

Reflections on psychiatry in Aboriginal Australia

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Eighteen months ago I came to Geraldton, Western Australia from the United Kingdom to help develop a psychiatric service for Aboriginal people in the mid-west region of the state. This has been a fascinating and challenging experience both professionally and personally and I would like to outline the context of this work and to reflect on some of the issues that seem particularly relevant.

Historical perspective

Current evidence indicates that Aboriginal people have been living in Australia for at least 50 000 years before it was colonised by the British, a little over 200 years ago. It is now estimated that there were approximately 750 000 Aborigines in Australia when the colonists first arrived and this total had fallen to less than 70 000 by the 1930s after 150 years of exposure to 'White civilisation'. The relative degrees to which massacre and disease contributed to the decimation of the Aboriginal population is debatable. What is certain is that Aboriginal people have traditionally had a very close relationship with the land, which was central to their lifestyle and spirituality. As the colonists expanded their horizons, Aboriginal people were displaced from their traditional lands to be herded into missions and reserves, radically changing their lifestyles and substituting conditions and diet often poorer than those of the poorest of the newcomers. Even those who sought the welfare of Aboriginal Australians remained paternalistic and fatalistic in their approach well into this century. Daisy Bates (1938), writer and advocate for Aboriginal people in the 1930s, wrote of "smoothing the pillow of a dying race". The view became widely held that assimilation of Aboriginal people into the dominant White population was the only way forward and on the basis of this policy the authorities justified the forcible removal of part Aboriginal children from their Aboriginal families to be placed in White foster homes or missions. This practice continued in some parts of Australia up to the early 1970s.

Citizenship rights for Aboriginal people were only brought into being following a national

referendum in 1967. For the first time all indigenous Australians were to be included in the national census and the Commonwealth Government was able to legislate on Aboriginal affairs, which had previously been the responsibility of the individual states. In the 1960s Aboriginal people began to protest increasingly in relation to their rights and their land and this protest movement has continued to grow.

The first community controlled Aboriginal Service was started in the early 1970s. Since then a network of such organisations has developed around the country. These medical services are essentially primary care facilities employing general practitioners, nurses and Aboriginal health workers, and are commonly informed by a philosophy of self-determination. The development of these services was a recognition of the poor accessibility of mainstream health services for Aboriginal people.

A number of key socio-political developments of recent years are worthy of note. The publication of the report of the *Royal Commission into Aboriginal Deaths in Custody* (1991) clearly identified the disproportionate rate of incarceration of Aboriginal people and the high rate of deaths in custody. It also identified inequitable access and poor standards of existing mental health services for the Aboriginal population. The High Court 'Mabo' decision, in 1993, was a landmark judgement in terms of recognising native title which had never been previously accepted in Australian law. The implications of this judgement are still being worked out. Most recently the publication of the *Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (Wilson & Dodson, 1997) officially validated for the first time the emotional damage done by the removal of children from Aboriginal families.

A broad understanding of the issues highlighted above is vitally important when considering the situation Aboriginal Australians find themselves in at the end of the 20th century. Both historically and from a clinical perspective loss is a recurrent theme. The loss of traditional lands with the disruption of kinship groups and

cultural associations has ongoing repercussions. Many Aboriginal people struggle for a sense of identity in a society from which they are marginalised. High levels of unemployment, disproportionate rates of incarceration, low average incomes, high rates of alcohol dependence and high rates of suicide, particularly among young men, are all characteristic of the current Aboriginal situation. In addition, the incidence of diabetes and heart disease is four times that of the general population and the life expectancy of an Aboriginal person is 20 years less than for the rest of Australia's population. Thus the loss of family and friends through early death from disease and suicide is also a relatively common experience among Aboriginal people.

On a more positive note, Aboriginal people have retained their strong family ties and networks. These can be great sources of support in times of need and help to retain a degree of identity among the chaos other changes have brought about. In addition, the emergence of Aboriginal community-controlled organisations in a number of fields in recent years reflects an increasing self-empowerment for a community that has been disempowered and dependent for so long.

Mental health of Aboriginal people

In very recent years there has been a growing interest among Aboriginal people themselves in mental health issues. Coming as they do from a traditionally holistic philosophy of life, mental health is seen in very broad terms encompassing spirituality, relationship with the land and social issues of particular concern such as domestic violence and alcohol and drug misuse. As a psychiatrist working with Aboriginal people, I have tried to focus my energies primarily on the diagnosis and treatment of psychiatric disorders. Working alongside a team of general practitioners and with a community mental health nurse and two Aboriginal health workers the focus has been the treatment of patients presenting with major depression, dysthymia, anxiety states and functional and organic psychoses. Drug and alcohol disorders are also addressed with the support of an Aboriginal drug and alcohol counsellor. This approach has been generally well received by staff, carers and patients. However, there are instances when it seems appropriate to offer assistance with individuals whose distress is situational in nature rather than strictly psychiatric. Nevertheless to take on the entire burden of these broader problems would be inappropriate and overwhelming. Other initiatives are required to address these issues.

Key issues

Although my nursing colleague and I have received no formal training in Aboriginal culture we have learnt a fair amount on the job through our colleagues and patients. We have therefore attempted to use our 'western' model psychiatry in which we are trained within the Aboriginal context while being as sensitive as possible to cultural issues. This approach seems to be reasonably successful. The placing of our service within an Aboriginal-controlled health organisation has undoubtedly increased its acceptability and also accessibility. Aboriginal health worker colleagues have effective networks within the community and are able to access homes which we could not. Their knowledge of the local community is invaluable in the day-to-day running of a service such as ours.

As a non-Aboriginal, I have had to learn to be flexible and adaptable in the way I practise. Rigid appointment systems are not feasible. Referrals are accepted from a wider range of sources than I am accustomed to – health workers, relatives, self-referrals as well as general practitioners. Follow-up within the community needs to be assertive but sensitive to cultural issues and the need for strict confidentiality in a community of fast and efficient communication networks. Finally, it is impossible to work in this setting without reflecting on the broader political and social issues which impinge upon the mental health of Australian Aborigines. The socio-economic deprivation that affects so many of their communities, the loss of traditional lands, the disruption of families through government intervention and persistent racist attitudes in main stream society are surely contributory to the high levels of psychological distress which are found in Aboriginal communities. It is encouraging that in recent decades the philosophy of self-determination has become more widely accepted so that Aboriginal-led organisations are able to make more decisions on behalf of their people in health and in other arenas. However in the last 12 months or so there has been very clear friction at the highest political levels in relation to the way forward over land rights and an appropriate response to the Wilson & Dodson report (1997). There is much talk in the media about reconciliation between Aboriginal and non-Aboriginal Australians and while there are some promising signs there are also indications there is still a long way to go before these major issues are resolved and Aboriginal Australians are able to find their place within Australian society. Until such progress has been made at the political and social levels it is difficult to see significant improvement in the high levels of psychopathology and psychosocial distress evident in Aboriginal communities

despite the best efforts of both Aboriginal and non-Aboriginal mental health professionals.

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Ethnicity: An Agenda for Mental Health

Edited by Dinesh Bhugra

This book sets the scene for identifying and meeting the mental health needs of black and minority ethnic groups. Clinicians, researchers, academics, hospital managers, commissioners and voluntary organisation workers come together to discuss the problems in health care delivery and the way of moving the agenda forward. In addition to multi-disciplinary working, the key emphasis here is in involving commissioners and voluntary organisations in deciding how best to meet the needs of the communities. It will be of interest to all mental health professionals including psychiatrists, trainees, nurses, occupational therapists, psychologists, social workers and health care managers.

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