

# Chapter 1

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# Chapter 1

## THE SURVEY – OBJECTIVES, DESIGN AND PROCESS

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*The Western Australian Aboriginal Child Health Survey was undertaken in 2000 and 2001 by the Telethon Institute for Child Health Research. The survey provides an epidemiological knowledge base of the health and wellbeing of Western Australian Aboriginal and Torres Strait Islander children. From this knowledge base, preventive strategies can be developed to promote and maintain healthy development and the social, emotional, academic, and vocational wellbeing of Aboriginal children and young people.*

*This volume reports on the social and emotional wellbeing of Aboriginal children and young people, particularly protective and risk factors that shape the development of both their physical and mental health. In this chapter, issues of defining mental health and mental health disorders in Indigenous populations are discussed in order to provide the context for the detailed findings which follow.*

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### SUMMARY

- ◆ The primary objective of the Western Australian Aboriginal Child Health Survey (WAACHS) was to identify the developmental and environmental factors that enable competency and resiliency in Aboriginal children and young people aged 0–17 years.
- ◆ The survey describes the population of families with Aboriginal children under the age of 18 years. Data were collected for 5,289 eligible children.
- ◆ An Aboriginal Steering Committee has directed the planning, implementation and reporting of the survey. The survey content and processes were developed in consultation with Aboriginal leaders, key Aboriginal bodies, and through extensive consultations throughout the state with Aboriginal community councils, parents and key service providers.
- ◆ The Institute for Child Health Research (ICHR) is home to the Kulunga Research Network – a collaborative maternal and child health research, information and training network. The Kulunga Research Network is an advocate for Aboriginal children and families in Western Australia and is developing additional materials from the survey for Aboriginal readers.
- ◆ An index of Level of Relative Isolation (LORI) has been specifically developed for use in this survey. LORI allows greater discrimination of the circumstances of survey respondents with respect to their isolation from population centres of various sizes and helps to better differentiate between respondents in areas and communities that are extremely isolated from those in major metropolitan centres.



**SUMMARY** *(continued)*

- ◆ There has been a meagre epidemiological base, both within Australia and internationally, from which to draw conclusions about the scope, prevalence and burden of mental health problems in Indigenous children. From information that is available, the prevalence rates of emotional and behavioural problems in Indigenous populations are, in all likelihood, higher than in the majority populations.
- ◆ Population studies of Australia's Aboriginal people to date have largely focused upon Aboriginal and Torres Strait Islander people aged 18 years and over. Relatively few data are available from which to describe the current social and emotional circumstances in which young Aboriginal people live and develop.

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## THE TELETHON INSTITUTE FOR CHILD HEALTH RESEARCH

The Telethon Institute for Child Health Research (ICHR) is a centre of excellence for the conduct of research into child health. Founded in 1987, the Institute's research programs include the study of asthma and allergic diseases, birth defects, child and adolescent social and emotional wellbeing, childhood death and disability, leukaemia and other cancers, as well as Aboriginal health and infectious disease.

The Institute's mission is to improve the health of children through the development and application of research into:

- ◆ causes of ill health
- ◆ the maintenance of good health
- ◆ prevention of ill health
- ◆ the treatment of conditions affecting children.

The Institute is the home of the Kulunga Research Network – a collaborative maternal and child health research, information and training network, involving the ICHR and member services of the Western Australian Aboriginal Community Controlled Health Organisation (WAACCHO). The Kulunga Research Network is an advocate for Aboriginal children and families in Western Australia. The Network seeks to ensure that community-based and culturally relevant research benefits Aboriginal people by influencing the policy and planning of government and other key agencies, and by involving Aboriginal people in all areas of research and implementation of outcomes. The WAACHS was a project of the Network.

## SURVEY OBJECTIVES

The survey's primary objective was to identify developmental and environmental factors that enable competency and resiliency in Aboriginal children and young people. There was emphasis on defining priority targets for existing and future health, education and social services. Building an epidemiological knowledge base from which preventive strategies can be developed to facilitate the social, emotional, academic and vocational competency of young people was a notable feature of this survey.

The specific aims of the survey were to:

- ◆ describe and define the health and wellbeing of Western Australian Aboriginal and Torres Strait Islander children and young people aged 0–17 years
- ◆ estimate the prevalence and distribution of commonly occurring chronic medical conditions and disabilities (e.g. asthma, cerebral palsy, visual and hearing impairments, intellectual disability) and describe how they may affect a child's wellbeing and functioning
- ◆ estimate the prevalence, distribution and functional impact of common physical health and social and emotional problems in Aboriginal children and young people aged 0–17 years and their families
- ◆ estimate the prevalence and distribution of adverse health behaviours (e.g. smoking, alcohol, drug and volatile substance misuse)



- ◆ estimate the prevalence and distribution of other psychosocial problems, such as early school leaving, conduct problems, and juvenile offending
- ◆ describe Aboriginal and Torres Strait Islander children, adolescents and their families' access to, effective use of, and satisfaction with health care, education, juvenile justice, housing and social services
- ◆ identify factors resulting in protection from poor health and wellbeing, adverse health behaviours and other psychosocial problems
- ◆ develop estimates of risk and markers identifying Aboriginal and Torres Strait Islander children and young people at increased risk for various health, educational and vocational outcomes.

## SURVEY CONCEPT AND DEVELOPMENT

The concept of gathering child health and wellbeing information from families with Aboriginal and Torres Strait Islander children was first proposed in 1991 during the development of the Western Australian Child Health Survey. However, for reasons owing to scale, cost, and expertise, families with Aboriginal children were principally excluded from this earlier survey. The Telethon Institute for Child Health Research undertook to reassess the feasibility of conducting an Aboriginal Child Health Survey following the conclusion of the original Western Australian Child Health Survey. The assessment of the feasibility, design and scope of the Western Australian Aboriginal Child Health Survey (WAACHS) was subsequently undertaken between 1996 and 1999.

Survey methodology and instrumentation were developed in consultation with Aboriginal leaders, key Aboriginal bodies (the Aboriginal and Torres Strait Islander Commission regional council, the Aboriginal Council of Elders, the Aboriginal Justice Council, and WAACCHO), and through extensive community consultations throughout the state. A survey project team, reporting to an Aboriginal Steering Committee, had basic carriage of securing funding, developing the survey instruments, and implementing the fieldwork.

The Australian Bureau of Statistics (ABS) was a principal provider of consultancy services, expertise and support through all phases of survey development, implementation and analyses. Efforts were made to ensure that the data collected are both scientifically relevant and pertinent to current government information needs and policy initiatives. To do this, reference groups were convened during 1997–1998 with representation from the various government departments and community agencies that had an interest in the outcome of the survey findings. This process involved senior policy input from the Western Australian Government Departments of Health, Education and Training, Community Development and Police; the Alcohol and Drug Authority; the Disability Services Commission; the State Housing Commission; the Catholic Education Office of Western Australia; and the Association of Independent Schools of Western Australia. Commonwealth Departments were also consulted to advise on policy needs and were asked to specifically comment on content and design of the survey.



## ABORIGINAL DIRECTION

All phases of the survey and its development, design, and implementation were under the direction of the Western Australian Aboriginal Child Health Survey Steering Committee. Established in 1997, the Steering Committee had the responsibility to control and maintain:

- ◆ cultural integrity of survey methods and processes
- ◆ employment opportunities for Aboriginal people
- ◆ data access issues and communication of the findings to the Aboriginal and general community
- ◆ appropriate and respectful relations within the study team, with participants and communities, with stakeholders and funding agencies and with the governments of the day.

## COMMUNITY CONSULTATION AND APPROVAL

The survey represented a large undertaking involving extensive household sampling and voluntary participation in the survey of many Aboriginal and Torres Strait Islander people across Western Australia. Seeking support and approval for the survey required establishing an extensive and ongoing process of consultation. Repeated consultations were undertaken during 1998 and 1999 with specific visits to Aboriginal communities in Albany, Bunbury, Broome, Carnarvon, Collie, Derby, Esperance, Fitzroy Crossing, Geraldton, Halls Creek, Kalgoorlie, Karratha, Katanning, Kwinana, Kununurra, Narrogin, Perth, Pinjarra, Port Hedland, and Roebourne. Every attempt was made to engage participation of community leaders, community councils, administration staff, service providers, and local residents in discussing their views about the need for the survey and to request their approval to be included in the survey. People were asked about the methods and processes that they felt would assist or hinder the success of the survey, their requirements with respect to specific survey content, their expectations about the use of the survey data, and intended outcomes.

The initial community consultations for the survey established that most participating carers and young people expressed a preference for the survey to be written and administered in English. The precise wording of survey questions was kept as simple as possible. The survey materials presented in this format were assessed in the pilot test and dress rehearsal and found to yield reliable and valid information for all but the most isolated and culturally intact Aboriginal communities where there was a high level of traditional language use. In these communities, the majority of (but not all) families chose to be interviewed with the assistance of an Aboriginal language translator employed through the local community council or Aboriginal Medical Service.

Approval for the survey was also obtained from WAACHO, the Western Australian Council of Elders, the Aboriginal Justice Advisory Committee and the Aboriginal and Torres Strait Islander Commission (ATSIC) State Council.



## ETHICAL APPROVAL FOR THE SURVEY

This project met the requirements of, and was approved by, the Western Australian Department of Health's Aboriginal Health Information and Ethics Committee as well as the Ethics Committee of King Edward Memorial and Princess Margaret Hospitals. These clearances ensured that the survey process and procedures conformed with requirements and protocols for health research with Aboriginal people and that they adhered to National Health and Medical Research Council (NHMRC) ethical standards and guidelines for research with human subjects.

## ABORIGINAL IDENTIFICATION AND THE SCOPE OF THE SURVEY

The survey was based on an area sample of dwellings (see *Glossary*). Families in selected dwellings who reported that there were 'Aboriginal or Torres Strait Islander children or teenagers living at this address who are aged between 0 and 18 years' (see *Indigenous status* in *Glossary*) were eligible to be in the survey.

Children living within group homes, institutions and non-private dwellings were not in the scope of the survey. However, where a selected household had a child temporarily living away from home (e.g. in a boarding school or hostel), these children were included in the scope of the survey.

Once the authority for the survey and the nature of the survey was explained to a responsible adult (usually the carer(s) or head of the household), and consent to participate was obtained, Aboriginal status was determined for each person who was reported to usually live in the dwelling by asking, 'Does (the person) consider him/herself to be of Aboriginal or Torres Strait Islander origin?' Data were gathered on all Aboriginal and Torres Strait Islander children under the age of 18 in each of the participating households.

### TERMINOLOGY

Throughout this publication the term 'Aboriginal and Torres Strait Islander peoples' has been used as the most precise and inclusive reference for Aboriginal Australians. This is the form recommended by ATSIC for use in official documents. Where other group terms such as Aboriginal people have been used, it should be noted that this is intended to refer to Aboriginal and Torres Strait Islander peoples.

## THE SURVEY POPULATION

The terms 'children' and 'child' for this survey refer to persons under the age of 18 years at the time of the initial interview.

For purposes of analysis and presentation of the findings, they are further grouped into the following age groups:

- ◆ 0–3 years
- ◆ 4–11 years
- ◆ 12–17 years.



## SURVEY OUTPUTS AND COMMUNITY FEEDBACK

This is the second volume of results from the WAACHS. Volume One was published in June 2004, and is available from the ICHR web site: [www.ichr.uwa.edu.au](http://www.ichr.uwa.edu.au). After this volume, three further volumes of results are planned. These volumes will focus on education, family and community, and justice issues. A summary booklet for each volume will be produced. As well, there are plans to write a number of research papers and professional journal articles based on the findings of the survey.

A communication and dissemination strategy has been designed to maximise knowledge and awareness of the findings to both the Aboriginal and wider communities. The strategy, driven by the Kulunga Research Network, aims to engage Aboriginal communities in committed action using the data as a catalyst for political and community action and social change. The data results and findings are being reported and profiled for each of the ATSIC regions throughout the state.

ATSIC regional profiles have been produced for each ATSIC region in WA based on results published in Volume One of the WAACHS findings. These have been disseminated throughout the regions during consultation and feedback visits that have been conducted in every ATSIC region. This process will continue with each subsequent volume. The results published in each main volume will guide the production of community information resources which will be followed by the conduct of an extensive series of meetings, workshops and seminars in each ATSIC region to inform and educate survey participants and Aboriginal communities in general about the survey findings.

## LEVEL OF RELATIVE ISOLATION

### MEASURING ACCESS TO SERVICES

A new classification of remoteness and isolation – the Level of Relative Isolation (LORI) – has been used in the WAACHS. The LORI is based on a product from the National Key Centre for Social Application of Geographic Information Systems (GISCA) at Adelaide University, called ARIA++. The ARIA++ is an extension of ARIA (the Accessibility/Remoteness Index of Australia), which has been widely adopted as the standard classification of remoteness in Australia. Because ARIA is based on describing the entire population of Australia, it has not been specifically designed to describe the circumstances of Aboriginal people living in remote areas. The ARIA++ gives a more detailed description of the most remote areas of Australia by including more service centres, of smaller sizes, in calculating the remoteness scores.

Under the original ARIA, over two-thirds of the land mass of WA, and over one quarter of Aboriginal people in WA live in areas classified as ‘very remote’. However, WAACHS data have revealed that, within this group, there were marked differences in access to basic services, cultures, lifestyles and health outcomes. The greater detail of ARIA++ enables these differences to be more adequately described in the Aboriginal population.

The Australian Bureau of Statistics has incorporated a measure of remoteness into the Australian Standard Geographic Classification (ASGC). The five ‘Remoteness Areas’ are based on ARIA+ and differ slightly from the original ARIA categories. However the Remoteness Areas have been defined to describe the total population of Australia, and the ‘very remote’ remoteness area is quite similar to the area defined as ‘very remote’ in the original ARIA.



## ILLUSTRATING THE DIFFERENCE BETWEEN ARIA AND ARIA++

As an example of the difference between ARIA and ARIA++, the town of Halls Creek in the East Kimberley – population about 1,300 people – is classified as ‘very remote’ under ARIA. However, it has a 4-bed hospital facility which provides health services to the town and communities throughout the surrounding region. One of those communities, Yiyili, about 120 kilometres east of Halls Creek, has a population of around 250 people. The Halls Creek Health Service provides a weekly community nursing clinic in the Yiyili community. Under ARIA’s 12 point remoteness scale, both Halls Creek and Yiyili receive the maximum score of 12 (‘very remote’).

Under ARIA++, which has an extended 18 point remoteness scale, Halls Creek receives a score of 12 and Yiyili receives a score of 18. Compared with major capital cities, both Halls Creek and Yiyili would be regarded as small places with limited access to services. However, analysis of WAACHS data has shown that the difference in isolation between Halls Creek and Yiyili is reflected not only in different access to basic services, but also in a different level of adherence to traditional cultures and languages, and different health outcomes.

## LORI CATEGORIES

Based on the ARIA++ scores, five categories of isolation have been defined to more appropriately reflect differences in cultures, access to services and health outcomes for Aboriginal children. To avoid confusion with the original ARIA, the five categories are referred to as Levels of Relative Isolation (LORI) and range from None (the Perth Metropolitan Area) to Low (e.g. Albany), Moderate (e.g. Broome), High (e.g. Kalumburu) and Extreme (e.g. Yiyili).

Figure 1.1 shows the proportion of Aboriginal children under 18 years in each LORI category. While one quarter of Aboriginal children in WA live in areas classified as ‘very remote’ in the original ARIA, only 9.5 per cent (CI: 6.8%–12.7%) of children live in areas of extreme relative isolation.

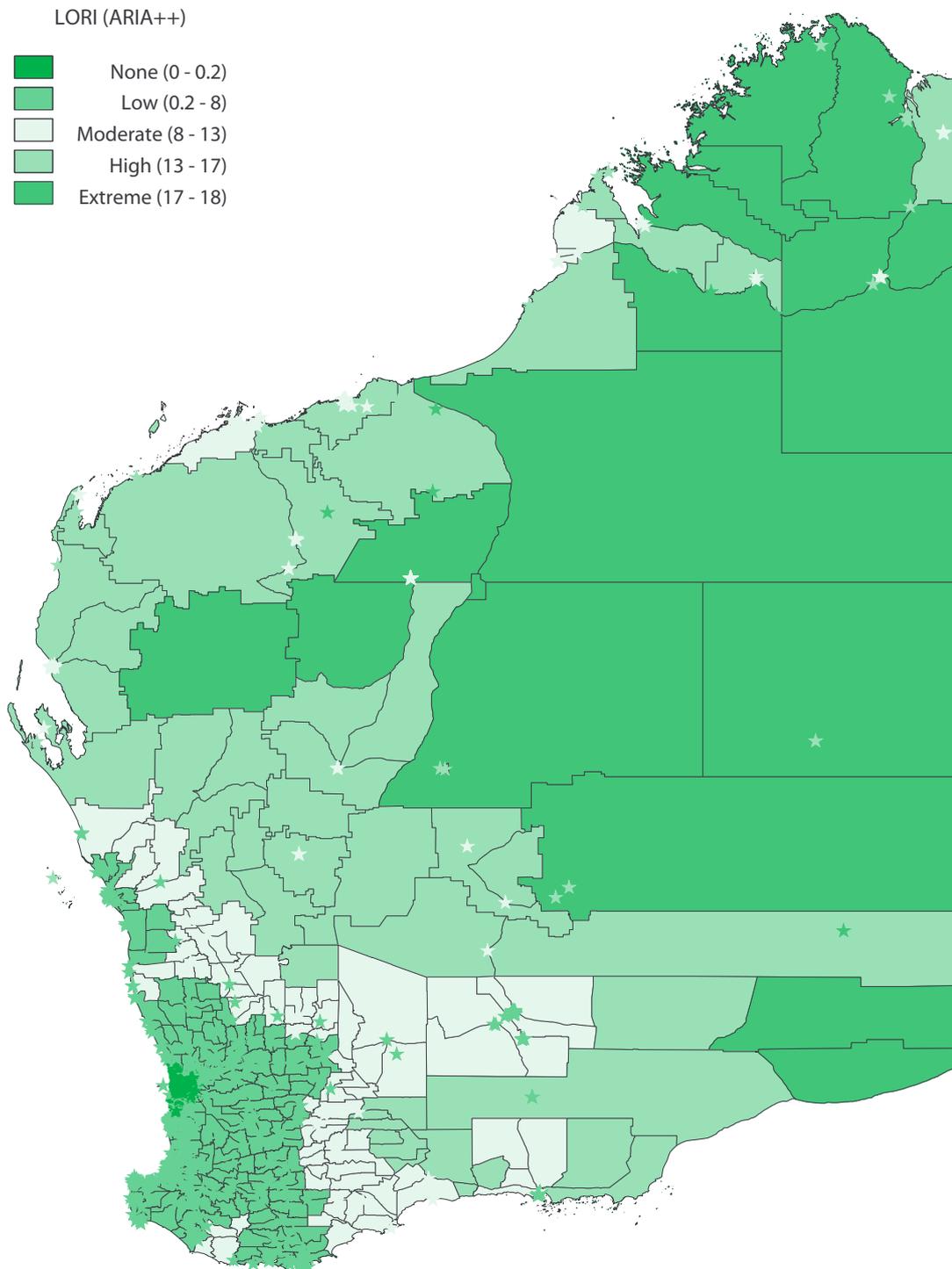
Figure 1.2 illustrates the five LORI categories for Western Australia. This map is based on 1996 Census Collection districts, which were used as the sampling frame for the WAACHS. An important feature of the LORI categories is that, except for LORI none which is virtually identical with the Remoteness Area ‘Capital City Australia’ from the original ARIA, each area is more remote than the equivalent point on the ARIA scale. Areas classified as ‘very remote’ under the original ARIA can be classified as moderate, high or extreme on the LORI scale.

**FIGURE 1.1: ABORIGINAL CHILDREN AGED 0–17 YEARS, BY LEVEL OF RELATIVE ISOLATION (LORI)**

LORI	Number	95% CI	%	95% CI
None	10 200	(10 000 - 10 400)	34.1	(31.5 - 36.8)
Low	7 270	(6 640 - 7 930)	24.4	(21.8 - 27.0)
Moderate	6 390	(5 400 - 7 420)	21.4	(18.1 - 25.1)
High	3 170	(2 360 - 4 160)	10.6	(7.9 - 14.0)
Extreme	2 830	(2 040 - 3 800)	9.5	(6.8 - 12.7)
<b>Total</b>	<b>29 800</b>	<b>(29 800 - 29 800)</b>	<b>100.0</b>	



**FIGURE 1.2: WESTERN AUSTRALIA — LEVEL OF RELATIVE ISOLATION (LORI) CATEGORIES BASED ON ARIA++ VALUES**



## INDIGENOUS CONCEPTS AND DEFINITIONS OF MENTAL HEALTH

Perhaps in no other circumstance is the unity of mind, body and place more vivid than when attempting to define mental health in Indigenous populations. Researchers face formidable challenges given the cultural and linguistic diversity within the Australian Aboriginal population and the totality of the Indigenous experience. Nowhere is this diversity more evident than in the historical tendency of writers to combine definitions of Indigenous mental illnesses with their causes. Much of this reflects the past and present impact of colonisation, along with contemporary social and cultural factors, on the physical health and emotional wellbeing of Indigenous populations. As a result, any attempt to establish the incidence of mental health problems in Aboriginal communities begs the larger question of what constitutes a valid definition of mental health and a valid classification of mental health disorders.

In order to provide some perspective on this, historical and contemporary definitions of mental health, and particularly mental ill-health, are reviewed here. Because various terms have been used through time to describe the mental wellbeing of Aboriginal Australians, including 'social health', 'social and emotional wellbeing', 'social wellbeing' and 'spiritual wellbeing' some clarity in choice is required here. In this section the term 'mental health' is used to maintain a consistency in terminology with the scientific literature. At present, the term 'mental health' has been consistently used by the World Health Organisation to refer to the mental wellbeing of Indigenous peoples in the world.<sup>1</sup>

### EARLY DEFINITIONS OF MENTAL HEALTH IN AUSTRALIAN ABORIGINAL CULTURES

While the terms, 'mental health' or 'mental illness' are Western medical terms, distress and disturbed behaviour are recognised in most cultures, although their causes and meaning may be understood in many different ways.<sup>2</sup>

Within Australia, the first systematic descriptions of Aboriginal mental health commenced in the 1960s and early 1970s with the work of Cawte,<sup>3-6</sup> Jones and Horne,<sup>7</sup> Nurcombe *et al*,<sup>8</sup> Eastwell,<sup>9</sup> Kamien<sup>10</sup> and others. These investigations were mostly of remote Aboriginal communities and tended to employ Western ethnographic and psychiatric conceptual frameworks to describe firstly the 'traditional' mental health disorders unique to various Aboriginal cultures and the 'transitional' disorders considered to arise from the impact of ongoing colonisation on traditional culture, ties, lands and obligations. During the 1970s and 1980s there were few reports on the mental health of urban and country town Aboriginal communities and these, apart from some notable exceptions,<sup>10</sup> tended to focus on more general community problems such as domestic violence and alcohol abuse<sup>11</sup> and on specific incidents such as deaths in custody.<sup>12</sup> The studies of this period were characterised by a greater convergence of medical anthropology, psychiatry, cross-cultural psychology and other social sciences in the consideration of broader contextual factors in understanding the nature and dynamics of adjustment to social and cultural change.<sup>13</sup> It was only a decade ago that Radford *et al*,<sup>14</sup> and Clayer and Divakaran-Brown<sup>15</sup> provided the first description of the psychosocial circumstances of Aboriginal families in urban areas. Using a random sample of approximately 15 per cent of Aboriginal households in the urban areas of Adelaide, Radford *et al*<sup>14</sup> employed multidisciplinary and participatory methodologies that addressed community defined mental health issues. While primarily focusing on adults, the findings provided a unique insight into historical, cultural and situational



contexts of specific mental health problems such as stress and depression, exposure to destructive behaviours such as domestic violence and sexual abuse, deliberate self-harm and suicide.

Aboriginal languages provide essential insight into traditional Aboriginal concepts of mental health. In Central Australian Aboriginal communities, aberrant behaviour is described as ‘silly, stupid, mad (*rama-rama*), mad or crazy (*walpanalpa*), or thoughtless (*kawa-kawa*)’.<sup>16</sup> Dunlop found that in all languages of the areas in Central Australia where she conducted her research, the terms used for ‘madness’ also applied to ‘deafness’, and there were a variety of descriptive words for abnormal or disturbed behaviours. In general, there was a high degree of acceptance of abnormal behaviour in the communities. There are also important subtleties of language that distinguish between certain types of emotional and mental disorder. For example, both grief and depression were considered as normal reactions. Anger was commonly understood to be acceptable in the presence of socially justifiable context. Aggression, on the other hand, was distinguished as a personality trait or disorder.<sup>17-20</sup> Importantly however, where local service providers considered someone to be mentally ill, the Aboriginal communities also perceived them as having a problem.

With respect to causal attribution, disturbed behaviour was attributable to ‘some problem in the head’. Disturbed people were seen as affected by external forces that they have no control over: they could not ‘see’ or ‘hear’ when acting in a disturbed way. Spiritual causes were most often cited for severe cases. Behavioural disturbance was seen to operate at different levels and relate to intermediate or recent past experience. Disturbed behaviours included: walking around the camp all the time, talking non-stop, having sleep disturbance, hearing voices, frequently moving between communities or heading ‘out bush’, keeping out of normal social interactions, sleeping anywhere, being naked. Such behaviours were viewed as pointless, worrying and irritating. Personality traits that described disturbed people included: angry, upset, restless, frustrated, mistrustful, bored, and lonely.

Based on a sample of over 200 people described as problematic by the Aboriginal communities where Dunlop carried out her research, two different types of behavioural problems were identified – those which were disruptive and those which were not. Individuals with behaviours that were not disruptive were seen by the community as being ‘abnormal’ or ‘mad’; this group of people demonstrated ‘odd’ traits, were or were not able to communicate verbally and they caused problems principally to themselves and carers. In contrast, those individuals with disruptive behaviours displayed varying degrees of violence, and people with such behaviours were seen as a significant burden to the community and carers.<sup>16</sup>

Early mental health researchers described the nature and extent of disturbed behaviour found in traditional Aboriginal communities as ‘mental illness’ and described syndromes similar to those in Western medicine (e.g. schizophrenia and depression).<sup>4-6,21</sup> Cawte detailed two types of mental illnesses afflicting Aboriginal Australians: those arising in traditional life and those arising in communities undergoing transition.<sup>4,5</sup> Dunlop emphasized that substance abuse was closely interwoven with disturbed behaviours and with the perceptions, descriptions and understanding of them. Therefore, it was impossible to completely separate behaviours that were induced by substance abuse from those with other causes.



This early literature is meagre. However it points to both differences and similarities in the majority culture and Aboriginal views of mental health. In both views, distress and disturbed behaviours, including violence, were seen as problem behaviours and a burden to the community and family. Major differences exist in the labels and causal attributions of mental health problems. Also, there is a greater emphasis in Indigenous cultures on the interconnection between physical and mental health and on the interrelationship between social and cultural environments and mental health outcomes.

## CONTEMPORARY DEFINITIONS OF MENTAL HEALTH BY AUSTRALIAN ABORIGINAL PEOPLE

*Ways Forward* represents a comprehensive contemporary overview of the mental health needs and problems of Aboriginal Australians.<sup>22</sup> Conceived through the National Aboriginal Mental Health Conference (Sydney, November 1993), the report incorporates many insights and recommendations from Aboriginal people from different Australian settings and communities who attended the conference. *Ways Forward* details Aboriginal perspectives of health and mental health as being holistic, encompassing spiritual, social, emotional, cultural, physical and mental wellbeing. Such a definition is intimately related to both historical and contemporary social and political contexts. For these reasons, the subsequent discussions about contemporary Australian Aboriginal definitions of mental health will be mainly based on this literature.

Indigenous mental health is defined as:

*'The capacity of the individual, the groups and the environment to interact with one another in ways which promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective (or emotional) and relational), the achievement of individual and collective goals consistent with the attainment and presentation of conditions of fundamental equality.'*<sup>22</sup>

A mental health problem is defined as:

*'A disruption of the interactions between the individual and the environment producing a diminishing state of mental health.'*<sup>22</sup>

A mental disorder is defined as:

*'A recognised, medically diagnosed illness that results in the significant impairment of an individual's cognitive, affective or relational abilities.'*<sup>22</sup>

Since *Ways Forward*, considerable effort within government has been brought to bear on defining mental wellbeing and mental ill health with respect to Australian Aboriginal and Torres Strait Islander people. Both the *National Mental Health Plan 2003–2008* and the *National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004–2009* build on and extend the principals and definitions embraced in *Ways Forward* (see *Preface*). While these definitions of mental health are consistent with the perspectives from other disciplines on health and wellbeing, such as medical sociology and anthropology and social epidemiology, they are also similar to the WHO's definition of health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'.<sup>23</sup>



## DEFINITIONS OF MENTAL HEALTH IN OTHER INDIGENOUS POPULATIONS

Limited data are available on Indigenous mental health worldwide.<sup>1</sup> There are no data on the mental health of Indigenous people in developing countries and regions, such as China, India, and Africa. Given the fact that Indigenous peoples worldwide have endured severe traumas in the past five hundred years as a result of colonisation, genocide, historical and continuous loss of lands, culture, traditions and family stability and economic disadvantages, it is of little surprise that the physical and mental health status of many of the world's indigenous populations is far below that of general populations.<sup>1</sup>

The available literature on the definitions of Indigenous mental health in other parts of the world is predominately derived from trans-cultural and cross-cultural studies in psychiatry and the terms used reflect this taxonomy. Central to many of these studies is the issue of the diagnostic validity of proposed definitions and taxonomies.<sup>1</sup>

For example, the lack of well-validated assessment instruments for American Indians and Alaskan Natives has hindered substantive research on psychopathology in these populations.<sup>24</sup> Depressive symptoms may be culturally constructed: depression in non-Western populations tends to express itself in the form of somatic rather than psychological symptoms,<sup>25</sup> and the symptom duration differs.<sup>26</sup> Only a small minority of the research subjects from the Hopi Indians in the American Southwest knew of any Hopi word or phrases equivalent to the term 'depression'.<sup>26</sup> Yet depression is the most frequently diagnosed problem among American Indians who present at mental health treatment services with about 50 per cent of a clinical sample, as compared with 25 per cent from the general population suffering from depression.<sup>1,26</sup> In Tarahumara Indians of northern Mexico, the concept of mental illness refers more to antisocial behaviour than to other symptoms of mental disorders.<sup>1,27</sup>

Similar to the Australian Aboriginal concept of holistic health, Maori peoples in New Zealand traditionally view health holistically. Maori theories of health have been based on a strong belief in the power of the mind and vulnerability to deities.<sup>28,29</sup> Mental illness (*wairangi, porangi*) is considered to be a subset of illnesses for which there are no obvious external causes. This type of illness is seen to be of spiritual origin and to be an illness of the Gods. Such mental illness tends to be attributed to either an infringement of the laws of *tapu* (an effective social sanction which guided interpersonal interactions and the relationship with the physical environment) or to the sensitivities of powerful others whose retaliation could produce derangement even without physical confrontations. Mental illness is closely linked with accepted social values and often indicates a deviation from community norms either by the patient or the wider family. Distinctions between individuals and the family have less emphasis to Maori people, as they regarded the health of an individual as a symptom of the other.<sup>30</sup>

Depression has become the leading mental health problem in Maori women in New Zealand since 1977, and although suicide rates have been rising since then, the overall suicide rates among Maori women remain lower than that of the general population.<sup>30,31</sup> Increases in suicide rates in the 1973–1984 period raised alarm in Maori communities.<sup>30</sup> This emergence of suicidal behaviour is linked to the rapid economic, social and cultural changes in Maori society, with the removal of social sanctions, such as *tapu*, and the diminishing authority of tribal elders without clear and meaningful substitutes.<sup>30</sup>



Indigenous (i.e. 'culturally-bounded') mental health disorders have been reported among American Indians and Alaskan Natives. It remains unclear whether or not, and to what extent, these syndromes have their parallels in categories of Western classifications. Some of the better documented mental disorders include *pibloqtoq* (arctic hysteria) which may have environmental and dietary causes, and more general categories of disorders, such as soul loss, spirit intrusion, syndromes which are related to the breaking of religious or social prohibitions, and ghost sickness.<sup>24,32</sup> Five categories of illness internal to the culture were identified by Hopi informants in Arizona.<sup>26</sup> Each was associated with a cluster of cognitive, affective, and behavioural states. None of these disorders, however, met the standard criteria for a major depressive episode.

Even the defining characteristics of disorders that have more manifest organic causes can be culturally bounded. To the Tamong of Nepal, mental retardation manifests itself mainly in the form of speech problems rather than cognitive disabilities.<sup>33</sup> Symptoms of lack of emotional responses, 'hallucinations involving spirits', and 'prolonged mourning' have been reported as more frequent among American Indians and have been treated as serious disturbance.<sup>34</sup> Yet it is possible that the converse of these manifestations, such as 'emotional lability', 'inability to contact the spirit world', or 'truncated mourning' may in fact signal a greater pathology for these populations.<sup>34</sup> Depression may also have positive meanings: it may be an expression of belonging, and to be depressed demonstrates maturity and connectedness to the Indian world.

Despite these differences in Western and Indigenous conceptions of mental disorders, substance abuse, depression and suicide represent the most debilitating mental health problems in Indigenous populations worldwide, which cannot be separated from the social, cultural and historic contexts in which they occur.<sup>1</sup> For instance, Australian Aboriginal people consider the conditions of their mental health to be both serious and disabling, and they fall into the terms of 'serious mental health problems and mental disorder' as identified by the National Mental Health Policy. Furthermore, Aboriginal people saw the loss of mental wellbeing as a major contributing factor to their poor physical health.

These observations suggest there must be a certain degree of agreement between Western and Indigenous conceptualisations of mental illness and perceptions of the severity of the mental problems, despite marked differences in the labels, causal attributions and sometimes manifestations of mental disorders between the majority and Indigenous cultures. In the end, specific labels and causal attributions make little difference to how people react to deviant behaviour. What is important are greater familiarity of a particular mental health problem and expectations for recovery.<sup>35</sup> The attitudes of Indigenous communities towards mental illness are an important determinant of the helping-seeking behaviour of those who suffer from the problem and as well the effectiveness of treatment. For example, stigmatisation inhibits individuals with mental illness from seeking treatment and care.

## SUICIDE

Suicide is taken as a primary indicator of psychological distress by lay and professional people alike. Definitions of mental illness inevitably cite suicide and suicidal behaviour as a significant outcome or symptom of mental ill health. The relationship between suicide and psychiatric disorder has been demonstrated time and again and



suicide rates are commonly used or recommended as an indicator of cause-specific mortality linked to psychological state and psychiatric illness.<sup>36</sup> Not surprisingly, the international literature documenting the mental health of Indigenous populations tends to be better developed, particularly with respect to the epidemiology of suicide and suicidal behaviour. These findings show considerable variability in Indigenous populations.

In Micronesia and Western Samoa, the rate of suicide is high due to the unusually high incidence among adolescent men (160 per 100,000 by 1990) and a very high ratio of male to female suicides.<sup>1,37</sup>

The suicide rate in Native youths (aged 15–24 years) in the Province of British Columbia was five times as high as that of youths in the general population (about 110 per 100,000 compared with 30 per 100,000) in 1987–1992.<sup>38</sup> Substantial variability exists within the First Nations population of the Province. For example, in six of the 29 tribal councils, there were no deaths from suicide during the study period of 1987–1992, and among the 23 remaining councils, suicide rates ranged from below the provincial average (around 30 per 100,000) to 633 per 100,000. Among the 16 language groups, five groups had no youth suicide. The remaining 11 groups had rates that ranged from 25 per 100,000 to as high as above 200 per 100,000.<sup>38-40</sup>

Major depression and substance abuse were the most common mental health problems in American Indians and Alaskan Natives, and the prevalence of depressive disorders is higher in this population than other groups.<sup>24</sup> Suicide rates for people aged 10–24 years were reported to be around 2.3 to 2.8 times as high as overall U.S. rates, and some communities experienced even much higher rates at times and clusters of suicides.<sup>41</sup> Mortality rates as a result from para-suicidal accidental injury were also high, and often involved alcohol drinking immediately before the act.<sup>42</sup>

There are also temporal variations in the incidence of mental health problems. In Micronesia and Western Samoa, children born after 1950 were the first generation to enter adolescence at a time of social and cultural disruptions eroding traditional support for adolescent socialisation. As a consequence, the suicide rates surged between the mid 1960s and the late 1970s.<sup>37</sup> In New Zealand, since 1977 depression among Maori women has become a leading mental health problem.<sup>30</sup> Prior to 1968, Native Hawaiian men had the lowest crude suicide rate in the state (10.5 per 100,000). But by the 1978–1982 period, the rate increased to the second highest (25.5 per 100,000).<sup>1</sup> Cheng and Hsu (1992) suggested a dramatic increase in alcohol abuse among the aboriginal peoples of Taiwan in the decades following World War II and speculated that the incidence of mental health problems has also increased significantly during this period.<sup>43</sup>

Similar temporal trends in suicide and mental disorders have also occurred in the Australian Aboriginal population as evidenced by a change in the pattern of mental disorders in the recent past as Aboriginal communities have undergone rapid social changes. Suicide was rarely reported in the 1960s and 1970s in Indigenous communities, but has increased dramatically over the last fifteen years.<sup>44,45</sup> Hunter attributes this trend to what he calls the ‘deregulation’ period in the 1970s, a period when the legislation that had previously constrained the freedom of Australian Indigenous people was replaced by structural and economic impediments. He also attributes this trend to increases in access to the cash economy and alcohol.<sup>45</sup>



In Australia, positive changes have also occurred during this period, including the foundation and expansion of community-controlled organisations, the land rights movement, and increases in the number of Aboriginal students progressing to tertiary education. It would seem puzzling on one hand that, despite these positive trends, the incidence rate of suicide and other mental health problems has increased dramatically since 1980, and suicide is now becoming more common in not just urban but also remote and 'traditional' communities.<sup>45</sup> On the other hand, there are major offsetting trends since 1980: namely, widespread community and family instability caused by alcohol and substance abuse, continued disenfranchisement through social exclusion and inequality, and the ongoing trauma of loss.

## THE MENTAL HEALTH OF INDIGENOUS CHILDREN AND YOUNG PEOPLE

Given the relative paucity of data to describe the mental health and wellbeing of Indigenous adults, it is not surprising that data on mental health among Indigenous children are extremely limited. In Australia, the few small-scale studies that have investigated mental health problems in Aboriginal children have done so with respect to behavioural disorder, conduct disorder and social maladjustment.<sup>13,45-49</sup> These studies were based on small and non-representative samples of Aboriginal children and collected no data on non-Aboriginal children for comparison, thus limiting policy implications for population level interventions. As Hunter concludes, there is a shocking lack of knowledge about patterns of normal childhood development in Australian Aboriginal children and the effect of physical, emotional, and social disturbances on these processes.<sup>45</sup>

Beiser, too, noted in 1981 that there were scant data on Native North American children's mental health and, fifteen years ago in the United States, Neligh (1990) noted that children's mental health was the largest area of unmet need for American Indian people.<sup>50</sup> Attempts to comprehensively ascertain the incidence and prevalence of mental health problems in Canadian First Nations children and their families pose some striking similarities to the Australian experience. Reviews of the literature on the mental health of First Nations peoples noted four key issues or recurring themes: the residential school experience in which government policies of the day permitted the compulsory removal of children from their families of origin to government residential schools; suicide and suicidal ideation; abuse (physical, sexual and emotional); and alcohol and substance use.<sup>51</sup> Since then Canada has made progress in developing more appropriate and culturally sensitive approaches to measuring mental health in its minority First Nations population. These include the Flower of Two Soils Study<sup>52,53</sup> which sampled children living in two Canadian and two USA sites, the Ontario First Nations Regional Health Survey<sup>54</sup> and the First Nations and Inuit Regional Health Surveys.<sup>55</sup> These approaches estimate that almost 17 per cent of First Nations and Inuit Regional Health Survey children aged 6–17 years have behavioural or emotional problems that exceed other children of a similar age<sup>55</sup> while 25 per cent of First Nations children aged 12 and above were reported to have mental health problems in the Ontario First Nations Regional Health Survey.<sup>54</sup> A more comprehensive coverage of trends in research on mental health in Canadian Aboriginal peoples can be found elsewhere.<sup>56</sup>



In summary, both within Australia and internationally, there remains a meagre epidemiological base from which to draw conclusions about the scope, prevalence and burden of mental health problems in Indigenous children. What is available suggests that prevalence rates of emotional and behavioural problems are, in all likelihood, higher than in the majority population. Based on the information about mental and physical health of Indigenous adult populations, one could reasonably expect at least a parallel differential between Indigenous and non-Indigenous children and young people for one simple but important reason. The mental wellbeing of children is intimately connected to the emotional and physical wellbeing of their parents, and risk factors for vulnerability to mental and physical illness are often transmitted across generations in the absence of interventions to break the cycles of vulnerability.

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