Where The Past Meets The Future: A Role For Prevention In Aboriginal Mental Health?

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You steer the plane with both arms,
Sending it straight through the air.
Inside, what a noise!
We are nobody with all our cleverness,
Against the whitefellow.
He can read, and write, and sure enough,
Drive those big things in the sky -
Magic? He doesn't need it.
Our medicine men, the whole lot
Are utterly useless.

This Aboriginal song was recorded during a frenzy of economic expansion in the Pilbara. We might wonder at how European technology was received by people whose world of thoughts and things appear so manifestly different. Many of us presume that, confronted by the advantages and potency of European machines and consumer culture, traditional Aboriginal ontology collapsed, just as autonomy and their mobile subsistence seemed to give way to dependence and sedentariness. However, this denies that fundamental attribute of culture - adaptation.

In this paper I will focus on the difficulties and consequences of Aboriginal adaptation to institutional intrusion in Cape York. I begin with two cases of young Aborigines from remote Cape communities and will develop to a historical context to facilitate understanding behaviour that otherwise appears meaningless. I shall then address certain dimensions of mental health engagement and the beckoning but threatening domain of prevention.

Case 1
Eighteen year old Cathy was evacuated from an East coast community to Cairns following threats of harm to herself and her newly discovered pregnancy. She had arrived at the local clinic intoxicated and agitated, her cousin having killed himself the previous day. Two months earlier she had been admitted, complaining of "seeing things" and had been sedated, as happened on other occasions. Five months earlier she had been seen following a sexual assault by three men who remained in the community.
Cathy is the oldest of three children to parents who are both heavy drinkers. She was exposed to violence when young, particularly from her mother, her parents separating when Cathy was in her early teens. She was thought to have been sexually abused during childhood, was treated for syphilis by 13 and was pregnant soon after, miscarrying that pregnancy, but delivering her first child at 15, by which time she was drinking heavily, had begun to self-mutilate and was talking of suicide. Cathy attributed this behaviour to chaotic alcohol-associated behaviour in her home. Although quiet when sober, when intoxicated she was aggressive, provocative and taunting, for instance lifting her dress defiantly in public, behaviour considered affronting in the community. Cathy grew up in a house with 4 adults and 14 children and had never lived away from home. She attended school sporadically then worked in a CDEP position, but had been caught stealing on several occasions. Her income was $111 per week, a case of beer locally costing $200. The only stable figure in her life is her grandmother who cares for Cathy's son.

Case 2
Colin, from a West coast community, was 10 when referred. He weighed 2400 grams at birth, his mother drinking heavily during the pregnancy. Episodes of gastroenteritis and dehydration required several evacuations in his first year, during which he was adopted by an aunt. By this time his weight had fallen below the 5th percentile where it remained. His aunt related that he was a sickly but undemanding infant with normal developmental milestones. She felt his behaviour was unremarkable until a year earlier when he joined a group of older children and followed them into trouble, missing school, staying away overnight, getting into fights, talking back, swearing and lying. Other informants related that at 8 he had been sniffing petrol, was drinking soon after and had been found by the police in possession of marijuana. There have also been several break & enter charges. His teachers described aggressive behaviour that had increased in the previous year. His defiance included openly abusing and throwing stones at the police, and swearing at parents and step-parents in public, behaviour which was largely ignored. He had also been present with other youths during an aggressive sexual assault of a local teenage girl.

What does a psychiatrist have to offer for Cathy and Colin? Perhaps a diagnosis before flying on? Possibly suggestions reflecting psychiatry's urban bias? Confronted by the scale of problems and the limited resources in remote communities, are we simply impotent observers? Indeed, working as a psychiatrist in these communities, I am reminded of the typology - Perpetrators, victims and bystanders. By perpetrators I mean that health professionals should not presume to be outside of the historical process. As representatives of agencies and institutions that historically undermined Aboriginal cultural life, we are part of it. In the mid-80s, Gary Foley made this point while speaking to a meeting of academics during which a well-intentioned anthropologist was moved to ask: "Gary, what can we do?". After a brief silence came the cutting response: "I don't know mate - slit your bloody throat". I read his reply as an ironic statement; for Aborigines - Europeans can't be the solution of problems for which they're the cause. As health professionals we cannot be part of the solutions until we locate ourselves as part of the problem.

And victims? Most health professionals working with Aborigines are admirably motivated and do so by choice. While bearing no personal responsibility, they may
be held accountable by those who were the victims of past injustice. At times resentment may be manifest, more so where, historically, as in Queensland, health services were part of a particularly oppressive political system. In Cape York this has included assaults on health professionals in all of the remote communities that I visit. And in communities where behavioural problems are tenaciously resistant to the best intentions, health professionals may also be victims as idealism submits to fatalism. They are thus both part of this historical process, and victims of it.

And bystanders? Well, at least in Cape York, after several months working in remote communities a nurse learns to expect that the same damaged and brutalised individuals will present at the clinic during heavy drinking cycles. A woman who has been flogged is bandaged and sent back to the fray - usually at her insistence. In fact she has little choice. A sexually abused child is sent home for want of alternatives. A young man settling in hospital after an agitated drug-induced psychosis is given his return plane ticket. He probably will not make it past his stranded drinking countrymen on the fringes of Cairns. I know these cases well because I see them regularly - they pass me by. I am the bystander.

So, is this simply fatalism intellectualised? I hope not, but resisting is an active process requiring engagement and disengagement. By engagement I mean, simply, being there. Rather than some esoteric cultural knowledge, the primary requirement for working with Aboriginal clients is the willingness to sit down and communicate. This is neither complicated nor exotic. In this regard I believe that 'cultural sensitivity' is sometimes used as a rationalisation for espousing interest and eschewing involvement. By disengagement I refer to developing an intellectual frame that gives meaning to the confusing, resistant, and sometimes personally and professionally threatening situations in which those of us who work in Aboriginal communities will eventually find ourselves.

To exemplify let us return to the two cases. A psychiatrist might venture to diagnose Cathy as a borderline personality disorder and Colin as an unsocialised aggressive conduct disorder, an incipient sociopath. However, if we were to take this course we would probably have to diagnose a substantial proportion of their peers as having a psychiatric disorder. For instance, in one of these communities in a recent year, the majority of adult males and all those between twenty and thirty were arrested at least once. At that time school attendance averaged less than 25%. In such settings behavioural 'disturbance' and risk factors operate on the population level - all are impacted in some way, usually from very early on. Visiting this same community in early 1994, health records revealed that of the 78 children born between 1990 and 1993, less than one third were above the third percentile for weight. None were above the tenth.

Nature or nurture? Certainly the latter if nurture is understood to encompass the social environment. But, "social factors" should not be confused with culture. Failure to thrive signifies a child in need, not an Aboriginal norm. Indeed, while mental health professionals claim a broad analytic frame, their vision remains pathology and client-focused, reflecting culturally-informed norms. To move from diagnosing to understanding Cathy and Colin we must have some familiarity with the world that shaped them. While I do not presume to be a cultural expert, I have access to historical material about the Aboriginal post-contact experience which, I contend,
powerfully informs the behaviours that are construed as 'deviance' and 'disorder'. So, what can we know of their world?

Cathy and Colin were born within a decade between the mid 1970s and 80s. Their mothers, who I shall refer to as Mable and Mary, were probably themselves born at the beginning and end of the 1960s, a time when the winds of change were freshening, the twilight of an era of rigid institutional control that began some six decades earlier with the setting up of the system of reserves that followed from the 1897 Aborigines Protection and Restriction of Sale of Opium Act, legislation which not only had enduring impact in Queensland, but was taken as a model elsewhere, for instance the 1905 Aborigines Act in Western Australia. This was the beginning of paternalistic legislative control over all Aborigines with absolute discretionary power over their children vested in the newly created position of Protector of Aborigines.

While the legislation was often amended, through these pupations the chrysalis stubbornly resisted change, State control of Aboriginal lives persisting despite Labor and Liberal Federal government opposition from the 1960s, particularly around land rights. The continuity of policy was paralleled by the tenacious inertia of bureaucracy. Between 1913 and 1986 the senior Queensland public service position in this field was held by only 3 men: JW Bleakley, who recommended a system of reserves to support a settled Christian social ideal, Con O’Leary and Pat Killoran.

Soon after the Second World War Elie Cohen wrote about the absolute institution that was the concentration camp universe, where norms and values were inverted in the collapsed world of total control. Aborigines on the reserve settlements of Cape York were trapped in a 'reserve system universe' that developed into a co-ordinated complex. Remote reserves isolated, contained and set about civilising. In others, such as Yarrabah, were collected mixed descent Aborigines, usually young, with whom the assimilation project was more vigorously pursued. There were holding centres, such as Palm Island, for Aborigines considered beyond the lofty aims of the project or threatening it, and yet others such as nearby and aptly named Phantom Island, to which were condemned the ultimate victims, Aborigines suffering from introduced contagions. Total institutional control was thus exercised regionally and on a community level, Cape York being ideally isolated. Of fourteen designated reserves in Queensland twelve were north of Townsville and nine were in Cape York itself.

These missions were the front-line of directed social change, beginning with the London Missionary Society in the Torres Strait in 1871, taken over by the Anglicans in 1915, with Cape Bedford (Hope Vale) and Bloomfield River (Wujal Wujal), both Lutheran, beginning in 1885 and 1886. A Moravian, later Presbyterian mission was begun at Mapoon in 1891, at Weipa in 1898, and at Aurukun in 1904. Anglican missions were formed at Cape Grafton (Yarrabah) in 1891, Mitchell River (Kowanyama) in 1905, Cowal Creek (Injinoo) in 1923, Lockhart River in 1924, and Edward River (Pormpuraaw) in 1936.

On the missions superintendents had absolute power, which under the 1897 Act and its successors to 1971, included deciding the best interests of children, often dormitory segregation or removal. Indeed, Noel Loos suggested that such separation was the principal aim of missions in the service of civilising and Christianising.
Those who took this role upon themselves were clearly committed - and persistent. William MacKenzie and Joseph Chapman were superintendents of Cape York missions for 43 years apiece.

The missions arrived at a time of massive Aboriginal population decline and redistribution. Indeed, the most important consequence of the mission/government association was centralisation and concentration. This is not to suggest that this relationship, which ultimately was one of necessity, was always harmonious. It was not, but the voice of pastoral protest was subdued, both because the social agendas were consistent and because the missions were, regardless, reliant on the government for funding. In a sense the power of the missions was an illusion which dissolved in the face of policy. For instance they had little effect in resisting later government instigated removals including Hope Vale, Mapoon and Lockhart River.

So, the mothers of Cathy and Colin grew up subject to discriminatory laws that still restricted movement, residence, alcohol consumption, education, partner selection and income, with specified punishment for offences against the Act. During their childhood, Mable and Mary probably spent time in dormitories. Such mission intrusion into the domain of childcare was ultimately destructive, Maggie Brady commenting that: "missionaries were not experienced in parenting, in relationships between spouses, in providing realistic models for those in their care". Although inexperienced, administrators privileged their standards of family structure and function. To the extent that change has been enduring it has been functional rather than structural and generally negative. For instance, the mean age at first live birth in one community, which was around 18 in the early mission days, by the mid-60s, at the height of mission control had increased to 21. Since the withdrawal of mission control the average age at first birth has returned to that of pre-mission times. However what has not necessarily returned is the integrity and functionality of families in which parents are responsible for child nurture and socialisation. Missionaries saw fit to sever the nexus of Law and land and to introduce systems of child socialisation based on rigid discipline that inevitably undermined traditional parental roles.

This was the probable childhood world of the mothers of Cathy and Colin and, of course, also of their fathers. However, while subject to the same legislation, there were differences in intent. For instance, comments at the 1937 State Protectors and Commissioners meeting in Canberra are telling. Specially designated reserves were recommended for those thought capable of "uplifting themselves" from the: "'inferior' type whose 'bloodcall' and tendency to revert to their mother's primitive ways were too strong", Daniel Craig pointing out that it was inconceivable to White policy-makers that a European woman could have a child to an Aboriginal man. Indeed, the idea of an Aboriginal man with a European woman could be conceived only as rape which, despite its rarity, was fabricated or sensationalised in the colonial Queensland press and used as a pretext for further violence against Aborigines, as well as Kanakas and Chinese.

The historical disempowerment of Aboriginal males in the intercultural domain has had consequences for relationships between Aboriginal men and women. Not only did some women have a degree of social mobility not available to men, but male roles in the sacred and economic domains were compromised by the suppression of
traditional lifestyles. Aboriginal women now generally receive more income than men due to their maternal role within the welfare economy. As a consequence, men are frequently economically doubly dependent - on the state, and on women. In the context of heavy drinking these tensions predispose to violence which, at least until recently, has almost exclusively been directed intraculturally. In the communities under discussion, as sly grog supplies and binge drinking escalated in the 1970s, patterns of violence and social disorder increased. The fathers of Cathy and Colin would have been adolescents and young men then, a time of confusion regarding appropriate adult roles during which, as David Martin points out, youths: "grew to maturity in a world where most older men essentially played little direct part in rearing them, and where there was no formal, socially legitimated means by which they were removed from the indulged world of women".

The availability of young men as fathers in heavy drinking settings is further compromised by alcohol-related premature mortality and morbidity, enormous rates of arrest and detention, absence from families in pursuit of alcohol, and the dysfunctionality of intoxication. As Basil Sansom points out, fatherhood may be "contingent", the domestic unit serially reconstituting around a central female figure, the "concertina household". The consequences for the construction of male identity should be obvious.

Perhaps the most important difference between the lives of the parents under discussion, Mabel, Mary and their partners, and the two individuals presented for psychiatric opinion, Cathy and Colin, lies in their experiences of socialisation. In this regard alcohol has loomed large. The parents’ first encounter with widespread alcohol-related problems would have been in adolescence. Their parents would have had no precedent for dealing with these situations, having lived most of their lives under the controlling paternalism of the mission panopticon. By contrast, for Cathy and Colin, alcohol-affected uninhibited behaviour would have been expected if not accepted adult behaviour, perhaps punctuating the dulled rhythms of community life.

These tensions are amplified in remote communities by the built environment. Mission and government settlement layout was dictated by bureaucratic expediency. Overcrowding in grossly substandard housing remains the norm. Populations have expanded and their structure changed as falling infant mortality rates through the 1970s increased the ratio of youth to adults. In addition to population density, concentration and sedentariness challenged the constraints of traditional social structure, adding further complexity and ambiguity to what David McKnight calls "relational density", a factor he suggested as contributory to patterns of violence in the nearby ex-mission community of Mornington Island.
So, is our understanding of Cathy and Colin any clearer? We can see that they were born into an environment of uncertainty as restrictions were lifted from their parents and grandparents whose world, consequently, careered sharply to accommodate a range of new responsibilities and rights. At that time suppressed inter-cultural tensions and resentments emerged, and were amplified by freely-available alcohol, but expressed largely intra-culturally and within the family. Cathy and Colin grew up with normative instability and witnessed the expansion of this resentment to include non-Aboriginal groups and institutions as the expectations of their parents have remained unrealised. Rather than being unsocialised they have been thoroughly socialised by environments in which young adults construct their social identity through themes of separateness, difference, and the rejection of expectations and norms that remain experienced as imposed. In the confines of small but densely populated settlements in which any disturbance reverberates, the ability of children to develop coping mechanisms is limited and has not been substantially helped by the formal systems of health, justice or education. Indeed, they often submerge their personal pain in behaviour, including drinking and violence, that emulates that of their peers and young adults, and which invites response or censure mainly from non-Aboriginal professionals. The apparent lack of intracultural controls might reflect traditional constraints on disciplining children or the undermining of traditional means by decades of institutionalisation. However, it might also be understood as resulting from identification by the adults with youths whose behaviour articulates the grievance and distress of all.

So, I return to professional roles. The majority of non-Aboriginal professionals who work in remote Cape York communities are there briefly, moving on when their contract or idealism expires. Perhaps not universally the case across remote Australia, but probably not uncommon. Mental health professionals are new and fleeting shadows. By and large their roles are limited to chronic mental illness and crises which, of course, are important roles - Aborigines deserve, but still do not have, equal access to appropriate services. But clients such as Cathy and Colin challenge in a very different way - they confront us with our impotence. They are where they are in large part because of white professionals and their anger towards us, who have inherited the mantle of administrator and protector, is close to the surface. The problems are entrenched, generation wide and reinforced by a social context that:

- amplifies the tensions through concentration and crowding in conditions of poverty;
- has already compromised traditional homeostatic mechanisms through dislocation and undermining adult social roles;
- restricts the conventional means to redress those factors through a failure to provide functional educational or employment opportunities;
- stifles dissonance by ensuring dependence on direct or indirect government transfers; and,
- lubricates the whole system with alcohol, the proceeds of which rapidly return to the non-Aboriginal economy.
Consequently we are almost inevitably saddled with interventions that are superficial. How is it possible to move beyond this veneer? Is there scope for prevention?

Primary prevention is integral to the conceptions of well-being associated with the New Public Health. The biopsychosocial orientation of psychiatry would seem suited to that project, particularly given the WHO's well known social construction of health that is echoed in the Ottawa Charter for Health Promotion and, ultimately, in the Australian mental health statement of rights and responsibilities in which good mental health is "the capacity of the individual and the group to interact effectively with the environment."

In Australia, prevention has been embraced as a goal in the National Mental Health Policy. The scale of the problem for Aboriginal health is suggested by the conditions and resources considered fundamental for health in the Ottawa Charter, these being: "peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity". Need it be said that Aborigines are disadvantaged in all these areas, or that they suffer rates of morbidity and mortality frequently compared with 'Third World' populations? An often invoked but problematic comparison. As Powles notes, Aborigines are, rather: "an extremely disadvantaged 'underclass' with greatly amplified rates of the major diseases responsible for inequalities within the white population". By being so disadvantaged indigenous Australians, as a group, are more likely to encounter multiple risk factors and to have access to fewer sources of resilience. They are also less likely to benefit from conventional prevention measures.

It is no surprise then that Aborigines are at greater risk of mental health problems, or that social change is repeatedly identified as a precondition for sustained improvement. Here is the sting: While social change is necessary to primary prevention in mental health, and while mental health professionals may well contribute analysis, directing social change per se is not within their province. Indeed, mental health professionals working with indigenous populations will find defining a role in prevention difficult. They will function amid rapid change and must have an understanding of its precursors and consequences, particularly for children and families. Paradoxically, this is the same domain that historically was the locus of institutional intrusion. Clearly we have no right to demand let alone impose. We can only advise, in full consciousness of a long history and continuing legacy of well-mean but ill-fated interventions.

Acknowledging these caveats, as a clinician working in remote communities, my time is largely consumed dealing with crises and serious mental disorder. But one is inevitably drawn into activities with individuals that have as their aim primary prevention. However, is it possible to proceed systematically? I'm not sure, but if so, two levels need be considered, the first political and the second practical.
The political issues are many. Before presuming competence in this field we must acknowledge and rectify our abysmal record in providing basic clinical services to those for whom our professional role is probably clearest - indigenous Australians suffering from psychiatric disorders. In other words, before anticipating acclaim for primary prevention we should demonstrate competencies in secondary and tertiary prevention. Furthermore, while believing primary prevention to be important we must also be alert to the possibility of unforeseen and negative outcomes which are all the more likely in contexts with which our own cultural background is not congruent. As these preventable conditions largely reflect social factors, interventions must be informed by a recognition of them, and by an awareness of local circumstances and intercultural dynamics.

There are more obvious political issues. The same ethical guidelines should be adhered to as apply to research, particularly as we usually arrive as representatives of institutions with limited indigenous input. We should change that and work through Aboriginal organisations in community controlled projects. We should also recognise that the social and political values that inform our analyses may not be shared by Aborigines. Consider unemployment, which we usually consider a risk factor. But:

Such time might be experienced as no more than a depressing idleness - Tim Rowse notes - on the other hand it may be one of the richest resources of a materially poor people, the opportunity to pursue an Aboriginal sociability in which the connections among kin and friends are maintained in their amicable density. Perhaps.

And so to practical considerations, in the foreground of which is the paucity of reliable information which suffers from the same shortcomings identified in studies of native Americans: poor denominator data; cultural factors in defining problems; and, reliance on inadequate sources of information. However, intervention should not be deferred for want of baseline studies, the need is too urgent. These activities should proceed apace.

Acknowledging these historical and political issues, prevention demands attention to the environment of childhood. The risk factors that disproportionately impact Aboriginal children in Cape York begin early, persist through childhood, are usually multiple and interacting. Mental health problems in remote Aboriginal Australia are overdetermined, the indicators many and manifest, at least for those that wish to see. Consider, in the United States since the mid-80s schools and agencies have been mandated to develop strategies for nine categories of youth presumed at risk for substance abuse:

1) Children of substance abusers;
2) victims of abuse;
3) school dropouts;
4) pregnant teenagers;
5) economically disadvantaged youth;
6) delinquent youth;
7) those with mental health problems;
8) suicidal youth; and,
9) those with disabilities.

Of the Aboriginal children such as Cathy and Colin with whom I work, most belong to many of these categories. Not only is risk widespread, the multiplicity of factors overwhelms sources of resilience. That Colin was adopted by a stable family was not sufficient, for him, to overcome the burden of other risk factors. Equally clearly, not all children succumb and we need to explore what influences the shifting balance between stressful events that heighten vulnerability and protective factors that enhance resilience.

These realities suggest some general principles. For the sake of this discussion I am focusing on those behavioural outcomes which are ultimately self-defeating and which in a non-Aboriginal population would attract diagnoses such as conduct, personality or substance-abuse disorders. Interventions will be more effective to the extent that their focus is early, including prenatally. Within that group they should be universal rather than selective and should aim both to reduce the burden of risk and to support resilience. Consequently there is an urgent need for work that focuses on adaptation rather than pathology in order to elucidate predictors of resilience.

If primary prevention is to target children and families, it must be linked with effective approaches for dealing with substance abuse. Not only is functional access to appropriate treatment services a necessary prerequisite there must be specific programs, which may mean drawing on the experience of other indigenous populations and supporting innovative Aboriginal approaches. It will also mean accepting the failure of some ventures. Whether alcohol is considered a cause or consequence of psychological and social problems in Aboriginal communities, for instance child abuse, any intervention that does not incorporate an effective substance abuse strategy, is doomed.

Given the historical issues, if the locus of action is the family, interventions should be culturally informed, locally adapted, and community initiated and driven. The outcomes, necessarily long term, need to be widely defined, relevant to local circumstances, and linked to realisable and desirable opportunities with the provision of skills to access them. This must include major gains in educational outcomes. Long term interventions are also long on cost. Can we afford to fund projects of unproven effectiveness? The question might reasonably be turned around: Can we afford not to? The burden of substance abuse and behavioural disorder among young adults in Cape York is increasing and the impact on their children may be even greater. Cost is unavoidable, the question is whether it is upstream or downstream. If upstream, it should be predictable and recurrent, demanding bipartisan political support. Mental health professionals may thus have an important advisory role, but must be willing to work across disciplinary lines. They must accept being consultants, not captains.
Finally, even when working on a population level we should not lose sight of the individual. While a historical overview adds to our understanding of Cathy and Colin as members of a particular group, that contextualisation does not predict the future for them. The most we can say is that their future is uncertain. Their decisions and choices may be limited by their social disadvantage, and may seem to compound it. But in every instance they will be attempting to adapt, and their decisions will be meaningful and purposeful. We need to engage on this level, with individuals who have personal histories and private tragedies. Only by so proving our worth, as clinicians and teachers, can we presume a wider role. We must also interrogate our own assumptions and how these inform our social analyses. If we are to help the children of the Colins and Cathys in remote Aboriginal Australia look to the future, we must be aware of their past and attentive in the present. The last words are from Jack Davis' poem, "Slum dwelling".

Big brown eyes, little dark Australian boy
Playing with a broken toy.
This environment is his alone,
This is where a seed is sown.
Can this child at the age of three
Rise above this poverty?