CENTRAL AUSTRALIAN ABORIGINAL CONGRESS

AND

ANYINGINYI CONGRESS ABORIGINAL CORPORATION

JOINT SUBMISSION ON

HUMAN RIGHTS ISSUES

RELATING TO

ABORIGINAL PEOPLE WITH MENTAL ILLNESS

IN

CENTRAL AUSTRALIA

Submission to the Human Rights and Equal Opportunity Commission's National Inquiry concerning the Rights of People with Mental Illness.

JULY, 1992.

INTRODUCTION

The Central Australian Aboriginal Congress and Anyinginyi Congress Aboriginal Corporation are Aboriginal community controlled organisations established in 1973 and 1984, respectively, by Central Australian Aboriginal community leaders to address health and welfare issues affecting our people.

Programs run by both organisations include:

- Comprehensive Primary Health Care Program, including:
  - Primary Medical Services;
  - Community Health Program;
  - Family Support Program;
  - Dental Services;
  - Aboriginal Health Worker Education;
  - Community Health Education;

  Within these programs we run immunisation programs, TB control, STD control, HIV/ AIDS Education, Nutrition programs, and medical care to Aboriginal residents of Nursing Homes for the Aged.
- Transport Services.
- Welfare Services.
- Child-care.

Anyinginyi Congress also run an Arts and Crafts centre, and are involved in the development of services to the Barkly.

CAAC also run the Congress Alukura (Women's Health and Birthing Service), the Alkngiltye Congress Shop and the Housing and Referral Service.

Congresses, with other Aboriginal organisations, especially Tangentyere Council, have also been involved for many years with the development of alcohol programs, which has culminated recently in the establishment of a new organisation - the Central Australian Aboriginal Alcohol Program Unit.

Whilst providing the above services, it is recognised that our health status will not improve until the fundamental questions of sovereignty and self determination are resolved.

An important part of Congress' role is to advocate for the rights of our people, and the immediate implementation of recently adopted national policies as detailed in the National Aboriginal Health Strategy and the Royal Commission into Aboriginal Deaths in Custody.

MENTAL HEALTH ISSUES

BACKGROUND:

The impact of colonisation has caused enormous distress to our people. Much of this impact can be broadly categorised as loss.

Losses include:
- loss of land (this involves economic, spiritual and cultural loss);
- the death of family and relatives by introduced diseases and massacres;
- loss of country by forced resettlement;
- children taken away as a result of the assimilationist policies;
- the ongoing high death rate from disease and grog .

The loss associated with this dispossession is frequently catastrophic.

Our people were forced from their country, and into mission or government settlements. This loss involved economic, spiritual, and cultural disruption. There were massacres of our people as recently as the 1930s. Forced settlement came with hand outs of food - white flour, sugar and tea. We were denied access to our natural sources of food. Then a policy of assimilation was imposed on us and our children were taken away, and families split up.

The losses continue. Even in the last ten years 'unofficial' and secret shootings of our people on stations has been rumoured, and poisoned alcohol has resulted in death.

Our people in Alice Springs and the Barkly attend the funerals of relatives many times each year. The repeated grieving for these often violent and premature deaths saturates our life.

Those children taken away and grown up in institutions have had to struggle hard to find their families and overcome the effects of institutionalisation. Many are permanently traumatised.

As a consequence our people die on average 20-30 years younger than other Australians.

This sad history of violation of our human rights has caused what could be termed 'generational grief'. All of our people are caught up in a cycle of grief. This is a mental health problem for all of our people. Many have turned to alcohol. This has resulted in high levels of violence turned in on ourselves. It has resulted in more deaths and more grief.

Dispossession has resulted in our people being marginalised from economic activity with widespread unemployment and boredom.

However, our strength is that we "have survived". We are strong, or we would not have survived. Our culture is alive, and is central to our strength. The colonisation process of dispossession has made us strong. We depend on each other, we understand and support each other. Our brothers and sisters who drink too much are not to us simply 'hopeless black drunks', but are our family. We understand their grief - we share their grief.

But the colonial bureaucracies, often well meaning, continue to decide what is best for us. They can't understand why we resist. We have been adapting to the invasion for many generations. We know this country. We know our people. But they think their way is the only way. They do not know who they are - they are a long way from their roots, and do not recognise that their ways are from their culture, and not universal truths.

So, our people live marginalised from mainstream Australia, and are fairly powerless under this domination - but are powerful with our knowledge, culture and relationships.

CROSS-CULTURAL PSYCHIATRY:

There is fairly widespread acceptance that psychiatry is culturally located. The expression of mental disorders will vary according to cultural values, beliefs and group experiences. The very idea of cross-cultural psychiatry recognises that psychiatrists are generally from one culture, but frequently practising upon another. A better understanding by psychiatrists of the different culture, and expressions of psychiatric disorder within that culture assists them to practise more appropriately.

The Congresses support the practise of cross-cultural psychiatry as essential in the short term - but long term strategies must be developed to enable our people to develop the skills and resources needed to develop and run our own mental health services.

All mental health services staff should have intensive cross-cultural orientation with major involvement of Aboriginal organisations. The Congresses and the Institute of Aboriginal Development (IAD) are ideally placed to assist this process.

MENTAL HEALTH SERVICES:

In Central Australia there are no Aboriginal Community Controlled Mental Health Services. Aboriginal Community Controlled Health Services are not funded to provide specific mental health services, but do provide support where possible in the course of comprehensive primary health care. This is grossly inadequate. Aboriginal Health Workers have virtually no effective training in even elementary counselling skills.

Instead, the NT Department of Health and Community Services control existing Mental Health Services as part of Alice Springs Hospital. Services include a 14 bed acute in-patient ward, community program based in Alice Springs, and a minimal bush communities service. No Aboriginal people are employed in these services.

Staffing is inadequate. Ward 1 (Psychiatric ward) is frequently staffed with only two nurses. If the severity of particular cases demand, extra staff are called in to assist. To complicate matters observation of suicidal or otherwise seriously disturbed people can be extremely difficult. Staff must actually enter some rooms in order to observe the client. This was no doubt a factor in the death by hanging of a Tennant Creek man in Ward 1 in 1991, and the assault of another man in 1989.

Last year nursing staff at the Hospital took industrial action over inadequate staffing levels. Whilst this has improved the situation to some extent, the problems have not been resolved.

There are no Aboriginal interpreters employed. This complicates the job of medical and nursing staff - especially in mental health services where communication is so critical. For many Aboriginal people English is their second, third or even fourth language.

We understand that Community House (of Mental Health Services) have very poor involvement of Aboriginal clients in their programs. We believe this to be due to the cultural inappropriateness of their programs. Again, no Aboriginal staff employed, and no input from Aboriginal community organisations.

DISABILITY SERVICES OF CENTRAL AUSTRALIA (DSCA)

DSCA was established as a result of a CAAC research project looking at the needs of people with disturbed or challenging behaviour. This project resulted in the publication of the *RAMA RAMA REPORT*. These people are not considered to be 'mentally ill' by Mental Health Services, and are not eligible to receive their services. Before DSCA there were no services for these people, and they caused great distress to their community.

DSCA is a non-Aboriginal community based organisation which actively involves Aboriginal people, carers, kin and clients in the management of people with challenging behaviour. They have been successful in minimising the destructive behaviour of a number of clients, and generally have worked appropriately with our people. Two Aboriginal workers are employed, and Congress believes this to be a key factor in their effectiveness. However, a major weakness in DSCA is the lack of Aboriginal control of the program. DSCA will need to address this issue, particularly as community controlled mental health services are developed, as we believe is eventually inevitable.

The Congresses believe that DSCA services are due for appropriate and supportive evaluation. As the authors of the original report, CAAC would be happy to coordinate such an evaluation if resources were made available.

NT GOVERNMENT POLICIES

The Northern Territory government has a very poor track record on Aboriginal human rights issues, and is frequently part of the problem which engenders stress, anxiety and mental ill health in our people.

Whilst formally endorsing, and paying lip service to, policies of self determination and the National Aboriginal Health Strategy and most of the recommendations of the Royal Commission into Aboriginal Deaths in Custody, the actions of the government have undermined our people's efforts. Little respect for our culture has been shown by the government in many of their actions.

Recent examples of this include the Todd River dam campaign, the Traeger Park school closure, the power charges dispute and their policy on land rights.

In the health area the CRESAP changes to NT Health were a cost cutting exercise. But they claim publicly to have increased their effort and expenditure on Aboriginal health. They claim to have created around 60 new Aboriginal Health Worker, Health Promotion Officer and Environmental Health Worker positions as part of the CRESAP changes. However, they already had around 40 AHW positions unfilled. Community controlled health services have applied for some of these positions, but so far none of these submissions have been accepted.
Recently a consultancy was conducted by Ms Christine Franks, a non-Aboriginal employee of NT Health, to try and find out why the Department could not retain AHWs. In the course of this consultancy, no attempt was made to consult with either of the Congresses about this issue. It is widely known that the Congresses place a high priority on Aboriginal Health Workers.

There are many other examples where the NT Government has ignored the principles so strongly stated in the NAHS and RCIADIC.

The Royal Commission into Aboriginal Deaths in Custody, as well as making specific recommendation about the conduct of government and other agencies, set out some clear principles about how issues relating to Aboriginal people should be handled.

The most fundamental principle is that of self determination; this means that **problems affecting Aboriginal people can only be effectively dealt with if Aboriginal people are in control of the process**.

The National Aboriginal Health Strategy also sets out some principles to be followed in addressing Aboriginal Health problems. The central principle of the strategy is that health problems, including mental health problems, are best addressed by Aboriginal community controlled comprehensive primary health care services.

Until the Northern Territory government and its departments put these principles into practice, any action they take actually blocks progress toward improving health. Since so much mental ill health is occasioned by the structural racism in this country, mental health is being actively undermined.

APPROPRIATE MENTAL HEALTH SERVICES

We are concerned that a process of developing a range of specialist health workers (eg Aboriginal Mental Health Workers) is likely to be counter productive until all Aboriginal communities have adequate numbers of appropriately and broadly trained Aboriginal Health Workers working in comprehensive primary health care services. Specialist health workers are too often narrowly trained in one area only, and are forced to provide services intermittently from central locations. This does not develop appropriate community based services so that community needs in these areas can be met as they arise. Communities will remain dependent on external resources if this trend continues. It is essential that existing community resources be developed and strengthened in the community itself.

Appropriate courses addressing mental health issues, and especially counselling skills should be developed under Aboriginal control, and made available to the key resource people in communities whether they be Aboriginal Health Workers, Women's Centre workers, or the respected people as determined by a particular community.

Aboriginal Community Controlled Health Services need to be specifically resourced to develop appropriate mental health programs.

THE ELDERLY

The mental health problems of elderly Aboriginal people in Nursing Homes is of great concern. Many of these people become profoundly depressed, and sometimes agitated, due to their being away from their country. There is often great pressure to treat these people with anti-depressants, when the cause of depression is their being unable to return to their country. For many of our old people it is important that they grow old and die in their country.

There are few resources available to support old people to stay in their communities. Family resources are frequently already over stretched. Community clinics have often resisted old people returning to their community, despite the old persons explicit desires. We strongly support the rights of our people to return to their country to age and die. To help overcome the resistance by clinic staff and others, we believe their needs to be a minimal care protocol developed. It maybe acceptable for an old person to live out bush with basic shelter, water, blankets, firewood, one meal a day, and one clean-up per day. There may need to be a nominated carer who would be paid for their work from HACC funds. This process may help overcome the resistance to people returning home.

Since the establishment of the Central Australian Advocacy Service, it has been clear that many people are being kept in Nursing Homes against their will.

However, the Nursing Homes tend to lack Aboriginal staff, and certainly do not employ Aboriginal Health Workers, or interpreters. As people get older they tend to revert to their first language. This has been sometimes interpreted as a sign of dementia. Becoming non-communicative and withdrawn due to depression has also been interpreted as dementia.

Of course once old people are diagnosed as demented, they can have guardians appointed, with resultant loss of rights.

Attempts were made last year to assess all residents for dementia. The Adult Assessment Team staff, and the Nursing Home administration attempted to utilise a simplified dementia assessment test routinely on residents. This was resisted on the grounds that it was a breach of their rights. Dementia assessment is actually more difficult in a cross cultural situation. It cannot be done in a simplified form. In the end, routine dementia assessments did not proceed.

Apart from the Old Peoples Service run by Tangentyere Council, there are no Aboriginal controlled services to meet the needs of our old people. Tangentyere's service is restricted to Town Campers.

CAAC recently reported on the needs of our people who are frail aged or disabled and the availability of Home and Community Care Services. The investigation found that the non-Aboriginal services were largely inappropriate to meet their needs. Some had preferred to go without these services rather than change their life to fit the needs of the service providers. Most had not had an opportunity to use them at all.

There is an urgent need for the development of support services for our old people to enable them to remain where they wish to be and to die in dignity where they chose. The range of services needs to cover Home and Community Care services, respite care for the carers, and culturally appropriate residential care for those requiring it. Such services should be developed under Aboriginal control.

To achieve this there is a need for training of Aboriginal workers in home support skills.

A major problem in developing these services is a lack of funding. Home and Community Care funding is based on a shared basis with State/ Territory and Commonwealth Governments. The NT Government indexes their expenditure by only 3% (in the last financial year) whilst some States have indexed their expenditure up to 20%. This resulted in $8million being returned to the Commonwealth Treasury in the last financial year. The Aboriginal community is being denied access to resources for these programs by the practise of the Territory Government. It is time the Commonwealth took back control of these funds and distributed them directly to community organisations equipped to deliver these much needed programs.

ALCOHOL ABUSE:

As mentioned earlier, both Congresses have been involved with the development of alcohol programs for many years. Alcohol abuse is a reflection of mental health problems in the community, and also in many ways exacerbates these problems.

In recent years a significant group of Aboriginal people have taken on this issue with vigour and vision. They have investigated the Canadian Indian experience, and have been inspired by their success. They have run a number of training programs, and have opened an interim treatment centre. They are determined.

These programs are fundamental to improving the mental health status of our people. Already they have made an impact.

However, they have had to fight hard to get where they are, and the Dependency Resource Services of the NT Department of Health and Community Services actively opposed some aspects of the programs.

These programs deserve strong support.

We are also concerned about a research project to detect alcohol induced brain damage in Aboriginal people using computer based tests.This project is being pursued by Mr Trevor Cox, a Psychologist employed by NT Health. When Mr Cox was beginning this project he consulted with Congress to gain our support. We did not give this support. It was pointed out to Mr Cox that their were no alcohol rehabilitation programs in place. We already know that alcohol caused brain damage (and other things), and that we know people should drink less. But those who want to stop had no culturally appropriate programs that they could access. Whilst it is understood that these tests may be useful to assist clients of rehabilitation programs to access the most suitable type of program, it was absolutely no use in the context of no or minimal rehabilitation or treatment centres. We advised that all available human resources should assist those Aboriginal people who were actively pursuing the development of programs to help people off the grog, as a matter of priority. Once programs were in place the use or otherwise of such tests could be then assessed. We believe that Aboriginal input at that point may really assist in the cultural development of such tests. We understand that despite this advice, Mr Cox has pursued his research. However, we have not been informed of any progress.

The Congresses believe that research directed to Aboriginal people should be under Aboriginal control wherever possible. This is consistent with the NAHS and Royal Commission findings. Further, the National Health and Medical Research Council have now endorsed ethical guidelines for Aboriginal research that supports this position.

RECOMMENDATIONS:

1. The recommendations of the National Aboriginal Health Strategy and the Royal Commission into Aboriginal Deaths in Custody on mental health be implemented immediately.

2. Resources be made available to Aboriginal community controlled health services to develop and deliver culturally appropriate mental health services under Aboriginal community control for Aboriginal people.

3. Aboriginal Health Workers, and other Aboriginal community based resource people, be trained so that they attain the skills and expertise required to provide mental health services to our people.

4. Aboriginal controlled adult education organisations (such as IAD) be resourced immediately to develop and deliver Aboriginal Counselling Courses.

5. Aboriginal people be employed at all levels in mental health services.

6. Government controlled Mental Health Services must, as a matter of urgency, ensure appropriate staffing levels, employ Aboriginal people in the services, and provide intensive cross cultural orientation for staff.

7. The Commonwealth Government take back control of HACC funding and distribute such funds directly to community agencies delivering HACC services.

8. A Treaty be negotiated with Aboriginal Australia.