AUSEINET • Australian Network for Promotion, Prevention and Early intervention for Mental Health

PPEI

Auseinetter

Contents:

Issue 15 – July – No 2/2002
ISSN 1329 – 8720

Comment – Jennie Parham 2
Editorial – Professor Graham Martin 3
Building Healthy Lives 4
The Djirruwang National Indigenous Mental Health Pilot Project 7
Mental Health in the Right Spirit 10
@ AUSEINET 13
Warren Milera 13
Visiting Fellow – Michael Murray 14
Putting It All Together Forum 15
Auseinet Resources Database 15
Chris Alliston 16
Mental Health Promotion and Work 18
NATIONAL ACTION PLAN – STATE AND TERRITORY CONSULTATIONS 19
Overview 19
Western Australian Symposium 20
TELL US WHAT YOU'RE DOING 21
BOOK AND OTHER RESOURCE REVIEWS 29
ON THE WEB 32
Conference List 33

national mental health strategy

www.auseinet.com

Funded under the National Mental Health Strategy by the Commonwealth Department of Health & Ageing.

LiFe Living Is For Everyone

Comment –

Jennie Parham - Project Manager

How the time goes ever so quickly. Its now mid-year. Its very exciting to see the mailing list for the Auseinetter grow and that people are finding this a helpful and valuable resource. Keep encouraging others to read it and please give us any feedback that will help ensure that it continues to meet your needs. I would like to take this opportunity to thank all those who have contributed to this issue.

Its a busy and exciting time at Auseinet and I want to highlight a number of important developments. We are gearing up for our Forum to be held from September 15-17th here in Adelaide. It promises to be a stimulating two days with a diversity of eminent invited speakers. The Forum has been structured in such a way to provide opportunity for discussion and debate of the issues that are so important in the progression of PPEI initiatives in Australia. We are particularly delighted to have Michael Murray, CEO of the Clifford Beers Foundation as our international keynote speaker who will also be a Visiting Fellow to Auseinet for two weeks following the Forum. In that time, he will be conducting a seminar tour of Australia. The dates and times of Michael's seminars around Australia will be posted on the Auseinet web site as soon as they have been confirmed. There has already been a lot of interest in the Forum from a wide range of people and sectors which is very encouraging. A comprehensive registration booklet is enclosed and I urge you to consider participating in this important event.

Auseinet is really pleased to announce that the Commonwealth has extended our funding to the end of June 2003 enabling us to have some continuity in progressing our work.

Another exciting development is that Auseinet is involved in two additional Projects, funded by the Commonwealth Department of Health and Ageing in partnership with other organisations. They are the CommunityLIFE Project and the Media Dissemination Project.

The CommunityLIFE Project aims to build community capacity for suicide prevention and is based on the LIFE Framework, a comprehensive framework for suicide prevention activities in Australia. The Project will have both a mainstream and Indigenous component. This Project is being managed by a consortium of partners including, Curtin University, Centre for Developmental Health, SPA (Suicide Prevention Australia) and Auseinet. Auseinet's key role in this Project will be in the development of the communications infrastructure and in supporting the co-ordination of the Indigenous component of the Project. This is a very substantial and significant Project for Auseinet to be contributing to.

The Media Dissemination Project has arisen out of the work of the National Media and Mental Health Group. It involves the dissemination of resources that have been specifically designed for the media to assist them in reporting on mental health issues including suicide. This Project is being jointly managed by the Hunter Institute of Mental Health, SANE, University of Queensland and Auseinet. Auseinet's role will be to develop and maintain the web site and to manage the dissemination process. We are delighted to be involved in such an innovative and important Project.

Involvement with these Projects has enabled formal and significant partnerships to be established with a diversity of partners.

I hope you enjoy this issue of Auseinetter and I look forward to seeing many of you at the Auseinet Forum in September.

Auseinet Mailing List

Please contact the Auseinet office if you wish to be added to the mailing list.

Contact Jill on
Tel: (08) 8404 2999
Fax: (08) 8357 5484
Email: auseinet@flinders.edu.au
Auseinet Web Site: www.auseinet.com

Name: ____________________
Organisation: ____________________
Address: ____________________
____
Postcode: ______ **Tel:** ____________ **Fax:** ____________
Email: ____________________

Please let us know if we need to update your mailing details.

Editorial: Professor Graham Martin

Spirituality and Suicide Prevention

As I have suggested in previous articles, there are many people for whom the thought of suicide is anathema. They are happy, active, an accepted part of their family, contributing to their school, work and/or community, and committed to an appropriate range of life tasks. They know they have options and the right to take decisions about their life and its path within their abilities. They maintain a hope for the future right through their lives, and may even maintain this sense of a better future right up to the point of death. At each stage of life they maintain a trust in the process, come to terms with changed circumstance, and have a sense of where they fit in, what their part in the whole is about. They react with joy to fun events, to success and to new birth. They are appropriately saddened by loss of any kind, but this rarely translates into depression and despair. They do not lose their sense of hope, the balance in all things, and natural cycle of life.

One word that has been explored to describe these individuals is 'resilient', the ability to bounce back from adversity. We are beginning to be much clearer about the elements that make up resilience; the contributions of genetic factors such as female gender, good temperament and natural intelligence, 'good enough' parenting at critical stages, the absence of overwhelming stress in a context where neither the individual nor the environment have the ability to reduce anxiety and fear, and the presence of plentiful opportunity.

But there may be more. I have a younger colleague who survived many weeks of isolation, deprivation and hunger while lost in Nepal. He recounts that he was able to use memories of his family and his partner to maintain his sense of self. In addition he used the discipline of a previously learned martial arts ritual to maintain some of his physical wellbeing, and when his muscles began to fail, he used visualisation of the same ritual to maintain his sanity. Throughout, and despite times of great despair, he maintained a belief in himself, a belief in something bigger than himself, a belief in his place in the world, and a hope that he would be rescued.

He told his story at a recent congress to a hushed and awed audience of psychiatrists. Prior to the congress there was a well-attended workshop on spirituality and psychiatry; subsequently there was a whole day given to papers and discussions about research and reflections of spirituality. Many of the known faiths were represented, but the discussion focused more on a beginning distillation of what spirituality might mean to the recovery of people with mental illness. Turns out the answer is 'Quite a lot', many commenting that it was time for psychiatry to understand what may previously have been hidden in our somewhat secular discipline.

There are links between spirituality and 'belief'. Belief in a higher order being, in stories about the beginning of humankind, lead to a sense of meaning and purpose. Regular practice of worship in any form, with the associated prayer or meditation leads to forgiveness of wrongs committed or received, a belief in specialness or purpose, and a sense of personal acceptance and peace. In slightly reductionist psychiatric terms, prayer or meditation may lead to reduction of guilt or shame, those twin evils that can drive depression and despair.

It is the sense of peacefulness and acceptance that we so often associate with those whom we see as spiritual. They can acknowledge what may be wrong in the world, may be realistic about their own failings, but have the capacity to not allow either to weigh them down to the point of despair and hopelessness, but most of all inactivity. They are still able to function, to love, to contribute, to work, and to see where they may be able in a small way to make a difference.

Belief may, however, be less spiritual but still able to sustain us in hard times. Recent work on 'narcissism' has shown that the belief in self, or the importance of the self, can protect from adversity. Further, research has shown that when the going gets tough, it may not

...continued on page 4

Contributions to this newsletter do not necessarily reflect the views of the Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet).

Auseinet National Team:

Please feel free to contact any of the team members directly if you have any queries regarding Auseinet programs and activities.

Jennie Parham
Project Manager
Tel: (08) 8404 2999
Email: jennie.parham@flinders.edu.au

Professor Graham Martin
Project Adviser
Tel: (08) 8404 2999
Email: g.martin@uq.edu.au

Jill Knappstein
Office Manager
Tel: (08) 8404 2999
Email: auseinet@flinders.edu.au

Gwyn Elson
Administration Officer
Tel: (08) 8404 2999
Email: gwyn.elson@fmc.sa.gov.au

Lou Morrow
Project Officer, Academic Input and Quality Control
Tel: (08) 8404 2993
Email: lou.morrow@flinders.edu.au

Chris Alliston
Project Officer, Consumer and Carer Issues
Tel: (08) 8404 2990
Email: chris.alliston@flinders.edu.au

Joy Sims
Information Officer
Tel: (08) 8404 2992
Email: joy.sims@flinders.edu.au

Warren Milera
Project Officer, Indigenous Issues
Tel: (08) 8404 2995
Email: warren.milera@flinders.edu.au

Abbie Patterson
Project Officer, Communications
Tel: (08) 8404 2994
Email: abbie.patterson@flinders.edu.au

Web Site: www.auseinet.com
Fax: (08) 8357 5484

Einet Discussion Group

Have you subscribed to the Auseinet email discussion list? Members of the Einet list post a broad range of information relating to all aspects of mental health promotion, prevention and early intervention, including suicide prevention. Members of the Auseinet team will also be using this list as a way of communicating with a range of individuals interested in these issues on a regular basis. To subscribe, please email **majordomo@auseinet.flinders.edu.au** In the text write "subscribe einet" in the mail message body.

be the tough that get going – it is in fact those who believe that their own survival is important. They maintain personal standards and habits, expect the best of support from others, and continue to seek the best for themselves in order to survive.

So, where does that all come from. To a certain degree there may be some circularity. Families who are connected, manage their lives well, transmit effective parenting practice down the generations, also are more likely to have membership of a faith, and/or a set of personal beliefs, which increase spirituality. On the other hand, most of the world's faiths preach family strengths as basic to the future of humankind.

So, let us return to consider suicide. Religion as such may not be a protection against suicide; after all some devout or religious countries have much higher rates than others not known for religious affiliation. But spirituality, as something that crosses all religions, perhaps transcends them, may well protect against despair in the face of the world's ills. Central to this may be belief – in the self, in the family, in the peer group, in the country, or in some higher force. And promotion of the regular rehearsal or practice of belief in any of these may be the key to survival in those who, for whatever reason, have personal or contextual risk factors for suicide that increase the odds of life time suicide. Any belief may be better than none, and strongly held beliefs may provide the central core around which a meaningful life can be rebuilt.

Building Healthy Lives: Partnerships to Promote Aboriginal Child Health & Wellbeing and Family & Community Resilience

A. Robson, S. Silburn and members of the Aboriginal Suicide Prevention Steering Committee, Western Australia

"The past is never fully gone. It is absorbed into the present and the future. It stays to shape what we are and what we do."

(Sir William Deane, Inaugural Lingiari lecture, Darwin, 22nd August 1996).

The problem of fatal and non-fatal suicidal behaviour, particularly among younger age groups, is one of the most pressing social concerns for Aboriginal people in Australia (Hillman, Silburn, Zubrick & Nguyen, 2000). Available evidence from a number of sources suggests that, without concerted action to address the immediate and underlying causes, the number of Aboriginal people affected by suicidal behaviour is likely to rise. In recognition of community and professional concern there has been a number of prevention initiatives developed at national, state and local levels, to address this issue. In Western Australia (WA), as elsewhere in Australia, there has been a move toward more culturally responsive approaches to mental health care provision. There is still a considerable way to go. Effective processes and outcomes require ongoing reflection and consultation.

This paper focuses upon the current work being undertaken by WA's Aboriginal Suicide Prevention Steering Committee (ASPSC). This committee comprises senior policy representatives of ATSIC, OATSIH, WAACCHO and state government departments with responsibilities in this area. The ASPSC has been developing a collaborative intersectoral state plan for integrating community-based prevention initiatives over the past two years. This plan focuses on fostering community capacity and new partnership arrangements to build healthy lives for Aboriginal children and youth. It proposes a strengths-based model for coordinating local community action to reduce some of the early 'up-stream' causes of suicide, self-harming behaviour and other adverse youth outcomes that share similar causal pathways of development. The proposal is the outcome of wide ranging community consultation and the advice of key Aboriginal and non-Aboriginal service providers in Western Australia.

Suicide Amongst Aboriginal People in Western Australia

Since the 1970's there has been a dramatic and concerning increase in fatal and non-fatal suicidal actions among Aboriginal people. Western Australian figures reveal the average suicide rate of Aboriginal males was almost double the rate of all males in the state, at 37 per 100,000 population (Hillman et al, 2000). This study noted a rising trend, particularly among Aboriginal males in their 20's, over the period of the study (1986 – 1997). There has been a parallel rise in the rate of identified self-harm and attempted suicide. Statistics currently available are likely to be an under-estimation of the full extent of the problem given that aboriginality is not always accurately recorded and not all deliberate self-harm reaches the attention of service agencies, particularly in remote settings.

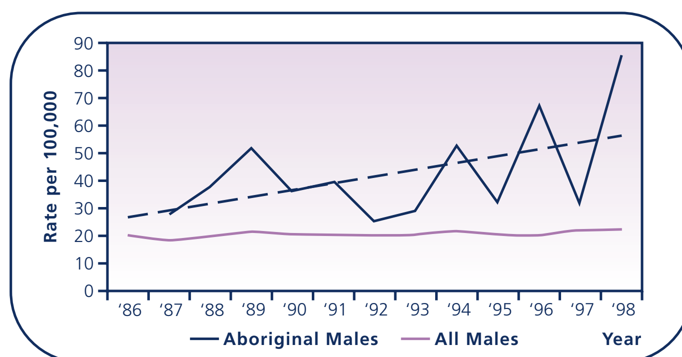


Figure 1. WA Male Suicide 1986 – 1998

In the Indigenous community suicide is closely linked with alcohol use and with impulsivity. It occurs in the context of high rates of death that are both premature and due to unnatural causes (Hunter, 1998). Hunter et al (1999) found that in several communities in Far North Queensland, risk of self-harm appears to persist over time - young Aboriginal people at risk in childhood and adolescence, continued to be at risk into their adult years (Hunter et al, 1999). This trend is of particular concern given that the majority of the Aboriginal population in WA consists of young people, less than 25 years (Australian Bureau of Statistics, 1999). The obvious implication is that without concerted action to address the underlying issues this situation may deteriorate further.

The extensive and inclusive nature of kinship relations within and across Aboriginal societies means Indigenous society as a whole is disproportionately bereaved by suicide. Losses through suicide have a much greater whole-of-community impact. Similarly the problem of social contagion* is more pronounced in communities given the extensive kinship linkages. Contagion may leave communities vulnerable to further losses by suicide.

The causes of suicide in Aboriginal contexts are complex. There is little evidence-based research specifically on Indigenous suicide. While it is likely that risk factors for individuals are similar to those in the broader population, there are factors which contribute to suicide and self-harm in the Indigenous population that are also different. These have to do with the contexts in which Aboriginal people live today, which are affected by the history of colonisation and institutionalisation of Aboriginal children and families; and by the ongoing impact of government policies and interactions with broader Australian society. Aboriginal Australians today continue to experience significant discrimination, as well as high rates of incarceration, family dislocation, poverty and unemployment, which collectively contribute to alienation and despair, particularly among young Indigenous Australians. Some understanding of these layers of adversity, their origins and their ongoing impact on child, family and community wellbeing, is critical to the development of appropriate responses to address this issue within Indigenous communities.

Developing Greater Effectiveness in Service Response

Preventing suicide and promoting life is a shared community responsibility, necessarily involving all levels of government, and Indigenous and community organisations holding responsibilities in relation to Aboriginal children, young people and their families. In response to representations from the Aboriginal community, the WA Ministerial Advisory Group for Suicide Prevention (MCSP – formerly YSAC), began a process of consultation engaging Aboriginal service providers, resulting in recommendations for Across Government Policy and Programs for Preventing Suicide and Suicidal Behaviour Among Aboriginal Youth in Western Australia. The WA Cabinet endorsed this as State policy in 1998. It is built on a partnership model that encompasses Aboriginal and non-Aboriginal perspectives.

The Aboriginal Suicide Prevention Steering Committee (ASPSC) was established to oversee implementation of these recommendations. This committee comprises key members of state and commonwealth agencies and Aboriginal community agency representatives concerned with Aboriginal suicide issues. The group has been critical in ensuring that the issue of suicide within WA's Aboriginal community remains a high priority on the government agenda and in ensuring the uptake of recommendations by government.

To date the recommendations of the Across Government Policies which have been implemented include the employment of more Aboriginal staff within health and human service agencies; training to promote greater cross-cultural awareness for non-Aboriginal practitioners in relevant departments; as well as changes to policies and procedures within departments, allowing for more culturally responsive practices. Most recommendations required individual responses within different departments, and were incorporated into agency outputs, thus allowing funding and implementation of such initiatives.

The final recommendations of the Across Government Policies have been much more difficult to operationalise and implement. These include the development of a collaborative intersectoral state plan for integrating universal primary prevention initiatives. This required a multi-agency approach acknowledging shared responsibilities and a focus on joint outcomes. The ASPSC have guided the development of this community-focused prevention plan through consultation with key Aboriginal service providers, communities and stakeholder groups over the past two years.

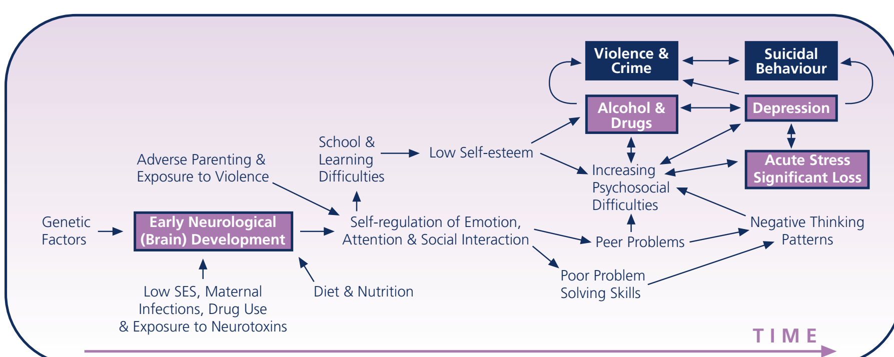


Figure 2. Shared early risk pathways to suicide and other problems

Recognition of the Failure of Existing Policy Responses

There is recognition that existing policy responses and service delivery arrangements have failed to adequately address the continuing health and social problems facing Aboriginal communities. The proposal was initiated out of the need to formulate relevant community responses to suicidal behaviour and other adverse outcomes that require urgent attention within WA's Indigenous communities. Among the most pressing of these concerns are family violence, alcohol and substance misuse, juvenile and adult offending, sexual abuse of children and women – all of which are known to develop along similar causal pathways to suicide (see Figure 2). The overlap of risk settings and risk exposures in which these problems arise clearly indicates the need for significant new investment in broadly based primary prevention.

Outcome of Community Consultation

Consultation with a range of Aboriginal service providers indicated the need for more inclusive partnership arrangements at the local and regional level. It also indicated the need for joint-planning across traditional service boundaries to ensure prevention efforts are grounded within Aboriginal world-views of health and wellbeing and are guided by community determined processes for action. Likewise feedback emphasised a 'whole of community-in-context approach' – a need for locally responsive, integrated approaches, coupled with supportive changes at a broader level in funding, management and accountability; and incorporation of a communication strategy for the broader community. Such an approach is supported by recent developments in prevention science, which indicate strategies need to be preventive, comprehensive and integrated across communities and across the lifespan. Maximum gains can be achieved when interventions are appropriate to the specific needs of children and families at those key points in human development that have a disproportionate effect on later outcomes in life (Marshall and Watt 1999, National Crime Prevention, 2000). Such periods include pregnancy, early infancy, the transitions to pre-school, primary school and high school, and the transition to the workforce and adulthood. There is good evidence for the cost savings of such an approach (Karoly et al, 2001).

Genuine community ownership of the process is fundamental to the capacity of communities to sustain community and child health and thereby reduce adverse health outcomes. A recent Canadian study of First Nation communities throughout British Columbia, showed that those communities where issues of land ownership and self-governance have been positively resolved had significantly lower rates of suicide and self-harm (Chandler & Lalonde, 1998).

Value-adding to Other Policy Development

The proposed prevention approach is consistent with, and adds value to, concurrent work being undertaken in Western Australia by ATSIC, State departments and the Commonwealth to build community capacity within Aboriginal communities. This approach aims to strengthen the community in the areas of governance, management, leadership and cohesion; and work with government agencies to build their capacity for collaborative practice. The prevention approach enhances this work through fostering capacity in the social infrastructure of a community. Joint implementation of these projects is likely to result in significant efficiencies at a local and regional level. It represents an opportunity to assess the validity and utility of the 'whole-of-government' strategic change indicators of Indigenous disadvantage, recently proposed to the Coalition Of Australian Governments by the Ministerial Council for Aboriginal and Torres Strait Islander Affairs (MCATSIA).

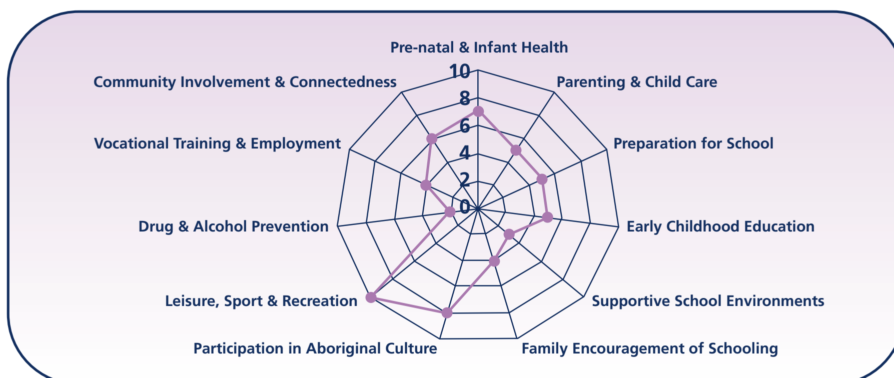
Strategies to Fund and Support Community Capacity Building

The proposal aims to build community capacity by creating substantial new funding for primary prevention through pooled funding across departments. Funding will be used strategically to provide incentives to collaboration between community and government agencies, at the local, regional and state levels. The proposal includes an across-government commitment to longer term strategic funding for these collaboratively developed local prevention plans. Initiatives need to be implemented and supported over a sufficient time to produce meaningful local results and to build sustainability.

Local action groups will require access to administrative support, training of community members and program development expertise. Support will be provided through the proposed local project officers based in the region or community to work with community agencies. These officers could in turn be supported through their region and a state office. Resourced and supported local action groups will develop a business case for the funding required to implement the locally developed action plans for child and community wellbeing.

These plans will address service provision across agencies within the communities, fostering a comprehensive community-determined response, which strategically targets key transition points for children, families and the community (see Figure 3). 'Local action plans' are to be commissioned within a 'tight-loose-tight' framework in which there are clearly specified aims and accountability requirements for funding. Sufficient flexibility should be allowed, enabling plans to take account of particular local and regional requirements enabling locally relevant results to be delivered.

Figure 3. **Areas for consideration in community action plans**



Summary

This model of community and agency partnerships requires recognition of shared outcomes across sectors and agencies. It invites government and non-government agencies to become responders to communities, rather than providing program driven, centrally determined responses. The community determined action plans for children should allow a range of appropriate responses to be developed concurrently. This enables a range of risk and protective factors in the various contexts of family, school and community to be addressed, thus supporting real change in developmental pathways for children and young people. In summary, the program aims to build community capacity to maximise strong children being raised within the context of strong families and communities.

References

• Statement of Commitment to a New and Just Relationship between the Government of Western Australia and Aboriginal Western Australians, ATSIC and Government of Western Australia, 2002. • Chandler M.J. & Lalonde C. 1998 "Cultural continuity as a hedge against suicide in Canada's First Nations." Transcultural Psychiatry, 35 (2): 191-220. • Hillman, S. D., Silburn, S. R., Zubrick, S. R., & Nguyen, H., 2000. Suicide in Western Australia 1986 to 1997. Youth Suicide Advisory Committee, TVW Telethon Institute for Child Health Research, and Centre for Child Health Research, Faculty of Medicine and Dentistry, The University of Western Australia, Perth, WA • Hunter, E, 1998. "Early intervention for Indigenous Social and emotional health problems." Auseinetter (5): 1-2 • Hunter, E., Reser, J., Baird, M., & Reser, P., 1999. An analysis of suicide in Indigenous communities of north QLD: the historical, cultural and symbolic landscape. QLD: University of Queensland, Gurriny Yealamucka Health Service and the Yarrabah community Council, James Cook University of North QLD. • Karoly, L.A., Kilburn, M.R., Bigelow, J.H., Caulkins, J.S. & & Cannon, M.R., 2001. Assessing costs and benefits of early childhood intervention programs: Overview and application to the Starting Early Starting Smart Program (pdf). USA, RAND Corporation. • Marshall, J., & Watt, P., 1999. Child Behaviour Problems: A literature review of the size and nature of the problem and prevention interventions in childhood. Perth WA, Interagency Committee on Children's Futures. • National Crime Prevention, 2000. Pathways to prevention: developmental and early intervention approaches to crime in Australia. Canberra, NCP Report No. 6 • WA Youth Suicide Advisory Committee, 2000. Working together to stop Aboriginal suicide and self-harm in Western Australia. Recommendations for across-government action to reduce suicide and suicidal behaviour among Aboriginal youth in Western Australia. Report presented to the Hon Kevin Prince MLA LLB Minister for Health, November 1998. Perth, Office of Aboriginal Health, Health Department of Western Australia.

*Contagion: A process seen in relation to suicide, whereby a loss within a defined group/community is followed by subsequent similar fatal or non-fatal suicide attempts.

The Djirruwang National Indigenous Mental Health Pilot Project: Addressing Promotion and Prevention

Dr A. Basseer Jeeawody and Jane Havelka

Basseer Jeeawody PhD – *Director, Djirruwang National Indigenous Mental Health Pilot Project.*
Jane Havelka – *Indigenous Lecturer, School of Clinical Sciences, Charles Sturt University.*

Introduction

Over the past two decades, Aboriginal people have become increasingly concerned about being more fully involved in mental health services for Aboriginal communities. This has been part of a more general tendency to view the health arena as an area of opportunity for involvement, professional advancement, and a cultural stand vis-à-vis majority culture misunderstandings of Aboriginal realities. There exists a substantial mental health 'problem' in Aboriginal communities today, a multifaceted problem that somehow needs to be addressed continuously. The mental health problem relates to complex historical causes as well as contemporary stresses and strains within Aboriginal culture and communities. One way this problem is currently being addressed is through the ***Djirruwang National Indigenous Mental Health Training Pilot Project*** conducted by Charles Sturt University and funded by the Commonwealth Government, Office of the Aboriginal and Torres Strait Islander Health.

An Overview of the Djirruwang Project

The Djirruwang project is developing and implementing a framework for high quality tertiary education programs, including continuing professional education for Australian Indigenous professional practitioners in the field of mental health. The project fosters an awareness of the cultural differences that affect the full participation of Indigenous Australian people in the program. The project is engaged in the promotion of aspirations of Indigenous Australians in the program ensuring that graduating students are highly competent and highly employable to perform higher level duties within the field of Indigenous mental health. Specifically, the objective of the project is to establish a framework for:

- The recruitment, retention and support of Aboriginal and Torres Strait Islander students from rural, remote and urban areas to enrol in and complete the Diploma, Degree and Higher Degree in Health Science in Mental Health;
- The development of a culturally appropriate Diploma/Degree/Master in Health Science (Mental Health) for Aboriginal and Torres Strait Islander Mental Health Workers thus fostering 'best practice' in the care of Aboriginal people experiencing mental health problems;
- The progressive implementation of professional development activities in the field of Aboriginal mental health across a broad spectrum of health expertise; and
- The development of mechanisms to provide cultural awareness seminars to professional practitioners and students alike in the field of medicine, nursing and allied health.

The nature of the project is the establishment of a framework to implement a culturally appropriate program towards the enhancement of the Indigenous people's social and emotional wellbeing. Cultural appropriateness represents a challenge. Cultural appropriateness is best achieved when it is an interactive process. The project is achieving such a process though intersectoral collaboration and through a national reference committee with diverse representation from states, educational establishments, government departments and Aboriginal organisations. Memberships of various advisory committees and curriculum writers are made up of over seventy five percent of Indigenous professionals.

Promotion and prevention is one of the overarching aims of the National Indigenous Mental Health Pilot Project. A number of strategies form part of the undergraduate program/s in Indigenous Mental Health currently being developed, encompassing the promotion of social and emotional wellbeing, and the prevention of the development of mental health problems and mental disorders. In this paper a broad overview of how the Bachelor of Health Science (Mental Health), which is part of the Djirruwang project, is particularly addressing promotion of mental health and prevention of mental disorders, is presented. Other aspects of the project may form part of future publications.

A Structure (pathways) for the Djirruwang Program

The development of a culturally appropriate Diploma/Degree/Master in Health Science (Mental Health) for Aboriginal and Torres Strait Islander Mental Health Workers, fostering effective practice in the care of Aboriginal people experiencing mental health problems, is a key objective for the Djirruwang project. A pathway demonstrating how this is put in place is illustrated. It is envisaged that the undergraduate program will provide graduates with greater educational pathways and stronger career opportunities in the field of Indigenous mental health. The first stage of the project is the development of the undergraduate program, described herein. Postgraduate programs will be developed progressively.

The Bachelor of Health Science (Mental Health) is a three-year undergraduate course available specifically to meet the needs of Aboriginal and Torres Strait Islander students. Students need to be of Aboriginal and Torres Strait Islander background to gain entry in the course. The course has one entry point and three exit points namely:

- University Certificate in Health Science (Mental Health) – equivalent to one year of study (8 subjects)
- Diploma of Health Science (Mental Health) – equivalent to two years of study (16 subjects)
- Bachelor of Health Science (Mental Health) – equivalent to three years of study (24 subjects)

Illustration:
A Structure (pathways) for the Djirruwang Mental Health Program

Professional Doctorate/PhD ***(Mental Health)***
[Opportunity for specialisation in the field of Indigenous Mental Health]

Master of Mental Health
[Opportunity for specialisation in the field of Indigenous Mental Health]

BHSc ***(Hons)(Mental Health)***
[Opportunity for specialisation in the field of Indigenous Mental Health]
[Opportunity to advance straight to Professional Doctorate/PhD Program]

(Proposed Future Course Structure)

BHSc ***(Mental Health)***
[Opportunity for articulation with courses such as Welfare, Psychology, Medicine, Nursing]
[Opportunity for exemption from Foundations Level in recognition of:
(i) Prior learning (ii) Relevant professional experiences (iii) Previous TAFE/University courses]

DipHSc ***(Mental Health)***
[Opportunity to exit and/or articulate with courses such as Welfare, Psychology, Nursing]
[Opportunity for exemption from Diploma Level in recognition of:
(i) Prior learning (ii) Relevant professional experiences (iii) Previous TAFE/University courses]

Foundations Level – University Certificate in HSc ***(Mental Health)***
[Opportunity for exemption from Foundations Level in recognition of:
(i) Prior learning (ii) Relevant professional experiences (iii) Previous TAFE/University courses]

(Current Course Structure – to be implemented from Autumn 2003)

Mental Health Promotion and Prevention in the Djirruwang Program

The mental health and wellbeing issues of Aboriginal and Torres Strait Islanders can only be understood within the context of the Aboriginal concept of health. It is not possible to understand the mental health outcomes for Aboriginal peoples and Torres Strait Islanders without recognising the impact of historical events, the ongoing trauma and loss and the high levels of disadvantage in Indigenous communities. Mental health promotion aims to enable people to increase control over and to improve and maintain their optimal mental health, wellbeing, resilience and social functioning. Prevention programs target populations at high risk to lessen vulnerability and prevent the development of mental illnesses. Early intervention programs are aimed at the pre-onset phase of mental illness to lessen the severity and prevent further mental health problems (NSW Health Department, 'Caring for mental health: A framework for mental health care in NSW', Oct 1998, p.19).

The current levels of loss, trauma, premature death, family breakdown and separation of children from their families, racism, and social disadvantage are among the effects of colonisation that have contributed to the present high levels of stress, grief, depression and suicide in Aboriginal and Torres Strait Islander communities (Swan & Raphael 1995; Raphael & Swan 1997). The Bachelor of Health Science (Mental Health) program is being structured in a way as to sufficiently address these issues. Elements of mental health promotion and mental illness prevention, with close relationship with these factors are addressed in the course. A synopsis of the contents, under the umbrella of each subject, is presented herewith.

Synopsis of Contents in the Bachelor of Health Science (Mental Health)

Generic Skills in Aboriginal Mental Health
This subject offers students orientations and functional skills in academic work and professional practices with particular reference to professional development in the field of Aboriginal mental health. This includes life long learning and the importance of health promotion and illness prevention as part of on-going professional practice.

Introduction to Mental Health
This subject introduces the broad concepts of mental health and wellbeing. It explores issues in mental health in relation to the principles of care and examines the roles and functions of the mental health professionals. It provides an overview of ATSI mental health. It offers ways forward to more culturally appropriate methods of care.

Aboriginal Mental Health and Wellbeing 1
The holistic concept of health, encompassing mental and physical health, cultural, and spiritual health, is addressed in this subject. The inter-relating factors categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical are addressed. This subject generates an understanding of Aboriginal ill health in connection with the disruption in the harmony of these inter-relations.

Working With Families
This subject aims to enhance the students' knowledge and skills required to work with ATSI clients and their families in the management of mental disorders and promotion of emotional and social wellbeing. The causes of family breakdown are examined and ways to initiating a healing process are discussed.

Aboriginal Health Promotion
This subject explores creative approaches to Aboriginal health promotion and community development in the context of self-determination. Issues of empowerment, self-management, conflict resolution in communities and practical skills of developing community health programs are discussed.

Healing Our Spirit: Grief and Loss
This subject firstly examines the causes and consequences of individual, family and community grief and loss. It then explores and discusses the healing process including de-colonisation and the significance of healing for achieving self-determination and strength within ATSI communities.

Healing Our People (Counselling 1)
This subject examines and focuses on the principles of basic counselling skills. The process of counselling as empowerment for ATSI people is explored. The emphasis on self-awareness and the appropriate counselling knowledge, skills and attitude in developing positive therapeutic relationships with clients is also examined.

Substance Abuse: Assessment and Management
Healthcare professionals are often confronted with the complexities of caring for people who are affected by the use of substances. Substance use issues in ATSI communities are poorly understood and are often stigmatised in mainstream health thereby leading to less than satisfactory health outcomes for Indigenous people. This subject, therefore, introduces the issues of problematic drug use in ATSI communities.

Aboriginal Mental Health and Wellbeing 2
This subject addresses the causes, incidence of mental health problems in ATSI communities and models of care underpinning 'health'. It is discussed that, health does not just mean the physical wellbeing of the individual but refers to the social, emotional and cultural wellbeing of the whole community. The experiences of human trauma and loss are recognised as contributing to the impairment of health and wellbeing suffered by ATSI people.

Gender and Mental Health
Studying gender issues is an important facet of understanding the concept of mental health promotion and mental illness prevention. This subject explores Aboriginal beliefs about gender. It presents gender as a significant aspect of the way psychiatry identifies a mental illness, its cause, appropriate cure, and most importantly its prevention. It determines both male and female vulnerability to mental health problems and specific strategies for mental health promotion and mental illness prevention.

Crisis Management 1
This subject describes the term 'crisis' and compares it with 'stress'. Types of crisis, factors that cause a crisis and crisis resolution are discussed. Crisis situations from an ATSI's perspective are explored. The principles involved in the management of a crisis situation are described and practiced.

Diagnosis and Management in Psychiatry 1
This subject introduces the major mental health disorders and focuses on the causes, prevalence, clinical features, classification, treatment and care of people experiencing these disorders. Students are introduced to the principles involved in providing culturally appropriate mental health models of care.

Ageing and Aboriginal Mental Health
The need to consider the ageing and wellbeing of the Indigenous population raises many issues that are relatively new to many ATSI communities. This is mainly due to the fact that many ATSI people do not live as long as their counterparts within the wider Australian community. This subject assists students in identifying these issues. It helps them develop ways to assist ageing people and work towards promoting their wellbeing.

Forensic Mental Health
This subject enables students to have a broad understanding of the forensic services including mental health care. The focus is upon the type of clients, disorders and treatment modalities available for forensic clients within the correction health service. Preventative measures and mental health promotional strategies form part of the program.

Crisis Management 2
This subject expands upon the subject contents covered in the first crisis management subject. It defines, explores and discusses the preferred models in crisis management for psychiatric emergencies, including the management of difficult and aggressive clients, post traumatic stress reactions, suicide, domestic violence and the acutely disturbed psychotic client.

Diagnosis and Management in Psychiatry 2
This subject expands on the first subject 'Diagnosis and Management in Psychiatry 1'. It provides students with the theoretical knowledge and the practical skills to assess, formulate a diagnosis, develop treatment plans and provide care for people experiencing a range of mental disorders. It provides the opportunity to explore culturally appropriate models of mental health assessment, diagnosis and care within existing legislative requirements and industry standards in mental health.

Research in Mental Health
This subject equips students with grounding in basic research methodology. It integrates action research theories and practice methods and is designed to prepare students to conduct action research projects within ATSI communities and mental health settings. Mental health promotion and mental illness prevention are also integral parts of the action research projects.

Healing Our People (Counselling 2)
This subject expands on 'Healing our people: Counselling 1'. It identifies three major different counselling theories, modalities and intervention strategies. The focus is on self-awareness, practice and analysis of strengths and weaknesses of each theory, in relation to the appropriateness to ATSI clients and other cultures. The important legal and ethical issues in counselling are explored, and psychosocial and spiritual assessment and interventions are discussed.

Mental Health and Substance Abuse (Dual Diagnosis)
This subject introduces the twin issues of problematic drug use and co-existing mental disorders in ATSI communities. It examines basic concepts and terminology in both the mental health and alcohol and drug field and the pharmacology of commonly used psychoactive drugs, substance use assessment instruments, and guidelines for managing intoxication and withdrawal. It also examines early and brief interventions and drug diversion pharmacotherapies.

Child and Adolescent Mental Health
This subject gives a broad view of the theories associated with developmental stages of children and adolescents. It addresses issues associated with working with young people and their families and explores the term 'mental health' in relation to socioeconomic, psychological and spiritual factors. It discusses issues such as mandatory reporting, intergenerational trauma, youth suicide, intervention and assessment. It presents a broad set of issues associated with racism, identity and culture.

Family Violence
This subject builds on the students' knowledge of family violence and how it impacts on ATSI communities. It addresses the prevalence, effects and impact of family violence. It covers the effects of family violence on children and

how it may link with mental health issues. This subject empowers the students to work more effectively with survivors and communities in a culturally appropriate way.

Sexual Assault

This subject builds on the students' knowledge and insight into sexual assault generally. It discusses how it impacts on ATSI survivors of sexual assault. It highlights the links between mental health issues with child sexual assault. It covers the prevalence, effects and impact on survivors of adult and child sexual assault. This subject empowers the students to work more effectively with survivors and communities in a culturally appropriate way.

Professional Issues in Aboriginal Mental Health

This subject explores contemporary issues in the field of Indigenous Mental Health and its future development. It examines issues underpinning and influencing the dynamic relationships that exist between and within professional groups in the mainstream mental health and Indigenous mental health from a global, national and local perspectives. Such issues also encompass mental health promotion and mental illness prevention.

Conclusion

This paper has presented only a selected aspect of the Djirruwang project. Field and clinical practicum experiences are not discussed. The structure of the program, constituting learning resources, distance education materials and block programs are other aspects of the project. A framework for an outreach delivery, preceptorship arrangement, and marketing and recruitment are currently being developed.

References

• NSW Health Department 1998, "Caring for mental health: A framework for mental health care in NSW", Oct, p.19 • Mental Health Promotion and Prevention National Action Plan (Under the Second National Mental Health Plan: 1998-2003) (1999), Commonwealth Department of Health and Aged Care, 28-29. • Raphael, B. & Swan, P. (1997). "The mental health of Aboriginal and Torres Strait Islander people". International Journal of Mental Health, 26(3): 9-22. • Swan, P. & Raphael, B. (1994). Ways Forward: National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health, (Parts 1 & 2), AGPS, Canberra.

Dr A. Basseer Jeeawody PhD
Djirruwang National Project Director
School of Clinical Sciences
Charles Sturt University
Locked Bag 588, Wagga Wagga, NSW 2658

Tel: (02) 6933 2492
Email: bjeeawody@csu.edu.au

Are We Approaching Mental Health in the Right Spirit?

Dr Craig Hassed
Senior Lecturer
Monash University Department of General Practice
craig.hassed@med.monash.edu.au

Science without religion is lame, religion without science is blind.[1]

Albert Einstein, along with many of his contemporaries, was as much a philosopher as he was a scientist. To him science uninformed by spirituality and ethics was cold, barren and misguided.

Possibly the far more common view, particularly in modern circles, is for spiritual issues to be ignored, derided and even pathologised. But is such a view wise, broad minded or even based on evidence? Are we risking losing something of central importance to humans? Is it a therapist's role to become involved in spiritual issues? Do we need to explore how spiritual and philosophical issues can be applied in medical and therapeutic settings? If so then how can it be made more relevant for young people and in ways which are culturally tolerant and sensitive to individual needs? When I reflect upon the dilemmas facing clinicians working in mental health these questions are high in my mind.[2]

Religion and spirituality are rarely mentioned in medical education nor are they generally seen as an integral part of a medical history or therapy, with the possible exception of a person with a terminal illness. There are movements within psychology and psychiatry, perhaps more so since the time of Jung, to reestablish connections with the spiritual dimension of the psyche. In the biomedical sciences promising fields of study like mind-body medicine and psychoneuroimmunology are challenging our materialistic ways of viewing health and illness but shifts in paradigms seem to take generations.

Spirituality and Religiosity

Spirituality and religiosity are not the same although they are intimately related. Although hard to rigidly define 'spirituality' in the medical literature refers to a range of things including 'having a belief in a higher being', 'a sense of purpose or meaning', 'connectedness to nature and humanity' and perhaps even 'altruism'. Religiosity or religious commitment, on the other hand, generally refers to things which are easier to measure in questionnaires such as 'participating in a religious group', 'adhering to a religious creed or set of beliefs' or merely 'attending church'. Therefore this aspect is far more commonly referred to in studies. Although they overlap it is not difficult to conceive of a person being religious without being spiritual or spiritual without being religious.

Religion, Spirituality and Health

It would seem that the ignoring of religion and spirituality in health circles is not consistent with the evidence. For example, one comprehensive review demonstrated consistently that religious commitment was protective for both physical and mental health.[3] It mattered little if the studies were prospective, retrospective, controlled for social contact or other lifestyle and socioeconomic

factors or looked at prevention of, coping with or recovery from illness. Importantly, the benefits seem not to be restricted to any particular mainstream religion. On the other hand religious thinking may be a part of psychosis for some people and many people do have negative experiences in their religious life or in their dealings with religious organisations. Indeed, it would be hard to envisage that intolerance, abuse or fanaticism, for example, could do individuals or communities any lasting good.

Nevertheless there are many studies confirming that for the great majority, having an active spiritual or religious life, or perhaps an active search for meaning, is highly protective against a wide range of problems right throughout the life cycle. A variety of reviews over many years have consistently confirmed that the vast majority of studies show a positive correlation between religion and mental health and protection against depression and suicide.[4] The reduction in relative risk is significant being associated with a four-fold reduction in suicide risk for adolescents[5] and also for the elderly.[6] Notwithstanding catastrophes that have befallen some extreme cults, no study has yet found a positive correlation between religion and suicide. Eighty-four percent of studies in the 2 leading psychiatric journals between 1978 and 1989 reported that religious commitment was clinically beneficial, 13.5% reported it as neutral and only 2.7% as harmful.[7] Another review over a 10 year period showed similar findings for diverse populations and experimental methods.[8,9]

People with 'high levels of religious involvement', 'religious salience' and 'intrinsic religious motivation' are all at reduced risk of depression.[10] It has further been shown that religious commitment was associated with significantly quicker recovery from depressive illness for the elderly.[11] The causation for these findings is probably multi-factorial but it cannot be explained merely by increased social contact or reduced exposure to drugs and alcohol. Explanations differ depending on who is asked. There is probably a buffering effect against stress and depression which comes with a belief in a benevolent God or some prospect of transcending suffering. There is also the health giving effects of contemplative practices such as prayer and meditation not to mention the possibility of grace.

Other data suggests that religiosity protects against drug and alcohol abuse.[12,13] One interesting study on 1337 medical students at Johns Hopkins Medical School from 1948-64 showed that being unaffiliated with a religious group in medical school was a strong predictor of future development of an alcohol problem.[14] Large scale epidemiological data suggests that religion is protective for a wide range of problems for which youth are at risk.[15]

Also interesting are studies demonstrating the positive effects of religious commitment on physical health including a reduced risk for hypertension, heart disease[16], cancer[17] and other medical conditions have also been found. For HIV patients, religious coping (placing trust in God, seeking comfort in religion) and religious behaviour (church attendance, prayer, spiritual discussion, reading religious literature) were associated with reduced scores for depression and the latter was associated with better immune parameters like higher white cell counts. This effect was independent of symptom status.[18] Religion may well be associated with greater longevity. A recent review of 22,000 people over 9 year follow-up showed that the all-cause mortality was significantly reduced for regular church attenders. Life expectancy was 75 years for non-church attenders, 79 years for those who attended less than once per week and 82 years for those who attended at least once per week. The study controlled for other lifestyle and social variables and these only explained a smaller part of the differences.[19] This is consistent with other data showing lower mortality over 28 year follow-up (relative hazard 0.64: 0.77 when controlled for other lifestyle and demographic factors)[20] and better quality of life for those with the religious part of their lives active.[21]

That having been said, it would seem that not all forms of religiousness are healthy. We may well view 'religious struggle' as an indication of an active search for meaning, which is a good thing. When that struggle is underpinned, however, by thoughts such as 'Wondered whether God had abandoned me', or 'Questioned God's love for me', and 'Decided the devil made this happen' then it was a predictor of an approximately 25% increase in mortality over two-year follow-up.[22] So it would seem important not just that people get help in their respective spiritual paths but it also matters in what way they are helped.

If religion can play an important role in enhancing mental health then it is probably through mechanisms delineated by mind-body medicine and psychoneuroimmunology which explains how these psychological benefits translate into physical health benefits.[23] Research is clearly showing that stress and negative emotional states are powerful catalysts for illness. Used wisely religion can be a powerful source of healing for negative states of mind and emotion but used unwisely it probably ingrains them. Studies on the effects of intercessory prayer, however, are a little more challenging. The only two large scale well-controlled studies,[24,25] both on patients in coronary care units, showed significantly fewer complications in the group who were prayed for. Interestingly, in both studies the patients and staff were 'blinded', that is, they didn't know if they were in the group being prayed for or not. Systematic reviews[26] on prayer and 'distant healing'[27] (Reiki, faith healing and therapeutic touch) have been justifiably cautious in their conclusions based on the present evidence although they did conclude that the initial promising findings certainly warrant further research. Grander claims such as tumour regression through prayer, therapeutic touch and faith healing have not been rigorously investigated thus far although there is gathering data to suggest that improved quality of life translates into improved survival for heart disease and cancer patients.

With all that might seem to be positive about the relationship between religion, spirituality and health there are also some negative aspects which tend to attract far more media scrutiny. This bad press is understandable to some extent when one considers some of the unenlightened and intolerant things that are done in the name of religion. An example in the medical sphere of the negative application of religion is illustrated by a review of a series of preventable paediatric deaths where the parent's religious views played a significant role in delaying access to necessary medical care.[28] 'Blind faith' and rigid adherence to dogma, especially when unsupported by reason, common sense or effective action, can indeed be harmful to oneself and others.

Exploring Spirituality

There are probably as many ways to explore and express spirituality and religion as there are people and societies, although it may also be true to say that not every way works as well as every other. Many who might not otherwise consider themselves as 'spiritual' may nevertheless express something of their spirituality in a philosophical search. Others, like Einstein, Plank, Heisenberg and others, might also find something in a scientific search for knowledge. For others it is found in humanitarian, civil justice and altruistic pursuits or through a desire for connectedness. Others might also search for beauty, creativity and even sporting excellence. Indeed there is often something of the transcendent described in all manner of pursuits.

Where are We and Where are We Going?

Mainstream psychiatry in its theory, research and practice, as well as its diagnostic classification system, has tended to either ignore or pathologise the religious and spiritual issues that clients bring into treatment.[29]

Why is there a tendency to reject or at least be suspicious of the religious and spiritual in health care and education? It may represent a healthy, cautious and methodical scientific approach which bases conclusions on evidence rather than superstition let alone revelation or intuition. As Alastair MacLennan[30] said, ***"You need to keep an open mind but not so open that your brain falls out."*** It is also very easy for science to disregard what it finds difficult to quantify. The rejection may also be symbolic of an increasingly fractured, dispirited, and cynical community which struggles to, but never does, find in materialism the deeper satisfaction it searches for. Much of this may have started with Freud who saw religion as 'a universal obsessional neurosis' and felt that the spiritual and mystic perception of unity was a 'regression to primary narcisism,' but it would be too simplistic to lay any such blame at the feet of one man. He was probably simply giving voice to pervasive shifts in human thought at the time. Nevertheless, his rejection of the deepest levels of human experience and emotion might be part of the reason why therapy based on Freudian psychoanalysis has found it difficult to demonstrate convincing evidence for any beneficial effects for that form of therapy. Eysenck at one stage even produced some very controversial research to suggest that such therapy may even be harmful to health.[31] Carl Jung, on the other hand, vigorously questioned many of Freud's ideas about therapy and his view of human nature upon which it is based. To him meaning and spirituality were central.

The lack of meaning in life is a soul sickness the full extent and full import of which our age has not even begun to comprehend. *Carl Jung*

Certainly Jung took psychoanalysis in a different direction and this trend seems to be continuing when one looks at some interesting synthesis of spirituality with mainstream counselling and therapy. One interesting example of a cross-pollination between philosophy and psychology, and between East and West, was a recently released book called *The Art of Happiness* [32] which recounts an exchange of ideas between the Dalai Lama and a western-trained psychiatrist.

What are the Implications?

How far, clinically and ethically, should a therapist become involved in the spiritual life of their patients or clients is hotly debated.[33] Helpful encouragement to consider issues of meaning might be encouraged but imposition of an agenda or dogma on an unwilling person is likely to be very unhelpful. Taking one's lead from the person and gauging their spiritual awareness and sense of meaning in life may well form an integral part of a thorough medical, social and psychological history. It would seem more than a little remiss that people working in mental health and education are not at least aware of the current body of evidence so that they might be able to develop more informed views. From that point motivated practitioners and patients, educators and students, support groups and therapeutic communities have a far firmer foundation from which to build a truly holistic approach.

The first law of ecology is that everything is related to everything else. ***Barry Commoner***

Each person or group will need to explore these issues in a way which is relevant to their needs, culture, upbringing, language and natural disposition. One expects that imposing a rigid or dogmatic approach is not going to be helpful especially considering the questioning nature of the young and the cultural diversity which exists in modern society. More specialised questions of a spiritual and religious nature should probably be referred to culturally appropriate 'experts'. Either way, one suspects that if we consistently continue to ignore the larger questions of meaning and existence we might truly come to comprehend Jung's sobering warning. The question is, can we afford to?

References

1. Einstein A. Out of my early years. New York: Philosophical Library, 1950. **2.** Hassed C. Depression: dispirited or spiritually deprived? MJA 2000;173:545-7. **3.** Matthews D. et al. 'Religious commitment and health status: a review of the research and implications for family medicine.' Archives of Family Medicine 1998;7(2):118-24. **4.** Gartner J., Larson D., Allen G. Religious commitment and mental health: a review of the empirical literature. J Psychol Theol 1991;19:6-25. **5.** Comstock G., Partridge K. Church attendance and health. J Chron Dis 1972;25:665-72. **6.** Duberstein PR. Conwell Y. Seidlitz L. The effect of participation in religious activities on suicide versus natural death in adults 50 and older. Journal of Nervous & Mental Disease 2000;188(8):543-6. **7.** Larson DB. Sherrill KA. Lyons JS. Et al. Associations between dimensions of religious commitment and mental health reported in the American Journal of Psychiatry and Archives of General Psychiatry: 1978-1989. American Journal of Psychiatry 1992;149(4):557-9. **8.** Craigie FC Jr. Liu IY. Larson DB. Lyons JS. A systematic analysis of religious variables in The Journal of Family Practice, 1976-1986. Journal of Family Practice 1988;27(5):509-13. **9.** Craigie FC Jr. Larson DB. Liu IY. References to religion in The Journal of Family Practice. Dimensions and valence of spirituality. Journal of Family Practice 1990;30(4):477-8, 480. **10.** McCullough M, Larson D. Religion and depression: a review of the leterature. Twin Research 1999;2(2):126-36. **11.** Koenig H., George L., Perterson B. Religiosity and remission of depression in medically ill older patients. American Journal of Psychiatry 1998;155:536-42. **12.** Larson D., Wilson W. The religious life of alcoholics. Southern Medical Journal 1980;73:723-7. **13.** Ped Adol Med 1998;152:952-60. **14.** Moore RD. Mead L. Pearson TA. Youthful precursors of alcohol abuse in physicians. American Journal of Medicine 1990;88(4):332-6. **15.** Resnick MD, Bearman P, Blum R et al. Protecting adolescents from harm; findings from the National Longitudinal Study on Adolescent Health. JAMA 1997;278(10):823-32. **16.** Fraser G., Sharlik D. Risk factors for all-cause and coronary heart disease mortality in the oldest old: the Adventist's Health Study. Archives of Internal Medicine 1997;157(19):2249-58. **17.** Kune G., Kune S., Watson L. Perceived religiousness is protective for colorectal cancer: data from the Melbourne Colorectal Cancer Study. Journal of the Royal Society of Medicine 1993;86:645-7. **18.** Woods TE. Antoni MH. Ironson GH. Kling DW. Religiosity is associated with affective and immune status in symptomatic HIV-infected gay men. Journal of Psychosomatic Research 1999;46(2):165-76. **19.** Hummer R., Rogers R., Nam C. et al. Religious involvement and U.S. adult mortality. Demography 1999;36(2):273-85. **20.** Strawbridge WJ, Cohen RD, Shema SJ, Kaplan GA. Frequent attendance at religious services and mortality over 28 years. Am J Public Health 1997;87:957-61. **21.** Clark K., Friedman H., Martin L. A longitudinal study of religiosity and mortality risk. J of Health Psychology 1999;4(3):381-91. **22.** Pargament KI, Koenig HG, Tarakeshwar N, Hahn J. Religious struggle as a predictor of mortality among medically ill elderly patients: a 2-year longitudinal study. Arch Intern Med. 2001;161:1881-1885. **23.** Hassed C. New Frontiers in Medicine: the body as the shadow of the soul. Melbourne: Hill of Content, 2000. **24.** Byrd R. Positive therapeutic effects of intercessory prayer in a coronary care unit population. Southern Medical Journal 1988;81(7):826-9. **25.** Harris W, Gowda M, Kolb J, et al. A randomised, controlled trial of the effects of remote, intercessory prayer on outcomes in patients admitted to the coronary care unit. Archives of Internal Medicine 1999;159:2273-8. **26.** Roberts L., Ahmed I., Hall S. et al. Intercessory prayer for the alleviation of ill-health. The Cochrane Database of Systematic Reviews 1999;Vol 2. **27.** Astin J, Harkness E, Ernst E. The efficacy of "Distant Healing": A systematic review of randomised trials. Annals of Internal Medicine 2000;132(11):903-10. **28.** Asser S., Swan R. Child fatalities from religion motivated medical neglect. Pediatrics 1998;101(4):625-9. **29.** Lukoff D, Fu F, Turner R. Cultural considerations in the assessment and treatment of religious and spiritual problems. Psychiatr Clin North Am 1995;18(3):467-84. **30.** Professor of Obstetrics and Gynaecology in Adelaide who has done research into the uses of complementary medicine. **31.** Grosarth-Maticek R., Eysenck H. Prophylactic effects of psychoanalysis on cancer prone and coronary heart disease prone probands, as compared with control groups and behaviour therapy groups. Behav Ther Exp Psychiatry 1990;21(2):91-9. **32.** "The Art of Happiness - a handbook for living." His Holiness the Dalai Lama and Howard Cutler, Published by Hodder (Sydney), 1999. **33.** Koenig HG. Religion, spirituality, and medicine: how are they related and what does it mean? Mayo Clinic Proceedings 2001;76(12):1189-91.