SUBMISSION TO SENATE SELECT COMMITTEE

Indigenous people and Mental Health on Cape York Peninsula

Individual Submission from Dr. Roger Cribb

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About the author

As an archaeologist I worked in Cape York Peninsula for over 20 years on research and consulting projects, and have a good knowledge of the people and communities. I was adopted into an Aboriginal family (Wik people, Coen) and have maintained close ties with them over the last 10 years. Some of these close relatives and others on the Cape have been troubled by mental health problems. I have accompanied them on their trips to the mental health unit, tried dealing with them on my own, and visited them in prison (where many of them end up). As I suffer from bipolar affective disorder myself this may give me certain insights into the problems they face.

Other Sources of Information

In the course of preparation for this submission I have drawn on interviews with Prof. Ernest Hunter, Dept. of Psychiatry, University of Queensland; Andrew Brownley, Director of Nursing, Cairns Base Hospital Mental Health Unit; Mercy Baird Indigenous Coordinator at the Cairns Integrated Mental Health Service and Tully Wheeler, Indigenous Mental Health Worker, Cairns Base Hospital. I am very grateful to all.

A Holistic View of Mental Health

All mental health conditions are embedded in the circumstances of a person's life including their relationships, work situation, life experiences (eg. abuse) and other problems (eg. addictions). Indigenous mental illness presents greater problems to the extent that it is embedded in a culture which is unfamiliar to most clinical workers, can be influenced by unfamiliar belief systems and is often associated with a pattern of substance abuse which differs from that found in the mainstream.

Andrew Brownley suggested that it is often difficult to identify mental health issues and this is particularly difficult where the culture is so different from the mainstream and where substance abuse is such a significant factor. He outlined a model where the basic personality is modulated by the culture in which they live , which is in turn influenced by any underlying mental conditions, in turn affected by substance abuse.

Substance abuse

v
Mental health issues
v
Culture
v
Basic personality

All those interviewed stressed the interaction between culture and clinical features in the detection and treatment of mental health problems in indigenous people.

The Incidence of Mental Illness

The health workers interviewed agreed that the incidence of mental health problems among indigenous people from the Cape was higher than for the rest of the population but that this largely reflected social disadvantage and the effects of substance abuse, exacerbated to an extent by the limited reach of mental health services. Levels have been fairly consistent since about 1997. Many people were in the acute stages of a psychotic episode by the time they were detected and had to be flown down to Cairns for their own safety and for assessment. According to Tully Wheeler there would be around 20 indigenous patients on the ward per month, about half of these from Cape York Peninsula.

Detection and Diagnosis

Ernest Hunter pointed to the need for better mental health 'literacy' among Aboriginal people on the Cape and suggested the production of leaflets and brochures to partly offset this. But this is underlain by problems of terminology and semantics. For instance depression may not be perceived as such but as being 'sad', 'slack' or 'slow' or 'womba' in the local creole while these terms may be applied to other conditions such as the effects of stokes or dementia. In order to improve mental health 'literacy' it will be necessary to establish a cross cultural terminology which has both cultural and clinical relevance.

The indigenous family of an affected person may presume that the person has far greater 'will' (or will power) than is the case and cultural beliefs dictate that they should not intervene in a person's 'will'. Cross cultural difficulties in the identification of mental illness in the remote communities were also stressed by Tully Wheeler. Relatives may also be reluctant to talk about mental health not because of stigma, but because of a sense of 'shame' concerning family and substance abuse issues.

Mental Illness in 'Traditional' Aboriginal Society

All human populations have approximately 3% of their population suffering from chronic mental illness of some kind - mainly schizophrenia and bipolar affective disorder - though societies vary widely in terms of their handling of mental conditions.. This applied to both pre-contact and post-contact Aboriginal societies. It is now impossible to know how mental health was managed in pre-contact times. Extrapolating back from remote communities who have been in contact for only a short time, it is most likely that a largely tolerant

attitude prevailed. Those in the grip of major depression would probably have had a hard time surviving. However it is possible some people suffering from schizophrenia (visions, hearing voices) and bipolar disorder (delusions of grandeur) would have actually gained status as religious specialists ('medicine men/women').

In contemporary remote communities on Cape York Peninsula, while there is little understanding of the clinical aspects of mental illness, those so afflicted are generally well integrated into the communities and there is little evidence of stigma. This fact alone can make it unlikely that specialized treatment will be voluntarily sought.

Cultural Factors in Indigenous Mental Illness on The Cape

While Cape York remote communities have about the same incidence of mental health problems as the mainstream, these conditions are mediated by cultural factors and other considerations.

Among these factors are the following:

- In Aboriginal societies on Cape York Peninsula people are raised to be very personally and physically assertive, including the women. This kind of behavior is tolerated, even encouraged within Aboriginal society but often leads to problems with the mainstream legal system. It could greatly enhance paranoid or manic-type behavior.

- Depression and self-harm ('anomic' rather than 'altruistic' in Durkheimian terms), at the levels currently experienced, are not a part of traditional Aboriginal society and people are less able to perceive and manage them. Following on from this it may be less likely that these problems come to the attention of the mainstream health services although Ernest Hunter is confident that this situation has improved over the last few years..

- Mental illness among Cape populations is usually associated with alcohol and drug abuse, particularly among young people. In particular marijuana (gunja, yandi, patcha) may exacerbate the symptoms of people with mental illness. The effects of drugs such as alcohol and marijuana are often difficult to distinguish from the symptoms of the mental health condition itself.

The detection and treatment of mental health are affected by cultural attitudes and definitions as well as cultural understandings of the nature of society and the self. The social construction of 'self' as embedded in the wider social network also leads to a corresponding construction of 'health'. As Ernest Hunter (1998: 526) has expressed it:

> It should thus not be surprising that the indigenous concept of 'health' is different…being more holistically and collectively defined. We also know that when indigenous individuals are pressed to provide assessments of personal health they often report levels of well-being that are in sharp contrast to the objective evidence of Aboriginal ill-health.

Thus for the remote communities it is difficult to understand the mental health of an individual in isolation from the 'health' of the social networks within which he/she is embedded.

Perceptions of Depression

Clinical depression is a good example of the above. A major influx of patients from remote Cape York communities into the Cairns Base psychiatric ward in 2003 followed a trip around the Cape by a qualified psychiatrist (Hunter,pers.comm.) who was able to identify the symptoms of major depression in people, while those around them, both family and health workers, were largely unaware that there was a problem.

It is this comparative 'invisibility' of depression which may be partly responsible for much of the high levels of self harm and suicide (both attempted and successful) in the remote communities. It is also possible that in many cases depression may be viewed as a return to normality by a previously 'difficult' person - an episode of self-harm comes as a surprise. Non-indigenous health workers may be particularly prone to such perceptions. A good example is a tribal niece (or 'daughter') of mine, incarcerated in Townsville Correctional Center, who oscillated between episodes of hyper-activity and withdrawal. The perceptions of the staff were that when hyperactive she was 'a problem', when withdrawn she was 'just fine'. It was invariably during periods of being 'just fine' that her frequent suicide attempts (by 'slashing up) occurred.

In a more general sense it might be said that mainstream Australian society has a high tolerance for depressive behavior in others and a correspondingly low tolerance for assertive or aggressive behavior. This may partly account for the very high national youth suicide rate. For indigenous communities on the Cape this is reversed. While depressive behavior may not be condoned, as in the mainstream society, people's reaction is more one of puzzlement than alarm. There is therefor a kind of double filter in the detection of major depression - non-comprehension within the indigenous community and lack of perception on the part of mainstream health workers.

The implications of this for indigenous people in custody are far reaching as many features of indigenous culture (eg. kinship) are imported into prison and the custodial system is often insensitive to the mental health conditions of indigenous inmates.

In dealing with mental health in indigenous communities detection and diagnosis should involve both mainstream health workers and those within the community who are knowledgeable and respected.

Substance Abuse and Mental Health on Cape York Peninsula

The interaction of mental health with substance abuse on the Cape is, in the words of Prof. Ernest Hunter, an 'absolute disaster'. Drugs such as marijuana can act to both induce psychosis in otherwise 'normal' people and to exacerbate clinical conditions such as schizophrenia and bipolar disorder. As well as the direct intoxicating affects they can have long term affects on development, particularly when engaged in by the young (eg. petrol

sniffing). The effects persist across the generations as children are exposed to neglectful or destructive parenting.

The effects of marijuana have been vastly underrated. The general population, including mental health clinicians, may be influenced by the kind of marijuana use in the 1970s. However the type of marijuana available in the Cape at present has many additives and a far higher toxicity than earlier forms. According to Mercy Baird, while prolonged use of alcohol has a depressant affect over a long period of time, marijuana induces a moderate 'high' which is often followed by a profound depression reaching clinical levels at which point suicide may become a major concern.

From what the interviewees have said it seems to be very difficult to extricate the influence of drugs such as alcohol and particularly marijuana from that of clinical conditions. The multiple use of drugs, such as alcohol and marijuana in combination, further complicates the issue. Tully Wheeler drew attention the practice of treating the substance abuse issues and mental health issues by two different agencies rather than in a holistic fashion.

Self Harm and Suicide

Again cultural factors complicate the issue in a way that may be confusing to mainstream clinicians. Many forms of self harm are not related to suicidal tendencies. For example a young man, forcibly prevented from involvement in a fight, may slash his arms or chest, the point being: 'I'm angry. I'm brave and not afraid of pain'. Acts of self harm, as well as belligerence, during bereavement and mourning are culturally sanctioned and 'normal'. The act of cutting the arms (and legs), known as 'slashing up', while often associated with depression, may be at least partly in this tradition. It produces permanent scars or cicatrices superficially similar to ritual scarification. I once had a tribal niece with a history of slashing up say to me: 'I'm proud of my scars. Each scar tells a story'.

There is no doubt however that some forms of suicide or attempted suicide, such as hanging or overdosing, have little precedent in the traditional culture. Even so they may be modulated by indigenous culture and often occur in response to family situations rather than what the mainstream health services may regard as clinical depression.

Tully Wheeler drew attention to the high proportion of young indigenous patients who had attempted suicide. Often this did not arise from classic depression but from situational factors - family matters, fights and arguments. Suicide attempts are often motivated by anger, defiance or an attempt to opt out of untenable situations.

The hallmarks of indigenous suicide on the Cape are its impulsive nature, its linkage to substance abuse and its cultural embeddedness. In some ways attempted suicide is 'political' in the sense of trying to influence others' behavior. Further evidence of cultural context are the occasional 'epidemics' of suicide and attempted suicide within a single community - or even family - over a short period of time.

Psychological Trauma and Abuse

The high incidence of childhood sexual abuse in Aboriginal communities on the Cape leads to certain sub-clinical psychological conditions. Sexual abuse may give rise to a form of Post Traumatic Stress Syndrome with the person constantly re-living the experiences. This is familiar to me as the tribal niece mentioned above was frequently unable to sleep for this reason and 'freaked out' to the extent that she was begging to be taken to the psychiatric ward. Only marijuana would settle her down - or so she claimed. Associated behaviors are hysteria, self destructiveness and the tendency to form destructive relationships.

Magical Influences - 'pourri pourri'.

Belief in magical influences in Cape York Peninsula have not lessened with increasing European contact. 'Pourri pourri' is often invoked to explain physical and mental states which, to clinical workers could be easily explained in other ways. Pourri pourri is frequently blamed when deaths or physical illnesses occur. This extends to mental conditions such as depression or psychosis. The fear of being accused of pourri pourri may also cause great distress and anxiety. Those suffering from mental conditions such as major depression or schizophrenia are often highly sensitized to such explanations for their condition and, in the latter case, may believe they have the power put pourri pourri on others.

Related to this is the role of indigenous traditional healers. Mental health workers are generally aware of this and are encouraged not to place indigenous people in the position of having to choose between traditional and mainstream treatments - the two may be complementary. Some indigenous patients seem to be able to relate to their mental illness only through cultural rather than clinical explanations and perceptions.

Mental Health and the Justice system

Due to the very high profile of indigenous people in the justice system, it is inevitable that many people who are acting out psychiatric conditions rather than criminal behavior get tangled up in the sausage machine of the criminal justice system. In specific terms the police are poorly equipped to distinguish between the criminally motivated and the mentally ill, though this may be ameliorated where police have been in a community sufficiently long to get to know individuals with such problems. Once Aboriginal people enter the criminal justice system, it is very difficult to extricate those who are there for mental health reasons. The result is a tendency for mental illness to be criminalized among indigenous people.

It is a fallacy that no mentally ill person can commit a crime. The key element is whether or not they are capable of making an informed judgement on the criminality of their actions and therefor whether or not they are responsible. Those who are deemed responsible will continue in the criminal justice system while those who are not will most likely become forensic patients in the mental health system. It is easy to see how such judgements can be culturally mediated, based on assumptions derived from mainstream culture. Quite often the assessment of indigenous patients may be inadequate particularly if made away from the community and without contact with relatives.

From initial involvement with the police to the court and on to the prison system, the characteristic behavior and special needs of indigenous people with mental health issues are often ignored and this process can become cumulative. The overworked Aboriginal Legal Services are often unable to uncover or follow up such issues, including the niceities of 'responsibility' and may not have the time to follow up evidence held in indigenous people's mental health files.

Discharge and Follow Up

Aboriginal patients from remote communities are often unable to get back after being discharged. While the hospital has a policy of returning them, there are many things that can go wrong. For example patients may leave the psychiatric unit of their own accord. Even when they are not regulated this will result in the forfeiture of a return air fare. At the same time it is not possible to have them located by police. Others, whether officially discharged or not, may simply disappear into the group of itinerant people from Cape York Peninsular who hang around Cairns. In some ways the mental health system (along with the hospital system generally and the justice system) simply have the effect of bring down more people to swell the ranks of the homeless people or 'park people'. Aboriginal psychiatric patients are extremely vulnerable in these situations.

Those patients who do return to remote communities often lack adequate follow-up. Clinics in the communities are often too stretched to keep track of such people and ensure that they are properly monitored and remain compliant with medication.

Marginalized People and Mental Health

The definition and detection of mental illness varies according to the degree of marginalization of sufferers. Few in our society are more marginalized than Aboriginal people. As a white person with bipolar affective disorder, if I go over the top (mania), I will be taken to the psychiatric ward and receive treatment. The same behavior on the part of an indigenous person will often result in a trip to the watch house and possibly a custodial sentence. This is not the result of the direct application of racist attitudes but rather to the fact that Aboriginal people are marginalized.

The Cornelia Rau case serves to illustrate the fact that those who are marginalized in society are least likely to have mental health issues treated in an appropriate manner. In Miss Rau's case this occurred because she was perceived as an illegal immigrant. Only when this perception was corrected, and it was acknowledged that she was a bona-fide Australian resident, was the situation turned around. It is highly significant that only when she lost her marginal status was her mental illness appropriately treated. As has been observed by a number of commentators, there remain many people in the detention centers suffering mental problems who as 'illegals' remain marginalized and lack adequate treatment. The same applies in prisons.

Aboriginal people from the remote Cape York communities are equally marginalized in terms of mainstream society, economy and health issues. As such they are often

subjected to harsher treatment and, in terms of mental health issues, to a more limited range of options than those in the mainstream.

Conclusion

It is clear that we are dealing with a multifaceted problem in which many of the components interact closely: the clinical condition itself, cultural beliefs and practices, life experiences and substance abuse. I can suggest a number of points of entry into this complex.

Recommendation 1

Consciousness raising within the remote communities (leaflets etc.) should begin with the careful definition of the terms used. The terminology should reflect indigenous concepts as well as clinical ones. It should be designed to alert people to the fact that certain kinds of behavior (eg. hysteria, withdrawal, self harm) may need to be referred to the health services.

Recommendation 2

The highest profile groups in most contemporary communities are the Justice Groups. They make recommendations to the justice system about offenders from the community and are also active in decision-making about and policing of the various alcohol management plans. As such they are likely to be closely involved in the process of deciding whether an offender's actions are due to criminal intent or the effects of an underlying mental condition - ie. the definition of 'responsibility' mentioned above. The Justice Groups are also heavily involved in the issue of substance abuse.

Justice group members are all of high standing in the community and familiar with all the residents. They should be encouraged to work more closely with clinical workers as well as bringing mental health considerations to the attention of the police and the justice system.

Recommendation 3

The effects of marijuana, particularly on young people on the Cape, are poorly understood. Responses to this problem need to be informed by the latest research findings. Basic knowledge also need to be obtained about the composition of the various forms available. The psychiatric, behavioral and long term effects of heavy marijuana use need to be monitored within the communities. A community response similar to the alcohol management plans, and in conjunction with them, needs to be mounted in the remote communities.

Recommendation 4

The mental health system needs to establish connections with the Aboriginal legal services in order to ensure that their clients are offered the full range of options when facing the

court. The raising of mental health issues by Legal Service defense lawyers may well result in charges being dropped or a reduction in sentence.

Recommendation 5

Aboriginal people from remote communities who leave the psychiatric unit of their own accord should not be ‘written off’. They would be relatively easy to find by anyone familiar with the street scene in Cairns. Those officially discharged also need to be followed up to ensure that they return to their communities.

Recommendation 6

Research is needed on the complex interaction between clinical perceptions of mental illness and the effects of substance abuse - often multiple substance abuse. Underlying issues such as family background and abuse also need to be factored into this. This in turn needs to be related the issue of self harm both case-by-case and statistical approaches may be tried.