and their consequent mental health and other issues.</p> <p>Barriers: Existing social issues and a sense of learned helplessness holds men back and that contributes to poorer health; criminal records, which affect education and employment opportunities, impact on self-esteem and motivation.</p>				
8. Hirsch et al. (2016)	Study aims: To provide an interpretive description drawing from autobiographical accounts of the	Study setting: Nain, Nunatsiavut, Canada. Target group: At-risk youth.	Policy/ program/ intervention/ service: Going Off, Growing Strong program. Sample Size: Ten at-risk youth participants (ages 14–21)	Strategies/ activities: A community freezer youth outreach program intended to build the resilience of a group of Inuit youth in the face of widespread social, environmental and cultural change. Goals were to:	Outcomes: A multifaceted approach to relationship and skill-building can help communities respond to change and adversity through individual and collective resilience.	Workforce requirements: Staff are attuned to community needs, traditional knowledge, and	Cost/ referral pathways: N/A.	Level of evidence: Emerging practice.

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	development of the innovative Going Off, Growing Strong program.		were selected for this program by the steering committee — youth most at risk (suicidal ideation and substance abuse at home) and with the least access to healthy adults who could take them off on the land.	1) enhance the mental, physical and spiritual health of a group of at-risk youth; 2) build social connections between the youth and other community members; and 3) transmit environmental knowledge, skills and values from experienced harvesters to youth. Experienced and trusted harvesters are recruited to take the youth out on the land, in small and large groups, to teach them how to hunt, fish, collect firewood, navigate on the land and prepare country foods. Community-based activities aim to build connections among the youth, between youth and program staff, and between youth and other community members, such as elders. Conditions: Dispossession and disconnection from traditional lands, governance systems and cultural practices are associated with poor mental, physical and spiritual health. The deterioration of family bonds and other social relationships is a recognised risk factor for mental health issues, such as depression, substance abuse and suicide. A growing body of literature indicates the importance of social, cultural and ecological connectedness to build the resilience necessary to heal	Outcome measures: N/A. Screening/ measurement tools: N/A.	youth engagement. They are themselves accomplished researchers and actively solicit feedback from community members and from the program steering committee. Steering committee members are community representatives with expertise in experiential education, mental health and suicide prevention, youth engagement, and sustainable harvesting. The committee has helped to guide Going Off, Growing Strong and advocate on behalf of youth,		

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				<p>and adapt to current and future change. Community members speak of the healing effect and sense of freedom that comes with being on the land. Concerns about country food access and the prevalence of youth suicide in the community led to development of the Nain community freezer and youth outreach programs. 45% of households reported being severely or moderately food insecure. Six suicides of male youth in two months.</p> <p>Enablers: Regular meetings have been held throughout the program operations with the youth participants, their parents, harvesters, program staff and others. Meetings with the steering committee assist ongoing efforts to improve the program and to respond to the changing social context of the community.</p> <p>Barriers: Pairing of youth with harvesters has been one of the greatest challenges of the program, as working closely with youth requires much time from these volunteer hunters.</p>		help select program participants, and act as key points of contact for any concerned adults and community agencies.		
9. Isaacs & Lampitt (2014)	Study aims: To describe the design, implementation	Study setting: Central Gippsland, Australia.	Policy/ program/ intervention/ service: Koori Men's Health Day.	Strategies/ activities: Invitations to attend a Koori Men's Health Day were distributed via flyers and posters. Using an	Outcomes: Seven of 17 participants who completed the K-10 scored significantly for psychological distress.	Workforce requirements: At the outset, cultural safety	Cost/ referral pathways: N/A.	Level of evidence: Emerging practice.

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	and outcomes of an innovative model for the early detection of mental illness among rural Aboriginal men.	Target group: Koori men over the age of 18 years.	Sample size: 20 men; 17 participants whose data were available.	assembly line technique and avoiding any reference to the term 'mental', all participants underwent a complete medical examination, a blood test for diabetes and a psychological assessment using the Kessler-10 schedule. Conditions: High prevalence of mental health conditions among Aboriginal people; low rates of help-seeking for mental health issues among Aboriginal men; barriers to help-seeking experienced by Aboriginal men; partnership between ACCHOs and mainstream services; request for KMHD by community elders. Enablers: There were several measures taken to ensure there was good rapport and trust between the Aboriginal and non-Aboriginal stakeholders in the steering group; collaboration between a university, an Aboriginal organisation and a regional mental health service; support from the local Aboriginal community; formal introduction by elders and acceptance among community members enabled better engagement with clinical staff; the presence of Aboriginal steering group members and local elders put participants at ease and enabled them to have open	Follow-up was offered to these participants, and three participants engaged in follow-up. When conducted on a regular basis, the Koori Men's Health Day could be a useful method for the early detection of mental illness among rural Aboriginal men in Australia. Outcome measures: Level of psychological distress. Screening/ measurement tools: Kessler 10 questionnaire (K-10).	training was provided to the mental health staff. Later, Aboriginal steering group members were invited to the hospital to meet the triage staff and other mental health professionals. In addition, the senior mental health male nurse spent several weeks interacting with various members of the community in an effort to build trust and friendships with them.		

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				<p>discussions of their mental and social problems; mental health education by clinical staff and the offer of further mental health consultation with other preferred service providers helped improve linkages between community members and other service providers, and encouraged acceptance of the Community Mental Health Service (CMHS); conducting mental health screening in the context of a general health check-up enabled the identification of mental health issues while removing some of the barriers experienced by this population group.</p> <p>Barriers: Comprehensive client follow-up was limited due to difficulties in coordinating appointments; the K-10 as a self-report tool may not be valid due to literacy issues and lack of understanding among participants; sense of shame around not being able to read contributed to high ratings of depression and anxiety; different terms used and meaning given to terms may effect K-10 validity with this group.</p>				
10. Le & Gobert (2015)	Study aims: To engage in adaptation/	Country: US Study setting: Native American	Policy/ program/ intervention/ service:	Strategies/ activities: The adaptation/translation of a mindfulness curriculum for cultural	Outcomes: Results of the mixed-methods process and outcome evaluation suggest	Workforce requirements: Facilitators	Cost/ referral pathways: N/A.	Level of evidence:

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	translation of a mindfulness curriculum for cultural relevancy with Native American traditions and spiritual practices AND to test the feasibility of translating and implementing a culturally adapted mindfulness-based prevention curriculum with a sample of Native American youth from a Native American school.	school in a reservation located in rural northwestern Montana. Target group: Eight Native American youth, ages 15–20. Sample size: Eight youth (mean=17 years old, range=15–20; five males) signed up for the class and participated in the pilot study.	A school-based culturally adapted mindfulness curriculum for Native American youth to provide tools to recognise and manage self-destructive thoughts and emotions along with developing the capacity 'to be' with difficult thoughts and emotions (distress tolerance). The mindfulness class was offered as an elective class at a Native American school, with four sessions per week, 55 min per session, over 10 weeks. The mindfulness intervention was part of a larger comprehensive suicide prevention strategy called the Circle of Trust Suicide Prevention Program, which included coordination of suicide prevention services, gate-keeping activities and a social media campaign.	relevancy with Native American traditions and spiritual practices; the nine included modules covered: mindful breathing; mindful listening; mindfulness of nature; mindfulness of body; mindfulness of thoughts; mindfulness of emotions; cultivating compassion and empathy; judgement and forgiveness; and aligning with vision; the class was conducted in council style, a Native American practice, whereby everyone sits together in a circle to encourage and practise speaking and listening from the heart; use of local facilitators; a safety protocol for the mindfulness facilitators was implemented that detailed the steps to be taken should any adverse reaction occur during the session or if they suspect any among the participating youth. Conditions: High rates of suicide among Native American youth; high levels of cumulative suicide risk-factor experience; limited evidence-based culturally appropriate suicide interventions; strong evidence base on the effectiveness of mindfulness-based interventions for physical and mental health conditions with adults; limited but promising	that the intervention is acceptable to Native American youth, with positive indications in terms of better self-regulation, less mind wandering, and decreased suicidal thoughts. Slight trending towards lower impulsivity. Youth self-reported that they gained useful skills to help them deal with stress and gained new friendships and strong connections. Outcome measures: Mindfulness, self-regulation, impulsivity and suicidality. Screening/ measurement tools: Measures included a two-item mindfulness measure, a 12-item health self-regulation measure, a four-item teenage impulsivity measure; and suicidality was assessed using the Patient Health Questionnaire (PHQ-9).	needed to be Native American people living in the community so they could understand experiences of the participants, such as inter-generational trauma and loss from suicide, and who could model authenticity and vulnerability, mindful presence, and an open-hearted, guiding facilitation style. Once the facilitators were identified, mindfulness group facilitation and curriculum training were offered to both the recruited facilitators and the larger tribal community. The training included		Emerging practice. Some level of intervention effectiveness

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				<p>evidence of the impact of mindfulness interventions with children and young people and on suicidality; assertion that mindfulness is culturally congruent with Native American cultures.</p> <p>Enablers: Collaboration with esteemed elders, community practitioners and cultural committee members in the cultural adaptation of the curriculum; Tribal Council and elder approval of the curriculum; permission from the school site for the pilot study; collaboration with a Tribal Social Service to examine the curriculum for cultural responsiveness of the content.</p> <p>Barriers: Future studies will need to explore whether the young people's acquired skills actually translate to the real-world settings with their family members, their peer groups, their tribal community and the community at large; uncertainty regarding how much mindfulness training and practice is needed by facilitators; lack of community resources for facilitator training; potential selection bias due to elective nature of the intervention; small sample size.</p>		2½ days of intensive mindfulness and mindfulness group facilitation. In addition, after each session with the youth, debriefing and coaching sessions were provided with the facilitators, lasting 1–3h per week over nine weeks.		

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11. Lee et al. (2013)	Study aims: To provide a profile of Aboriginal women attending an inner-city outpatient alcohol and other drug (AOD) treatment service; insight into how effective women and staff perceive the support group to be at meeting their needs and suggestions for improvement.	Country: Australia. Study setting: Inner-city outpatient alcohol and other drug treatment service. Target group: Aboriginal women. Sample size: Interviews were conducted with 24 Aboriginal female clients and 21 staff members.	Policy/ program/ intervention/ service: Aboriginal women's group offered one morning a week for three hours.	Strategies/ activities: The group format changes but includes informal conversation, art and craft, and recreational and educational activities (e.g. on treatment options, parenting, first aid or financial management); childcare was provided; lunch was provided. Conditions: Negative impact of AOD misuse; social and cultural determinants of health and their contribution to health inequities; limited evidence to guide adaptation or development of AOD treatment for Indigenous populations; indication of the appropriateness and effectiveness of support groups for Aboriginal peoples. Enablers: The group was requested by the Aboriginal women; the evaluation was requested by clients and staff. Barriers: Small sample size; no Indigenous interviewers; AUDIT-C had not been validated for use with an Indigenous Australian population.	Outcomes: Clients reported social and health indicators illustrating disadvantage and complex needs. Most clients and staff perceived the group to be useful and easily accessible. The participants discussed positive elements including opportunities for shared experience in a non-judgemental environment, practical support and health education. Staff reported how the safe, relaxed environment of the group helped with early identification of issues and user-friendly pathways for treatment access. Suggested improvements included greater involvement from Aboriginal staff and community members and enhanced communication with other staff. Outcome measures: Alcohol consumption, mental health risk and participant and staff perceived effectiveness of intervention. Screening/ measurement tools: Alcohol consumption questions were based on the AUDIT-C. Mental health risk	Workforce requirements: Facilitators included a senior Aboriginal woman with experience in AOD work and a non-Indigenous counsellor. Aboriginal health promotion, health education, early childhood and mental health workers employed by the same health district periodically attend as support staff. A non-Aboriginal volunteer assists with child minding.	Cost/ referral pathways: Referral through alcohol and other drug outpatient treatment service.	Level of evidence: Emerging practice. Evidence of client- and staff-perceived usefulness.

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					was assessed using the IRIS mental health items.			
12. Malone (2013)	Study aims: Describe the first-person account of a psychologist and a social worker on their experiences developing and piloting community-based mental health programs for a rural Albertan Cree community AND provide an overview of two pilots, the Family Wellness Program and the Community-Based Anger Management Workshops, reflecting on attempts to integrate mental, physical, emotional and spiritual considerations	Country: Canada. Study setting: Cree (First Nations) community. Target group: Cree (First Nations) community. Sample size: N/A.	Policy/ program/ intervention/ service: Community-Based Anger Management Program: A two-day program focused on identity, multi-generational trauma, power and control, and developing support networks. Core aspects of the program integrate physical, mental, emotional and spiritual aspects of anger with a focus on wellness rather than pathology consistent with the understanding of local Cree cultural teachings. Family Wellness Program: A family wellness program for parents focused on identity, self-care and relational health rather than strictly parenting. The program's aim evolved to empower rather than to teach.	Strategies/ activities: Multidisciplinary team work. Community-Based Anger Management Program: Includes prayer, art therapy, cultural teachings, psycho-education, group sharing circles and relaxation training. Program development included planning meetings, debriefings and direct collaboration with program participants. Community elders were frequently consulted and periodically attend the program. Transportation and food were provided and the training took place at a neutral community location, with time balanced between indoors and outdoors, in conversation and in activity, in sharing and in teaching. Other professionals were invited to attend both to participate and to provide consultative evaluations on the program itself. Family Wellness Program: Included workshops, crisis intervention, support to single mothers, a family wellness component that incorporated cultural teachings, elder support, psycho-education, group sharing	Outcomes: Anecdotal evidence of strong community support and demand for the program, as well as positive, healing and empowering experiences for those attending the group. Outcome measures: N/A. Screening/ measurement tools: N/A.	Workforce requirements: Facilitated by a registered psychologist.	Cost/ referral pathways: N/A.	Level of evidence: Emerging practice.

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	consistent with the community cultural context.			<p>circles and regular home visits and individual counselling sessions. A maternal health coordinator provided individual and group support to the mothers in the program. A Native American male social worker conducted psycho-education groups and individual and group work with the fathers in an attempt to engage them in family processes as fathers and men.</p> <p>Conditions: The need for culturally responsive community-based mental health services; dissatisfaction with individualistic, deficit-focused existing services; impact of the social determinants of health.</p> <p>Enablers: Collaborative development with the local National Native Alcohol and Drug Abuse program; program coordinator/staff commitment to community wellbeing.</p> <p>Barriers: Lack of official funding for programs; extra demands on staff and coordinators' time, taking away from their availability to do other aspects of their roles; funding silos that do not allow for community responsiveness.</p>				
13. Ritchie, et al. (2014)	Study aims: Evaluated the impact of an	Country: Canada.	Policy/ program/ intervention/ service:	Strategies/ activities: The OALE included many natural challenges such as rapids, portages,	Outcomes: Over two years, 73 youth participated the program, representing 15%	Workforce requirements: N/A.	Cost/ referral pathways: OALE	Level of evidence:

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	outdoor adventure leadership experience (OALE) on the resilience and wellbeing of First Nations adolescents from one reserve community. The secondary purposes were to explore whether this impact was sustainable, and whether there were any intervening factors that may have influenced the impact.	Study setting: Wikwemikong Unceded Indian Reserve in northern Ontario, Canada. Target group: First Nations adolescents. Sample Size: 73 youth 12–18 years of age.	The OALE is a 10-day intensive program involving a wilderness canoe expedition homeward through the traditional territory of Wikwemikong.	navigation and open-water crossings. Participants were assigned day leadership responsibilities, and the experience included a half-day solo component. Group discussions and talking circles occurred each night around a campfire, and other program components were interwoven into the routine of the travel day. Program staff and guides from Wikwemikong facilitated the experience, mentored the youth participants, and implemented program elements as needed and when appropriate. Conditions: Health and wellbeing inequities experienced by Aboriginal/First Nations youth in Canada, including mental health; concern about poor youth mental health; a holistic view of health as represented through the medicine wheel; the role of connection to cultural heritage on health and wellbeing; lack of evidence of efficacy of programs to improve the mental health and wellbeing of on-reserve First Nations youth; growing evidence of the effectiveness of outdoor adventure therapy in improving youth mental health, and the cultural relevance of such programs.	of the on-reserve adolescent population. Survey responses from 80.8% of participants were available at T1, 64.4% at T2 and 45.2% at T3. The mean RS-14 improved between T1 and T2 but returned back to pre-OALE levels at T3. The mean MCS score improved from T1 over the subsequent two time periods. Several intervening factors reported at T3 may have influenced the decrease in resilience scores from T2 to T3. These included changes in family living situation, death in the family, and other life stressors that occurred over the course of the year. Outcome measures: Resilience, the four dimensions of wellbeing (physical, mental, emotional and spiritual) from the Medicine Wheel framework, self-esteem, satisfaction with life. Screening/ measurement tools: 14-Item Resilience Scale (RS-14); Mental Component Score (MCS) from the SF-12v2; Physical Component Score (PCS)		participants were recruited through various promotional campaigns coordinated by the Waasa Naabin Community Youth Services Centre. Adolescents for a comparison group were recruited from a summer youth employment program in the community.	Emerging practice. Weak evidence of short-term effectiveness

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				<p>Enablers: Collaboration between community leaders and university researchers; oversight and guidance provided by a local Community Research Steering Committee.</p> <p>Barriers: Lack of measurement scales developed or normed with First Nations adolescent populations; challenges in family and community life identified as intervening factors impacting on changes in resilience and wellbeing; challenges in conducting follow-up survey with transient population; small sample size; lack of randomisation; low response rates from the comparison group; and potential for sample selection bias effecting study quality.</p>	from the SF- 12v2; Scale of Positive and Negative Emotion — Balance (SPANE); Flourishing Scale (FS); Self-Esteem Scale (SES); Satisfaction with Life Scale (SWL). Other questions were asked related to social support (SS), spiritual values (SV), and community values (CV).			
14. Robinson et al. (2016)	Study aims: Describes the development and pilot implementation of Skills for Life (SFL), the Indigenous Youth Life Skills Development program. The aims of the pilot project were to develop a 12-	Country: Australia. Study setting: Very remote community college in the West Arnhem region of northern Australia. Target group: Indigenous middle school	Policy/ program/ intervention/ service: Skills for Life (SFL), an Indigenous Youth Life Skills Development curriculum that integrates proven educational and psychological techniques with culturally informed notions of relatedness.	Strategies/ activities: In total, 11 lessons were developed on the following themes: strengths in the community; character strengths; emotional literacy and managing strong emotions; positive thinking and problem solving; passive, aggressive and assertive communication; dealing with grief and loss; saying 'no' to alcohol; and help-seeking and working together with friends. Indigenous co-facilitators were involved in program delivery to	Outcomes: The pilot program yielded important insights into requirements of a curriculum for young people with low English literacy levels and with variable school attendance patterns. It confirmed the need to adjust both pedagogical approach and curriculum content for the program to have resonance with students from this linguistic and cultural	Workforce requirements: It was decided that local Indigenous staff were needed to facilitate youth engagement.	Cost/ referral pathways: N/A.	Level of evidence: Emerging practice. Evidence of community support for the intervention. No evidence of effectiveness due to challenges

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	week curriculum and resources that could address both general promotion of resilience and the need for specific prevention relevant to known risks in Indigenous communities, to trial a collaborative process for joint delivery in middle school classes and to gauge student responses to content and the program delivery process.	students in years 7–9. Sample size: 51 students.		<p>help make it more culturally safe for young people and to help with youth engagement.</p> <p>Conditions: High rates of suicide among Indigenous Australian youth, particularly in rural and remote areas; social disadvantage associated with the social determinants of health; international evidence of the effectiveness of school-based interventions to address suicide risk and or social and emotional skills and behaviours, particularly social and emotional learning (SEL) approaches; lack of such programs developed specifically for Indigenous Australian youth in remote communities.</p> <p>Enablers: Government funding; school commitment to supporting student social and emotional wellbeing as demonstrated by existing programs; support from community elders, committee/networks and school staff for the program; advice provided from the Indigenous advisory committee and community members; the involvement of Indigenous co-facilitators in group sessions.</p> <p>Barriers: The need to switch from native languages spoken at home to English spoken in the classroom</p>	<p>background and with varying levels of exposure to multiple stressors in disadvantaged community settings. No evidence of impact, but it includes very important lessons on some of the challenges and considerations for implementing such programs in a remote school context.</p> <p>Outcome measures: N/A. Screening/ measurement tools: N/A.</p>			outlined in outcomes.

1 st Author/ publication year/ publication type	Study aims/ brief description	Study setting/ target group	Policy/ program/ intervention/ service	Components: Strategies/ activities, conditions, enablers & barriers to effective implementation of the policy, program or services	Outcomes: Outcome measures/ measurement tools	Workforce requirements (e.g. skills, qualifications, training, cultural awareness)	Cost: Cost- effectiveness/ referral pathways	Level of evidence
				contributed to challenges for participants; low levels of English literacy and even spoken fluency impeded effectiveness; highly variable student attendance significantly affected the delivery of the program.				
15. Southcombe et al. (2015)	Study aims: To investigate management capacity-building approaches at the community level in Indigenous Men's Groups and Sheds. Three key research questions were examined: (i) What are the needs of Indigenous men in Men's Groups and Sheds? (ii) How does community capacity building, as a management practice, work in Indigenous Groups and	Country: Australia. Study setting: Men's sheds from urban, regional and remote communities. Target group: Men who are involved in Men's Sheds. Sample size: 15 Groups/ Sheds involving 45 men.	Policy/ program/ intervention/ service: As safe men's spaces, Men's Groups and Sheds represent an ever-growing social and health and wellbeing community service across Australia.	Strategies/ activities: 'Yarning circles' were conducted with men who participate or want to participate in Men's Sheds. Semi-structured interviews were conducted with leaders/co-ordinators of Men's Groups/Sheds. Conditions: Social isolation and poor social and health outcomes among Aboriginal men; recognised role of Men's Sheds in improving men's health and wellbeing and encouraging service access; community capacity-building as a health promotion exercise; lack of evidence on capacity-building interventions for Indigenous men. Enablers: Support from key Indigenous representatives who facilitated contact with Groups/Men's Sheds; 'yarning circle' method for collecting data providing a safe space for participants to share. Barriers: N/A.	Outcomes: Themes in the data revealed: (i) the need for men to connect and engage with community groups; (ii) the main issues that impact on Indigenous men and the support groups provide; (iii) how Groups and Sheds are pivotal avenues for capacity building; and (iv) the ways in which Groups and Sheds provide opportunities to make a difference to men's overall health and wellbeing. The study found capacity building is primarily about securing relationships between Group leaders/Shed co-ordinators and government services. Capacity building establishes links to services such as Centrelink, Medicare, Department of Housing, Probation and Control, and positive outcomes such as Indigenous men securing	Workforce requirements: N/A.	Cost/ referral pathways: N/A.	Level of evidence: Emerging practice.

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	Sheds? and (iii) In what ways does capacity building impact on Indigenous men's health and wellbeing outcomes?				housing and Centrelink payments. Capacity building resulted in better health outcomes and educates and empowers men to improve their social, cultural, emotional and economic wellbeing. It helps men to better connect with family and community. The current research paves the way for countries worldwide to explore the conceptual and empirical approach of capacity building applicable to other Indigenous [and non-Indigenous] Men's Groups/Sheds. Outcome measures: N/A. Screening/ measurement tools: N/A.			
16. Togni, SJ 2017	Study aims: The Uti Kulintjaku Project took an innovative approach to developing a process to strengthen shared understanding of mental health between	Study setting: Emerging from within the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (NPYWC) in Central Australia with a community	Policy/ program/ intervention/ service: Uti Kulintjaku (UK) Project. Sample size: N/A.	Strategies/ activities: A series of 10 3–4-day workshops over three years has been a key mechanism of the project. Also, reflective practice, participant observation, focused discussion groups with Aboriginal participants, and 21 semi-structured, in-depth key stakeholder interviews. Conditions: The UK Project emerged within the context of the Ngangkari (traditional healers)	Outcomes: A model has been developed that facilitates clear thinking, enables safe ways to talk about difficult issues, fosters healing and empowerment, and promotes finding new ways to enhance mental health and wellbeing. A range of outcomes at a personal, group and project level has been achieved:	Workforce requirements: The UK Project team comprises 17 senior Anangu women, some of whom are ngangkari, and all of whom are leaders in their communities	Cost/ referral pathways: N/A.	Level of evidence: Consistent with programs identified as most effective in enhancing the social and emotional

1 st Author/ publication year/ publication type	Study aims/ brief description	Study setting/ target group	Policy/ program/ intervention/ service	Components: Strategies/ activities, conditions, enablers & barriers to effective implementation of the policy, program or services	Outcomes: Outcome measures/ measurement tools	Workforce requirements (e.g. skills, qualifications, training, cultural awareness)	Cost: Cost- effectiveness/ referral pathways	Level of evidence
	Aboriginal people and non-Aboriginal health professionals with the long-term aims of increasing help-seeking, strengthening health services' cultural competency, and Aboriginal leadership.	development approach. Target group: Anangu people/ culture.		Program's work with mainstream health and mental health services over more than a decade. Enablers: The UK Project is Aboriginal-led, explores and is informed by Aboriginal understandings of SEWB, is context-specific and collaborative. It involves the Anangu women in the project's design, implementation and evaluation. It also incorporates processes that have enabled healing, personal growth and empowerment: elements recognised as essential for enhancing Aboriginal SEWB. Guided by community development principles, the UK Project focuses on developing individual and group capacity. Uti Kulintjaku Iwara components that promote healing and empowerment at an individual and group level have been critical to the model's ability to facilitate clear thinking to respond to the challenges of strengthening Anangu SEWB. Barriers: To date, the evaluation has focused primarily on understanding the project's process and the experiences of the project team. Some external stakeholders were interviewed to gain their perspectives of the	capacity development of the team of senior Aboriginal women; increased bi-cultural understanding of mental health; and emphasis on the importance of culture in enhancing Aboriginal mental health and wellbeing. A multi-lingual compendium of words and phrases was created and innovative resources were produced. Partnerships with mental health services were strengthened. The UK poster — or 'words for feelings map' — is the most widely known resource produced to date. It contains Pitjantjatjara or Ngaanyatjarra and English words for feelings and emotions and includes drawings of people expressing these feelings and emotions within a community setting. Outcome measures: N/A. Screening/ measurement tools: N/A.	across the remote NPYWC region. These women bring considerable cultural knowledge and authority and high-level language skills, and none have Western tertiary education qualifications. All speak Pitjantjatjara, Yankunytjatjara or Ngaanyatjarra as their first language and many are multilingual and fluent in spoken and written English. The project team also includes four non-Aboriginal MHPs, the Ngangkari Program manager, the UK Project officer, an interpreter		wellbeing and 'suicide proofing' of Aboriginal communities Emerging practice.

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				project; however, most of these stakeholders are UK Project partners and supportive of the project's work. This could, therefore, positively bias their perspectives of the project. The UK Project is context-specific, meaning the way of working that it developed may not be appropriate or effective in other settings. It was outside the current evaluation's scope to interview Anangu in communities to gain their perspectives of the project's resources; however, if the project receives further funding the intention is to include their perspectives in future evaluation.		and an evaluator. Most non-Aboriginal team members have more than 10 years' experience working effectively and respectfully with Aboriginal people in the region and had pre-existing relationships with the Anangu team members.		
17. Victor, et al. (2016)	Study aims: The focus of this paper is to demonstrate the efficacy of an after-school visual arts program both for wellness promotion and as a research method among First Nations youth.	Country: Canada. Study setting: After-school arts class in an Anishnabe and Nahiyawak (Cree) community in southern Saskatchewan, Canada. Target group: First Nations youth.	Program/ service/ policy description: A four-month after-school program in 2014 that blended a participatory visual method of research with Indigenous knowledge, methodologies and practices to provide sociocultural health programming for First Nation youth. It was part of a larger project in wellness promotion where	Strategies/ activities: Program facilitators guided group-building activities, taught visual art techniques, held discussions on the topics of identity and wellbeing, and conducted talking circles with youth that typically focused on a health-related theme. Storytelling and sharing circles were used in the project primarily to emphasise relationality and subjective experience. Conditions: Growing recognition of the sociocultural determinants of health; evidence base supporting the positive impact of	Outcomes: Participatory arts methods created a safe space for youth to express their views of health and wellness issues while developing self-knowledge about their individual and cultural identities. Outcome measures: N/A. Screening/ measurement tools: Field notes and interviews.	Workforce requirements: The facilitators were two male community research associates originally from nearby Anishnabe and Nahiyawak reserves. Both facilitators were experienced high school teachers with	Cost/ referral pathways: N/A.	Level of evidence: Emerging practice.

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		Sample size: 13 youth – seven females and six males.	engagement in the creative arts is used to facilitate self-expression, leadership skills and healthy decision-making. One goal of the overarching project, called 'Acting Out! But in a Good Way', is to explore how arts-based work grounded in Indigenous values and practices improves First Nations youths' sense of wellness and wellbeing, and how arts-based Indigenous methods have an impact on youths' health choices and actions.	arts-based research and programs on promoting health and wellness; creative arts as a culturally appropriate decolonising approach. Enablers: Research/health service partnership; Elders Advisory Council request for the program. Barriers: Difficulties following-up to see long-term outcomes.		expertise in culturally appropriate arts programming.		

Appendix 4

Grey literature

1 st Author/ publication year/ publication type	Study aims/ brief description	Study setting/ target group	Policy/program/ intervention/service	Components: Activities; enablers /barriers to effective implementation of the policy, program or services	Outcomes: Outcome measures/ measurement	Workforce requirements (e.g. skills, qualifications, training, cultural awareness)	Cost: Cost- effectiveness/ referral pathways	Level of evidence
1. Department of the Prime Minister and Cabinet (2017). National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023	Study aims: Provide a National Strategic Framework for Indigenous Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023	Study setting: The framework is a critical part of ongoing reform to the mental health system and interconnected with a number of strategic responses to Indigenous health. Target group: All Indigenous Australians and those who provide healthcare to them.	Policy/ program/ intervention/ service: National framework to guide and inform Indigenous mental health and wellbeing reforms. Sample size: 745,000 Indigenous Australians.	Strategies/ activities: A comprehensive and culturally appropriate stepped-care model. Action areas include: 1. Strengthen the foundations; 2. Promote wellness; 3. Build capacity and resilience in people and groups at risk; 4. Provide care for people who are mildly or moderately ill; 5. Care for people living with a severe mental illness. Conditions: Culture is central to the health and wellbeing of Indigenous peoples. Enablers: Ensuring cultural considerations are embedded in practice. Nine guiding principles. Barriers: N/A.	Outcomes: N/A. Outcome measures: Suggests that indicators could include: <ul style="list-style-type: none"> • Social and emotional wellbeing; • Mental health problems and mental illnesses; • The determinants of mental health problems and mental illnesses; • The performance of the mental health system overall; • Specific indicators for services disaggregated for Indigenous peoples. Screening/ measurement tools: N/A.	Workforce requirements: N/A.	Cost/ referral pathways: N/A.	Level of evidence: Promising practice.
2. Victorian Government (2017). Balit Murrup:	Study aims: To present a framework that aims to inform	Study setting: N/A.	Policy/ program/ intervention/ service: The principles espoused in the framework include:	Strategies/ activities: <ul style="list-style-type: none"> • Delivering locally designed community responses; 	Outcomes: N/A. Outcome measures: N/A.	Workforce requirements: Strengthening the Aboriginal mental	Cost/ referral pathways: N/A.	Level of evidence: Promising practice.

Aboriginal Social Emotional Wellbeing Framework 2017–2027	<p>and provide strategic direction to improve the mental health service system's capacity to support and improve the social and emotional wellbeing and mental health of Victorian Aboriginal people, families and communities. It is part of Victoria's 10-year mental health plan, which outlines a long-term vision to improve mental health services and outcomes for Victorians with a mental illness.</p>	<p>Target group: Aboriginal peoples, families and communities in Victoria.</p>	<ul style="list-style-type: none"> • Self-determination and community control • Embedding healing and protective factors • Culturally capable services • Person-centred care • Community engagement • Partnerships. <p>Key aims of Balit Murrup include:</p> <ul style="list-style-type: none"> • Building the resilience, engagement, skills and self-determination of Aboriginal people • Enabling Aboriginal people to be heard, to make decisions, and to plan and shape their own journeys of care recovery and healing • Supporting the planning and delivery of culturally appropriate care for the clinical, cultural and social and emotional wellbeing needs of Aboriginal people across all service systems • Supporting and investing in local Aboriginal community-led initiatives and strategies. <p>Sample size: N/A.</p>	<ul style="list-style-type: none"> • Investments in mental health to improve the service system's capacity to meet the needs of Aboriginal Victorians; • Strengthening the evidence base on effective and culturally appropriate service models; • Strengthening the provision of SEWB services in ACCHOs; • Strengthening the Aboriginal mental health workforce; • Piloting place-based suicide prevention strategies; • Youth mentoring; • Strengthening self-determination and negotiating treaties with government; • Culturally appropriate Aboriginal rehabilitation programs for people incarcerated and support programs post-release; • Improving the cultural connections of Koori children and young people who are unable to live with their families; • A forensic mental health implementation plan to expand mental health support for those who are in (or at risk of entering) the criminal justice system, with a focus on preventing offending in the first place; • Government/community collaborations to develop and provide holistic and healing therapeutic responses for survivors of family violence, and provide specialist family violence support in drug and alcohol and mental health services; • Built on the social and emotional wellbeing model, a strengths- 	<p>Screening/ measurement tools: N/A.</p>	<p>health workforce is a key strategy outlined.</p>		
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				<p>based therapeutic model that emphasises the importance of building strengths, resilience and connectedness in Aboriginal people and communities as pathways to positive mental health and wellbeing;</p> <ul style="list-style-type: none"> • Social and emotional wellbeing; • Connection to spirit, spirituality and ancestors; • Connection to land; • Connection to culture; • Connection to community; • Connection to family and kinship; • Connection to mind and emotions; • Connection to body. <p><i>Domains:</i></p> <ul style="list-style-type: none"> • Improving access to culturally responsive services • Supporting resilience, healing and trauma recovery • Building a strong, skilled and supported workforce • Integrated and seamless service delivery. <p>Conditions:</p> <ul style="list-style-type: none"> • High rates of mental health and SEWB issues among Aboriginal people • Impact of factors such as colonisation, trans-generational trauma, racism, discrimination, marginalisation and disadvantage on Aboriginal people's mental health • Mental health issues significantly contribute to the high rates of Aboriginal children being placed in out-of-home care 				
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				<ul style="list-style-type: none"> The current service system is not capable of meeting the needs of Aboriginal people. <p>Enablers:</p> <ul style="list-style-type: none"> Government funding support; Community engagement and endorsement of programs and projects; Government/community partnerships; Service collaborations; Holistic, multidisciplinary healthcare. <p>Barriers:</p> <ul style="list-style-type: none"> Service barriers for Aboriginal people in mainstream services; Ineffectiveness and inappropriateness of mainstream services resulting in less contact with primary health services and more contact with expensive tertiary services. 				
3. Haswell MR 2013	<p>Study aims: The project aimed to obtain a deeper and broader understanding of current knowledge regarding how policy can support what works to promote the SEWB of Aboriginal and Torres Strait Islander youth, and translate this into practical and useful</p>	<p>Study setting: N/A.</p> <p>Target group: Indigenous youth.</p>	<p>Policy/ program/ intervention/ service:</p> <p>The project involved four components:</p> <ul style="list-style-type: none"> A systematic review of the existing published and grey literature covering research on Indigenous youth SEWB up to 2010; A review of current policies at national and jurisdictional levels and a review of programs and services specifically addressing Indigenous youth SEWB; Completion of in-depth case studies of six programs with evidence of success and capacity to 	<p>Strategies/ activities: N/A.</p> <p>Conditions:</p> <ul style="list-style-type: none"> Health and wellbeing disparities; Life circumstances that seriously challenge their social and emotional wellbeing and limit their capacity to fulfil their potential; Reports of programs that help young Indigenous people build their strength and resilience. <p>Enablers:</p> <p>Critical success factors include:</p> <p><i>Critical effectiveness factors:</i></p> <ul style="list-style-type: none"> Common elements that make things happen at the youth/program Interface, such as focusing on strengths not deficits, building trust and being consistent, modelling strong 	<p>Outcomes:</p> <p>There is limited evidence on SEWB for Indigenous people. There is an urgent need for more research focused on protective as well as risk factors. Successful SEWB programs:</p> <ul style="list-style-type: none"> Address the upstream social determinants of SEWB as well as current issues; Recognise and build on the strengths of Indigenous culture, 	<p>Workforce requirements: N/A.</p>	<p>Cost/ referral pathways: N/A.</p>	<p>Level of evidence: Emerging practice.</p>

	information to enhance policy, resource allocation decisions and practice.		<p>inform across a range of settings and groups;</p> <ul style="list-style-type: none"> - Cross-case analyses identifying themes and variations across the six case studies and a meta-synthesis generating four sets of key distilled and cohesive messages to advance theory and assist policy and practice to foster program strength and impact. <p>Sample size: N/A.</p>	<p>cultural connection, and celebrating small achievements.</p> <p><i>Critical Sustainability Factors:</i></p> <ul style="list-style-type: none"> - Common elements that make programs strong and sustainable such as programs coming from the community, embedding Aboriginal ways of being and doing in all levels of the program, fostering innovation, supporting continuous improvement, and creating an open, honest and safe work culture. <p><i>Critical Growth Factors:</i></p> <ul style="list-style-type: none"> - Common elements that enhance program reach and capacity to support more youth most effectively, such as not expecting rapid changes among youth with complex problems, supporting workforce growth and development, cross-organisational collaboration and referral, and promoting prevention and early intervention. <p><i>Critical Societal Factors:</i></p> <ul style="list-style-type: none"> - Common elements that facilitate these programs to reach their full potential to improve the lives of Indigenous youth, such as funding strategies that support the growth of established and experienced programs, are not competitive, and provide adequate funding for program growth to meet need. <p>Barriers: N/A.</p>	<p>community and family;</p> <ul style="list-style-type: none"> • Pay careful attention both to content and process, specifically: <ul style="list-style-type: none"> - <i>Deliver culturally appropriate content in a culturally appropriate way</i> - <i>Use program content relevant to the Australian Indigenous context as well as the local context</i> - <i>Employ a holistic approach, encompassing the physical, emotional, mental, cultural and spiritual dimensions of health</i> - Are developed and led by local people (a 'bottom-up' approach) and have an impact at multiple levels, noting that even where the focus is the individual, strengthening community and culture including establishing or re-establishing connections with family and country is a common feature - Engage the broader community, too, 			
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					<p>involving elders and older Indigenous community members as mentors and role models, and drawing on relevant skills and resources from the non-Indigenous sector.</p> <p>Outcome measures: N/A.</p> <p>Screening/ measurement tools: N/A.</p>			
4. Newell S.	<p>Study aims: Not explicitly stated</p>	<p>Study setting: Tweed Heads area, NSW, Australia.</p> <p>Target group: Indigenous men aged 17–60+ years in the Tweed Heads area.</p>	<p>Policy/ program/ intervention/ service: Tweed Yarn Up Group for Indigenous Men.</p> <p>Sample Size: 31 men attended at least one group session; 12 attended more than 50% of the groups they were eligible to attend.</p>	<p>Strategies/ activities: Structured group program delivered over a 14-week period, with 10 broad topic areas centred on violence. Weekly sessions lasted 2.5–3 hours.</p> <p>Conditions: A pilot program.</p> <p>Enablers: Facilitator's knowledge and expertise in optimising group functioning and impact on the participants.</p> <p>Barriers: Limited session time available to cover the pre-planned content-specific activities.</p>	<p>Outcomes: There was a strong sense that the Yarn Up group filled a real gap in existing services or activities by offering a unique opportunity for Aboriginal men to come together in a positive way. Examples of changes in the men included:</p> <ul style="list-style-type: none"> • Increased awareness of their own behaviour, thoughts and/or emotions; • Taking more responsibility for and control of their behaviour, thoughts and/or emotions; • Becoming more understanding and/or compassionate 	<p>Workforce requirements: Male facilitator of group sessions from Rekindling the Spirit (RTS).</p>	<p>Cost/ referral pathways: The Yarn Up Group was initially promoted by On Track Community Programs, Tweed Valley Early Childhood Intervention Service and community elders – to Aboriginal men who may be interested and benefit from such a group. Word also spread through the Koori grapevine and,</p>	<p>Level of Evidence: Emerging practice.</p>

					<p>towards their partners or children, including better acknowledgment of their struggles with their own issues and changes in the men;</p> <ul style="list-style-type: none"> • Increased awareness of the importance of children's early years and how experiences then can have an impact throughout their lives; • Increasing levels of self-confidence, self-respect, pride and trusting themselves; • Increasing levels of trust in and respect for others, including being more open with their partners; • Feeling more empowered, energised and/or motivated, with multiple examples of the men getting to grips with things they had been putting off; and • Feeling less isolated, from seeing others experiencing similar issues. <p>Outcome measures: N/A.</p> <p>Screening/ measurement tools: N/A.</p>		<p>as the groups progressed, many participants brought other men along, often their relatives.</p>	
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5. Aguiar W, Halseth R.	Study aims: Explores the educational domain as a place for healing and disruption of the inter-generational transmission of trauma. Provides an overview of the residential school system and its social and psychological impacts, examines the impact of trauma on learning, and how to support learning among Aboriginal people, and provides a case study on how the Blue Quills First Nations College (BQFNC) has worked to foster healing and disrupt the inter-generational transmission of trauma through its culturally appropriate curriculum and holistic	Study setting: Canadian community-owned First Nations Community College. Target group: Aboriginal/ First Nations Canadian adults.	Policy/ program/ intervention/ service: BQFNC is a community-controlled educational institution that incorporates features important for supporting educational success, health and wellbeing for Aboriginal students living with the impact of intergenerational trauma. The centre aims to promote a sense of pride in Aboriginal heritage and reclaim traditional knowledge and practices. Sample size: N/A.	Strategies/ activities: <ul style="list-style-type: none"> • Addressing the effects of trauma on the learning process in educational settings • Regaining a sense of control, connection and meaning in life through education • Assuring that educators are aware of the various impacts that trauma can have on the learning process • Supporting educators to appropriately address the classroom impact of trauma • Making educational environments places of healing, in the classroom context • Understanding the intergenerational impact of trauma from residential schools and reclaiming history and culture • Decolonisation approaches; • Incorporating Aboriginal culture and traditions into the classroom setting • Individualised approach and support • An approach to education that is based on the natural laws of love, honesty, sharing and strength • Incorporating: circular approaches based in spirituality; elders; traditional and local forms of wisdom; strengths-based approaches; empowerment strategies; humour; storytelling; and role modelling • Holistic approach to healing and wellbeing based on the Medicine Wheel. 	Outcomes: <ul style="list-style-type: none"> - Canada's first Aboriginal community-controlled educational centre; - Transforming a past symbol of violence into a symbol of empowerment through gaining community control over a past residential educational facility; - The college developed its own accredited programs that can be transferred to mainstream educational facilities. Outcome measures: N/A. Screening/ measurement tools: N/A.	Workforce requirements: Characteristics of educational programs to facilitate great achievement among Aboriginal people who have experienced trauma include: <ul style="list-style-type: none"> • Creation of a safe environment; • Acknowledgement of violence and its impact on people's lives; • Flexibility with deadlines; • Completing more research and homework in class; • Alternative assessment options; • Creating an environment of full participation. BQFNC is governed by seven appointed board members, each representing one of the seven local First Nations communities. First Nations educators/ facilitators who have done their own healing and are able to create a safe	Cost/ referral pathways: N/A.	Level of evidence: Emerging practice.
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	educational program.			<p>Conditions:</p> <ul style="list-style-type: none"> • Colonisation and ensuing oppression, loss of land, loss of self-determination and erosion of native culture • Intergenerational trauma and its legacy in social and health inequities; • The residential school system and resulting physical, sexual, emotional and spiritual abuses • Inequities in educational outcomes for Aboriginal people. <p>Enablers:</p> <ul style="list-style-type: none"> • Strategies that target the broader collective, not only individuals • Collaboration with other Indigenous institutions and programs. <p>Barriers:</p> <p>Impact of trauma on learning through cognitive, physiological and behavioural symptoms, including mental health issues such as PTSD and depression, or short attention span and learning disorders, and low self-esteem and lack of trust in self and others.</p>		space to support others' healing.		
<p>6. Powell et al. (2014)</p> <p>Book chapter</p>	<p>Study aims: To describe Red Dust Healing, an innovative and highly effective approach to assisting men and women in their efforts to heal and make better choices for themselves</p>	<p>Study setting: 300 different communities in rural, remote, regional and urban Australia.</p> <p>Target group: Although designed for Aboriginal Australians, it applies equally</p>	<p>Policy/ program/ intervention/ service: Red Dust Healing.</p> <p>Sample size: Program delivered to more than 5300 attendees (aged 8–70+). Preliminary data on 118 attendees.</p>	<p>Strategies/ activities: Examines the nature of rejection, the causes of rejection, the results of rejection and, most importantly, the remedies for rejection. Red Dust Healing identifies a model of oppression and how this oppression worked to remove the four core values (identity, responsibilities, relationships and spirituality) from man as the individual. The program addresses</p>	<p>Outcomes: Red Dust Healing is providing useful tools that attendees are willing to apply.</p> <p>Outcome measures: N/A.</p> <p>Screening/ measurement tools: In development.</p>	<p>Workforce requirements: N/A.</p>	<p>Cost/ referral pathways: Commissioned by various agencies and community groups to address a range of presenting issues including</p>	<p>Level of evidence: Emerging practice.</p>

	and in their relationships.	well to those from other cultural backgrounds who have themselves suffered loss and rejection in the context of their families and communities.		<p>oppression in ways that reverse the colonisation process. Each person is supported in developing an individual case-management plan to meet their personal needs. Red Dust Healing promotes follow-up by directly providing links and referrals to relevant services. The case-management plan can be supported by a buddy and mentor system that can assist and enhance completion of individual case plans.</p> <p>Conditions: If there is to be recovery, it is critical for governments to acknowledge or face the fact that future generations of families are growing up without fathers, and that decades of hurt are at the basis of many of today's social and personal difficulties. Approximately 30% of Aboriginal families in Australia are single-parent families. The authors propose that a key cause of hurt among all Aboriginal people is a history of rejection that continues in their daily life.</p> <p>Enablers: Program is based on six philosophical principles that guide the work by trained facilitators. Credibility and community recognition of the facilitators and the widespread success of the program play an important role in getting attendees to show up. The program must be facilitated by a properly trained First Nation Australian.</p> <p>Barriers: N/A.</p>			sexual assault, suicide prevention, grief and loss, family and domestic violence, harmful substance use, law and order concerns, mental health and social and emotional wellbeing, anger management, education, employment and housing issues, encouraging community contribution and more independent governance.	
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<p>7. Palmer 2013</p> <p>Attachment to a submission</p>	<p>Study aims: Final report of a three-year evaluation of the Yiriman project. It involved identifying factors contributing to the successful implementation of various projects carried out, factors that may hinder the implementation of the work, and assessment of other outcomes that are unintended but socially productive. The intention was to help: i) record the methods and outcomes of the project for future generations of staff, participants and cultural bosses; ii) articulate the efficacy of the Yiriman Project to outside bodies including governments, philanthropic organisations</p>	<p>Study setting: Remote Aboriginal communities in Australia. Target group: Young people in remote Aboriginal communities in Australia.</p>	<p>Policy/ program/ intervention/ service: The following methodological devices were used to help check, compare and offer contrasting illumination on the performance of Yiriman: • A review of the literature concerned with youth practice and community • Development in remote settings to establish features of good practice in order that this could be compared with the approaches taken in the Yiriman Project • An appraisal of media reviews and articles; • Written and verbal feedback from community members about trips and other project work • Direct participation and observation in field trips, bosses' meetings • Workshops and other activities involving young people and others (field visits included time spent in Fitzroy Crossing, Derby, Broome and a range of remote communities in the Fitzroy Valley, including extended visits of two months during 2009 and 2010. Visits were timed to allow some firsthand</p>	<p>Strategies/ activities:</p> <ul style="list-style-type: none"> • Examining different stakeholders' goals in regard to programs • One-on-one client support, family client support, other workshops; cultural activity (e.g. language, skin education, artefact production, visits to sites, traditional knowledge transmission) • Cultural activity on land, including ancestral walks, bush food harvesting, filming of senior people's stories • Women's trips and men's trips for cultural relevance and safety/specific cultural teachings for young men and young women • Cultural exchanges in other parts of Australia and internationally • Caring for country and reinvigorating culture and lore. <p>Conditions: N/A. Enablers:</p> <ul style="list-style-type: none"> • Consideration of the views, goals and explanations of multiple stakeholders • Multiple methods of data collection • Collaboration between the Kimberley Aboriginal Law and Cultural Centre (KALACC), Murdoch University (Western Australia) and community members • Community people/elder involvement in trip planning and trips on country, sharing cultural knowledge and experiences. 	<p>Outcomes: There were highly varied perspectives on the goals of the program among many different stakeholders, with little agreement. Outcome measures: N/A. Screening/ measurement tools: N/A.</p>	<p>Workforce requirements: N/A.</p>	<p>Cost/ referral pathways: Intense response (suicide, mental health referral); referred from family/ community; referred through other contacts; referred through police and justice.</p>	<p>Level of evidence: Emerging practice.</p>
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	<p>and the corporate sector;</p> <p>iii) test the goals and interpretive explanations of funding bodies and other outsiders;</p> <p>iv) shape future planning of activities; and</p> <p>v) assist staff and bosses to build into their work a cycle of review.</p> <p>Part of its aim is to allow the Yiriman Cultural Advisory Body (including Fitzroy Valley elders and cultural bosses) and staff to reflect on the processes they have developed and to participate in strengthening its structure.</p>		<p>observation of various elements of the project and attendance at a number of key events)</p> <ul style="list-style-type: none"> Interviews with various Yiriman staff while they were visiting Perth. <p>Sample size: N/A.</p>	<p>Barriers:</p> <ul style="list-style-type: none"> Polarised public opinion and political debate about what are the best solutions to the challenges facing young Aboriginal people in remote communities; Focus on outcomes-based measures to measure program impact and value Challenges in demonstrating efficacy in programs for Indigenous peoples The impact of government agendas, funding regimes and strategic guidelines Siloed approaches to addressing issues affecting young Aboriginal people Lack of funding for evaluation of programs Narrow focus on cause and effect conclusions Inappropriateness of mainstream evaluation/ research methods. 				
<p>8. Peeters et al. 2014</p> <p>Book chapter/ not peer-reviewed</p>	<p>Study aims:</p> <p>Aim of the Marumali Program: to increase the quality of support available for survivors of forcible removal</p>	<p>Study setting:</p> <p>While the program was developed specifically to support the members of the Stolen Generations to heal, all</p>	<p>Policy/ program/ intervention/ service:</p> <p>Marumali Journey of Healing.</p> <p>Sample size: N/A.</p>	<p>Strategies/ activities:</p> <p>A five-day workshop to train Indigenous counsellors and case workers employed in Link-Up services and ACCHOs, plus a two-day risk management workshop.</p> <p>Conditions: The Marumali Program provides an overview of the healing journey and how it might unfold.</p>	<p>Outcomes:</p> <p>The healing journey may include:</p> <ul style="list-style-type: none"> Learning about removal policies; Making sense of memories as they come up; Taking stock of what has been lost; 	<p>Workforce requirements:</p> <p>Aboriginal counsellors.</p>	<p>Cost/ referral pathways:</p> <p>N/A.</p>	<p>Level of evidence:</p> <p>Emerging practice.</p>

	undertaking their healing journeys.	<p>Aboriginal people have been affected by removal policies to some degree and may draw meaning and strength from the program.</p> <p>Target group: Survivors of forcible removal, whether removed to institutional care, foster care or adoptive families.</p>		<p>It identifies the core issues that need to be addressed at each stage of the journey, the risks associated with these issues and how to anticipate and manage these risks to ensure a safe passage for the survivor. It aims to help people who were removed to face the pain, and to work through it in manageable steps so that they can reclaim their identity and eventually arrive at a place of peace and strength. The program works in conjunction with Link-Up family tracing and reunion services.</p> <p>Enablers: N/A. Barriers: N/A.</p>	<ul style="list-style-type: none"> • Accessing files and reports written about us; • Putting all the pieces together to find out what really happened to us and why; • Finding out who our family is and where we are from; • Facing our demons; • Reconnecting mind, body and spirit; • Reclaiming our spiritual heritage; • Working through issues of blame; • Retracing our steps; • Looking at what has been taken, left behind or unlearned; and • Replacing some of the mainstream values implanted by others with relearned Aboriginal values. <p>The Marumali Journey of Healing model and workshop was endorsed by co-author of the Ways Forward report, Professor Beverley Raphael, and Aboriginal organisations Link-Up NSW and the NACCHO as being a safe, effective and culturally appropriate model to use with</p>			
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					<p>survivors of forcible removal.</p> <p>The Marumali Journey of Healing has been variously identified as a 'good practice', 'promising practice' and 'best practice' Aboriginal model of healing for those who have been forcibly removed, by the Moving Forward Conference (2002), the evaluation of the Bringing Them Home and Indigenous Mental Health Programs.</p> <p>Outcome measures: N/A.</p> <p>Screening/ measurement tools: N/A.</p>			
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Appendix 5

Suicide-prevention, mental illness, and alcohol and other drug focused papers that also include a SEWB component

Author/date	Title	Primary focus	SEWB measure and/or implementation approach
Armstrong et al. (2017)	Re-development of mental health first aid guidelines for supporting Aboriginal and Torres Strait Islanders who are engaging in non-suicidal self-injury	Non-suicidal self-injury (NSSI)	Providing mental health first aid
Brooks et al. (2013)	Reaching rural communities with culturally appropriate care: a model for adapting remote monitoring to American Indian veterans with post-traumatic stress disorder	Post-traumatic stress disorder	Implementation of the adaptation model
Cox et al. (2014)	Using participatory action research to prevent suicide in Aboriginal and Torres Strait Islander communities	Reduce the high reported rates of psychological distress and suicide	Promote positive social and emotional wellbeing to increase resilience
Cwik et al. (2016)	Suicide Prevention Gatekeeper Training: Can They Advance Prevention in Indian Country?	Suicide prevention	Knowledge, self-efficacy, satisfaction
Doll & Brady (2013)	Project HOPE: Implementing Sensory Experiences for Suicide Prevention in a Native American Community	Suicide prevention	A sensory curriculum
Goss et al. (2017)	Rural American Indian and Alaska Native veterans' telemental health: A model of culturally centered care	Described a model of telemental healthcare to AI/AN veterans who are in need of mental health care, often but not limited to treatment for PTSD or substance use disorders	Wove together evidence-based Western treatment, traditional Native healing, and rural Native communities in 4 components: mental health care, care coordination, technology and cultural facilitation
Harder et al. (2015)	Nges Siy (I love you): a community-based youth suicide intervention in Northern British Columbia	Youth suicide prevention, depression	Youth self-esteem
Isaacs & Sutton (2016)	An Aboriginal youth suicide prevention project in rural Victoria	Youth suicide prevention	Building resilience, early intervention response and immediate postvention support
Kelley et al. (2015)	Recommendations from an American Indian reservation community-based suicide prevention program	Suicide prevention	Uphold cultural values; recognise the spiritual aspects of the endeavour
Povey et al. (2016)	Acceptability of Mental Health Apps for Aboriginal and Torres Strait Islander Australians: A Qualitative Study	Mental illness and psychological distress	Culturally relevant content and graphics, a purposeful journey, clear navigation, meaningful language
Saree et al. (2013)	Gatekeeper training for suicide prevention in first nations community members: A randomised controlled trial	Risk for suicide and assistance in getting care	Comparison group involved participation in a Resilience Retreat

Author/date	Title	Primary focus	SEWB measure and/or implementation approach
Wexler et al. (2016)	Creating a Community of Practice to Prevent Suicide Through Multiple Channels: Describing the Theoretical Foundations and Structured Learning of PC CARES	Suicide prevention and health promotion	Education strategies to build a 'community of practice' among local and regional service providers, friends and families that fosters personal and collective learning about suicide prevention in order to spur practical action on multiple levels to prevent suicide and promote health
Wexler et al. (2017)	Promoting Community Conversations About Research to End Suicide: learning and behavioural outcomes of a training-of-trainers model to facilitate grassroots community health education to address Indigenous youth suicide prevention	Suicide prevention	Community health intervention that responds to the need for culturally responsive and evidence-supported prevention practice, using a grassroots approach to spark multilevel and community-based efforts
Wexler et al. (2015)	Why an alternative to suicide prevention gatekeeper training is needed for rural Indigenous communities: presenting an empowering community storytelling approach	Youth suicide prevention	Consideration of local contexts, culture-centric narratives and the multiple, interacting conditions of suicide
Whiteside et al. (2018)	Acceptability of an Aboriginal Wellbeing Intervention for Supporters of People Using Methamphetamines	Use of methamphetamines	An Aboriginal family wellbeing intervention was piloted and found to improve the empowerment and wellbeing of workers. Participants regarded it as highly relevant for families supporting people using methamphetamines and other drugs