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ORIGINAL RESEARCH

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How First Nations peoples living in the Torres Strait and Northern Peninsula Area describe and discuss social and emotional well-being

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Abstract

Objective: This study was the first phase of a broader project designed to develop a new tool to screen social and emotional well-being (SEWB). Its objective was to identify words used by First Nations people living in the Torres Strait (Zenadth Kes) and Northern Peninsula Area (NPA) to describe and discuss SEWB. We pay our respects to Elders past and present. We acknowledge the First Nations peoples who took part in this project as holders of their cultural knowledge now and forevermore.

Setting: This study took place in community and primary health care settings located on islands of the Torres Strait and NPA of Australia.

Participants: Twelve yarns with 35 community members and health professionals were led by Torres Strait Islander members of the project team between August and December 2022.

Design: This study employed a descriptive qualitative design. Yarning, an Australian First Nations relational method, was used to share stories about SEWB. All but one yarn was audio recorded and subsequently professionally transcribed. Inductive thematic analysis was used to analyse the yarns.

Results: Worry, sad and stress were the words most often used by participants to describe feelings of low SEWB. Signs of low SEWB included behaviour change, particularly significantly reduced community engagement.

Conclusions: Worry is not a word that is used in Australian mainstream tools that screen for psychological distress. Findings of this study indicate that a question that asks about worries should be included when screening for low SEWB in Australian First Nations peoples living in the Torres Strait and NPA.

KEYWORDS

mental health, psychological well-being, psychology, social determinants of health

Torres Webb and Kathryn Meldrum are co first authors.

1 | INTRODUCTION

According to the United Nations, Indigenous peoples have ancestral connections to the lands or country prior to colonisation, conquest or establishment of new state boundaries.[1] Indigenous peoples globally share a holistic conceptualisation of their health and well-being which is interrelated and interconnected with that of their communities and traditional lands[2] and is different to the individualistic conceptualisation held by the dominant Western biomedical paradigm.[3,4] Historical and continuing impacts of colonialism continue to affect many Indigenous peoples' health and well-being outcomes. However, they are often positioned as in deficit relative to the dominant population.[5] An example of the continuing impact of colonialism is the use of screening tools designed to assess depression and anxiety that are underpinned by the individualistic Western biomedical paradigm being used with Indigenous peoples globally.[6] Additionally, that most screening tools need to be more robustly validated for the populations that they are being used with.[6]

Previously, many authors raised issues about approaches used to assessing depression and anxiety in Indigenous peoples[4,7–13] citing that their holistic worldviews of health and well-being make them inappropriate. In line with the issues raised about the inappropriateness of Western screening tools for Indigenous peoples, several authors have called for psychology to be decolonised. Decolonising psychology removes the 'impacts of historical domination on subordinated populations by powerful outsiders'[14] (p. 259). It can be realised by acknowledging different worldviews[15] and integrating First Nations peoples' cultural practices into service provision.[16] Australian First Nations peoples share a holistic view of their health and well-being, called social and emotional well-being (SEWB). Social and emotional well-being acknowledges that Australian First Nations peoples well-being is influenced by seven interconnected domains: a person's body, mind and emotions; their family and kinship relationships; and their interactions with their community, culture, country and spirituality.[16] As SEWB is inclusive of multiple domains and their interactions, it is broader than Western conceptualisations of mental health.[17] In addition, SEWB adopts a strengths-based approach to health and well-being.[18]

In recognition of the issues of using Western screening tools to screen for depression and anxiety in Australian First Nations peoples, much work has been done by Australian researchers to cross culturally adapt,[19–21] validate[22,23] and develop entirely new screening tools based on the conceptualisation of SEWB for young people[24] and adults.[10,25] These adapted and new screening tools recognise that culturally valid understandings including signs, symptoms and words used by First Nations peoples to describe and discuss their SEWB are necessary for appropriate diagnosis and treatment. For example, both Esler and colleagues[21] and Brown and colleagues[20] identified that anger was a common sign and symptom of depression in Aboriginal people from the Northern Territory and central Australia. This sign/symptom did not appear in the original Patent Health Questionnaire – 9 (PHQ-9) before being adapted by both author groups. Therefore, it would have been missed in screening. Use of inappropriate screening tools also has implications for equitable access to diagnosis and treatment. Without appropriate tools, there is a real risk of under-or over diagnosis leading to delayed or absent interventions and management.

What is already known on this subject?

- Tools used to screen for depression and anxiety developed using the Western biomedical paradigm are inappropriate for Australian First Nations peoples.
- Australian First Nations peoples use the term social and emotional well-being (SEWB) which is inclusive of Western conceptualisations of depression and anxiety.
- According to community and health professional feedback, depression and anxiety screening tools used during a recent dementia prevalence study conducted in the Torres Strait and Northern Peninsula Area (NPA) were not appropriate.

What does this paper add?

- Australian First Nations peoples living in the Torres Strait and NPA use the word worry to describe and discuss low SEWB.
- Worry is not one of the words listed in SEWB screening tools advocated by key health agencies.
- These findings have implications for screening tools used with First Nations peoples across Australia.

1.1 | Setting

This study took place on the islands of the Torres Strait (Zenadth Kes) and NPA region of Far North Queensland, Australia. The Torres Strait is located between the

eastern tip of the Australian mainland and Papua New Guinea. It consists of over 200 islands, 17 of which are permanently inhabited, and a geographic area of over 44 000 square kilometres.[26,27] According to 2021 census data approximately 6093 people of Aboriginal and/or Torres Strait lived in the Torres Strait and NPA region.[28]

Torres Strait Islanders are a distinctly different Australian First Nations population of Melanesian descent[29] (Torres Strait Regional Authority, 2013 cited in Dudgeon et al., 2014, p. 10). The Islands are broken up into five traditional island clusters. Torres Strait Islander peoples living in the eastern cluster on the inhabited islands of Mer, Erub and Ugar are of the Kemer Kemer Miriam Nation and the Miriam Mir/Mer language group. The top western cluster consists of the inhabited islands of Boigu, Duan and Saibai. Torres Strait Islander peoples from this group are from the Guda Maluilgal Nation and speak the Kalaw Kawaw Ya Dialect of the Kala Lagaw Ya (KLY) language group. The central cluster consists of the inhabited islands of Iama, Masig, Poruma and Warraber. Torres Strait Islanders from this cluster are of the Kulkalgal Nation and speak the Kulkalgau Ya dialect of KLY. The inhabited islands of Mabuiag, Badu and Mua, which includes the Arkai and Wug communities, are in the western cluster. Torres Strait Islander peoples from this cluster are of the Maluligal Nation and speak the Mabuyag dialect of KLY. The inner cluster comprises the inhabited islands of Waibene, Ngarupai, Kiriri and Muralag. Aboriginal peoples of the Kaiwalagal Kaureg Nation who speak the Kaurareg dialect of KLY originate from these islands.[30]

As previously described, the health and health-related outcomes of Australian First Nations peoples are affected by historical and ongoing impacts of colonialism.[5] Additional impacts for people living in the Torres Strait and NPA includes their very remote location and its associated effects on availability of health services and high staff turnover, as well as the impact of climate change.[31] Notwithstanding, the Australian Institute of Health and Welfare (AIHW) report that 49% of First Nations Australians 15 years and over living in the region rate their health status as very good or excellent.[32] However, 48% reported a current and long-term health condition and close to 20% over the age of 18 reported high psychological distress. However, the AIHW indicated that statistics related to psychological distress be viewed with caution due to up to 15% margin of error due to a low sample size.[32]

1.2 | Rationale

The rationale for this study is situated in previous work undertaken by the research team between 2015 and 2018 to determine the prevalence of dementia in the Australian First Nations peoples living in the Torres Strait and NPA.[33] Feedback from First Nations community members and health professionals during and after the dementia prevalence study indicated that depression and anxiety screening tools, the KICA-Dep[34] and Geriatric Anxiety Inventory[35] used during the study were not appropriate.[36] Particularly the items relating to suicidal ideation which were offensive to some participant's Christian beliefs and generally, both tools used words and concepts that were unfamiliar to the participants.

In response to feedback from community members and health professionals in the Torres Strait and NPA, the research team subsequently secured funding for a four-phase project designed to develop a more appropriate screening tool(s) for Australian First Nations peoples living in the Torres Strait and NPA. Originally the project set out to develop tools to screen for depression and anxiety. However, during the project when western concepts of depression and anxiety were identified as inappropriate the focus switched to developing a SEWB screening tool. This paper reports findings from the first phase. This paper answers the research questions (1). What words are used to describe and discuss SEWB in the Torres Strait and NPA? and (2). How are signs and symptoms of low SEWB expressed in the Torres Strait and NPA?

2 | METHODS

2.1 | Study design and participants

This study was conducted according to the previously published protocol.[37] The overarching methodology for this study was decolonising methodology,[38] which aims to extend fundamental knowledge principles beyond western ways of knowing and doing.[39] In enacting decolonising methodology non-Indigenous members of the research team acknowledge historical and continuing impacts of colonialism and research on Australian First Nations peoples. The research team are critically reflective, seek opportunities for reciprocity and respect all First Nations peoples' rights to self-determination. Non-Indigenous team members work actively with First Nations colleagues to transform their practice and foreground First Nations peoples ways of knowing, being and doing.[39] This was achieved by working with the team's Knowledge Circle (Indigenous Reference Group). Additionally, and in accordance with the study's protocol,[37] ethical and ongoing community engagement approaches included the principles of reciprocity and mutual benefit. Multiple approaches to inclusive community engagement including speaking with a range of

community members prior to and during visits, flyers on community notice boards, radio interviews and regular newsletters. This phase was led and governed by First Nations team members.

Yarning circles, an Australian First Nations relational method,[40] were conducted with community members and health professionals living and working in the Torres Strait and NPA. Yarning, meaning 'let's talk' uses storytelling as a way of sharing knowledge.[40–42] Yarns can occur individually or in groups, the latter being a yarning circle. According to Bessarab and Ng'Andu[41] there are four different types of yarn: (1) social yarn; (2) research topic yarn; (3) collaborative yarn; and therapeutic yarn. Yarning circles should begin with a social yarn where general news is shared, ideally it is also where relationships amongst the participants, including the facilitators, are established.[41] Subsequently a research yarn commences which initially opens with the facilitator asking a question related to the research topic. Equality and shared responsibility are two if the principles fundamental to yarns, hence participants have control over what is yarned about. Consequently, yarns should not be re-directed if the facilitator thinks that it is 'off-topic'.[43] This study used social and research yarning to gather knowledge about participant experience of SEWB.

2.2 | Participant selection and setting

To develop a range of perspectives about SEWB a range of Torres Strait and NPA community members, Elders, psychiatrically stable First Nations mental health clients, or past clients, First Nations peoples with a mild cognitive impairment or early dementia and aged care, SEWB/mental health and primary health care staff were purposively sampled. Purposive sampling took place through face-to-face, telephone and email contact facilitated by existing community networks. While a range of potential participants were contacted many were unavailable to participate when the research teams was in their community. Consequently, 35 people consented to participate in yarning circles conducted in community and primary health care settings. Of participants that were available when the research team were in community, no one declined to participate, and no participants subsequently withdrew their consent.

2.3 | Yarning circle procedure

The male co-first author (TW) and female third author (CW) who are both Torres Strait Islander research team members, led the yarning circles after establishing their relationality with participants. Establishing relationality was achieved in the social yarn by sharing information about where they were from, identifying their families and clarifying their connections with participants. In all but one yarning circle the female co-first author (KM), a non-Indigenous Australian, was present. She also identified her relationship with the project prior to the commencement of yarning circles and subsequently took written notes.

Before starting the research topic yarn, the yarning circle leader discussed the project and shared the written information sheet and consent form with participants. Participants were told that participation in the yarns was entirely voluntary. Confidentiality and anonymity of the participants has subsequently been maintained and there were no foreseeable risks of harm or discomfort to participants.

Agreements to acknowledge and protect the participants existing intellectual and cultural knowledge were also made. After answering any questions, the yarning circle leader sought consent from participants by asking them to sign the consent form/give verbal consent. When all participants agreed the research topic yarn commenced. Only participants and facilitators were present during yarning circles. The yarns were audio recorded with written and verbal consent from the participants. Transcribed yarns and associated notes were de-identified to preserve the anonymity of participants. Participants received a locally redeemable store voucher as a token of appreciation for their participation in a yarning circle.

2.4 | Data collection

A yarning guide with broad topics related to words used to describe strong and low SEWB as well as related signs and symptoms assisted the facilitator during the yarning circles, by providing suggested questions and prompts, The yarning guide is available as part of the published protocol[37] and was pilot tested with stakeholders. A strengths-based approach was taken to yarning with community members who were asked to yarn about strong SEWB first. Table 1 illustrates topics used with community members and health professionals.

All but one yarning circle was audio recorded and professionally transcribed. Consent to record was not provided by one participant at one of the yarning circles so the second co-author (KM) took notes. Each yarning circle took up to an hour to complete. During the data collection period, the facilitators discussed themes arising from the yarns, and as a result, were able to identify when data saturation (no new themes) had been achieved. Finally, transcripts were not returned for member checking to all communities due to the geographic dispersion of participants. However, as

described in the new SEWB screening tool development[44] and as the research team are returning to many of the communities now as part of validating the SEWB tool, checking of the words, signs and symptoms is has been taking place as part of the validation process.

2.4.1 | Ethical considerations

Local community protocols were respected and followed prior to and during visits to each community. The knowledge created through this study is owned by the participants in the study. All the yarns and related knowledge created by the study will be returned to the Aboriginal and Torres Strait Islander peoples once a data repository for the region has been created. In lieu of a data repository, findings of this project are continually being shared with members of peak bodies in the region such as Gur A Baradharaw Kod (GBK), Torres Shire Council and the Torres Strait Islands Regional Council. Additionally, governance for this project has been granted by the Anonymous Health Service. They receive annual updates to the project and findings are also shared with the Chair of the board who is a Torres Strait Islander.

Finally, this study was guided by the Code of Ethics for Aboriginal and Torres Strait Islander Research provided by The Australian Institute of Aboriginal and Torres Strait Islander Studies[45] and The National Health and Medical Research Council Guidelines for Ethical Conduct in Research with Aboriginal and Torres Strait Islander Peoples and Communities.[46]

2.5 | Ethics approval

Ethics approval for this project was granted by the Anonymous Human Research Ethics Committee (HREC) (HREC/2021/QCH/73683-1518), Anonymous HREC (H8606) and Anonymous HREC (2022/HE000395).

2.6 | Data analysis

The co-first authors (TW and KM initials removed for double-blind reviewing) thematically analysed[47] the data deductively. The first co-author (TW) listened to the audio recordings and used field notes to identify themes. Whereas the second co-author (KM) used NVivo™ (QSR International Version 12) to code the data. The research questions guided coding in both instances. For example, the first research question asked: 'What words are used to describe and discuss SEWB in the Torres Strait and NPA?' so both co-authors initially looked for words used to describe and discuss SEWB in recordings (TW) and in the written transcripts (KM). While their methods for identifying themes were different, both TW and KM used thematic analysis.[47] The co-authors checked their findings with each other using the coding tree created in NVivo™. This was the first time that the first co-author (TW) had analysed qualitative data. Consequently, the data analysis process provided a rich opportunity for capacity strengthening and opportunities for both co-first authors to learn from each other. Discussions between the first co-authors revealed that there were no differences in the words, signs and symptoms that participants used to describe and discuss SEWB identified by the coders. The findings were subsequently checked with key stakeholders, some of whom also participated in the yarning circles.

The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist[48] (File S1) and the Aboriginal and Torres Strait Islander Quality Assessment Tool[49] (File S2) were used to ensure that the research and reporting conformed with expected standards for working with Aboriginal and Torres Strait Islander peoples.

3 | RESULTS

3.1 | Participant characteristics

The nature of the yarning circles was inclusive, and the facilitators did not ask for specific demographic information from the participants. However, in general terms, of the 35 people who participated, two thirds ($n = 21$) were First Nations peoples. With most non-First Nations peoples being health professionals working in the region. Just under three quarters ($n = 25$) of the participants were female and all participants were aged between 25 and 92 years with an even range of age across the sample.

TABLE 1 Yarning topics used during yarning circles with community members and health professionals.

Participant group	Yarning topics
Community members	• Words used to describe strong and low SEWB • Signs and symptoms of strong and low SEWB
Health professionals	• Words clients used to describe low SEWB • Signs observed and symptoms of low SEWB described by clients

3.2 | Words used to describe low social and emotional well-being

Worry was the most frequent word used by community members and health professionals to describe low SEWB. The range of words used to describe low SEWB are illustrated in Table 2 below. Stress[6] and sad[6] were the next most frequently used words. This suggests that, while worry is the most frequently used word, stress and sadness are the underlying feelings that people are experiencing. This was expressed in this quote from a First Nations health professional and community member.

> I think worry is like because they don't really know if they're sad or like the emotions.... But sometimes it means they're sad.
>
> (Yarning Circle Twelve)

Stress worries were more likely to be related to anxiety about insufficient resources, relationships or a family member. Sad worries were more related to sad news or sorry business, kin moving away and sadness in the community or on the Island/Country. When hearing the word worry, health practitioners emphasised the need to ask further questions to try to identify which type of worry their client was experiencing. One approach was highlighted in the following quote by a First Nations health professional and community member:

> .....so I have to try and get in depth with it, I have to go another way, ask auntie, uncle, are you like, you worry for, you notice something wrong or you sad and they do come across and they do say, no it's sad, like I'm upset, I just want to cry and stuff like that. But yeah, worry just covers all the emotions....
>
> (Yarning Circle Twelve)

3.3 | Signs and symptoms of low social and emotional well-being

A change in a person's normal behaviour patterns was the most dominant sign of low SEWB and was one of two sub-themes identified under signs. The other sub-theme was decreased community engagement. Table 3 identifies the words used to signify low SEWB.

Key behaviour changes identified were people being unable to or nor wanting to do their usual activities. This was closely linked with the next most frequent sign, lack of community engagement and social isolation. Both key signs of low SEWB are highlighted in this quote from a First Nations health professional and community member.

> I ask family..."Have they been doing their normal things like gardening or are they just sitting on the veranda?" People either don't want to do their normal routine or can't do their normal routine.
>
> (Yarning Circle 13)

Words used to describe symptoms of low SEWB mirror those used for signs, but in lower numbers. Across the yarns, the facilitators heard that participants were really focused on a strengths-based approach to supporting their SEWB. So, while they were asked: What does low SEWB feel like or look like to you? What words do you use?

TABLE 2 Word frequencies for describing low SEWB.

Word	Frequency
Worry	20
Stress	7
Sad	6
Angry	4
Down	4
Slack	4
Low	2
Upset	2
Do something stupid	1
Mad	1
No good	1
Wild	1

TABLE 3 Frequency of words used to describe signs of low SEWB.

Words used	Frequency
Behaviour change (sub-theme)	18
Decreased community engagement (sub-theme)	11
Sad	6
Quiet	5
Crying	4
Body posture	3
Worry	3
Anger	2
Irritable	2
Harm	1
Tone of voice	1
Substance use	1
Violence	1

Participants did not dwell on the description but switched their focus very quickly to their approaches to bringing their SEWB up, so that they were feeling strong again. For example:

> So, when I feel that I feel low, I get away, I walk away and stuff. Or I think, leave me alone, I'll go a drive. I run away in the dingy all by myself. Yeah. That's how I – then it leads onto making myself happy is like practice the things where you calm yourself down.
>
> (Yarning Circle 4)

4 | DISCUSSION

In this study, worry was the most frequent word used to describe low SEWB by Australian First Nations peoples living in the Torres Strait and NPA and reduced community engagement and social isolation were key signs of low SEWB. This discussion is focused on discussing the relationship between the words used to describe and discuss low SEWB and those used in mainstream screening tools. It will then relate the findings of this study to the overarching conceptual model of SEWB. Finally, the implications of these findings on clinical practice will be considered.

The rationale for this study was grounded in the findings of previous work done by the research team who used the KICA-Dep[34] and GAI[35] to screen for low mood and anxiety in First Nations peoples living in the Torres Strait and NPA. Both the KICA-Dep and GAI were identified as being inappropriate for this population because of the words used to describe signs and symptoms and questions related to suicidal ideation that were offensive to many participants' Christian beliefs.[36] This study found that the predominant words used by First Nations peoples of this region differed from those used in the KICA-Dep and GAI, but also other tools that screen for psychological distress such as the adapted PHQ-9[23,50] and the Kessler Psychological Distress Scale that is used in the Australian First Nations peoples adult health check.[51,52] For example, worry, the most frequent word used by First Nations peoples living in the Torres Strait is not listed in the symptoms described in the adapted PHQ-9. The purpose of these examples is not to critique these tools, but to highlight the importance of health practitioners' understanding of the culture of First Nations peoples living in the Torres Strait and NPA region which includes appropriate terms of reference[17] for low SEWB. Adams and colleagues[17] also noted that communication skills needed for assessment included an 'awareness of the client's use of language' (p. 283). This project provided the foundation for the development of a new tool to screen for SEWB that will be appropriate for use with Australian First Nations peoples living in the Torres Strait and NPA.

4.1 | Relationship of yarning circles findings with Australians First Nations peoples concept of SEWB

As previously discussed SEWB is an interrelated and interconnected concept of holistic well-being for Australian First Nations peoples. Connections between self, family, community, and Island home/Country, culture and spirituality are integral to strong SEWB.[16] In addition, a sense of self is 'grounded within a collectivist perspective that views the self as inseparable from and embedded within family and community'[18] (p. 57). Torres Strait Islander communities on the islands and NPA are more traditionally orientated[53] where an established communal life[54] continues. In this context, withdrawal of oneself from family and community should be recognised as 'red flag' for low SEWB. This finding is in line with Gee and colleagues'[18] assertion that a disrupted connection between self, family and community often results in lower SEWB.

Australian First Nations peoples' connection to their culture is strengthened when they live on their traditional islands/country. Consequently maintaining or strengthening SEWB can be supported by connecting with their culture and country, helping to ensure a strong sense of cultural identity and values and enabling them to participate in community by undertaking their cultural rights and obligations.[18]

4.2 | Implications

The findings of this project have implications at three levels. At a broader level, this study responds to the call for appropriate tools that screen for low mood in Indigenous peoples globally.[3] At a national level, Dudgeon and colleagues[16] identified that Australian psychology 'colonises both directly through the imposition of universalising, individualistic constructions of human behaviour and indirectly through the negation of Aboriginal knowledge and practices'. (p. 276). Therefore, new SEWB screening tools that embody Australian First Nations people's holistic conceptualisation of well-being need to be developed to ensure that appropriate treatment can be accessed. For example, Basit et al.,[55] recently outlined that the major depression module of the Composite International Diagnostic Interview led to an incorrect diagnosis of bipolar disorder in some of their Australian First Nations

participants. This finding highlights how mainstream tools have the potential to misdiagnose First Nations peoples, with potentially significant negative implications and impacts for them.

At a local level, screening tools that use words, signs and symptoms of First Nations peoples have the potential to reduce the cognitive load needed by health professionals who usually need to translate the words used in mainstream tools to support their clients' access to appropriate services. Screening tools developed using local words, signs and symptoms may also increase health workers confidence in their ability to screen for low SEWB. It is anticipated that the outcome of this project, a SEWB screening tool will be used in primary care and geriatric settings across the Torres Strait and NPA. Use of the new screening tool has the potential to bring about sustainable changes in practice, as currently adaptations of the PHQ-9 are used to screen for low mood. This change in practice has the potential to benefit the study participants and wider communities by supporting their SEWB and facilitating appropriate diagnosis and treatment.

4.3 | Study limitations

Integral to the aim of this project was to yarn with First Nations peoples from as many Torres Strait Island communities as possible to ensure that a wide range of words, signs and symptoms used to describe low SEWB were heard. Project planning included visits to at least one island in each of the five island clusters. Unfortunately, logistical issues including bad weather that led to cancelled charter flights and activities associated with the ongoing impact of COVID-19, meant that yarns were not conducted with community members of two island clusters. To ameliorate these issues, yarns with health professionals who regularly conduct outreach visits to all inhabited islands across the Torres Strait, were also asked about differences in words, signs and symptoms across the region.

Another limitation was that member checking was not able to be conducted with all yarning circle participants. This was due to the large geographical spread of communities and the associated cost of aircraft charters. This limitation has been ameliorated to a certain extent by ongoing engagement with key stakeholders who also participated in the yarning circles and have continued to support development of the new SEWB screening tool.[44] In addition, the new screening tool is currently being validated with communities that participated in the yarning circles, so checking of words, signs and symptoms is taking place as part of the determination of its validity.

4.4 | Recommendations

A recent scoping review found that screening tools developed using the western biomedical paradigm, including the PHQ-9, Center for Epidemiological Studies Depression Scale and the Kessler Psychological Distress Scale (and its adaptations) are still the most often used with First nations peoples globally.[6] Tools designed using the Western biomedical paradigm are not appropriate for Australian First Nations peoples[7,10] because of different conceptualisations of well-being and words used to describe and discuss SEWB. Consequently, we make the following three recommendations for practice and two for policy.

4.4.1 | Practice

First, screening tools designed using First Nations peoples' holistic conceptualisation of well-being need to be used in primary health care settings. Second, words, signs and symptoms used by the local First Nations peoples to describe SEWB need to be integrated into the screening tool. For example, a question that asks about worries should be included in a screening tool for SEWB. Third, tools need to be validated for the population that they are being used with.

4.4.2 | Policy

Policymakers should review screening tools being used in their services to screen for distress including low mood. Key questions that policymakers should be asking include:

- What was the underlying paradigm used to develop this screening tool?
- Has it been developed in collaboration with or cross-culturally adapted for Australian First Nations peoples?
- Is there a difference in words used between the tool and the First Nations population in our catchment area?
- Has it been robustly validated for use with the First Nations population in our catchment area?

5 | CONCLUSIONS

First Nations peoples living in the Torres Strait and NPA use the word worry to describe feelings of low SEWB. Worries could be further broken down to sad worries and stress worries. Behaviour changes and lower than usual community engagement were key signs and symptoms of

low SEWB. The findings of this study highlight that predominant word use of First Nations peoples living in the Torres Strait and NPA region is different to those used in screening tools across Australia. Implications of the study findings highlight the issue of inappropriate tools that screen for depression and anxiety. Inappropriate screening tools may misdiagnose and potentially limit First Nations peoples' equitable access to treatment.

AUTHOR CONTRIBUTIONS

Torres Webb: Investigation; writing – original draft; methodology; writing – review and editing; formal analysis. **Kathryn Meldrum:** Methodology; investigation; writing – original draft; writing – review and editing; formal analysis; project administration. **Chenoa Wapau:** Methodology; investigation; writing – review and editing. **Betty Sagigi:** Methodology; writing – review and editing. **Rachel Quigley:** Conceptualization; funding acquisition; methodology; writing – review and editing. **Edward Strivens:** Conceptualization; funding acquisition; methodology; writing – review and editing. **Sarah Russell:** Conceptualization; methodology; funding acquisition; writing – review and editing; supervision; investigation.

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CONFLICT OF INTEREST STATEMENT

The authors declare that there are no potential conflicts of interest regarding the publication of this article.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

Ethics approval for this project was granted by the Far North Queensland Human Research Ethics Committee (HREC) (HREC/2021/QCH/73683-1518), James Cook University HREC (H8606) and Queensland University HREC (2022/HE000395).

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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