Australia's Aboriginal Population and Mental Health

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Abstract: It appears that mental illness was present in Australian Aboriginal culture prior to European colonization of Australia but was, most likely, a relatively rare occurrence. The much greater prevalence of mental illness and suicide in the current Aboriginal population is a reflection of the significant disruption to Aboriginal society and has a strong context of social and emotional deprivation. Management of the issues of mental illness in Aboriginal people requires a strong emphasis on cultural safety along with the recognition of family, culture and community in any therapeutic process.

Key Words: Australian Aboriginal, mental illness, cultural safety, suicide

(*J Nerv Ment Dis* 2010;198: 3–7)

AUSTRALIAN ABORIGINAL CULTURE AND "MENTAL HEALTH"

Archaeological evidence suggests that Aboriginal (a term in this article to include both the multitude of over 200 Australian Aboriginal tribes in addition to the Austronesian population of the Torres Strait) people have been present in Australia for the last 45,000 to 50,000 years. The ethnographic evidence from early contact suggests that Aboriginal people who survived infancy were relatively fit and disease free (Flood, 2006). Further, Australia's native foods supported a nutritious, balanced diet of protein and vegetables with adequate vitamins and minerals with little salt, sugar, and fat. Life on the move kept people physically fit (Flood, 2006).

In terms of "mental health," traditional Aboriginal culture had a number of strong reinforcing factors. Aboriginal sense of self was seen in a collective sense, intimately connected to all aspects of life, community, spirituality, culture and country. The culture also provided for everyone through sharing rules and relationships and kinship were of prime importance, defining social roles. Aboriginal people were given a sense of meaning and understanding of life experience through their connection to country and their Dreaming. Spiritual beliefs offered guidance and comfort and offered a sense of connectivity and belonging despite distress, death and loss. Lore, the body of knowledge that defined the culture and the tribal elders who contained and interpreted the Lore were highly valued. Customary law defined rules and consequences. Over 200 traditional languages and other methods of communication allowed a rich expression of interaction in the above social context and formal ceremony allowed a method of dealing with life's transitions thought birth, initiation and death. Men and women had defined economic and cultural roles within the tribe. Children were well protected within the group with a range of "aunties" and older siblings able to take over the child care role if the mother was stressed (Milroy et al., 2003).

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ISSN: 0022-3018/10/19801-0003
DOI: 10.1097/NMD.0b013e3181c7e7bc

The current Aboriginal population of Australia comprises about 2.4% of the total population. About a quarter of the Aboriginal population live in remote or very remote parts of the continent with about 30% of Aboriginal Australians now living in major cities (Dillon and Westbury, 2007). However, it is also noted that Aboriginal people are over represented in the poorest city neighborhoods (Dillon and Westbury, 2007).

THE EXPERIENCE OF MENTAL ILLNESS IN TRADITIONAL ABORIGINAL CULTURE

Mood Disorder

Notwithstanding the above factors reinforcing mental health in traditional Aboriginal culture, medical and anthropological accounts do note occasional instances of mental illness. Individual Aboriginal community surveys have found differing rates of mood disorder with these being variously reported at 2.5% for Mornington Island Queensland, 6% at Bourke NSW, but 1% for a community in the Kimberley Western Australia (Hunter, 2003). Jones and de la Horne (1972) in a survey of a Central Australian Aboriginal group noted that people affected by mood disturbance in the group suffered vegetative disturbance and restriction of emotional response. However, they also noted that the affected population often projected feelings of unworthiness and guilt on to others, were more aggressive and had more physical or "somatic" symptoms. Cawte (1987) described a number of features of "atypical depression" experienced by Aboriginal people. He noted a "suicide fit" in the context of alcohol withdrawal where a person developed a significant degree of anxiety following an intense encounter with a relative. The affected person would often run away to seek a private place and may then attempt to harm themselves. Cawte also noted depression precipitated by a person being "shamed" or being fearful that they were subject to sorcery or "payback" (Cawte, 1987). Morice (1986) reported that the Pintubi people of Central Australia had a range of words to express a range of feelings of sadness and depression, from mild to severe.

Psychosis

Psychotic disorders have been reported in a number of cases of the traditional Aboriginal context. Kidson and Jones (1968) estimated that the rate of schizophrenia among tribal Aboriginal people in central Australia was about 0.46%. Aboriginal people apparently suffering from schizophrenia were observed by Jones and de la Horne (1972, 1973) in central Australia in the 1970s and both positive and negative symptoms were described in affected individuals. Morice (1986) noted that the Pintubi language had words to describe someone suffering from schizophrenia as having "closed ears" or "living in a world of their own." Meggitt (1962) described the case of a woman suffering from psychosis, most likely related to emotional stress as well as a person suffering from mania in the Walpiri tribe from the south of the Northern Territory. Eastwell (1976, 1977) commented on transient delusional states in certain Yolgnu family groups in the East Arnhemland region of the Northern Territory.

Anxiety

Anxiety disorders appeared to be a rare phenomenon in traditional Aboriginal society with low community prevalence rates

of about 1% reported (Hunter, 2003). There were probably a number of protective mechanisms in Aboriginal society to account for the low prevalence reported. Hunter et al. (1999) and Eastwell (1988) have commented on the ability of Aboriginal and Torres Strait peoples to express "strong feelings" within a defined cultural context such as a funeral. Eastwell (988) also comments that the Yolgnu tribe of Eastern Arnhem Land relieved stress by ascribing significant adverse personal events, such as the unexpected death of an individual, to sorcery which was satisfying to individuals and the community and carried great "local conviction." Despite the above, there are occasional case reports of the experience of significant anxiety in Aboriginal people. Meggitt (1962) described what is most likely a case of dissociative fugue secondary to intense anxiety resulting from a woman accidentally viewing sacred items during his time with the Walpiri tribe in the 1960s. Morice (1986) reports on Pintubi language describing extreme fear in addition to other grades of anxiety that could also account for such a phenomenon.

Personality Disorder

Community prevalence surveys have reported rates of personality disorder of 4% in Mornington Island, 16% in Bourke, and 8.2% in a Kimberley community (Hunter, 2003). However, Morice (1979) notes a number of qualifying issues in the diagnosis of personality disorder when the assessor is from a different culture from the person being assessed. He cautions that "there are many people who exhibit atypical (for themselves) behavioral responses to certain environmental stimuli. These behavioral reactions occur in direct response to the stimuli and usually disappear when the stimuli are removed. . . . A diagnostic dilemma occurs when adverse environmental stimuli are prolonged and behavioral responses may appear to be relatively fixed" (Morice, 1979).

Given this caution, there is still a range of information about the vulnerability of Aboriginal peoples to personality issues. A number of anthropologists (Strehlow, 1970; Hart et al., 1988; Hiatt, 1965) have commented on tribal sanctions that were applied to continuingly disruptive individuals (usually young men) that may be indicative of antisocial personality. Jones and De la Horne (1972) also report on individuals affected by an "excessive propensity to aggressive behavior even for their own culture" from Central Australia. Their account appears consistent with the anthropological accounts mentioned in this regard.

The Destruction of Aboriginal Culture and the Emergence of an Epidemic of Mental Illness

The British colonization of Australia in 1788 had major impacts for the physical and mental health of the Aboriginal population. Franklin and White (1991) further define the elements of destruction of optimum physical and mental good health of the Aboriginal people following the British colonization. These elements were the introduction of new diseases, the removal of ancestral land which led to psychological distress and spiritual despair and the herding of Aboriginal people into reserves and settlements, destroying lifestyle and leading to marginalisation and poverty. Other specific policies such as the Stolen Generations (the forced removal of Aboriginal children from their families on the basis of race with subsequent placement in institutions) which was in place from the 1930s to the 1960s have subsequently been recognized as leading to the destruction of family life and emotional desolation for many Aboriginal people (HREOC, 1997). The profound destructive effect of the Stolen Generations policy on Aboriginal Australians has recently achieved significant recognition through a formal Apology given to Aboriginal Australians in this regard by the Prime Minister Kevin Rudd on behalf of the Australian Government and people (Rudd, 2008).

Despite a recent plethora of policies to advance Aboriginal health, there has not been a lot of successes and this has been attributed to a pervasive culture of "welfare colonialism" (Anderson, 1997) affecting Aboriginal communities where most Aboriginal populations rely heavily on the provision of public sector resources and the mechanisms to deliver these have replaced the traditional methods of Aboriginal governance. In addition, the continuing experience of widespread racism against Aboriginal people within the Australian community appears to have a continuing negative effect, particularly on the mental health of Aboriginal people (Paradis, 2007).

The above issues have resulted in a terrible legacy of significant physical and mental health disadvantage for Aboriginal Australians. Hospitalization rates for cardiovascular disease in Aboriginal people were 80% higher than for other Australians in the North West of Australia in 2002 to 2004 (AHMAC, 2006). Rheumatic heart disease was 9 times more common for Aboriginal people than other Australians (AHMAC, 2006). Diabetes and renal failure also figure prominently in Aboriginal health issues. In 2004–2005, 3 times as many Aboriginal people were reported to have diabetes compared with other Australians (AHMAC, 2006). Hospitalization rates for Aboriginal people with diabetes are 6 times higher than for other Australians (AHMAC, 2006). End stage renal disease, often the consequence of poorly controlled diabetes was 8 times higher for Aboriginal peoples than other Australians (AHMAC, 2006). Given these alarming health statistics, it is not surprising that life expectancy for Aboriginal people is 17 years less than for other Australians (AHMAC, 2006), an issue now well recognized in the "CLOSETHEGAP" national health reform agenda for Aboriginal Australians (HREOC, 2008).

Aboriginal disadvantage is also apparent in other social indices. The 2002 National Aboriginal and Torres Strait Islander Social Survey estimated that 26% of the Aboriginal population over 15 was living in overcrowded housing. The overcrowding becomes more apparent in remote areas where it is estimated that 62% of Aboriginal people live in overcrowded housing (AHMAC, 2006). In respect to education, the National Schools Statistics Collection reported that the retention rate of Aboriginal students to complete high school was only 39.5% compared with 76.6% for other students (AHMAC, 2006). Given this trend in education, the accompanying statistics of significant Aboriginal disadvantage in employment and income to the rest of Australia are no surprise along with data from the prisons that shows that Aboriginal people are 12 times more likely to be in prison compared with the remainder of the Australian population (AHMAC, 2006).

The above indices of significant social disadvantage provide a substantive environment for the emergence of mental illness. Surveys have shown that Aboriginal peoples aged over 18 are twice as likely to report being victims of violence or threatened violence as other Australians (AHMAC, 2006). A further alarming statistic in respect to child safety was the significant rate of notifications to welfare authorities for Aboriginal children. In 2004–2005 the rate of substantiated child protection notifications to the welfare authorities was 24 per 1000 for Aboriginal children compared with 7 per 1000 for other children (AHMAC, 2006).

Given the above, it is not surprising that Aboriginal and Torres Strait Islander peoples report significantly higher levels of stress than the remainder of the Australian community. Forty-four percent of the respondents to the 2002 National Aboriginal and Torres Strait Islander Social Survey reported at least 3 life stresses over the previous 12 months while 12% reported the experience of at least 7 life stresses. Multiple stresses were much more commonly experienced in remote areas. Reported stresses identified include the death of a family member or close friend, overcrowding at home,

alcohol or drug related problems, serious illness or disability and unemployment (Trewin and Madden, 2005). The significant effect of stress on Aboriginal children in Western Australia is also of concern. The West Australian Aboriginal Child Health Survey reported that a significant number of Aboriginal children aged 4 to 17 years were living in families where 7 or more major stress life events had occurred over the preceding 12 months (De Maio et al., 2005). It is also not surprising, therefore that in the context of the above exposure to significant stressors that the numbers of Aboriginal people reporting anxiety symptoms has risen from the early estimate of 1% a number of decades ago (Hunter, 2003) to a current rate of 25% (AIHW, 2009).

In the context of the continuing exposure to stressors as described above, (Helen Milroy, Personal Communication) has described the phenomenon of "Malignant Grief" being the end result of persistent stress experienced in Aboriginal communities. Malignant grief is a process of irresolvable, collective and cumulative grief that affects Aboriginal individuals and communities. The grief causes individuals and communities to lose function, become progressively worse and ultimately leads to death. Milroy further comments that the grief has invasive properties, spreading throughout the body. She notes that many of Australia's Aboriginal people eventually die of this grief.

The impact of the Stolen Generations Policy on the psychological well being of the affected Aboriginal individuals and their children has also been recently noted in the West Australian Child Health Survey. The survey concluded that members of the Stolen Generation were more likely to live in households where there were problems related to alcohol abuse and gambling. They were less likely to have a trusting relationship and were more likely to have been arrested for offenses. Members of the Stolen Generation were more likely to have had contact with Mental Health Services. The survey commented that children of members of the Stolen Generation had much higher rates of emotional/behavioral difficulties and high rates of substance abuse (De Maio et al., 2005).

Given this level of background psychological vulnerability, it is not surprising that substance abuse also figure prominently as a background factor to mental illness. It is well recognized that Aboriginal people who consume alcohol are more likely to do so at harmful levels (Trewin and Madden, 2005). In addition, Hunter et al. (1999) comment on "the community at risk" and "lifestyle" at risk factors that may impact on Aboriginal people in the context of widespread alcohol use within their community. The community at risk concept is that young people become socialized not only to the way alcohol is used in the culture, but also to the manner in which its effects are manifest behaviorally and socially. The "lifestyle at risk" then relates to a regular pattern of heavy consumption of alcohol by an individual. In this context, particular events and circumstances function as catalysts for violence, the objects of which (self or other) may to a certain extent, be arbitrary. The implications of these issues for the personal development of Aboriginal children living in remote and rural communities in Australia is typified by the comments of Gruen and Yee (2005) in respect to their experience in a remote Aboriginal community that "alcohol is also a hardship, particularly for children who grow up with the impression that drinking, often excessively, is a normal part of adult life. Youth programs are short lived and, in the end, the only established gathering place for entertainment for anyone, including kids, is the licensed club" (Gruen and Yee, 2005).

Aboriginal communities are affected by other substance abuse, particularly cannabis (Clough et al., 2002) and solvents (Parker, 1993, Dingwall and Cairney, 2009) and that this tends to be more pronounced in rural communities (Trewin and Madden, 2005).

The rate of psychosis currently affecting the Aboriginal population appears to be particularly significant. Pink and Allbon (2008) report that Aboriginal men were admitted to hospital with mental disorders due to psychoactive substance abuse at 4.5 times the expected rate for their proportion of the Australian population and the same population had hospital admission for schizophrenia and related disorders at 2.7 times the expected rate. Aboriginal women have 3.3 times the expected rate of mental disorders due to psychoactive substance abuse and 2.5 times the expected rate of hospital admission for schizophrenia and related disorders. It appears, therefore that the experience of psychosis, particularly in the context of substance abuse, is a significant current issue for the Aboriginal population at present. It has been noted that the admission to hospital of Aboriginal men with severe mood and neurotic disorders is 1.2 times the rate of the non-indigenous population with the rate for Aboriginal women being the same as the non-indigenous population. However, community studies on urban Aboriginal populations such as the one conducted by McKendrick et al. (1992) demonstrated that 54% of Aboriginal people tested with standard psychiatric rating scales were suffering from psychiatric illness and that depression was the most common among this group.

SUICIDE IN ABORIGINAL POPULATIONS

It was thought that suicide was a very rare event in traditional Aboriginal culture (Eastwell, 1988). However, in the current context, deaths due to "external causes" (which included intentional self-harm) were the second most common form of mortality for Aboriginal people between 2001 and 2005 (Pink and Allbon, 2008). These deaths constituted 16% of all Aboriginal deaths compared with 6% of deaths in the non-indigenous population (Pink and Allbon, 2008). The rate of death from this cause for Aboriginal males between 0 and 24 years was double the rate for non-indigenous males and the rate for Aboriginal females aged between 0 and 24 years was almost triple the comparable non Aboriginal population (Pink and Allbon, 2008).

Hunter (2003) notes that suicide in Aboriginal communities is unevenly distributed with different communities contributing to excess mortality with overlapping "waves" of suicide. Hunter et al. (1999) comment that community at risk and individual at risk issues related to excessive and problematic alcohol consumption are particularly pertinent in this regard as are the ongoing psychological effects of a "public" suicide in small remote and rural Aboriginal communities. Hunter et al. (1999) note that the body has a "life in death," the suicide often being a public event where the body is viewed by others. It then becomes a statement of "rebuke, uncaring relations, unmet needs, personal anguish and emotional payback" (Hunter et al., 1999) and particularly so for the individuals at risk previously described. Tatz (2001) also comments on a number of factors that may impact on suicide in Aboriginal youth such as prolonged grief, racism and alienation in addition to the variables of social disadvantage and life stressors that are mentioned above.

There appears to be an association between self-harm behavior in Aboriginal people and later suicide (Parker and Ben Tovim, 2002; Measey et al., 2006) so such behavior should always attract an appropriate level of clinical review to ascertain whether the affected individual has mental illness, an intolerable level of stressors and vulnerability from substance abuse. However, community intervention strategies have also been proven to be effective such as the recent successful suicide prevention program on the Tiwi community on Bathurst and Melville Islands in the Northern Territory (Norris et al., 2007). The program focused on improved communication between individuals and the

development of enhanced community governance in addition to the increased recognition of the role of Aboriginal mental health workers.

THE ASSESSMENT OF ABORIGINAL PEOPLE PRESENTING WITH MENTAL ILLNESS

Given the above complexities that may affect an Aboriginal patient presenting for an assessment of mental illness, an atmosphere of cultural safety should be a component of any intervention. Unsafe cultural practice is defined as "any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual" whereas culturally safe practice is simply defined as "effective clinical practice for a person from another culture" (Clear, 2008). This is particularly the case for Aboriginal communities in remote Australia where Morgan (2006) notes that "serious and unrecognised miscommunication is pervasive in non-Aboriginal doctor/Aboriginal patient interactions." He adds that English is usually not the first language of (remote) community-based Aboriginal people and might be the fifth or sixth language. Morgan also observes that other complications to effective clinical practice in remote Aboriginal communities include differing belief systems regarding illness, a potential perceived inefficiency of health systems and the disempowerment of Aboriginal patients, poor compliance issues and overwhelming high burden of disease (Morgan, 2006). In addition, symptoms of mental illness may need to be understood within a specific cultural context and the use of Aboriginal mental health workers can be of great assistance in this regard. As an example, it is often common for Aboriginal people to hear the voices of deceased relatives in a culturally acceptable manner (Parker and Milroy, 2003) and it is important that this is not misinterpreted by an inexperienced clinician as the person experiencing auditory hallucinations.

The clinician's history should attempt to take account of the factors previously mentioned including potential stressors, identified carers and problems affecting those carers such as physical illness and substance abuse. Sheldon (2005) also notes the particular importance of an appropriate review of contextual data and the familiarity of an interview setting in engaging Aboriginal peoples in any therapeutic process for mental health issues. The involvement of Aboriginal Mental Health Workers in assessments of Aboriginal clients is also an important component of culturally safe practice and the reliability of information thus obtained (Parker, 2003). An additional factor is the use of appropriate translation services.

Therefore, the issue of cultural safety and involvement of family and adjunctive workers such as Aboriginal and Torres Strait Islander mental health workers is often going to be a key component of the assessment and further management of Aboriginal people experiencing mental illness. Other strategies such as the formation of an expert College of Aboriginal Health (Parker, 2009) to develop and promote expertise in the delivery of health and social policy initiatives to the Australian Aboriginal population may also be an advantage.

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