Ways Forward

National Aboriginal and Torres Strait Islander

Mental Health Policy

National Consultancy Report

by P. Swan and B. Raphael

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Ms Mary Scott
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Dear Ms Scott

The National Aboriginal and Torres Strait Islander Mental Health Policy and Plan represents a national overview of the mental health needs and problems of the Aboriginal and Torres Strait Islander people around Australia. The policy and its guiding Principles, Strategies and Targets clearly outlines 'Ways Forward' to improve the mental health and wellbeing of the Aboriginal and Torres Strait Islander population. All provision of these services is through Aboriginal Community Controlled Health Services and/or management.

This significant report has been fully endorsed by the National Aboriginal Community Controlled Health Organisation and is submitted by the two principal investigators, Sr Pat Swan and Professor Beverley Raphael.

Sr Pat Swan   Professor Beverley Raphael

Foreword

The consultancy process

This report follows the National Aboriginal Mental Health Conference, and incorporates many of the insights and recommendations supported by Aboriginal people at that meeting. It is built upon Aboriginal views of health and mental health as holistic, involving spiritual, social, emotional, cultural, physical and mental wellbeing and issues related to land and way of life. It supports the view that Aboriginal mental health inevitably relates to colonisation, history, racism and social factors.

The consultants believe that it is essential that Aboriginal people are given charge of their own mental health program development, because of the close relationship of mental health to wellbeing and the concerns that exist about genocide and assimilation, as well as the very adverse record of history. The consultants therefore support absolutely, the view of Aboriginal people that self-determination is central to mental health, and central in the provision of mental health services.

This report was developed on the basis of views and recommendations made to the consultants by Aboriginal people consulted around Australia. The consultants met Aboriginal people from Aboriginal Controlled Health Services, communities and those working in health departments in their visits to capital cities of all States, to a number of rural centres, Alice Springs and Broome. Resources provided did not enable the consultants to travel to all communities, nor to as many remote communities as they wished. They are very grateful to those Aboriginal people who travelled to meet them at other sites and who gave so generously of their time. They also met with Aboriginal people at Conferences, seminars and meetings, to seek their views. As well as Aboriginal Community Controlled Health Services were contacted and surveyed as to what they saw to be major mental health issues, the most critical needs and what they believed would be helpful. The consultants contacted Aboriginal and Torres Strait Islander Commission and at their suggestion, contacted all Regional Councils for their views and concerns.

The consultants sought information on, and where possible, visited and sought the views of those providing mental health services for Aboriginal people, and those planning or proposing new initiatives in this field. The consultants also met with Aboriginal consumers and sought their views.

State Mental Health Services were also contacted as to State program and contributions for Aboriginal Mental Health. Their response indicated a great shortage of support and services. Other agencies such as those potentially providing education relevant to Aboriginal Mental Health, Mental Health Workers are Mental Health Professionals were also contacted for information and contributions of relevance. While the consultants were unable to visit the Torres Strait Islands they consulted with Torres Strait Islander people and have included in the report, statements and submissions relevant to their views.

All Government policies and reports addressing Aboriginal mental health related issues were examined and documented. All studies, research and reports relevant to Aboriginal Mental Health were reviewed and summarised. Drafts of the report and recommendations were discussed with many Aboriginal groups and are fully endorsed by the National Aboriginal Community Controlled Health Organisation.

The proposals included in this report represent the views from many different Aboriginal people, settings and communities, as conveyed to the consultants. The consultants recognise that no consultancy process can be absolutely complete. Views were sought very widely and what is included represents these views.

Nevertheless, the issues documented were repeatedly identified as the priorities for and by Aboriginal people. The recommendations in this report are for Aboriginal people to take forward as they see fit and for adaptation and use in their own communities, according to priority and need. No recommendations are prescriptive, but rather reflect a range of programs that Aboriginal people had identified as needed for their communities. It was repeatedly stressed that mainstream mental health services were inappropriate and it was seen as critical that mainstream providers be educated in Aboriginal culture and mental health to

respond appropriately when Aboriginal people used such services.

The consultants consider that considerable resources must be found to develop mental health services for Aboriginal people, in view of: the dearth of services; the need to redress long-standing neglect; the close inter-relationship with physical health with mental health and wellbeing; and the increasing inequities of Aboriginal health generally; and the impact on mental health, of past and present policies, such as the forced removal of children, and of people from their land, and the loss of culture.

The consultants believe the most important next step is to constitute a group of Aboriginal people to oversight the next stages of consultation, program development, resource determination and co-ordination, as is suggested by the proposed National Aboriginal Mental Health Advisory Committee.

This policy should be taken forward, adapted and implemented by Aboriginal people to meet the needs of their communities. They should be adequately resourced to do this, and backed by all relevant Governments, organisations and other bodies to achieve appropriate and equitable mental health programs for Aboriginal people.

Professor Beverley Raphael

Ms Pat Swan

Executive summary

The National Aboriginal Mental Health Policy and Plan have been developed after extensive consultation with Aboriginal and Torres Strait Islander people around Australia and with relevant groups and organisations.

(note: The word Aboriginal is used throughout this report to cover Aboriginal and Torres Strait Islander people as Indigenous Australians)

The consultation process revealed extensive problems of Aboriginal mental health and high levels of unmet need. Evidence was presented that mental health problems were a major difficulty for most communities, and that there were few health and mental health resources available to deal with them. While data was generally inadequate, available evidence of a systematic kind indicated that Aboriginal people suffered mental health problems such as depression at a very high rate, compared to non-Aboriginal people, that rates of self-harm and suicide are higher, and that substance abuse, domestic violence, child abuse and disadvantage contribute additional risk factors. Trauma and Grief were seen as overwhelming problems, both related to past history of loss and traumatisation and current frequent losses with excess mortality in family and kinship networks. Evidence from the many Aboriginal people and organisations presenting to the consultancy highlighted the extent and severity of these problems and their strong relationship to mental and physical health problems. State reports highlighted the limited data available and shortage of services. Aboriginal people perceived mainstream mental health services as failing them, both in terms of cultural understanding and response, and repeatedly identified the need for Aboriginal mental health services, which took into account their concepts of the holistic value of health and their spiritual and cultural beliefs, as well as the contexts of their lives.

Numerous reports supported these findings and made recommendations with respect to the needs for mental health services for Aboriginal people. The limited scientific literature available supported the nature, extent and severity of problems identified, and the multiple risk factors contributing. All evidence drawn together highlighted the severity of the problems, the extent of the despair and hopelessness, and the failure of service provision.

Aboriginal people emphasised the strong relationship of mental health and well-being to physical health and saw loss of mental well-being as contributing in a major way to the poor physical health and health outcomes of Aboriginal people. There is much to suggest that this is indeed a further significant and major contributor to the adverse and deteriorating state of the health of Aboriginal people.

The policy described below rests on a number of guiding principles, namely: that the concept of health as holistic, encompassing mental, physical, social, cultural and spiritual health; that self-determination is central; that culturally valid understanding must shape the provision of services; that experiences of trauma and loss are major factors contributing to impairment of health and well-being; that human rights of Aboriginal people must be recognised and respected; that racism, stigma, environmental adversity and social disadvantage have negative ongoing impact on health and well-being; that family and kinship are central; that there is no single Aboriginal and Torres Strait Islander culture or group; and that Aboriginal and Torres Strait Islander people have great strengths.

Aboriginal concepts of mental health are holistic and are defined as follows:

> *"Health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well-being of their communities."*

> *"This is an evolving definition."*

This definition has also been endorsed by the National Aboriginal Health Strategy. The concept of mental health is thus encompassed in this and is accepted in this framework by Aboriginal people.

Any delineation of mental health problems and disorders must encompass a recognition of the historical and socio-political context of Aboriginal Mental Health including the impact of colonisation; trauma, loss, and grief; separation of families and children; the taking away of land; and the loss of culture and identity; plus the impact of social inequity, stigma, racism and ongoing losses.

The policy described is set on the background of these principles and understandings. It is supported by the findings of a review of relevant policies, reports and enquiries; a review of studies and the limited scientific literature concerning Aboriginal Mental Health; extensive consultation processes with Aboriginal people, communities, organisations, agencies and other relevant bodies. These matters are detailed in Part II of the report.

Part I of this report describes the Policy proposals that constitute a strategy for Aboriginal Mental Health. It must be emphasised that these:

- arise from the consultation process with Aboriginal people.
- are developed as a set of guiding principles to be shaped and modified by Aboriginal communities in ways they deem to be appropriate to meet their needs.
- are at all times intended to be developed and implemented by Aboriginal people, under the control of Aboriginal people who will mobilise other resources (non-Aboriginal) as they determine the need.
- aim to provide a framework for commitment to meeting mental health needs for Aboriginal people in a holistic model and in line with the principles of equity and social justice.

It must be emphasised that the policy elements outlined below represent priority areas identified by Aboriginal people. There are neither the human resources nor other requirements to implement all of these at one time. However, as will be indicated under implementation and funding, discussed below, it is believed that priority should be given to certain areas to be funded in the first instance. And that the choice and further emphasis given to policy and program development should be determined by Aboriginal people according to local community need. All provision of these services is through Aboriginal Community Controlled Health Services and/or management.

It must be emphasised that the conditions described by Aboriginal people in terms of their mental health were considered by them to be both serious and disabling and that these fall, without doubt, into the terms of "serious mental health problems and mental disorders" as identified by the National Mental Health Policy.

These policy proposals described are set in the background outlined above as well as the National Mental Health Policy and are contained in sixteen key policy elements, which in each instance are supported by a description of Aims; Policy Initiatives; Rationale; Strategies; and Targets. These are then drawn together to constitute the Plan with a series of key proposals for implementation and Recommendations. The policy elements are described below.

1.   Self-determination in Aboriginal mental health

To ensure self-determination as a central determinant of policy and its implementation, it is proposed that a National Aboriginal Mental Health Advisory Committee (NAMHAC) be set up to oversight and monitor the National Aboriginal Mental Health Policy and Plan. Proposed terms of reference and membership are described. It is essential and required that Aboriginal consumers are actively involved in these processes. It is further proposed that there be two major working parties, an Education and Personnel Development Working Party, and a Data and Information Systems Working Party, to support essential elements of policy implementation. It is considered essential that this committee and its Working Parties be established within the first 6 months, to ensure self-determination, coordination and oversighting in the development of the Plan, and to link urgently to current initiatives of the National Mental Health Policy and Plan. Draft terms of reference and membership are included.

2.   Holistic approaches to Aboriginal mental health

Holistic approaches to Aboriginal mental health care provision are seen as essential, to ensure that there is appropriate recognition of and care for mental health problems in primary care settings; it is necessary for all those working in primary health care settings with Aboriginal people to be both culturally informed and knowledgeable and skillful with respect to Aboriginal mental health and health care. To this end it is recommended that Aboriginal Health Workers have prescribed education in Aboriginal Mental Health, as should other primary health care providers (e.g. doctors and nurses), who work with Aboriginal populations. Identified curricula and accreditation should address these needs. In addition it is recommended that there be further specific development of Aboriginal Mental Health Worker Education programs and positions, to provide further contributions at the primary care level and within the holistic frameworks. These matters should be oversighted by the National Aboriginal Mental Health Advisory Committee, and the Education and Personnel Development Working Party.

3.   Specialised mental health care

Specialised mental health care must also be provided to Aboriginal people in terms of need, equity and social justice. Such programs are identified as a major area of need by Aboriginal people. The provision of specialised care should be provided as Community Mental Health programs for Aboriginal people and should, as for the non-Aboriginal community, encompass a comprehensive mix of services and be provided for Aboriginal people in their own communities. There is a need to encompass innovative frameworks, to provide for those with serious suffering and disability including all major mental disorders, and the interplay of these with comorbidity and consequences of trauma and grief and substance abuse, for these are defined as critical and inextricably linked to mental health and disorder, by Aboriginal people. Management forms and processes, care providers and places of care, need to be taken into account and linked into a coordinated framework of specialised mental health care provision for Aboriginal people in urban, rural and remote communities.

The elements of service need to include crisis teams or programs; community based "Aboriginal Places for Care"; early intervention programs; inpatient mental health services; recovery and rehabilitation programs; consumer and carer involvement and networks; accommodation services; intersectoral links; access to traditional healers; mental health legislation considerations. The importance of these elements and this approach is supported by numerous reports and submissions to the consultancy.

At least 2 major and comprehensive Aboriginal Community Mental Health Programs should be developed initially in each State, one in an urban centre and one in a rural region with a linked remote region. In other regions "seed teams" should be commenced incorporating male and female Aboriginal Mental Health Workers and at least another Mental Health Professional. Data and information systems need to be developed for these programs and to clarify need. Coordination and intersectoral input should take place through Regional Mental Health Forums, and management should occur through Aboriginal community controlled health management systems. The necessary education and training should be developed to support staff for these programs. Non-Aboriginal Mental Health systems should also be educated in Aboriginal Mental Health and should contribute in appropriate ways, such as networks. Carer and consumer involvement should be formalised and mental health legislation reviewed. These processes should be progressively implemented and expanded through 1995, 1996 and beyond and monitored through the National Aboriginal Mental Health Advisory Committee and its major working parties.

4.   Trauma and grief

These were identified as amongst the most serious, distressing and disabling issues faced by Aboriginal people – both as a cause of mental health problems, and as major problems in their own right. They were seen as central to Aboriginal Health and well-being. There is a need to provide educational, preventive, and clinical responses to address these ubiquitous issues. A National program of Healing and Reconciliation to educate and facilitate community response to these issues: intersectoral approaches to prevent further trauma; separation and loss; recognition and support for Aboriginal cultural practices about child rearing; death and dying; support for reunion organisations and processes; the development of special

healing programs and places; and other community interventions are all relevant components. In the clinical area, assessment formats for trauma and grief, special counselling programs for a range of situations of trauma, including abuse and sexual assault, programs for grief and loss and stress debriefing should all be developed alongside Aboriginal community mental health services. It is also critical that special research initiatives examine the nature of post trauma morbidity and its effects on the mental and physical health of Aboriginal people.

Counselling was identified as a major area of need by the majority of Aboriginal people consulted. It was felt that counselling should be developed and widely available in terms of the needs of the community. It was felt to be particularly important in terms of response to trauma and loss, but also relevant in many other contexts, such as dealing with the long term effects of abuse, issues of identity and self esteem and so forth. There was a need for models such as narrative therapy, that were culturally appropriate. Speciality counselling was also necessary to deal with deaths in custody grief. There are also specific needs with respect to children, young people and families. Education programs are necessary to develop counselling skills for all those providing care to Aboriginal people with mental health problems and disorders, and research to develop the effectiveness of different counselling approaches.

5.   Suicide and self harm

Suicide and self-harming behaviours are frequent in Aboriginal communities and associated with alcohol and other mental disorders. There is much to suggest that rates of these behaviours are high and rising, and that factors such as trauma and loss may contribute . Although actions to lessen rates of self-harm and suicide may arise from other policy areas, it is also seen as important to have specific policy initiatives addressing these serious problems. Clinical policies, protocols and programs should be developed to provide mental health support and services, and counselling for those bereaved. Community education and community enhancement should also support efforts to lessen rates of these destructive behaviours. Specific attention is necessary for those at high risk because of past history, being in custody, alcohol, recent deaths by suicide of others, or other contexts of despair. Education of health workers in risk assessment and response, of community leaders and communities, is essential as part of such policy development.

6.   Aboriginal children, young people and families

There is a virtual absence of mental health programs for Aboriginal children, young people and families and evidence of major need in that estimates suggest at least a third of young people have problems, and 40% of the Aboriginal population is aged 15 years or less. These programs should, from the beginning, be oriented to optimising available resources through primary care and general mental health services, prevention initiatives, and development of intersectoral links and resources. Aboriginal Children's Services, SNAICC and other Aboriginal children's agencies should be actively involved. There must be a developmental perspective with interventions at individual, family, and community levels. Prevention must have a high priority and be a significant part of program development especially in the absence of even basic levels of service provision. Program elements must encompass promoting development, through antenatal and postnatal care, parenting support, young mother and Aboriginal home visitor programs. There is the need for special programs and parenting support for young children at risk and programs specifically aimed at preventing child abuse and neglect. Healthy schools programs, and prevention programs for young people of all ages are important elements. Services should be developed through specialised networks linked to child, adolescent and family therapy programs in the general mental health services, but ensuring that these are sensitive to, and culturally informed about, Aboriginal Mental Health. Special needs groups include Children who have physical illness and chronic disability, developmental disabilities, learning disabilities, and particularly the children of parents with mental illness. It is essential that young people are involved in program shaping and development where programs are oriented to their needs and age group. To achieve prevention and service development, each community should have a senior management and coordinating position for Children and Young people's mental health to link, coordinate and develop programs as appropriate to need. An intersectoral forum for "Our Children Our Future" should provide the focus and link to Aboriginal Children's Services, AMS, the venue for children,

young people and family prevention, education and services to meet these mental health needs. Prevention and early intervention programs for those at high risk, Youth programs, and community support should be developed. Special mental health networks should provide the framework for direct services and care. Education of health workers and general mental health services and the community will be necessary to support these programs. Data and information support should come also through a survey of Aboriginal children and young people linked to this component of the proposed National Mental Health Survey.

7. Aboriginal women and mental health

While a separatist approach is not recommended, there are a number of issues of women's mental health that should be addressed. These include the effects of violence and its consequences, including sexual violence, on women, its prevention, as well as women's support groups and healing and counselling programs. There is also the need to address women's issues related to reproductive health including young women's programs, psychosocial aspects of care in relation to pregnancy and childbirth, support, education and counselling, detection and management of women's problems such as post-partum depression substance abuse. A working group for women's mental health could complement other family health, e.g. short programs to address these issues. Educational programs for health and mental health problems will also be necessary. Specific data needs could also be developed through the proposed longitudinal women's study.

8. Men and mental health

It is essential that Aboriginal men are involved in the development of mental health programs to meet their needs, and that such programs are evolved alongside general health and mental health programs in Aboriginal communities. These initiatives will also need to be linked to other relevant program elements such as substance abuse and mental health, forensic issues, and prevention programs. In response to local needs, programs could include elements of building health (with the mental health benefits of involvement in sport and physical fitness) programs; as well as self-help and support programs for trauma, healing, mental illness and other outreach support (e.g. Men's business). These programs should complement and interact with other family health initiatives in relevant areas.

9. Elders and mental health

Old age for Aboriginal people may come earlier, because of illness and the high levels of premature mortality. Nevertheless older Aboriginal people still face many mental health problems for which they need care ranging from support for carers and caring roles, to do with the stresses inherent in these, specialised mental health care, for instance for depression, Grief – many elders still have unresolved issues of separation and grief, and care for those who have dementia. Community mental health programs need to address these issues and identify particular local priorities and provide relevant support for them.

10. Promotion and prevention in Aboriginal mental health

It is essential that mental health promotion and prevention programs are developed relevant to need, to enhance the mental health and well-being of Aboriginal people. Such initiatives are considered critical in terms of the needs of children and young people and families, for instance, but also in terms of the overall community. In this context violence and destructive behaviours should be the first priority. Program elements should include community education to change acceptance of violence and change attitudes; conflict resolution and skills programs; programs to combat youth violence; programs for young people with challenging behaviours; programs aimed at breaking cycles of violence and abuse; and counselling and care for those who have suffered violence (linked to trauma and grief programs). These should link to other program areas as relevant. Regional Mental Health groups should link to the National Aboriginal Mental Health Advisory Committee and other National initiatives to prevent violence in establishing these programs. And particular program elements should be developed linked to schools, community, mental health care and other relevant groups in these areas, as well as clinical services of relevance. Data and educational program development will be necessary to back these initiatives.

11. Alcohol and other drugs and mental health

Communities and the consultancy at every level identified the critical importance of the interrelationship between substance abuse and mental health, and that these should not be separated. Program collaboration should be established through mental health and substance abuse agencies at national and regional levels. Combined initiatives should address education; interventions for the affected and those at risk; special programs for young people; clinical programs; programs for alcohol-related brain damage; prevention programs including prevention of foetal alcohol syndrome; and prevention programs related to injecting drug use and other substances such as cocaine, marijuana, in areas of high use (e.g. inner city).

12. Forensic issues in mental health

These constitute a significant area for Aboriginal people, particularly in relation to high levels of incarceration and disproportionate numbers of young people in the juvenile justice system. Policy elements need to include education and early intervention of behavioural problems aimed at prevention; mental health outreach to those at risk or already in contact with justice or correctional systems; family support; court assessments and reports. Appropriate Mental Health Services be available to people in custody. These initiatives are strongly supported by the recommendations of the Royal Commission into Aboriginal Deaths in Custody and many other sources. Regional mental health groups need to assess and address these issues and there is a need for appropriate education and data systems to support policy development in this area.

13. Intersectoral programs and mental health

Intersectoral issues are important both in terms of dual diagnosis and the need for cross sector collaborative approaches to optimise client care and resource utilisation. Consultative frameworks need to be developed through the national body, state Tripartite Forum, the Regional Mental Health Forum, and for a care basis through interagency groups.

14. Research and evaluation

This is a critical policy area in that all aspects of program development needs to be supported by systematic research in the field of Aboriginal Mental Health. Research needs to be supported by special initiative findings, for instance through NH&MRC, RADGAC and other groups. It should encompass: the proposed National Mental Health Survey, Aboriginal Mental Health aspects; research priority areas for Aboriginal Mental Health, including trauma and grief, young people and children, and counselling in indigenous modes; mental health services research and evaluation; mental health outcomes; research methods and programs including a resource base; ethics and consultation in Aboriginal mental health. There is a need for the National Aboriginal Mental Health Advisory Committee to develop a Research Strategy for Aboriginal Mental Health incorporating the NAHS guidelines for research in Aboriginal communities, to establish a resource base, hold a workshop to establish research networks and working groups to seek special initiative funding for priority areas.

15. Education and personnel development

These are critical to program development and policy implementation. It is necessary that a specific framework is provided to ensure the development of high quality educational programs for all those working in the field of Aboriginal Mental Health. It is also essential that workforce development is oversighted from the beginning so that there are adequate numbers of appropriately qualified staff. Education needs to ensure not only expertise in the area of Aboriginal mental health, but also that non-Aboriginal mental health care providers are Aboriginal Culturally Informed in their practice. Thus it is proposed that the Education and Personnel Development Working Party of the National Aboriginal Mental Health Advisory Committee be established and develop, oversight and monitor this aspect of policy and infrastructure. Educational strategies should encompass: identification of current workforce and need, including Aboriginal Health Workers and Mental Health Workers, and other Mental Health professionals,

both Aboriginal and non-Aboriginal; the oversighting curriculum, consultation and accreditation necessary for education of Aboriginal Health Workers and Mental Health Workers nationally and in relevant localities, including ensuring adequate places; education, both qualificatory and continuing, for mental health professionals, and adequate numbers and opportunities for Aboriginal people to be educated as mental health professionals (this includes nurses, psychologists, social workers, doctors and psychiatrists); education and community awareness programs as relevant. To achieve these goals there is a need to link to current resources and initiatives in these areas, to develop resources for education and courses in this field, to promote education and to link to DEET, ATSIC and educational institutions to fulfil these roles.

16. Data and information systems

Data and Information systems are essential background to policy development and monitoring, both to ensure needs are identified and that program implementation and effectiveness can be assessed. The Data and Information Systems Working Party of the National Aboriginal Mental Health Advisory Committee should coordinate and oversight data and information system development for this National Aboriginal Mental Health Policy. An urgent priority for this group, linked to research development, to the proposed National Mental Health Survey and its Aboriginal Mental Health component. This group should be involved in this survey development as a high priority. The development of mental health information systems in consultation with Aboriginal Health and Mental Health providers is also a priority. Other elements should include: mental health outcomes and indicators; quality assurance; standards and monitoring; Aboriginal mental health data management; and a dissemination strategy. These processes need to be developed coincident with the development of the policy and its implementation, with progressive focus on areas in terms of the priority given to them.

Implementation, resources and funding

It is proposed that the above policy components be implemented progressively over five years. To ensure an adequate and coordinated approach it is proposed that the National Aboriginal Mental Health Advisory Committee be established and fully funded and supported as the first stage. This Committee when established should identify and further establish its two major working parties to support and develop concurrently with the other priority policy elements. These three groups should be established and commence working, with appropriate secretariat and infrastructure ideally by the end of 1995.

As the next stage it is proposed that in the first wave of programs five major policy elements be established and linked into this system. Each needs oversighting nationally by the National Aboriginal Mental Health Advisory Committee, and relevant Education and Personnel Development needs should be coordinated with that Working Party, and Data and Information Systems by the second Working Party. Both these groups should assist with defining and identifying needs and resources. The five elements of first priority, as identified in the consultancy process, are:

Holistic primary mental health care through Aboriginal Medical and Health Care Settings, general practice and other primary care providers

Education of these providers in Aboriginal mental health is a key component, plus the development of positions for Aboriginal Mental Health Workers to provide primary and holistic mental health aspects of care in these settings. A minimum of 60 Aboriginal Mental Health Worker positions should be established within two years and specialist educational programs to back these and other Aboriginal Mental Health care provision should be in place within the first two to three years of program implementation.

Specialised mental health care

provision should be developed and linked to Aboriginal community controlled mechanisms and in the framework of an Aboriginal Community Mental Health Program for each area or region of significant size,

or smaller Aboriginal Mental Health Teams or networks for other regions, with these services linked to, or using in relevant ways, mainstream mental health services. Service elements in terms of equity include crisis teams, early intervention programs, Aboriginal Places of Care in the community, homeland etc., and inpatient, rehabilitation and other programs necessary for a comprehensive and integrated service. It is proposed that 2 specific focal specialised Aboriginal Community Mental Health Programs be established in each State, one in an urban and one in a rural linked to a remote area within the first year; and that smaller programs be established in all communities greater than approximately 3,000 people within the first three years. Regional Mental Health Forums (Aboriginal Mental Health) should provide the coordinating mechanism at a local or regional level, but management of the Aboriginal Community Mental Health programs must be Aboriginal community controlled. Where mainstream mental health services are linked in networks to support Aboriginal Mental Health care provision in these or other settings, these workers should be educated to be Aboriginally culturally informed in their practices, and have policies for Aboriginal Mental Health.

Trauma and grief

Trauma and grief prevention, support and counselling programs were identified as central and a very high priority at every stage of the consultation process. It is proposed that, linked to the previous holistic and specialised programs, but also focused to community needs, specific programs for trauma and grief be developed and implemented within the first three years, and supported by educational and data resources. These should include a National program of Healing, Trauma and Grief. Counselling was also identified as a major need and education and research to support counselling program development and the provision of counselling skills in all communities should be progressively implemented over the first three years.

Suicide and self harming behaviour

Suicide and self harming behaviour are urgent priorities to be addressed in Aboriginal Communities and involve both holistic, primary and specialised secondary mental health care provision as well as specific community and forensic system initiatives. Because of the rising rates of violence and destructive behaviours it is essential that they are addressed progressively over the first three years in a coordinated and targeted way.

Aboriginal children, young people and families

These groups are a program priority, to be urgently addressed. This is the more so because 40% of the Aboriginal population is less than fifteen years, and there appears to be a growing level of mental ill-health in this age group and increasing recognition of the continuity with adult mental health problems. A central need is a coordinated intersectoral approach, that is developmentally oriented, acknowledges family and community contexts and mobilises both effective prevention and treatment interventions. In the first instance a senior level Coordinator for Children, Young People and Family Mental Health needs to be established in larger regions, and program elements developed progressively from there on. It is proposed that senior coordinator positions be established within the first year in regions with significant Aboriginal populations with at least 25 such positions within the first one to three years, and relevant education to back these. Additional resources for programs and further positions including Aboriginal Mental Health Care Professionals, for children, young people and families, as well as networks linked to mainstream mental health services, will be necessary. Intersectoral Forums for children, young people and families are key policy elements which also need to be developed within the first two years. Education and Data system developments need to back this policy area also.

In the next order of priority in a second wave of programs, Prevention of Violence should be a major initiative, with Women's, Men's, Elders' programs, Substance Abuse and Mental Health, Forensic and Intersectoral Programs evolving alongside further central program development as deemed relevant by local communities. It should be reiterated that all these elements will also need to be supported by appropriate Education and Personnel Development and Data and Information System responses.

Research and evaluation

Research and evaluation, like Education and Personnel Development, and Data and Information Systems, needs to develop alongside major policy development. Resources and funding for this area should be separately identified, but this area should be monitored nationally by NAMHAC.

Implementation

Implementation will require a coordinated and collaborative approach and key stakeholders should be represented nationally on NAMHAC, and regionally in the Aboriginal Regional Mental Health Forum, or the Intersectoral Forum for Children, Young People and Families. Nevertheless self-determination, through community control should be central. It is to this end that NAMHAC should be established with a firm and ongoing funding base, for 5 years in the first instance, the more so as it must act initially independently and urgently to start meeting mental health needs.

The proposals in this Policy have national support from Aboriginal people at all levels and thus form a firm basis for policy and program implementation. Nevertheless the system must allow flexibility for local need and culture, for the differences between urbanised, rural, remote and traditional and other communities. Thus the proposals outlined are extensive, but the components within them, or chosen, should allow self-determination at local or regional levels. The chart below indicates however a general flow chart for policy and its outcomes. Goals are service development, education and personnel programs or data and information systems, rather than mental health outcomes. Such outcome goals could be determined at a later stage but are meaningless currently in view of the lack of any baseline data, poor or absent information systems, and absent or inadequate mental health care provision.

Resources and funding

It is recognised that, as was established with the recent Evaluation of the National Aboriginal Health Strategy, affirmative action is necessary to establish even the most basic mental health care provision. It is also acknowledged that resources may need to be drawn from a number of sources, State and Federal and other. Nevertheless there is a need for equity in the provision of Aboriginal Mental Health Care. Issues paper no. 5 of the Commonwealth, dealing with chronic mental illness, identified State and Federal costs of mental health care per capita as totalling $201 per capita annually ($50 average per State, $151 Federal). It is proposed that in the first instance funding for Aboriginal Mental Health be allocated at approximately the level of $50 per capita to be increased to $100 per capita taking into account multiple sources and then to $200 per capita to cover not just chronic, mental illness, but be identified severe mental health problems and mental disorders, of Aboriginal people. Projected Aboriginal populations should reach 300,000 plus by 1996. This would then amount to $15,000,000 annually rising to $30,000,000 annually for Aboriginal Mental Health to be complemented to a further level progressively of $60,000,000. Clearly these resources will need to be identified and mobilised with Aboriginal people and should be provided on at least this per capita basis as minimum annually.

TABLE 1: Aboriginal and Torres Strait Islander population x proposed funding

Population (approx no.)	State	50 per capita	100 per capita	200 per capita
70,000	NSW	3,500,000	7,000,000	14,000,000
70,000	QLD	3,500,000	7,000,000	14,000,000
42,000	W.A.	2,100,000	4,200,000	8,400,000
40,000	N.T.	2,000,000	4,000,000	8,000,000
17,000	VIC	850,000	1,700,000	3,400,000
16,000	S.A.	800,000	1,600,000	3,200,000
9,000	TAS	450,000	900,000	1,800,000
2,000	ACT	100,000	200,000	400,000

The additional funds up to $15,000,000 should support National approaches and these initiatives should be funded to the level of $3,000,000 annually as a minimum with additional funds to the level of funding for special initiatives.

The costs proposed are intended to cover the full provision of mental health care to Aboriginal children, young people and adults and represent a minimum. These should be balanced by the higher costs of not providing care, for instance high dependency ratios, long patient stays for adverse complications of mental health problems, particularly those complicated by substance abuse, and the costs associated with premature deaths and disability. At a population level there should be between 25 and 30 psychiatrists serving Aboriginal people (accepted estimates of 1 per 10,000 population). Clearly these and other figures are meaningless in the absence of access to all levels of specialised mental health care provision in many communities. The initiatives proposed are costed with the aim of addressing the present gross level of imbalance.

It is therefore proposed that $5,000,000 be provided in the first year to establish the National Committee and its major Working Parties, secretariat, resources and infrastructure and to commence program development.

This should increase through the first year to $15,000,000 to progressively encompass the service strategies and targets identified.

In the second year, with dispersal of funding on a per capita basis for population/state needs in Aboriginal mental health $15–30 million should be provided through Aboriginal Community controlled health care systems for targeted mental health programs. Education should be identified through DEET and other resource bases to be negotiated by NAMHAC. This funding level, i.e. $15,000,000 increased to $30,000,000 annually, should be guaranteed for 3 years minimum, and progressively, increased and complemented through that time and subsequently, to ensure a target of equity with the general Australian population to at least the level of $60,000,000 annually for all Aboriginal Mental Health, as a minimum for program provision (excluding income support etc.).

Goals

The following goals are proposed. It is suggested that these should be:

1. A mechanism for developing, oversighting, and monitoring a National Aboriginal Mental Health Policy.
   Proposed Target:　　　To be in place and functioning by end 1995.
2. Educational programs and workforce development to support the provision of mental health care, equitably, to Aboriginal people.
   Proposed Target:　　　To be in place within 2–3 years.
3. Baseline data on Aboriginal mental health encompassing indicators of mental health and levels and nature of mental health problems and mental disorders experienced by Aboriginal people and the risk and protective factors contributing to these.
   Proposed Target:　　　To be in place within 2–3 years.
4. An acceptable and operational mental health information system for Aboriginal mental health which could link to National Mental Health Policy in data and information system development.
   Proposed Target:　　　To be in place within 2–3 years.
5. Equitable provision of mental health care systems for Aboriginal people in urban, rural, and remote settings through Aboriginally developed and controlled primary holistic and secondary mental health and related services, and where appropriate, Aboriginally Culturally Informed mainstream mental health services.
   Proposed Target:　　　To be in place by 3 years and improved by 5 years.
6. Mechanisms in place for the capacity to demonstrate clear outcome indicators of Aboriginal mental health.

Proposed Target: To be in place within 3–5 years.

7.   Mechanisms to be in place to demonstrate the capacity to intervene and to improve Aboriginal mental health and lessen the impact of mental health problems and mental disorders through Aboriginal mental health care systems defined above.

Proposed Target: To be in place within 3–5 years.

Recommendations

The following recommendations are formed to allow Aboriginal determination of policy detail and implementation, and self determination in overall policy management.

1. The National Aboriginal Mental Health Advisory Committee to be established as indicated, with its two major Working Parties, (Education and Personnel Development and Data and Information Systems) to develop, oversight and monitor the National Aboriginal Mental Health Policy.

2. Five major policy elements for Aboriginal Mental Health should be implemented within the first 3 years, commencing within the first year, namely:
   • Holistic Primary Mental Health Care Programs
   • Specialised Secondary Mental Health Care Programs
   • Trauma, Grief and Counselling Programs
   • Suicide and Self Harm Programs
   • Children, Young People and Family Programs

3. Throughout the period of the implementation of the National Aboriginal Mental Health Policy, Education and Personnel Development and Data and Information Systems Policy components should be progressively developed and implemented alongside the above and subsequent policy components.
   (a) Education and Personnel Development should be progressed as a priority in liaison with DEET to identify Aboriginal Educational needs, workforce needs and resources.
   (b) Data and Information System Development should be progressed as a priority with particular and urgent emphasis on the proposed National Mental Health survey and its Aboriginal component, as well as mental health information systems and outcomes in liaison with National Mental Health Policy Initiatives.

4. Research and Evaluation proposals should be developed and implemented throughout the whole of the Program implementation.

5. Progressively in the subsequent program years, Prevention, Women's, Men's, Elders', Substance Abuse, Forensic and Intersectoral Program elements should be implemented in line with local needs.

6. Funding should be provided to resource this program development to levels that are equitable with those of the general Australian community as follows:
   • $5,000,000 initially to $15,000,000 in the first program years.
   • $15,000,000 rising to $30,000,000 annually, allocated on a per capita basis of $100 per Aboriginal person and to regions on this basis. This should be complemented by equal State funding to reach $200 per capita. This is necessary for full coverage of all areas of Aboriginal mental health including that of children, young people and families.
   • Further sources of funding need should be identified and developed urgently proportionately to nationally and locally identified and justified need.

7. The National Aboriginal Mental Health Policy should be progressively implemented in this format and evaluated in terms of service provision as indicated above, and ultimately in terms of improved mental health and well-being as outcomes for Aboriginal people.

Contexts for a National Aboriginal and Torres Strait Islander Mental Health Policy and Plan

Guiding principles

There are a number of key principles which must guide the development of an Aboriginal and Torres Strait Islander Mental Health Strategy and Plan. These are not all inclusive.

1. Aboriginal concept of health is holistic, encompassing mental health and physical, cultural, and spiritual health.

   Land is central to well-being.

   This holistic concept does not merely refer to the "whole body" but in fact is steeped in the harmonised inter-relations which constitute cultural well-being. These inter-relating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these inter-relations is disrupted, Aboriginal ill health will persist.

2. Self-determination is central to the provision of Aboriginal health services. The mental health services provided for Aboriginal people must be developed in response to identified needs and be provided by Aboriginal organisations wherever possible. Responsibility for programs and services must rest with Aboriginal people.

   The right and process of self-determination is crucial to ensuring the harmony of these inter-relations. Self-determination is both a construct of Aboriginal culture and a globally recognised human right of peoples – distinct in their culture, territory and history – to their territory, land and resources and their own culturally shaped social, economic and political institutions. Further, as a process, self-determination can do much towards lessening the risk for mental ill health.

3. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal people's health problems generally and mental health problems in particular. These understandings must apply both in services developed by and for Aboriginal people and in mainstream health and mental health services.

4. The experiences of trauma and loss that have been present since European invasion, and are a direct outcome of the disruption to cultural well-being and have been ever-present since colonisation, and are still present. They must be recognised as contributing to the impairment of health and well-being suffered by Aboriginal people. Clearly then, the process and actions of colonisation constitute the major impairment to Aboriginal cultural well-being and as such, the major cause of Aboriginal loss and grief experiences. Strategies to address loss and grief must take full account of these factors. These experiences are of particular significance with respect to mental health. Any service development must address these issues in terms of prevention and healing.

5. The human rights of Aboriginal people must be recognised and respected. The human rights of Aboriginal peoples which are globally endorsed and recognised in international law by way of instruments such as the United Nations Charter and the International Covenant on Civil and Political Rights must be respected by the agencies of all levels of Australian government. Failure to respect Aboriginal people's human rights constitutes continuous disruption to Aboriginal well-being resulting in increasing "mental ill-health". Failure to ensure Human rights contributes to mental ill-health. Those specific aspects of human rights relevant to mental

illness and United Nations Instruments for the Human Rights of the Mentally Ill must be specifically addressed.

6. Racism, Stigma, Environmental Adversity and Social Disadvantage experienced by Aboriginal people constitute ongoing stressors and impact in very negative ways on their mental health and well-being. Any strategies to improve mental health and well-being must address these structural issues.

7. The centrality of the Aboriginal Family and Kinship must be recognised, as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing. The connections between Aboriginal people are also central to their identities and lives.

8. There is no single Aboriginal Culture or group but numerous groupings; languages, kinships, and tribes, as well as ways of living. Furthermore Aboriginal people may currently live in urban, rural or remote settings, in urbanised, traditional or other lifestyles, and frequently move between these ways of living.

9. It must be recognised that Aboriginal people have great strengths, including creativity, endurance, humour and compassion. They have strong spirituality, with a deep understanding of the relationships between human beings and their environment.

These strengths should be respected, encouraged and appreciated.

It is recognised that Aboriginal people and Torres Strait Islanders have different history and in many instances different needs. Nevertheless both groups are affected by the problems that face them as Indigenous peoples of Australia. Throughout this report the word Aboriginal is used to refer to Indigenous Australians. However these differences are fully acknowledged, and in specific instances addressed by particular policy or other proposals.

Aboriginal concepts of mental health

The National Aboriginal and Islander Health Organisation (NAIHO) (1982) and more recently the National Aboriginal Community Controlled Health Organisation (NACCHO) definition of health is as follows:

"Health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well-being of their communities."

"This is an evolving definition."

This definition is also that endorsed by the National Aboriginal Health Strategy, (1989, x). Quite clearly this definition, encompassing as it does social, emotional and cultural well-being, incorporates mental health in this holistic framework.

In the most significant report on Indigenous mental health to date, the N.S.W. Aboriginal Mental Health Report (p.7), mental health is also defined consistently with this holistic approach, in the framework used within the National Mental Health Policy, (which the N.S.W. report adopts) i.e. as follows:

"Mental health is the capacity of the individual, the groups and the environment to interact with one another in ways which promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective (or emotional) and relational), the achievements of individual and collective goals consistent with the attainment and presentation of conditions of fundamental equality."

Mental Health problem is defined as follows:

> *"A mental health problem is a disruption of the interactions between the individual and the environment producing a diminished state of mental health."*
>
> *(N.S.W. Aboriginal Mental Health Report (p.7)*

Such mental health problems are often associated with significant levels of painful emotion or mental suffering perhaps in the form of grief, fear, depression or demoralisation and anxiety (affective abilities). There may also be effects of this distress on concentration, thinking and decision making (cognitive abilities). And frequently there are impacts on relational abilities such as difficulties in interpersonal relationships including withdrawal, conflict and possibly violence.

Mental Disorder is defined as follows:

> *"A mental disorder is a recognised, medically diagnosable illness that resides in the significant impairment of an individual's cognitive, affective or relational abilities."*
>
> *(N.S.W. Aboriginal Mental Health Report (p.7)*

Such mental disorders include illnesses such as depression, dysthymia, anxiety disorders, post-traumatic stress disorder, somatization disorders, substance abuse, schizophrenia, bipolar disorder and so forth, as per ICDIO/DSM IV.

It should be emphasised that the diagnostic criteria for all these disorders encompass the requirement that they shall entail impairments of a significant degree for instance, cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (DSM IV Quick Reference 1994).

In a position paper on Aboriginal Mental Health alongside a "Manifesto on Aboriginal Well-Being" NACCHO (September 1993) it was stated that

> *"For Aborigines, mental health must be considered in the wider (Aboriginal concept of well-being) context of health and well-being. This requires that this health issue be approached in the social emotional context and that both social emotional health and psychiatric disorders encompass oppression, racialism, environmental circumstances, economical factors, stress, trauma, grief, cultural genocide, psychological processes and ill health."*

These matters are further supported by the Report and Recommendations of the National Aboriginal Mental Health Conference (see Appendix A).

The historical and sociopolitical context of Aboriginal mental health

Any consideration of Aboriginal Mental Health must acknowledge the historical context contributing to Aboriginal health and well-being. These are presented in a key conceptualisation by Swan (1988)

> *"Aboriginal peoples of different tribes, speaking their own languages and having their own cultural beliefs and practices were forced from their country.*
>
> *Their rights and laws were totally disregarded. They were treated with contempt and forced into a sub-human existence.*
>
> *They were herded onto missions and government reserves. The government and missionaries*

rationed out nutritionally inadequate foods – refined sugar, white flour and tea.

Discriminatory legislation was passed that empowered government officials, police, welfare workers and mission managers to force Aborigines onto reserves that were staffed and totally controlled by resident white managers.

With institutionalisation came the forced abandonment of social practices, breakdown in culture and life of authority and traditional law, resulting in a soul destroying dependency.

The differences in cultural beliefs and practices between groups caused social disharmony and were recorded as anti-social behaviour."

Not only did white settlement bring such social disintegration but it brought enormous loss, trauma and grief through the following:
- lack of recognition of human status (by Terra Nullius) (this was not totally dispelled until recent High Court Decision)
- loss of land;
- loss of hunting grounds and hence starvation;
- social fragmentation, war;
- loss of good health;
- enforced relocations onto missions and reserves;
- loss of freedom;
- loss of cultural and legal norms;
- loss of citizenship;
- loss of control over their lives and the environment;
- forced removal of children

The theft of Aboriginal children by non-Aboriginals in authority was a systematic attempt at cultural genocide, and to this day has produced the background for many years of horrific memories, distress, and mental health problems that still need to be addressed.

The devastating experiences of Aboriginal parents and their families brought on by the removal of their children, the loss of control over their own lives, powerlessness, prejudice, and hopelessness have left many problems for us to deal with today.

Some children were fostered out and repeatedly rejected by an assortment of non-Aboriginal foster parents. It was government policy at that time to "civilise" these children and train them as unpaid domestic servants, and useful non-voting citizens. They were raised in a foreign, regimented environment that was loaded with strong negative messages about their Aboriginality.

Most families provide growing children with stories of their past that help children gain a sense of self, belonging and a sense of history.

Attachment helps the child to:
- achieve full intellectual potential
- attain cultural identity
- sort out perceptions
- know the importance of family
- think logically
- develop a conscience
- become self reliant

- cope with stress and frustration
- handle fear and worry
- develop future relationships

There are a number of issues identified as being necessary to maintain mental health (Swan, 1988).

- high self esteem and self confidence
- the freedom to communicate needs and feelings
- the ability to love and be loved
- a sense of belonging to family and community
- ability to cope with stress
- being able to relate, create and to assert oneself
- having options for change that help the development of a problem solving approach
- being comfortable with your environment, and
- **believing in something (family, community, culture, religion).**

These issues were further addressed in the majority of presentations to the National Aboriginal Mental Health Conference (Sydney, November 1993) and identified as central to the health and well-being and to the mental health of Aboriginal people today.

Policy background

A number of relevant Policy initiatives including the National Aboriginal Health Strategy, the Royal Commission into Aboriginal Deaths in Custody, the National Mental Health Policy and Plan, the National Enquiry into the Human Rights of People with Mental Illness (the Burdekin Enquiry), the National Mental Health Committee Procedure and Reporting, and the National Goals and Targets in Mental Health have all been reviewed for their relevance and significance for the Aboriginal Mental Health Policy. This review is attached in Part 2 Section A of this Report.

National Aboriginal Mental Health Policy and Plan

In terms of equity and social justice, it is appropriate that a Policy for Aboriginal Mental Health incorporates key policy principles of the National Mental Health Policy, while shaping and extending these to meet the identified needs of Aboriginal people, and in line with the guiding principles outlined above.

Aims

The aims of the Aboriginal Mental Health Policy are:

1. to promote the mental health and well-being of Aboriginal people in their communities and where possible prevent the development of mental health problems and mental disorders, in ways consistent with the concept of Aboriginal mental health.
2. to reduce the impact of mental health problems and mental disorders on Aboriginal people, their families and communities by appropriate measures including the provision of optimal and effective care.
3. to ensure the rights of Aboriginal people with respect to mental health problems and mental disorders.
   (note: The word Aboriginal is used throughout this report to cover Aboriginal and Torres Strait Islander people as Indigenous Australians)

Key principles

Key principles of health care and mental health care must be subsumed in this policy of Aboriginal Mental Health.

Guiding principles for Aboriginal Mental Health
- National Aboriginal Health Strategy definition of Health;
- concepts of health as holistic;
- the right to self-determination;
- the impact of history in trauma and loss;
- the need for cultural understandings;
- the recognition of human rights;
- the recognition of Indigenous Rights;
- the impact of racism and stigma;
- recognition of the centrality of kinship;
- recognition of different communities and needs;
- Aboriginal strengths.

Basic principles for health care and mental health care provision for the Australian people include (National Mental Health Policy p.9)
- Universal access to basic health care
- High quality health care services
- Equitable funding for health care

Mental health care principles entail also for all Australian people, both Indigenous and non-Indigenous (see National Mental Health Policy)
- Priority to be given to people with severe mental health problems and mental disorders.
- Opportunities for recovery and personal growth for people with mental health problems and mental disorders.

- Positive outcomes for consumers should be the first priority in mental health policy and service delivery.
- Consumers and communities should participate in decision making processes.
- Civil, political, economic, social and cultural rights should be protected for people with mental health problems and mental disorders. There should be protection from stigma and discrimination.
- Protection of individuals and community

Thus components of the Aboriginal Mental Health Policy must reflect, as a minimum, the key guiding principles for Aboriginal people for mental health, and the principles guiding health care and mental health care for all Australians.

Policy components

Policy components identified in the National Mental Health Policy are: consumers rights; the relationship between mental health services and the general health sector; linking mental health services with other sectors; service mix; promotion and prevention; primary care services; carers and non-government organisations; mental health workforce; legislation; research and evaluation; standards; monitoring and accountability.

This policy also identifies the needs of special groups. (p.20–21)

> *"Adequate resources must be made available to meet the needs of special 'at risk' groups, such as older people, children and adolescents, people from non-English speaking backgrounds, Aboriginal and Torres Strait Islanders, people living in remote and rural areas, and offenders with a mental disorder. Since the needs of special groups are likely to vary between communities and over time, it should be the responsibility of those planning and allocating resources within an area/region to assess priorities for resource allocation.*
>
> *The optimum mix of services should be determined by each mental health service system, based on the needs of the population it serves and not bound by historical patterns of service delivery and resource allocation. This population focus should determine the allocation of resources. Consumer and community consultation and participation in decision-making about service mix is essential."*

Thus the Aboriginal Mental Health Policy, after consultation with Aboriginal people requires the following components. These will require ongoing development by Aboriginal people in their final conceptualisation and implementation.

This policy is composed of a number of key elements to be listed below. These components represent the priorities for development of services to meet the needs of Aboriginal people as identified by them. However they cannot be all-inclusive. They are intended to complement important initiatives by Aboriginal communities to deal with mental health issues, and to provide strategies to address mental health service needs systematically.

Each policy component will have a specific aim or set of aims; an outline of the policy initiative; its rationale; strategies to address the policy aims; and specific outcome targets where these are appropriate.

The plan arises from the implementation of this policy, by way of the strategies suggested and other effective means, and their achievement in a systematic way over the following five years, to set a basis for ongoing development.

Policy initiatives will cover the following areas:
1. Self-determination for Aboriginal Mental Health
2. Holistic Approaches to Health and Mental Health Care Provision
3. Specialised Mental Health Service Provision
   - Crisis teams or Programs

- Community based "Aboriginal Places for Care"
- Early Intervention Programs
- Inpatient Mental Health Services

- ***Recovery and Rehabilitation Programs***

    - Consumers and Carers
    4. Trauma and Grief: Healing and Reconciliation
    5. Suicide and Self Harm
    6. Children, Young People and Families
    7. Women and Mental Health
    8. Men and Mental Health
    9. Elders and Mental Health
    10. Promotion and Prevention in Mental Health: Violence the First Priority
    11. Substance Abuse and Mental Health
    12. Forensic Issues and Mental Health
    13. Intersectoral Programs and Mental Health
    14. Research and Evaluation
    15. Education and Personnel Development
    16. Data and Information Systems

It should also be noted that because the available information, limited as it may be, indicates the extent and severity of mental health problems and mental disorders, for Aboriginal people, and their relationship to environmental and external factors, it is also essential that the principles of a Public Health approach are incorporated in line with the Ottawa Charter and that inherent in this, a primary care focus is also central. Prevention, empowerment, education in health, community involvement, are thus also part of this framework. These elements are also incorporated into the policy proposals as appropriate.

It must be emphasised that the following proposals:
- arise from the consultation process with Aboriginal people.
- are developed as a set of guiding principles to be shaped and modified by Aboriginal communities in ways they deem to be appropriate to meet their needs.
- are at all times intended to be developed and implemented by Aboriginal people, under the control of Aboriginal people who will mobilise other resources (non-Aboriginal) as they determine the need.
- aim to provide a framework for commitment to meeting mental health needs for Aboriginal people in a holistic model and in line with the principles of equity and social justice.

Policy initiatives

1.   *Self-determination in mental health care provision*

It is essential in terms of recognition of the needs and wishes of Aboriginal people that the implementation of policy is managed, coordinated, monitored and evaluated by Aboriginal people and organisations.

Aim

To develop a framework for Aboriginal mental health care provision that enshrines the principles of self-determination.

Policy initiative

It is proposed that a national coordinating mechanism be established to oversight, develop, implement and evaluate the National Aboriginal Mental Health Policy and Plan, and that this framework be one of self-determination. Thus a national committee or group of Aboriginal people is proposed for this purpose, and as a key part of the National Aboriginal Mental Health Policy and Plan.

It is clear from all submissions to the consultancy that self-determination is central to Aboriginal people's well-being, and that denial of this right contributes significantly to mental ill-health (National Aboriginal Mental Health Conference Recommendations p25, 26 –Submissions from every State and Territory.)

- Mainstream mental health services have failed to provide adequately for Aboriginal people. There are problems in relation to understanding Aboriginal concepts of health and mental health; Aboriginal history; the nature of mental disorders among Aboriginal people (there is frequently misdiagnosis); failure to understand culture; incarceration and Western-dominated modes of care; further disempowerment. Aboriginal people may be further traumatised by Non-Aboriginal Mental Health Care systems (Human Rights and Mental Illness, Chapter 28)
- Any policy initiatives in Mental Health must acknowledge from the outset the centrality of self-determination to Aboriginal people, and its key place in Aboriginal well-being and mental health. Thus it is critical that the Policy and related strategies for Aboriginal Mental Health be implemented through a process of self-determination.

Rationale

The most effective forms of general health service provision for Aboriginal people have been those provided through Aboriginal community controlled health services, (Details of Aboriginal Health Services are available in Appendix B). These services are linked nationally through the peak organisation NACCHO: the National Aboriginal Community Controlled Health Organisation. It provides a unique forum for health care provision for Indigenous Australians and can be accessed by urban, rural and remote communities. Furthermore it provides a primary care basis consistent with the principles of the Ottawa Charter and the "New Public Health" approaches that can also link to specialised care provision.

The National Aboriginal Health Strategy identified the principles of self-determination in health care as essential (p.xiii). And the recent Evaluation of the N.A.H.S. (1994) again endorses this as critical to redressing the health inequities experienced by Aboriginal people.

Special initiatives in Mental Health Care provision have developed in frameworks of self-determination.

They include models linked to State and Public Sector Mental Health services, using the expertise of specific mental health professionals, but under the control of Aboriginal people. Examples of successful models include the Victorian Aboriginal Mental Health Network, and the new initiative in W.A. Kimberley Mental Health Project. Other proposals are being developed by Aboriginal people seeking funding from State and Commonwealth Mental Health Initiatives, or rural grants like RESET. In each of these instances self-determination in mental health care provision is central.

Recommendations from the National Aboriginal Mental Health Conference also emphasise that self-determination in Mental Health care provision is essential. This was expressed in the following and implicit in many other recommendations (see Appendix A).

> *"That State and Federal Governments provide a high level of resources for mental health services for Aboriginal people to be developed by, run by and for Aboriginal people, in ways that they see as appropriate for their people."*

> *"That Aboriginal mental health rights and needs be provided for by the NACCHO in the context of the Aboriginal definition of health."*

> *"That the Federal and State departments of health transfer responsibility for Aboriginal Mental Health to Aboriginal community controlled services and adequately resource and appropriately staff them."*

> *"Self-determination is when Aboriginal people decide policies, where funds go and what style of training Aboriginal people need to be effective with their communities."*

Submissions to the consultancy also identified self-determination as essential for any mental health policy or programs for Aboriginal people (see Consultancy Report). Virtually all groups consulted saw this as a priority, and the only way in which mental health problems affecting Aboriginal people could be appropriately managed.

Strategies

1. To achieve the aim of self-determination in mental health policy and program implementation, it is proposed that a National Aboriginal Mental Health Advisory Committee (NAMHAC) be established as the first stage of policy development and implementation.

   Proposed Terms of Reference and Membership are attached.

   As a basis for policy implementation it is essential that the needs for data, education and personnel development are addressed by NAMHAC.

2. To achieve these aims it is proposed that two major working parties of the National Aboriginal Mental Health Advisory Committee are established, the Data and Information Systems Working Party and the Education and Personnel Development Working Party.

3. To achieve these aims funding be made available immediately for the establishment of this structure for implementation and monitoring.

Targets

1. The National Aboriginal Mental Health Advisory Committee (NAMHAC) be established and hold its first meeting within six months, i.e. by June 1995.

2. The NAMHAC establish its two major working parties within the first six months.

3. The Education and Personnel Development Working Party agree on education needs by December 1995 and a coordinated national approach. Specific issues to be addressed are included in section 15 of this policy proposal.

4. The Data and Information Systems Working Party urgently identify a related survey process for Aboriginal people to be linked to the National Mental Health Survey and Report, and report on this by June 1995. Specific issues to be addressed are included in section 16 of this policy proposal.

National Aboriginal Mental Health Advisory Committee

There is substantial evidence reviewed above about the need for a coordinated National Approach to Aboriginal Mental Health. Such an approach should facilitate the implementation of the Policy and Strategies outlined below and should draw these together nationally, while at the same time recognising the multiple contributions of Aboriginal communities and individuals. To oversee the policy and its implementation it is proposed that a National Aboriginal Mental Health Advisory Committee be established. It is proposed that this committee be established as the first stage of implementation. This committee should be an arm of the proposed National Council for Aboriginal Health. However, pending the establishment of this Council, and because of the urgency of need in line with National Mental Health reform, it is proposed that this Committee be established initially in its own right in line with the principles of self-determination. This Committee would be able to oversight and monitor policy implementation. In the first instance two major working parties of this Committee could facilitate policy requirements and their achievement.

Proposed terms of reference

Aims

To oversee, coordinate and monitor the National Aboriginal Mental Health Policy and Plan including policy, program, intersectoral, and evaluative aspects.

Objectives

- To provide a coordinating mechanism to facilitate the implementation of the National Aboriginal Mental Health Policy and Plan.
- To ensure Aboriginal concepts of health as holistic incorporating mental, social, physical and spiritual well-being, as outlined above, are central to the policy and plan and their implementation.
- To ensure the guiding principles outlined above are incorporated into the policy and plan.
- To oversight resourcing and accountability for the National Aboriginal Mental Health Policy and Plan.
- To ensure that there is equity and access with respect to the provision of mental health care for Aboriginal people in urban, rural, and remote areas, and in appropriate cultural frameworks, and in terms of the National Mental Health Policy.
- To ensure the incorporation of relevant human rights instruments including the United Nations instruments for Human Rights generally, Human Rights for Indigenous People, Human Rights of the Mentally Ill, and Recommendations of the Royal Commission into Aboriginal Deaths in Custody.
- To ensure that Consumer needs, concerns and contributions are recognised and incorporated in policy development.
- To identify, monitor and report on key factors impacting on Aboriginal Mental Health, and to ensure that, where possible, they are addressed.
- To provide a forum for information, analysis and initiatives for Aboriginal people on issues of Mental Health.
- To provide a framework for intersectoral collaboration with respect to matters relevant for Aboriginal Mental Health.

- To facilitate working groups to address specific issues of identified priority.
- To monitor the implementation of the National Aboriginal Mental Health Policy and Plan.

Membership

Representation should draw together the principle stakeholders from Aboriginal organisations, community and government for these purposes. These representations should be included:

i) National Aboriginal Community Controlled Health Organisation. As the peak organisation for Aboriginal primary health care services, membership should include substantial NACCHO representation, and the chairperson of this committee must be endorsed by NACCHO.

ii) Aboriginal and Torres Strait Islander Commission. As the major body concerned with Aboriginal affairs, it is essential that the Commission is represented at senior level. This is particularly so in view of the intersectoral issues that are of great relevance to Mental Health.

iii) State Mental Health. As states have substantial responsibility for mental health programs generally including funding responsibilities, state mental health branch representation is appropriate.

iv) Consumer representation. The need for consumer input has been clearly identified both by Aboriginal communities and as part of National Mental Health Policy.

v) Federal Government Mental Health Branch. To facilitate policy implementation the input of Mental Health Branch would be critical.

vi) Professional organisations with responsibility for Mental Health such as RANZCP and APS, representatives could be recruited as appropriate, or for specific tasks. Mental Health Nurses Congress and Allied Health Professionals should also be involved as appropriate for specific tasks.

vii) Linkage with the AHMAC Mental Health working party either through Mental Health Branch, shared membership, or working parties for specific issues.

viii) Secretariat National Aboriginal and Islander Childcare Committee (SNAICC)

ix) Representation as appropriate from the following bodies or areas:
- Alcohol and Substance Abuse
- Children's and Young people's services and policies
- Aboriginal Legal Services with respect to Forensic Mental Health
- AECG (Aboriginal Education Consultative Group)
- DEET with respect to education and workforce initiatives
- Corrective Services and Justice systems

x) Other representation as determined, or as appropriate for specific tasks.

Major working parties

Two major working parties are proposed as urgent initiatives.

Education and Personnel Development Working Party

The role of this working party is to work with Aboriginal communities and organisations to support, and promote Education and Personnel Development. To achieve this, it should aim:

i) To link together any current major initiatives on Aboriginal Health Education, with specific reference to mental health and ongoing education that is specific to community needs or areas (clinical).

ii) To identify needs for education in mental health with respect to Aboriginal Health Workers generally, and Aboriginal Mental Health Workers specifically.

iii) To draw together current knowledge about curricula providing education in Aboriginal Mental Health including current courses and programs (as reviewed) and to provide a manual on these, and to regularly update this.

iv) To identify Educational programs in Aboriginal Mental Health on a regional basis and to promote the development of new programs into regions of unmet need.

v) To develop with relevant groups' standards for curriculum and accreditation of courses in Aboriginal Mental Health which are in line with Guiding Principles, as indicated above, and cognisant of community, setting and cultural considerations.

vi) To identify appropriate educational initiatives and programs in Aboriginal Culture and Mental Health to contribute to awareness and appropriate practice in mainstream health and mental health services, and to set standards for accreditation of such programs as being Aboriginal Culturally Informed in their Practice of Mental Health Care.

vii) To identify and advise on curriculum and education matters generally with respect to Aboriginal Mental Health, including those for Primary Care and General Practice, as well as in Tertiary Sector Health Care Courses.

viii) To report on specialised Mental Health training for professional disciplines with respect to:
- The degree to which Aboriginal Cultural and Mental Health issues are appropriately incorporated.
- Active support is provided for Aboriginal people to complete educational programs in these disciplinary areas.

ix) To identify and promote the numbers and placement of appropriately qualified Aboriginal specialised mental health workers including psychologists, mental health nurses, social workers, medical practitioners and psychiatrists.

x) To identify and promote the development of short courses in relevant aspects of mental health and mental illness and its management, to meet specific needs.

xi) To work with DEET and other relevant educational bodies to identify resources, opportunities and action that will enhance the development of an holistic understanding in Aboriginal Mental Health and Health.

xii) To inform education and workforce considerations that are operant under the National Mental Health Plan and to ensure that these are Aboriginal Culturally Informed.

xiii) To provide, inform and facilitate educational aspects of all matters relevant to the mental health and well-being of Aboriginal people, including the Community Awareness Project of the National Mental Health Plan, and matters impacting, such as racism and discrimination.

xiv) To monitor and evaluate overall courses that relate to Aboriginal Mental Health issues.

Data and Information Strategies Working Party

The role of this working party is to work with Aboriginal communities and organisations to support and promote and

i) To facilitate a national study or survey of Aboriginal Mental Health linked to the proposed National Mental Health Survey and to inform that survey.

ii) To facilitate a linked survey or study of the mental health needs and problems of Aboriginal Children and Young People.

iii) To work with Aboriginal Community Controlled health services through NACCHO to develop information systems for mental health care provision and service utilisation that are appropriate for Aboriginal people and health services.

iv) To ensure Aboriginal concerns about the nature and purpose of data, information gathering and use are fully addressed and that data is used appropriately (Guidelines on Aboriginal Health Research).

v) To support standards development and their monitoring through Quality Assurance data program development, and to develop a program specific to Aboriginal Mental Health.

vi) To determine health outcomes for Aboriginal people in terms of mental health and their assessment.

vii) To contribute to monitoring and evaluation of the Aboriginal Mental Health Policy and Plan.

viii)   To promote and facilitate research into issues relevant to Aboriginal Mental Health.

ix)   To interact with the AHMAC working party on Mental Health with respect to its data and information system development, including proposed Minimum Data Set and to educate this group on matters relevant to the Aboriginal community.

x)   To develop and implement or ensure appropriate dissemination strategies in coordination with the Education and Personnel Development Working Party and other relevant groups.

2.   Holistic approaches to health and mental health in mental health care provision

In line with holistic concepts of mental health it is clear that these must influence service provision at every level. This is reflected in service mix, in the relation of mental health care services to the general health sector, and in the concept of primary health care.

This approach is seen as most appropriate by Aboriginal people. In addition it fits with the Ottawa Charter and new public health approaches.

Aboriginal mental health programs should be provided wherever possible for people in their communities through or alongside general health services, in primary care such as Aboriginal Medical Services, where a holistic approach is incorporated in the overall provision of care. Aboriginal Health Services provide the ideal focus for generic mental health programs for Aboriginal people, and are self-determined and managed by Aboriginal communities.

Aim

To provide primary mental health services in an holistic framework, in line with Aboriginal concepts of health and mental health, in primary care settings, alongside and integrated with the provision of general health services.

Policy initiative

To provide mental health services at a primary level in such settings, it is essential that there are adequate numbers of appropriately qualified personnel, and that all personnel providing primary care to Aboriginal people are informed on mental health aspects of health and ill-health.

Aboriginal Health Workers should receive specific training to recognise and deal with mental health problems and mental disorders. This should be required in their training and specific courses for those not previously trained in this area should be provided. Each health service area should also have in its personnel grouping Aboriginal Mental Health Workers, i.e. Health Workers specifically trained in Mental Health. It is envisaged that there should be at least two such workers for each team, taking into account the high burdens of stress and care and the need for gender specific health care workers to deal with Men's issues in Mental Health and Women's issues in Mental Health.

In addition to such primary care workers dealing with mental health in holistic frameworks, there is a need for other specialised mental health care professionals who can provide secondary and tertiary level care where this is needed. Policies should ensure that all workers providing such care are attuned to these holistic concepts as well as other cultural understandings and the Guiding Principles outlined above.

Furthermore there should be requirements for education and health care accreditation systems to incorporate these principles. Non-Aboriginal primary care providers should be informed on Aboriginal

holistic concepts of health and mental health and able to provide appropriate care in this framework for Aboriginal people. It is also appropriate that special programs of affirmative action be implemented to increase the numbers of Aboriginal people who are educated in speciality mental health professions, including mental health nursing, clinical psychology, social work and psychiatry. Education in all these disciplines should incorporate these holistic concepts, as should general medical education.

It is a matter of urgent need that all generic services providing care to Aboriginal people understand the factors underlying mental health and well-being and are educated to recognise, manage or refer Aboriginal people with mental health problems and mental disorders, when this is necessary.

As the vast majority of Aboriginal people with problems of mental health will present to primary care services, it is essential that adequate education be provided for all health workers in mental health, and that specialised workers in Aboriginal Mental Health also be available and work through primary health care settings.

Curriculum issues with respect to Aboriginal Health and Mental Health Education for Aboriginal Health workers and professional groups are addressed elsewhere. (see Education and Personnel Development (Section 15 of this proposal)). Matters relevant to education and workforce development should be oversighted by the Education and Personnel Development Working Party of N.A.M.H.A.C.

Thus it is essential that to meet Aboriginal people's needs in this area, there are both adequate numbers of personnel (generic, and mental health), and that these personnel are appropriately educated in terms of necessary knowledge, and skills, and that positions to fulfil these roles are funded at appropriate levels.

Position numbers and placement

Position numbers and placement of specialised Aboriginal Mental Health Workers will need to be further developed. While Aboriginal Mental Health Workers are currently in educational programs, for instance Cairns, Queanbeyan, and many other sites, specific numbers needed are difficult to identify. It was suggested by some submissions to the consultancy that 2 per 100 population were needed in terms of health workers generally. Bearing in mind likely morbidity levels of 30% of more (see Literature Review), and the need for gender specificity in some areas, it seems likely that a baseline figure of 2 per 500 is appropriate to cover these generic aspects of mental health need and to link to specialised secondary and tertiary services. These matters should be further developed by the Education and Personnel Development Working Party. However initial approaches at a realistic level are suggested below.

Coordination

The Primary Care/Holistic approach to mental health care for Aboriginal people should be coordinated and developed locally, to meet local needs, and oversighted by the local community controlled health care mechanisms.

The general oversighting of this program component at a National level, including its policy principles and implementation should be carried out, monitored and evaluated by the National Aboriginal Mental Health Advisory Committee.

Rationale

Mental health has only recently been acknowledged as a significant issue for Aboriginal people. This late recognition relates to fears of stigmatisation, and to the failure of understanding with respect to the nature of mental health problems as they affect Aboriginal people. In addition Aboriginal people have often suffered prolonged hospitalisation, been separated from families and communities, or have been subject to such levels of demoralisation and despair that their physical as well as mental health has been adversely affected, for instance with substance abuse, violence and so forth.

Many remote communities particularly, are far from specialised mental health services, and often health services generally.

The close interrelationship of physical and mental health is identified in many reviews of Aboriginal Health (McKendrick and Thorpe,

1994; Hunter, 1993; Kamien, 1978). Furthermore, recommendations from two major reviews highlight the importance of the holistic approach to mental health and the need to address Aboriginal Mental Health issues at a primary care level, as well as through specialised Mental Health Services.

The N.S.W. Aboriginal Mental Health Report (Swan and Fagan, AMS Redfern, 1991) makes specific recommendations on the basis of the belief that

> *"mental health must be located in the wide context of health generally, which includes the physical, social, emotional and cultural well-being of the whole community."*
>
> *(N.S.W. Aboriginal Mental Health Report p.14)*

It goes on to emphasise the need for education and training in Mental Health for Aboriginal people to become Mental Health Workers (Recommendation IV, V, VI, VII) and the need for positions in areas with significant Aboriginal populations (Recommendations VII, VIII).

These recommendations also link to the recommendations of the National Aboriginal Health Strategy (1989) with regards to Health workforce (p.63) and Aboriginal Health Worker (AHW) education programs (p.85–90). It should be noted that in the education programs listed (p.88) Mental Health was covered in N.S.W. and W.A., A.M.S. Courses in the N.T. Government course, and in courses in Queensland and S.A. This report also emphasises other health professional education (p.90–101) with particular emphasis on the importance for medical education of this sphere of Aboriginal Health.

Recommendations of the National Aboriginal Mental Health Conference (Sydney, November 1993 – Report: Swan and Raphael, 1994) also highlight the importance of holistic approaches to mental health, provision of mental health care in primary care, and the need for workforce development and education. Numerous presentations by Aboriginal people at this conference, amongst the 900 plus attendees, also emphasised the importance of these issues. Examples of relevant recommendations include the following: (see Appendix A)

> *"That mental health services should be provided as a normal component of Aboriginal community controlled (primary) health services and mechanisms be established to enable the just and equitable flow of dollars to Aboriginal communities so that we may effectively take care of health business."*
> *(p.25)*

> *"That mental health be seen in the holistic definition of Aboriginal health of total well-being of the whole Community."*

> *"That mental health should be seen as part of primary health services and not separate from them."*

> *"The majority of mental disorders and mental health problems in Aborigines and Torres Strait Islanders do not require dual intervention for specialised secondary services. It is therefore illogical to separate emotional well-being issues and therefore mental health services from primary care (as defined by NACCHO). A holistic, integrated team approach to well-being is required through Aboriginal community controlled Health services."*

It should be noted that this orientation to primary care also fits with National Mental Health Policy and Plan proposals to enhance the involvement of primary health care providers in mental health care provision. This is covered specifically in the National Mental Health Policy (p25–26) in the orientation to Primary Care as an initiative, and the need for educational programs to facilitate this, both in undergraduate and continuing education programs.

Clearly such issues are closely interwoven with the education of those working in, or likely to work in, primary health care provision for Aboriginal people. These education and workforce issues must therefore be simultaneously addressed.

A significant number of State and other reviews have highlighted the significance of Aboriginal health worker training in Mental Health and the need for specialist Aboriginal Mental Health Workers (e.g. Alice Springs, NT Report on Aboriginal Mental Health Workers).

A number of curriculum developments also support education in mental health as a critical issue to thus provide increased numbers of Aboriginal Mental Health Workers.

Furthermore it is recognised that General practitioners and other health providers need Education in Aboriginal Mental Health as well as general health, as this area has been much neglected. Curriculum planning is addressing these issues (e.g.. Aboriginal Primary Health Care Project, Proposed Rural Doctors Training Scheme).

Submissions to the Consultancy from every State and from Territory and a great many Aboriginal organisations also emphasised the importance of Aboriginal Health Workers, being educated in Mental Health, and specialised Aboriginal Mental Health worker positions being developed with appropriate educational frameworks. Aboriginal Health and Medical Services addressed this issue as did individual community members and intersectoral groups (see Consultancy Report).

Strategies

1. **Brief Education Programs in Aboriginal Mental Health** should be developed as a high priority.

   These education programs should involve innovative content and methods and be produced in formats attractive to Aboriginal people, and by them. Potential content areas of knowledge and skills are outlined (see Attachment). These programs should use resources such as the "Our Way" videos from the National Aboriginal Mental Health Conference. These programs should be oversighted and monitored by the Education and Personnel Development Working Party as indicated above.

   These programs should be provided in
   - self-education
   - distance education
   - short course formats

   They could be developed as a National resource and provided at State level by Educational Institutions with specific programs and expertise in Aboriginal Health and Mental Health.

   It is intended that these courses by provided in the first instance to
   - Aboriginal Health Workers
   - All workers in primary health care provision currently working in such settings
   - Community workers involved indirectly in Aboriginal Mental Health – e.g. substance abuse, welfare and other workers

2. **Education Programs should be developed in all Programs for Aboriginal Health Workers** to ensure adequate coverage of Aboriginal Mental Health, encompassing at least the elements in "1" above and those indicated in the Educational Strategy described elsewhere. Curriculum content and accreditation should be monitored by the Education and Personnel Development Working Party. (see Section 15)

3. **Specialised Education Programs for Aboriginal Mental Health Workers** be instituted in each State as per attached educational strategy and in line with these recommendations.

   There should be at least a specific number of places for Aboriginal Mental Health Worker Education in all States (minimum 20 per State). These programs and their accreditation should be monitored by the Education and Personnel Development Working Party.

4. **Aboriginal Mental Health Worker Positions** should be established and workforce needs identified and funded in all communities of Aboriginal people of approximated 400–500 persons (this may include geographically widespread regions). There should be a minimum of 60 positions established within 2 years (i.e. by end 1996) and further numbers and placements

should be identified by the Education and Personnel Development Working Party.

There should be a minimum of two mental health workers – one male, one female – in each region. These workers provide support for each adult group (men and women) and relief and mutual support for one another. In smaller communities they may provide the only mental health resources. Where English is not the first language of the community, workers should be from language groups relevant to the area. They should be employed through Aboriginal Community Controlled Health Services or organisations, and operate to provide both direct care, and consultation liaison backup to other general health workers (in line with principles of holistic health and self-determination).

They should be provided with:
- regular relief
- appropriate pay and career scales, and opportunities
- recognition of the differences in role from other professionals in Western health care systems with the acknowledgement of family business (e.g. attendance at funerals), Aboriginal ways of working, and so forth
- links to specialised mental health services with expertise in Aboriginal mental health for purposes of support, referral and so forth
- opportunities for further education, exchange with colleagues, regular interactions with the workers on the field
- recognition of particular skills, standing and experience

5. **Education for Medical Practitioners, Nurses** and others working in Aboriginal health services, and in population areas servicing large numbers of Aboriginal people, in Aboriginal Mental Health is essential. Current curriculum proposals addressing Aboriginal Health cover mental health, but there is a need to oversight their implementation and accreditation to ensure coverage is adequate, and to ensure programs of continuing medical and health professional education. Current curriculum planning in medical (general practice) and nursing education, should address these issues (i.e.. Aboriginal Mental Health and Aboriginal Health).

Specific Educational initiatives are proposed in this sphere (see Section 15).

There should be a review of medical and nursing curricula to ensure coverage of Aboriginal Health and Mental Health.

Specific courses should also ensure that non-Aboriginal Primary Health Care Workers are Aboriginal Culturally Informed in their practice with Aboriginal people.

6. **Policies** in all Aboriginal Primary Health Care Settings should incorporate recognition of Aboriginal Mental Health care needs and identify programs to address these.

Targets

Under the auspices of the Education and Personnel Development Working Party
1. Brief Education Programs in Aboriginal Mental Health be established in All States and Territories by the end of 1995. These programs should be low cost and easily available to all Aboriginal communities with a target of at least 200 Aboriginal people having participated in such programs by end 1995.
2. Mental Health Content in Aboriginal Health Worker education programs be specifically identified and required minimum course content in Aboriginal Mental Health be negotiated by end 1995. All programs be monitored for implementation and outcome by 1997.
3. Specialised Aboriginal Mental Health Worker programs be established in each State through Centres of Excellence, with at least three such programs, with required curriculum covered by end 1995 and in remaining states by end 1997.
4. Positions for Aboriginal Mental Health workers nationally should be reviewed, with numbers, position descriptions etc. being examined. Targets of two workers for every "community" of over 3000 Aboriginal people be implemented with a minimum of 60 such workers by end 1996, with workers for the smaller regional communities by end 1998.

5. Basic protocols for submission to obtain funding for additional Aboriginal Mental Health Workers positions be developed for the assistance of communities and regions so that these can be used as a basis for seeking resources. Generic position descriptions should also be available to be modified for regional need, by end 1995.
6. Curricula and continuing education programs for medical practitioners, nurses, and other health professionals be monitored for inclusion of accredited education and training in areas of Aboriginal Mental Health by end 1996. Courses to ensure non-Aboriginal primary health care workers are Aboriginal Culturally Informed should also be provided for these workers.
7. Policies and programs of Aboriginal Health Services be reviewed to ensure inclusion of Aboriginal Mental Health requirements by end 1996.

3.   *Specialised mental health care: core components*

Aboriginal people seek not only provision of mental health care in holistic frameworks, but have rights to appropriate specialised care in their communities.

In line with National Mental Health Policy requirements, specialised Mental Health care should be provided for Aboriginal people as for other Australians. "Community-based mental health services need to be provided reasonably close to where consumers live." (p.22)

Services should be provided in an integrated way so that services follow the consumer. The mix of services should include community based services such as crisis, assessment and treatment programs, rehabilitation, and outreach. Consumers should be involved in program development and outcome monitoring.

Aims

To provide a range of specialised (or secondary) mental health programs for Aboriginal people, chiefly based as community mental health programs, but also providing an appropriate network of integrated programs with a full mix of services.

Policy initiatives

Aboriginal people, as other Australians, are entitled to a full range of high quality specialised mental health services. It is essential, that, in this development, priority be given to community based programs.

Community mental health programs

It is proposed that the program elements described below be part of an overall Community Mental Program for Aboriginal people, oriented in each region to regional needs. Such a program, and its elements, must provide the skills and expertise of a range of mental health professionals working as a team linked to other relevant groups (e.g. Substance Abuse programs; Children's, Young People and Family programs; Education; and Welfare sectors and so forth). While this model has been derived from Western Psychiatric systems of care, its key elements have been applied for indigenous populations and developed into special formats such as the Victorian Aboriginal Mental Health Network. Integrated Services across community and inpatient systems are best provided under the auspices of a community based approach. Unfortunately in many instances, even in the general Australian community, it has not yet been possible to develop such services, either at all, or to an adequate level. In many areas service components exist, or mental health services are provided in the framework of these general principles. Particular difficulties arise for remote and rural areas and visiting services, networks or the utilisation of telemedicine or related techniques have

proved helpful. These issues need to be taken into account with the gradual implementation of the policy initiatives proposed below, but equity, high levels of need and very little access to specialised mental health services make it critical that these elements are systematically and enthusiastically addressed.

The range of psychiatric conditions or mental disorders that are addressed will vary. While it is critical that the needs of the seriously mentally ill receive the highest priority, it is also clear that diagnosis is often complicated and very severe and disabling levels of mental disorders exist in a broad framework in Aboriginal communities. Furthermore, as indicated in both the Literature Review and Consultancy Report, Substance Abuse, especially Alcohol is seen as inextricably interwoven, as are issues of Trauma and Grief. Thus within the Aboriginal communities served, the Community Mental Health Program and its elements must meet with these needs and will disadvantage Aboriginal people if simply oriented to specific diagnosed conditions.

Nevertheless, it is critical that conditions such as schizophrenia, bipolar disorder, major depression, and other psychoses, including organic, are specifically addressed. There is a need for much further understanding of both the nature and extent of those problems in the community. State Mental Health data reports where available in terms of usage indicate that these disorders, particularly schizophrenia, residual or chronic and paranoid forms, bipolar disorder, depression and organic psychoses related to alcohol particularly are frequent sources of admission. However Depression generally and Anxiety disorders are also common as are other conditions. It is essential that data is gathered systematically as part of National Mental Health Policy proposals, or specific targeted research with Aboriginal people address these issues. Nevertheless program development must address the care and management of these problems and promote the fullest possible recovery for Aboriginal people. Evidence indicates they are at least as common, if not more so than in the non-Aboriginal population.

Particular management issues also arise. Acute evacuations for the mentally disturbed are traumatic in themselves and may transport the acutely disturbed person far away from family supports to city psychiatric centres. Psychotropic medication is also an issue for Aboriginal people who frequently see it as failing to help with their problems, or being overused, inappropriately used, or creating adverse and inexplicable additional disturbances (e.g. movement disorders). There is a need for much further research to explore the issue, but it implies that the most careful assessment, management planning and patient and family education, as well as outreach and monitoring, are essential for this component of care. Other physical treatments are equally problematic and require the fullest ethical considerations including informed consent. Similarly with respect to mental health legislation. Counselling and education are seen as important components of care but little appears to be available in terms of models for their optimal use with Aboriginal people who may be acutely disturbed. Family and kinship are central and are poorly dealt with in many instances. Consumers and families have frequently described the failure to inform them, to explain, to provide optimal care and there is a pervasive view that diagnosis and treatment are 'second class' for Aboriginal people with mental illness. This was also highlighted by the Burdekin report.

A range of professionals may contribute to care but it is critical that both they and the program they provide are informed about Aboriginal Culture and History, and views of mental health, and demonstrate sensitivity in culturally appropriate practices. Ideally these should be Aboriginal, but as much use will still be of general specialised mental health services they need to be educated and have policies in these areas. Contribution of Mental Health Nurses may be particularly relevant (see Holland's review of this issue and her experience as a lone Mental Health nurse practitioner operating in a primary health care model of "building bridges".

Psychologists' contributions have been identified in terms of clinical need, or perhaps the development of an indigenous psychology (see Reser, 1994). The importance of cultural perspectives for practice is described. Other professionals such as Occupational Therapists have written of Rehabilitation (e.g. Glynn, 1993) but not addressed mental health aspects. Similarly specific social work contributions in the field of Aboriginal Mental Health need further identification (Baban, 1993).

In overview, then, it is essential that these facets are shaped and integrated in Aboriginal ways and to meet Aboriginal people's needs in the program elements identified below. These elements should be linked together in a coordinated response relevant to these identified needs and in line with local requirements.

Crisis teams or programs

Crisis Teams or Programs with acute outreach to Aboriginal people, capacity to respond to crises and emergency, acute assessment, acute care and management. The need for such services is identified by communities as central. These programs would need to incorporate a broad understanding of the crises of mental disorders, and as well crises arising in circumstances of violence and substance abuse, because of the high concurrence of these problems with mental disorders. These programs should be developed in forms responsive to local needs and in forms acceptable to Aboriginal people and where possible provided by Aboriginal people who are appropriately educated for this task.

These programs should also encompass the capacity to detect, respond to, and treat acute psychotic illness in all its forms, other major mental disorders, and mental disorders connected with Substance Abuse. It is essential that program providers be specifically educated for Aboriginal Mental Health, be guided by principles of Aboriginal Mental Health outlined above, be mobile in terms of responding to Aboriginal people in their own communities and linked to Aboriginal Health Services, as well as being able to access, as appropriate, general mental health services in the broader community.

Community based "Aboriginal Places for Care"

While it is the preference of Aboriginal people to be treated with their families and in their communities, it is, as with all such care of mental disorders, at times necessary for people to be managed in specialised units.

It is proposed that community units (homes, or other facilities) are established as an "Aboriginal Place of Care" for acutely mentally ill Aboriginal people requiring inpatient care. In many, if not the majority of instances, a place where people can be cared for by a community team, perhaps with a small number of other mentally ill persons, will be most appropriate as a site of care, and should include options for the accommodation of children, spouse, or other family members as appropriate. This type of program is likely to make a significant contribution to more positive outcomes, and is regarded as a very important initiative by Aboriginal people.

Such centres would not be intended for long term supported accommodation, or protected care and these matters will be dealt with below.

Early intervention programs

The above programs should be oriented to the earliest possible and most effective forms of care for Aboriginal people with mental health problems and mental disorders and should be shaped to avoid additional morbidity related to the trauma of separation and hospitalisation.

These programs should be aimed at promoting as full a level of recovery as possible.

The evidence strongly supports the benefits of programs such as EPPIC (Early Psychosis Preventive Intervention Centre) for early recognition and management of psychosis near its inception, particularly with younger people. It is essential that similar models are developed and implemented as part of Aboriginal Community Mental Health initiatives. These programs should be informed by the work done in this field, but shaped, implemented and evaluated in terms of Aboriginal people's needs and wishes.

Inpatient mental health services

When inpatient care is needed it should be provided wherever possible in general hospital units, close to the potential client's community or Aboriginal community. Such units should develop specific programs and may have specific wards, or groupings of patients when servicing communities with high proportions of Aboriginal people. It is also vital that Aboriginal Mental Health Workers and Aboriginal Mental Health Professionals are able to provide care for Aboriginal patients, preferably through continuity from community to inpatient settings, for instance by the Crisis and Assessment team being able to continue the responsibility for care through inpatient and community settings. Where these standards are not possible it is critical that there is an Aboriginal Liaison Officer and Advocate to ensure cultural practice and

understanding optimises opportunities for care and optimal recovery.

Where there is a need to utilise psychiatric hospitals it is critical that there are specific policies utilising the guiding principles outlined above, and cognisant of cultural issues. Proposals for establishment of Aboriginal Mental Health Inpatient Units in significant population areas should be supported.

It is also important that provision is made for secure and long-term care where this is required. However as this can be an extraordinarily alien and frightening experience, there is a need for special initiatives or programs and policy development to prevent separation of Aboriginal people from their families and communities by this type of incarceration.

Recovery and rehabilitation programs

As part of the continuity of care and ensuring optimal recovery, it is important that there are programs specifically targeted at facilitating recovery, preventing relapse, and ensuring the fullest possible return to function and well-being in terms of adequate rehabilitation programs. While these programs are limited in the general community, those that exist are often viewed as inappropriate for Aboriginal people. For instance programs of rehabilitation focused on teaching skills more relevant for the non-Aboriginal community, or a return to work, when unemployment levels in communities are most often extremely high.

Aboriginal people and communities must be involved in the development of Recovery and Rehabilitation programs for Aboriginal people with mental disorders, setting goals cognisant of the guiding principles identified above, and incorporating Aboriginal cultural values.

Consumers and carers

It is essential that the needs of consumers and carers are identified and addressed. Consumers may find particular problems of access and understanding with general mental health services serving the broader population. In their own communities, consumers may fear loss of confidentiality concerning their condition and its treatment when they seek care. Those with mental illness may become sources of fear and stigma in their own communities. Carers may have little access to resources to assist them or respite, and may have chronic problems when family members are profoundly psychiatrically disabled.

Education programs about mental health problems and mental disorders should be provided to consumers and carers and address these issues in ways that incorporate Aboriginal understandings. The current mental health campaign on Community Awareness (National Mental Health Policy) should also have a component for Aboriginal people and mental health.

It is essential that consumers be involved in determining service needs, and have access, as in the non-Aboriginal community, to advocacy, to redress about care and have their full range of consumer rights (and responsibilities) acknowledged. These include:
- the right to respect for individual human worth, dignity, and privacy;
- the right equal to other citizens to health care, income maintenance, education, employment, housing, transport, legal services, equitable health and other insurance and leisure appropriate to one's age;
- the right to appropriate and comprehensive information, education and training about their mental health problem or mental disorder, its treatment and services available to meet their needs;
- the right to timely and high quality treatment;
- the right to interact with health care providers, particularly in decision making regarding treatment, care and rehabilitation;
- the right to mechanisms of complaint and redress;
- the right to refuse treatment (unless subject to mental health legislation);
- the right to advocacy;
- the right to access to relatives and friends;

- the right to have their cultural background and gender taken into consideration in the provision of mental health services;
- the right to contribute and participate as far as possible in the development of mental health policy, provision of mental health care and representation of mental health consumer interests; and
- the right to live, work and participate in the community to the full extent of their capabilities with negative discrimination.

All members of Australian society have responsibilities in relation to health care. Specifically, mental health consumers have a responsibility:
- to respect the human worth and dignity of other people; and
- to participate as far as possible in reasonable treatment and rehabilitation processes.

Aboriginal people also share these Rights and Responsibilities.

Aboriginal Mental Health Care Consumers and Carers should be represented on National and State Consumer Advisory Groups, and a network of Aboriginal Mental Health Consumers should also be established with groups in regions of high Aboriginal populative density.

Where Aboriginal people currently work through Non-Government Organisations (N.G.O.'s) for mental health matters such as support and community involvement, or similar carer or consumer formats, it is essential that such N.G.O.'s are properly supported and funded. Furthermore it is also critical that other N.G.O.'s in the mental health field also address issues of Aboriginal Mental Health within their organisation.

Mental health service requirements for Aboriginal people

In all of the matters presented above in terms of service mix and provision, it is critical that these are conveyed and implemented through self-determination principles encompassed by Aboriginal concepts of mental health and linked to Aboriginal Health Service programs. A coordinated intersectoral approach should be the aim, with the principal base of care with the community. Aboriginal Mental Health Workers and other Aboriginal Mental Health Professionals should be the providers of care wherever possible, and there must be requirements for care based on guiding principles identified above. When care is provided through non-Aboriginal systems these should be required to demonstrate culturally appropriate practices in mental health care. Case management was not seen as an appropriate concept by Aboriginal people who wished to be identified as people in a family and community context, with specific needs, and not as "cases".

Accommodation services

As identified by Aboriginal communities there is a need for accommodation services for Aboriginal people with mental illness living in communities. This is needed in forms consistent with Aboriginal cultural values and family needs, and should range from supported accommodation such as Aboriginal hostels or houses in larger population areas to respite settings. These services should be developed and managed by Aboriginal people with understanding of mental disorders and should be linked to family support mechanisms.

Aboriginal understandings: traditional healing and traditional healers

Aboriginal people may find, as do those of many other cultural backgrounds, that it is difficult to convey to non-Aboriginal people the nature and interpretation of their distress. Furthermore spiritual beliefs may be misinterpreted, or not able to be dealt with by non-Aboriginal mental health workers. It is important that Aboriginal people have access to Traditional Healers within Mental Health Services and that healers are involved in care when appropriate. Traditional healers must be respected for their contribution to well-being and the skills they may bring to the management of Aboriginal people with mental disorders or mental health problems. They should be appropriately recognised and rewarded for their services. There may also be, as part of care, the need for acknowledgement of specific cultural practices, involvement with

elders or other community leaders. These issues may be more obvious in Traditional communities, but should be taken into account wherever Aboriginal people require mental health care, if they so desire.

Mental Health Legislation affects Aboriginal people in significant and negative ways. It is essential that current proposals are informed by Aboriginal people's needs and specific components of any proposed changes respond to Aboriginal people's requirements.

Rationale

There is ample evidence that Aboriginal Communities are affected by a number of issues relevant to Mental Health (McKendrick and Thorpe, 1994). These include:
- "high rates of mental disorder combined with poor general health and extreme socio-economic depression
- paucity of good quality data about the extent and nature of mental disorders
- underutilisation of mainstream mental health services
- provision of culturally appropriate high quality mental health services" (p.151)

It is clear from the work of McKendrick et al (1992, 1993, 1994) that a high proportion of patients presenting to Aboriginal medical services have mental disorders, or are significantly psychologically distressed. Studies have found for instance that more than 63% of patients in such settings have a significant level of distress, principally depression. An excellent report (Dunlop, 1988) described disturbed behaviour in Aboriginal people in Central Australia, clarifying the patterns of behaviour (All That Rama Rama Mob). Depression, anxiety, heavy use of psychoactive substances and high risk behaviours are prevalent (McKendrick et al 1992, N.S.W. Aboriginal Mental Health Report, Swan and Fagan, AMS Redfern, 1991).

Problems are exacerbated by severe socioeconomic adversity, lack of basic requirements for healthy lifestyle in terms of housing and nutrition, frequent and repeated losses through high levels of premature mortality, high prevalence of major physical illness such as diabetes, heart disease, infectious diseases and so forth. Racism and other aspects of social stigma add additional risk factors for mental disorders and psychological burden.

Kamien's survey of Bourke in the early 1970's found that 37% of men and 28% of women were suffering from a mental disorder (Kamien, 1978), and 53% of men were also heavy drinkers. Suicidal behaviours are high, even in urban populations (Radford et al, 1990, 1991) as are feelings of demoralisation and despair. Suicide among young Aboriginal men has been reported to be rising (Hunter, 1988, a,b) and may be strongly associated with Substance Abuse (Hunter, 1993) or with incarceration (Royal Commission into Aboriginal Deaths in Custody, 1991).

The Literature Review of this consultancy indicates the need for further information. However this is also lacking for the general Australian population. Proposals are in process to address this with a National Mental Health Survey (Workshop, December 1994) and recommendations include the need to develop similar baseline data for Aboriginal and Torres Strait Islander people. Nevertheless available data (see Literature Review) indicates significant mental health problems affect at least 30% of the community and McKendrick's study using systematic measures indicates there is likely to be an even higher level for some groups. Thus it is urgent that programs are developed individually to address these mental health needs.

The need for specialised mental health services for Aboriginal people has been actively addressed in a number of reports and recommendations. For instance the N.S.W. Aboriginal Mental Health Report has as its major recommendation that:

> *"The mental health needs of the Aboriginal community be specifically identified and addressed in all national, state and territory mental health policies" (p.14)*

The National Aboriginal Mental Health Conference makes numerous recommendations with regard to the need for specialised mental health services for Aboriginal people and a large number of presentations dealt with these problems.

"That each State should establish Aboriginal Mental Health Reference teams in order to assist, support and help direct the establishment of mental health services." (p.26)

"That Aboriginal Health Services develop mental health services to care for:
- *People with psychiatric disorder*
- *Carers of people with psychiatric disorders*
- *Primary preventative programs*
- *Psychiatric follow up and support services.*
- *Mental Health Crisis Intervention Programs."   (p.31)*

"That mental health services for Aboriginal people should aim to maintain Aboriginal people in their communities not put them in mental institutions.

That Aboriginal mental health workers be placed in remote areas e.g. Pilbara, in Aboriginal community controlled services.

That specialist mental health services be made available to remote communities on a regular basis.

That psychiatrists work more in line with community based organisations." (p.31)

The Enquiry into the Human Rights of the Mentally Ill reported many problems for Aboriginal people in gaining access to appropriate mental health care (Chapter 23).

It reports that mental health services fail Aboriginal people because these services are designed and controlled by the dominant society, that society does not recognise or adapt to Aboriginal needs and beliefs.

The need for a cross-cultural perspective, particularly incorporating holistic concepts; failure to appreciate cultural and sociological frameworks; the need to understand and take into account Aboriginal spiritual beliefs; are all important to the provision of mental health care.

The need for data about the extent and nature of mental health problems and mental disorders among Aboriginal people is emphasised, in particular the need for a national survey.

This ongoing social disadvantage on the background on continuing effects of holistical and socio-holistical considerations also needs to be taken into account, particularly the ongoing negative effects of childhood separation from parents.

The links of disturbance and distress to substance abuse need particular attention.

Problems with the diagnosis of mental illness, and misdiagnosis, the need for access to traditional healers, cultural bias in psychological tests, the needs of special groups of Aboriginal people especially the young and old need to be addressed.

Servicing rural and remote communities was identified as a particular problem by this report in terms of Aboriginal people and mental health needs, and the need for cultural understandings by all mental health service providers, especially psychiatrists was emphasised. Training of all mental health professionals, and the specific development of Aboriginal mental health workers and education programs for them was emphasised.

Finally this Inquiry emphasised the need for self-determination generally and in the provision of mental health services:

"Self determination, in this context, involves providing Aboriginal people with the training, power and resources to determine their own mental health strategies within their own terms of reference"

Submissions to the Consultancy identified the need for specialised Mental Health services as a high priority to address Aboriginal Mental Health problems and Mental Illness. The shortage of adequate services was identified in Queensland, Western Australia, South Australia, Tasmania, New South Wales, Northern Territory and Victoria. It should be noted however that important initiatives such as the Victorian Aboriginal Mental Health Network (McKendrick and Thorpe, 1994) have been developed to address such problems and thus provide models of service delivery that may form a basis for service development in other settings. New initiatives have also appeared in the Kimberley, the Kimberley Mental Health Project (Bathgate et al, 1994) and in a collaborative consultation model in South Australia (Howsen, 1994).

The Consultancy Report indicates that submissions and responses provided extensive evidence of the inadequacy of current mental health services for Aboriginal people. It many remote and rural communities these were virtually non-existent. Where there was contact with or use of mainstream mental health services they were frequently seen as unhelpful, non responsive, inaccessible or unavailable and totally failing to respond to the needs of Aboriginal people with mental illness. Misdiagnosis, the inappropriateness of Western models, failure to recognise language differences, ignorance of Aboriginal culture and history, and racism complicated the picture. Mental health services were seen as needed in specialised formats by many of those consulted with. On occasions there were helpful individuals and models of service, but the overall picture is one of gross inadequacy and perceived need. The specific issues identified included: the need for crisis services and community mental health teams; need for Aboriginal places in the community; need for Aboriginal supported accommodation and respite care; need for Aboriginal Mental Health Workers and Aboriginal Mental Health Professionals; need for services to be provided in culturally appropriate ways with an understanding of Aboriginal history and experiences; need for enhanced understanding within communities of mental health issues to reduce stigma against the mentally ill; need for appropriate rehabilitation services; need for carers' and consumers' involvement and support; need for access to traditional healers; need for general mental health service systems to be more aware of Aboriginal people and their needs; need for education and training of Aboriginal health workers; need for secure units near population centres; need for programs to support families; special needs of remote and rural communities; avoidance of separations and further trauma.

Thus there is overwhelming support for the need not only for holistic mental health care provision in primary care, but for specialised secondary mental health services, developed and implemented in ways synchronous with Aboriginal needs and values.

Strategies

1. The National Aboriginal Mental Health Advisory Committee liaise with each State and Territory to facilitate the basis for the establishment of at least two major Aboriginal Community Mental Health Programs. Each program should encompass as a minimum a "Crisis Team", an "Aboriginal Place of Care" and an "Early Intervention Program" and should work in Partnership with Aboriginal Community Controlled Health services, while at the same time linking to, and being supported in funding by State as well as Federal resources for mental health. One such program should be established in each capital city to serve at least one area with a significant Aboriginal population base. A second such program should be established in a rural area and linked to a remote area serving a significant population, with manageable access. These teams should be appropriately resourced for infrastructure in terms of telecommunications, vehicles, facilities etc. It is essential however that staffing levels are appropriate to provide for adequate numbers to ensure that mental health needs of the communities are covered.

   These teams should be staffed by appropriately trained Aboriginal mental health workers and mental health professionals. Ideally, where this is possible they should be Aboriginal people educated in these professional roles. (e.g. Aboriginal mental health nurses, psychologists, social workers and eventually psychiatrists). However until this is the case, they should be staffed by appropriately qualified people who have been specifically educated in Aboriginal

culture and history and Aboriginal Mental Health. They should be responsible through a management group to the Aboriginal Community Controlled Health services of the region. Where specific initiatives exist such as the Victorian Aboriginal Mental Health Network, or the Kimberley Mental Health Project, these should be supported to the full range of functioning so that they may be adequately monitored and evaluated and provide models of excellence. As these centres develop, it is essential that they provide a focus for education and "good practice" models for programs to educate Aboriginal Mental Health Workers and other Mental Health Professionals. It is also essential that they are evaluated so as to gauge the most appropriate formats of this type of model for Aboriginal communities.

2.   In other regions of significant Aboriginal population, a "seed team" for community mental health should be established. This smaller group should be comprised of Aboriginal Mental Health Workers, (at least two in number, one male, and one female) plus at least one other mental health professional such as a community mental health nurse, psychologist or social worker with experience working in community mental health programs of the type outlined, and with Aboriginal Communities. These "mini teams" should form the basis of a full mental health team as services develop, and should link to appropriate resources in the general community mental health service, so as to ensure needs are met, and pending further Aboriginal service development.

3.   Data and information systems are essential to the development, monitoring and evaluation of these specialised mental health programs. These data and information systems should encompass the capacity for basic need assessment for the area (potentially linked to the proposed National Survey), information on cases and case management, as part of health system monitoring, and outcome assessment for evaluation.

This component should be monitored in its development by the Data and Information Systems Working Party, covering in the first instance the regions where teams are established. These systems should link to National Mental Health Policy initiatives in this area. (see Section 16)

4.   Links to general community mental health service are essential. This will require active program development with those services at regional and State levels. To achieve this, it is proposed that Regional Mental Health Forums be established, as a forum for ongoing monitoring and development of these programs so they are responsive to local need. These meetings would also provide a forum for intersectoral work.

5.   Aboriginal Mental Health services in those formats should be managed by Aboriginal Health Care System Management in line with the principles of self-determination, and holistic health. Ideally management would be through, and linked to Aboriginal Health Services (AMS's) with Aboriginal Community control and evaluation.

These programs should be oversighted, monitored and evaluated nationally by the National Aboriginal Mental Health Advisory Committee.

6.   Additional Service development such as recovery and rehabilitation programs, accommodation services, inpatient programs, should be progressively developed at a regional level under the planning and management of the team. There should be an integration of these elements of the service with continuity of care. This could be provided at a regional level by the Regional Mental Health Forum.

There should be a National Monitoring of these programs and their development by the National Aboriginal Mental Health Advisory Committee, with reporting.

7.   Central to these developments are approved education and training programs. These should include education of Aboriginal Mental Health Workers as outlined above. In addition, there should be the following components:

•   Education programs at undergraduate, postgraduate, and continuing education levels with respect to Aboriginal Mental Health for Aboriginal Mental Health Professionals in core mental health disciplines through affirmative action.

•   Education programs at undergraduate, postgraduate and continuing education levels for all mental health professionals on Aboriginal History and Culture, and on Aboriginal Health

and Mental Health.

- Specific programs for workers in regions with significant Aboriginal populations so that they are Culturally Informed on Aboriginal History and Culture, Health and Mental Health.
- Brief courses to educate, or maintain skills and knowledge in Aboriginal Mental Health.
- Development of Educational resources for Education in Aboriginal Mental Health both in State and Regional centres and Nationally.

These and related developments of education and training programs should be oversighted by the Education and Personnel Development Working Party which should also monitor curriculum and course development and establish accreditation mechanisms. (see Section 15)

8. Policies dealing with Aboriginal Mental Health should be a requirement for all service providers in Mental Health, including State Mental Health Care Systems. These Policies and related resources and programs should be required for accreditation and in all regions serving significant Aboriginal populations. Standards for quality and extent of care provided should be developed by the National Aboriginal Mental Health Advisory Committee and the Policy and Program development monitored by this body in liaison with relevant Federal and State Governments and Agencies. These policies should include the potential for specialised inpatient accommodation and rehabilitation services, the provision of Aboriginal Liaison and Advocacy Officers as well as Aboriginal Mental Health Workers and other qualified Mental Health professionals, and as well appropriate resource planning and distribution. Quality management mechanisms should eventually be developed. Wherever mental health services are provided to remote and rural regions an Aboriginal component is likely to be required.

9. Carers and Consumers should be involved and represented at Regional Mental Health Forums, and in State Consumer Advisory Groups as well as in the National Consumer Advisory Group. A network of Consumer and Carer support systems should be established in all regions with significant Aboriginal populations. Consumer advocacy mechanisms should be established as a part of all regional service development by providing in each region a specific Aboriginal Advocate for Mental Health (for instance an Aboriginal Mental Health Worker with this specific role).

10. Mental Health Legislation is currently in place in States, but being developed in a national co-operative framework. Aboriginal input into this should ensure specific accounting for Aboriginal cultural needs.

Targets

1. Two focal Specialised Community Mental Health Programs should be established in each State, as described, with appropriately educated team members and links to other health and mental health services by end 1995.
2. "Seed" or "Mini" Teams should be established in all "regions" with Aboriginal populations exceeding 3000 or appropriate defined communities by end 1996.
3. Data and information system development should be connected with basic needs analysis in focal regions (as above) by end 1995 and mental health care data and information systems in place by end 1997, and monitored by the Data and Information Systems Working Party of the National Aboriginal Mental Health Advisory Committee.
4. Regional Mental Health Forums should be established in the focal regions (as in 1 above) by end 1995. Other Regional Mental Health Forums should be established by end 1996 in "regions" greater than approximately 3000 Aboriginal people, or appropriate defined communities.
5. Management systems for Aboriginal Mental Health should be in place with Aboriginal Health Services or related Aboriginal Health Care Systems management by end 1995, and, should be supported and monitored by the National Aboriginal Mental Health Advisory Committee.
6. Recovery, rehabilitation and inpatient programs should be progressively developed, with these programs in place in focal areas by end 1997.

7. Appropriate Educational programs should be developed and in place, as identified in the education strategy by end 1996, and monitored by the Education and Personnel Development Working Party.
8. Policies on Aboriginal Mental Health in mainstream services should be developed and in place by end 1996.
9. Carers and consumers advisory networks should be in place by end 1996 with Aboriginal representation on other consumer groups by end 1996.
10. Advice on Aboriginal Mental Health issues should be incorporated into the Mental Health Legislation developmental process by end 1995.

It is essential that these processes are oversighted and monitored at a National level under the Auspices of the National Aboriginal Mental Health Advisory Committee. It is thus critical that this group is established in a first stage.

Resources to base these programs are discussed subsequently under Funding but it should be noted here that it is essential that program funding is established on at least a 3 year basis as a minimum in the first instance. No adequate program development can occur without this security.

4. *Trauma and grief: healing and reconciliation*

One of the most significant and frequent problems identified by Aboriginal people was "trauma and grief". The impact on their health and mental health and well-being was seen to be extensive. The impact of trauma and grief relates to the history of invasion, the ongoing impact of colonisation, loss of land and culture, high rates of premature mortality, high levels of incarceration, high levels of family separations, particularly those consequent upon the forced separation of children and parents, and also Aboriginal Deaths in Custody. Domestic violence, sexual and physical abuse, and a whole range of other traumas also contribute. Sexual assault is considered to be very frequent and traumatic. These matters are discussed in depth below and in the analysis of needs.

Aims

To provide specific mental health services to deal with the particular and extensive effects of trauma and grief on Aboriginal people, including preventive and health promoting approaches, education, assessment, counselling, healing programs and community interventions, so as to diminish the adverse outcomes associated with such trauma and grief for Aboriginal people.

Policy initiative

The policy components proposed below aim to provide a comprehensive and interlocking set of mental health services to deal with this identified priority need, while linking to other policy areas as relevant.

Education about trauma and grief

There is a need to educate the general Australian community about the experiences of trauma and grief, their extent and effect on Aboriginal people. This education should be linked to processes of reconciliation and acknowledged by the wider community, as a stage in a public commitment to a healing process. Specific ceremonies, memorials or other ritual occasions may contribute to this acknowledgement and set a general ethos of healing. It has also been suggested (Hayden, 1993) that Aboriginal people may not themselves at times recognise that they are a "traumatised people" and that this contributes to their ill-health, for instance with substance abuse. Recognising trauma and grief, and education in ways of healing

these, may have important public health outcomes for Aboriginal people.

Assessment of trauma and grief

The centrality of the experiences of trauma and grief for Aboriginal people mean that these aspects should be included in all assessments of distress and disorder amongst Aboriginal people. Furthermore it has been shown in other settings that bereavement may impact negatively on immune function (Bartrop et al, 1977) so that assessment and management of grief may also be relevant to physical health and well-being, in the holistic sense, synchronous with Aboriginal view of health. Family separation history and loss also contribute to mental disorders (e.g. McKendrick, 1993) so that it is appropriate that assessment address these possibilities. Counselling to deal with trauma and grief may be an essential part of management for many if not most Aboriginal people with mental health problems and mental disorders. It must also be further emphasised that the impact on physical health must also be considered.

Aboriginal cultural practices and death

There is a need for acknowledgement, recognition and practice which enables Aboriginal peoples to fulfil their particular cultural requirements about death and dying. These should include provision for healing with Aboriginal ceremonies and burials where these are wished for. This may include the deaths of babies, elders, and those who die prematurely. Hospitals and health care systems should be Culturally Informed, particularly those serving large populations of Aboriginal people, and should have policies and protocols to ensure Aboriginal ways of dealing with death and dying are provided for. There should also be full recognition of the importance of funerals for Aboriginal people and the greater likelihood of their wishing to attend because of extensive family/kinship ties, and high rates of premature mortality. Special requirements about not mentioning the name of the deceased and other cultural matters should be taken into account where these are required for the particular community. Special burial places are also helpful.

Prevention approaches

Clearly there needs to be specific policies to prevent undue trauma and loss for Aboriginal people and special sensitivity to the high background level of trauma and loss that are part of their experience. Thus there is a need for intersectoral and health care system interventions to prevent family separations which continue (for instance children into care, juvenile incarceration, separation with institutionalisation). It is also critical that health policies operate to reduce premature mortality, and where it occurs, deal with it in the most sensitive way, to thus facilitate grieving and resolution rather than additional trauma. The suggestions of explanations about premature mortality and its causes described by Rosas and Weeramanthri (1993) are likely to be helpful in this regard. Appropriate cultural practices are likely to be helpful in this regard, as is counselling aimed to prevent as far as possible pathological consequences of grief and trauma when these have happened.

Counselling for trauma and grief

There needs to be general availability of counselling services to help Aboriginal people deal with their experiences of trauma and grief as well as specific counselling to do with particular situations e.g. those that are consequent upon the forced separation of children from parents with transgenerational effects; those related to Aboriginal deaths in custody. Counselling formats need to be specifically developed in culturally appropriate ways to meet Aboriginal peoples' needs in this area. Models such as those of Collard and Garvey (1994) provide this in a holistic framework. Other useful initiatives are Narrative Therapy (Howson et al, 1994) and Family Therapy. It is likely that such therapy formulations may provide framework of particular value also, because of the special expressiveness of Aboriginal people in this form i.e. story and narrative (e.g. Stone and Swan, 1994). There is likely to be a specific need to address these issues with children, particularly children in care. (see Section 6)

Counselling, in particular short term, has been identified as a very high priority for Aboriginal people particularly with respect to trauma and grief.

Counselling to deal with particular traumatic experiences is also needed. While there may be acute

situations where models such as debriefing may be helpful, there is also the need for specialised counselling to deal with longstanding, past or profound, continuous and multiple traumatic experiences. For instance traumas of separation were often followed by adverse experiences of beating and threat for many Aboriginal children. It is also clear that many, boys and girls, were abused sexually. And many young women taken into domestic service were abused and raped by their masters. Aboriginal people experience not only trauma but profound shame. Recent increase in awareness of child sexual abuse has led to many of those who experienced this trauma when younger, being able to come forward and seek counselling and therapy.

Sexual assault is also, sadly, a frequent and traumatic experience for many Aboriginal people and may be associated with great trauma and shame. Counselling may be helpful in dealing with these issues and preventing further adverse impact on mental health.

It should be noted that special programs may also need to be directed towards children, young people and families.

Counselling issues as a general consideration for Aboriginal Mental Health care is addressed in detail in the Attachment to this Section.

Debriefing for stress, crises and critical incidents

Many violent, critical, and at times catastrophic events affect Aboriginal communities, in addition to the high levels of trauma and grief noted above. It has been found useful to provide a form of critical incident stress debriefing to communities at such times (Norris, 1993) with the aim of lessening the likelihood of ongoing community disruption and other negative consequences (e.g. payback, further violence). This form of debriefing may involve supporting community elders, and providing support, as well as focusing on the incident and helpful resolution of the problem (Norris, 1993). Its techniques are likely to be helpful in many such incidents in remote and rural and potentially also in urban communities.

Special healing programs and places

It has been suggested that there would be value in the development of special Aboriginal places of Healing, for instance in National Parks etc. and other relevant places of the land. It is proposed that Aboriginal people could visit and stay at such places and that this would promote healing. These places of healing should be developed with supportive programs with appropriate centres in each state.

Community interventions

While the above generally outlines ways of dealing with trauma and grief, these initiatives should be developed and determined at local levels in ways most appropriate for that community and its beliefs, by Aboriginal people. Special community programs, or guided interventions at a time of new major loss may be helpful in this regard.

Reunion and supportive organisations

The special contributions of organisations such as "Link Up" should be acknowledged and supported. Such groups facilitate reunion, shared grieving and often help to re-establish Aboriginal identity and kinship. They may provide counselling and education and have a special role in this aspect of the reconciliation and healing process. Their programs should receive special support and extension.

Rationale

The centrality of trauma and grief were repeatedly identified by Aboriginal people as one of the most critical issues affecting them. All groups reporting to the consultancy, both in face to face meetings, in individual reporting, as well as in the reports of medical and health services saw this as both a primary cause and a major area of problem and need.

A number of studies have identified the importance of childhood and later separations and losses as well as trauma as risk factors for psychiatric morbidity. These have been identified as relevant risk factors in the non-Aboriginal community (e.g. Raphael NH&MRC, 1992; Mrazek and Haggerty, 1994). Studies of Aboriginal people, as identified in the Literature Review have also demonstrated not only the high prevalence of such traumatic experiences, but also the adverse effects on Aboriginal Mental Health.

The Royal Commission into Aboriginal Deaths in Custody highlighted the vulnerability of those with a history of childhood separations in terms of high prevalence of such separations amongst Aboriginal people in such instances as a potential contribution to the suicidal behaviour. (RCIADIC 1991)

Radford et al (1991) in a sample of urban Aboriginal people found high levels of suicidal ideation and behaviours and that many had been separated from families and brought up in institutions. Similarly Clayer and Divakaran-Brown (1991) found risk of disorder correlated with separation and trauma, as well as possibly cultural loss.

Hunter (1993) examined suicide, alcohol problems and incarceration in the Kimberley. He examined respondents in the lock-up (usually for alcohol related problems), and concluded that a high proportion of these young men who were interviewed, especially those drinking heavily and with recent loss and disruption were at increased risk of suicide.

McKendrick and Thorpe (1994) describe the high levels of loss faced by Aboriginal people, and found in their studies that 63% of those presenting to Aboriginal health services had significant psychological distress (usually depression). One third had been brought up separated from families and communities, and such separations from their Aboriginal families correlated with prolonged distress.

The survey conducted by the Aboriginal Medical Service, Redfern, of Aboriginal Communities in New South Wales found substance use problems, stress problems, distress and anxiety were common. Childhood neglect, separation from parents and institutionalisation were the best predictors of mental disorders (Swan and Fagan, AMS Redfern, 1991, N.S.W. Mental Health Report).

Recent reviews have addressed Aboriginal people's needs in this area – for instance, Hunter (1993b) and Marcia Langton on the issue of "too much sorry business".

A number of sensitive accounts have highlighted the impact of removal of Aboriginal children –for instance, "The Stolen Generation" by Peter Read and "Take This child" by Barbara Cummings. It has been estimated in one survey that 65% of Aboriginal respondents had been separated from one parent in childhood, compared to 29% for non-Aboriginal people; and 47% of Aboriginal respondents had been separated from both parents compared to 7% of non-Aboriginals (NAHS, p175). As noted in the Literature Review, death rates are double at all ages and up to five times that of non Aboriginal adults in some age groups (25–44). Maternal and perinatal and infant mortality are all substantially higher for Aboriginal people than non-Aboriginal people. Experience of violence, injury, accident, trauma are all more frequent for Aboriginal people, at least in some groups according to health care utilisation data, crime and other statistics. Past history brings childhood and transgenerational trauma and loss. There is an enormous "load" of trauma and grief borne by Aboriginal people and likely to contribute significantly to mental ill health for them. Research in non-Aboriginal communities has highlighted the vulnerability associated with such death and trauma "overload" (Wilson and Raphael, 1993).

There are no adequate studies of the nature of grief in Aboriginal communities except the work of Reid (1979) describing bereavement and grief in the Yolngu in Australia. Selby (1994) in a general survey of attitudes to death, dying and bereavement in different cultural groups, and noted a wide range of beliefs and practices.

There has been no attempt to assess or investigate the consequences of trauma in terms of post trauma morbidity such as Post Traumatic Stress Disorder or Complex PTSD (Herman, 1992) and vulnerabilities such as borderline personality traits/disorder, substance abuse, and self harm. Post trauma morbidity could explain many of the patterns of problems experienced by Aboriginal people and warrants further exploration and research.

Of particular significance is the possible impact of trauma, separation, loss and grief on physical health. As noted above, there is demonstrated impact on immune functioning (Bartrop et al, 1977). Sibthorpe (1988) has postulated impacts on physical health status, as have recent reviews. These aspects must be factored into considerations of the ongoing adverse physical health outcomes for Aboriginal people.

Reports and recommendations

Presentations at the National Aboriginal Mental Health Conference (November, 1993) indicated that Trauma and Grief were of critical concern, and repeated papers drew attention to these issues. A video of these presentations highlights the ubiquity and importance of trauma and grief and the need for counselling for these. Submissions explained the need for services to deal with grief and loss (p31), the need for Aboriginal cultural practices in relation to death (p29).

Specifically it was recommended by this conference:

> *"That the Federal and State Governments acknowledge the trauma and grief that has been caused to Aboriginal people and provide resources to Aboriginal people to develop healing and counselling for the trauma and grief, and policies to prevent further trauma and grief"*
> *(Report on National Aboriginal Mental Health Conference 1993, p33).*

> *"That Aboriginal health services develop mental health programs to address*
> * *Sexual assault*
> * *Grief and Loss"*

> *"That Link-Up be resourced to provide treatment and healing to their client groups."*

> *"That there should be an extension of funding and support of programs such as LINKUP and ANOPS which examine and 'treat' the effects of separation from families (i.e. community driven support services).*

> *"That the money promised by the Commonwealth Government and ATSIC to the families of Aboriginal people who have died in custody for grief counselling be released immediately."*

> *"That the Federal and State Governments and all other relevant organisations recognise the severe and adverse effects of the dislocation of Aboriginal people from their lands and disruption of their families and take all possible measures to prevent further dislocation and disruption because of the very adverse effects on mental and physical health and well-being".*

"Aboriginal families"

> *"That family links be encouraged especially with the extended family by:*
> * *breaking the cycles of kids being placed in care from mothers who were in homes.*
> * *talking out and resolving family problems after separation".*

> *"That putting people back in touch with their families is a priority in achieving Aboriginal well-*

being and mental health."

"That the importance of grieving the loss of family caused by forced removal of children be acknowledged."

Aboriginal cultural practices and death

"That the use of ceremonies for dealing with death be promoted by:
* *healing through Aboriginal customs and burials.*
* *being assertive with funeral directors to get what you want and in control.*
* *need to ask for what you want e.g. getting a tombstone, Aboriginal people reclaiming their practices as therapeutic.*
* *need to look not only at individual grief but also family and community grief.*
* *workplaces to recognise need for Aborigines to attend funerals and to leave work swiftly.*
* *need to educate Aboriginal workers to do grief and loss work.*
* *use non-Aboriginal professionals as resource people.*
* *need to educate doctors especially when delivering babies to be koori sensitive especially if baby dies.*
* *Aboriginal cultural awareness needed in all hospitals.*
* *stop sterilisation of Aboriginal women, take control.*
* *Non-Aboriginal people to learn about Aboriginal culture".*

The families request that services be made available immediately to help address the suffering and grief and provide opportunities for healing. The services need to be planned by the families to meet their individual needs.

National Goals and Targets for Mental Health (1994) have also identified trauma and grief as major areas to be addressed with specific counselling and prevention programs. In terms of equity it is thus also essential that such approaches are provided for Aboriginal people.

Submissions to the Consultancy

Trauma and grief, the removal of children, and separations were one of the most frequently identified causes of mental health problems from all sources: Aboriginal Medical Services, individual presentations. This matter was repeatedly discussed at all meetings, was frequent, and central and identified as an urgent priority and major need. It was seen as central to all mental health issues by Aboriginal people (See Consultancy Report).

Strategies

Under the auspices of the National Aboriginal Mental Health Advisory Committee, and monitored by this group.

1. The National Aboriginal Mental Health Advisory Committee will liaise with the National Council for Aboriginal Reconciliation to develop a National Program for Healing, Trauma and Grief, including a series of working papers and educational programs for education of the broader community and Aboriginal Communities on the trauma and grief experienced by Aboriginal people, the importance of supportive and healing approaches to deal with these, as well as the critical importance of preventing further separation, loss and trauma. This National Program should be able to be adapted at regional levels and linked to appropriate local programs and responses. The National Programs of Healing, Trauma and Grief should include factual information on historical factors such as forced removal of children, but also current high levels of premature mortality, and preventable separations of children and families, and support for the development of rituals, ceremonies and memorial processes to facilitate resolution, taking account of what is known of the beneficial effects of recognition,

acknowledgement and testimony. Use of videos on Trauma and Grief plus presentations from the National Mental Health Conference would be valuable in this matter.

This National Program for Healing, Trauma and Grief should also incorporate recognition of art, dance, writing, theatre and other creative endeavours to facilitate the working through of these experiences and to provide positive support for prevention. The National Program for Healing, Trauma and Grief should also provide an intersectoral environment for the examination of present day policies to assess these to ensure their modification to minimise further separation and trauma (for instance of children and families) and promote recovery.

Within such policy review and this overall program, it is vital that appropriate recognition is also given to Aboriginal cultural practices, including opportunities for family reunion, attendance at funerals, and rites required in different communities to do with death, dying and bereavement. This National Approach also needs to ensure positive and empowering aspects of dealing with trauma and grief so as not to create a "victim" culture in this context, but rather link to the Positive Survival themes that have been successfully used by Aboriginal people. It is also important that there is recognition of the transgenerational transmission of the impact of trauma, and loss (e.g. Danieli, 1993; Oliver, 1993) and that opportunities are taken to prevent further consequences in the future.

2.   Clinical policies, protocols and programs should be developed building on successful programs and oriented to identified needs. In this context it is necessary that policies and regional programs for mental health include recognition of the contribution of trauma and loss and provide

    a)   Therapeutic assessments of the aspects modified to formats appropriate for Aboriginal people (Raphael, 1983).

    b)   Counselling programs and other interventions to deal with the distress associated with trauma and grief and the psychosocial morbidity that correlates with this.

    c)   Healing places or programs identified as important by the community in terms of particular aspects of trauma and grief.

    d)   Special bereavement programs for deaths by suicide and for families and all those affected.

    e)   Special counselling programs for those who have recently or in the past suffered sexual assault; sexual abuse; other traumas.

The presence of such programs and the use of traditional mourning, recovery or healing as well as professional counselling, should come under the brief of the Regional Mental Health Forum, and should be provided through Aboriginal Community Controlled Health Services through Mental Health teams as appropriate. The links to general health are also critical and counselling may need to be specifically provided in terms of

•   communicating appropriately about the death (see above)

•   high levels of maternal and infant mortality and in association with the women's business of health in these contexts.

•   premature deaths of adults, especially deaths from external causes such as violence, road deaths, suicide, homicide.

•   deaths of community leaders.

•   deaths in custody.

3.   Stress debriefing. Each region of Community should have at least one and preferably two persons identified and trained in stress debriefing. This model should be one such as that of Norris (1993) which is appropriate to a range of Aboriginal community settings. Ideally these programs should be carried out in collaboration with community leaders or elders, in the model of their special support (compare peer support programs in current C.I.S.D. programs). It is critical that people realise such programs should not stand alone, but be part of a safety net of mental health support and counselling follow-up after major incidents.

4.   Education about trauma and grief. The Education and Personnel Development Working Party needs to ensure courses for education and training in counselling and community interventions

so as to deal with trauma, and grief. These should be developed in culturally appropriate formats. This strategy should include ensuring adequate and specific coverage of these aspects within courses for Aboriginal Health and Mental Health Workers, and coverage by Mental Health Professional Curricula. These courses should cover both content and skills. They should also cover special aspects of counselling such as that for grief, for sexual assault, for long term effects of abuse, for past separations and losses, and for all those forms of trauma and grief experienced by Aboriginal people.

5. Healing Places or Centres to facilitate understanding, prevention and healing should be established. These should be responsive to local need and be used for the development of preventive approaches, healing, reconciliation and memory, as well as symbolising Aboriginal strengths and Survival. Elders could facilitate this process of continuity, growth and cultural development.

6. Research and Understanding should be promoted to further understand the particular issues of trauma and grief for Aboriginal people, strategies to deal with them, counselling modes and the impact on physical and mental health of individuals and community well-being. There is a need for specific research into PTSD and how it affects Aboriginal people and its links to other disorders/problems particularly Substance Abuse and physical health problems. A national network of Aboriginal people could address these issues, and develop a resource of knowledge in this sphere, as well as factors facilitating resolution.

Targets

1. The National Aboriginal Mental Health Advisory Committee should review current understandings, liaise with the Council for Aboriginal Reconciliation, develop a specific set of goals for the proposed National Program for Healing, Trauma and Grief and produce at least one Educational program, evaluate it and disseminate it nationally by end 1996. Further programs relevant to Education, Community Consultation, Healing and reconciliation with respect to Trauma and loss as part of the National Healing Program should be implemented by end 1997, with a complete program by end 1999.

2. Clinical policies and protocols should be established by end 1996 with programs of personnel education in trauma and grief by end 1996 and counselling programs in all larger communities (> 3000) by end 1997.

3. Stress Debriefing Courses should be provided for mental health workers by end 1995 and stress debriefing coordinators or debriefers established in larger communities by end 1996.

4. A review of Trauma and Grief Education Programs and specific courses and course or curriculum accreditation should be carried out by the Education and Personnel Development Working Party by end 1995 with courses in place by end 1996. Short courses for workers in place, including video, distance education and local seminars should be developed by end 1995 to facilitate work in this sphere.

5. Healing Places or Centres should be established in each State in areas or regions or significant sites developed by Aboriginal people. There should be at least 3 such places established by end 1996 and relevant prevention and networking by end 1997.

6. Research programs should be developed and special initiatives should be provided to fund Mental Health research by Aboriginal people to explore the impact of trauma and grief on mental health and patterns of survival and pathology that may result. There should be supported funding for this aspect, through NH&MRC special initiatives, RADGAC, or other relevant agencies.

Attachment

Counselling

Counselling has been repeatedly named as a greatly needed intervention for Aboriginal mental health, and

an essential part of service provision. It is also considered essential that counselling be developed and provided in culturally appropriate ways.

Nevertheless there are few defined models of counselling for Indigenous people; or models that have involved "talking treatments" that have been shown to be effective for Aboriginal clients.

There is also an identified need for educational programs, both brief and more intensive, to give people the necessary skills to carry out this work.

Counselling is seen as needed to deal with a wide range of problem areas, so that both generic and specific expertise is required. Areas of need that are seen to be of particular priority are those to do with

- Trauma, loss and grief including the effects of separation, deaths in custody and effects through the generations of removal, loss of land
- Violence and Assault
- Sexual Assault
- Relationship, and family including breakup of relationships
- Children's and young people's problems and disturbed behaviour
- Alcohol and drug problems
- Depression
- Child Abuse, especially childhood sexual abuse and its adult consequences
- In preference to treatment with medication
- A range of other areas

Counselling, in terms of talking therapy and mutual support, may be of such value that it should be understood, and its elements be able to be utilised widely by all members of the community (Rathman, 1995) to support and help one another.

Particular emphasis is repeatedly placed on the importance of counselling being in forms appropriate for Aboriginal people's culture and understanding.

Particular organisations have been identified as providing counselling – e.g. Link-Up (New South Wales). This organisation provides counselling to families and individuals who have experienced removal and separation, to address grief and loss, to facilitate healing and recovery. "Mental healing and social acceptance", with pride in Aboriginality, is a focus for this work, with a positive emphasis on the future. There is a need for "better health services in areas of counselling, and mental health". (Kendall 1994, p19)

In a series aimed at increasing awareness of Aboriginal Mental Health issues in the Aboriginal Health Worker Journal, Hunter 1993(c), deals with the question "just talking – or communicating". This useful paper clarifies a number of key requirements for effective communication: attitude, including acceptance, interest, concern, flexibility: competence; behaviour including distance, engagement, attention, encouragement; communicating verbally including clarity, delivery and direction, silence, assistance; delivering information including simplicity, accuracy, relevance, emphasis, repetition, ending, including summary; questions, expectations, availability. Clearly this presentation forms the basis for elements of extending into counselling and contributes in terms of basic skills.

Particular initiatives for counselling have been developed. One of these is "Narrative Therapy", described by Howson (1994) and taught in a course through the Aboriginal Community Recreation and Health Services Centre of South Australia Inc. This type of counselling derives from the model of Narrative Psychotherapy described in mainstream psychiatric literature and has evolved with this group through a consultative process with Michael White, Family Therapist. It is seen as a model of particular value to Aboriginal people in that it builds on the story telling and talking modes that are a central part of people's culture. The leaders of this course see it as providing "advanced counselling skills applicable across many problem areas".

A specific course to teach counselling for mental health has been developed at the Curtin University Western Australia, Centre for Aboriginal Studies. Collard and Garvey (1994) describe the program in some detail and the ways it talks about "mental health". These workers also identify the need for "practical

and experimental training formats, culturally appropriate ways of counselling Aboriginal people, for Aboriginal people" (p17). They go on to state that counselling needs to be at community, family and individual levels. This course builds on the holistic model of mental health, mental health and well-being, coping difficulties, and problems. The course has a positive orientation, takes into account emotional, physical and spiritual well-being, the physical environment and its impact, the past and the present. The person's future goals and dreams are examined. Counsellors are encouraged in problem solving and goal setting skills, so as to assist others in these areas. This approach suggests a range of intervention options and that people can call on a range of resources to deal with their mental health problems, including psychiatrists. The diversity of treatment options, it is felt, should reflect the diversity of Aboriginal and Torres Strait Islander peoples.

Pat Dudgeon and Sandra Collard (1993) speaking at the National Aboriginal Mental Health Conference, described the necessity for such a Counselling course. (National Aboriginal Health Strategy, the Burdekin Enquiry and the Western Australia Health Needs Survey all strongly indicated these needs.) The Curtin Aboriginal Counselling Training and Development Program evolved in response to these. It provides educational programs for Aboriginal people in their workplaces, and linked to their real experiences and needs, examining both concerns and strengths of individuals and communities. It also operates not only to deal with symptoms and their management, but the options for individual and collective action to deal with causes. Hence it has a community development context, and this provides the opportunity to deal with the causes of mental distress affecting Aboriginal people at all levels. This program clearly offers options for preventive as well as therapeutic interventions.

The approach described sees holistic mental health care as contributing to prevention as well as treatment. The individual is viewed in his or her context as a whole person "Within a broader network of people, places and organisations" (p20). Interventions may be primary, secondary or tertiary to prevent mental ill health. The course is said to be based on principles of empowerment. This includes a "shared learning processes", building on skills Aboriginal people already have in dealing with mental health issues: these skills and strengths are acknowledged and affirmed.

Most of the educational programs identified in recommendations indicate that counselling is an important intervention for Aboriginal people's mental health needs and the need for this to be culturally appropriate. It is identified as a general need for Aboriginal health workers and specifically for programs to educate Aboriginal Mental Health Workers. However specific details of such counselling education programs are not available.

Recommendations from the Royal Commission into Aboriginal Deaths in Custody identified the need for family counselling, particularly family counselling services for grieving families and some initiatives have been put in place to address this, for instance in New South Wales, a Family Counselling Meeting was set up to ensure the development of necessary programs. It was considered that such family counselling needed to be made as broad as possible, taking into account extended family, cell-mates and friends. It was considered that there was a need to establish definitions of counselling, and who should deliver it and where, as well as to whom it should be provided. There should also be an intervention program put in place to prevent deaths in custody. It was suggested that there was a need for mainstream counselling services, particularly as young people were reluctant to use juvenile justice services. There was seen to be a need for a data base on counselling services. In particular there was seen to be a need for an identified Aboriginal Health Worker in each area with counselling and Aboriginal cultural experience, who could help access appropriate counsellors and respond to develop programs relevant to past or continuing need. Initiatives in other States are also attempting to address the needs for counselling, but many approaches were seen to be fragmented, many families had not received counselling, nor were there programs for the ongoing bereavements that were occurring. The Recommendations of the National Mental Health Conference and reports from those attending also indicated the high levels of distress and the enormous unmet need.

Theoretical bases for counselling for Aboriginal people

Recent theorising and initiatives from Australian psychologists (e.g. Reser, 1994) discuss the need (or

otherwise) for an "Aboriginal psychology". Reser suggests that, for instance, when considering the question of alcohol related violence, differing viewpoints for interpretation of a wide range of possible contributing factors, could "carry very different intervention and prevention implications in terms of assessment, risk identification, counselling, clinical intervention" (p6) and actual understanding. He goes on to suggest that it would ultimately be more helpful to develop a "global perspective", which would challenge western psychology, could allow expression of "the diversity of voices to represent the human experience: This would require a "new understanding of personhood and involvement and concern with third and fourth world issues and collective experiences" (p9). Bolton (1994) in the same volume emphasises that Aboriginal people may need not only "culturally appropriate counselling" which empowers spiritual as well as other issues, but also traditional healing practices. This is similar to the call from Garvey (1993) at the National Aboriginal Mental Health Conference for a "new language for mental health based on a synthesis of indigenous and imported philosophies".

Miller (1994) examines the constitution of Aboriginal mental health and makes a case for an indigenous psychology to deal with "academic colonisation" that has occurred from western models. She believes psychology should be harnessed to "empower Aboriginal people and communities" that this should occur through community education, positive small group interaction, and altering power structures. She also significantly suggests the need for "decolonisation therapy" for Aboriginal people who have been adversely affected by colonisation. Aboriginal psychologists need to be trained and courses (such as the community psychology course at James Cook University and others around the country), need to develop programs to educate Aboriginal people in "culturally appropriate" counselling – "decolonisation therapy" so that Aboriginal people are "enabled and empowered to overcome feelings of grief, powerlessness, alienation and depression at loss of land and culture and loss of family members due to violence and suicide (p26). The approach also incorporates a different power structure of therapy which is seen as more equal than traditional therapies.

A number of publications have attempted to consider the issues of transcultural counselling and a bibliography of some of these has been drawn up (Alladin, 1993). A number of these may be relevant but none specifically address the issues of Indigenous populations such as the Australian Aboriginal people.

Cawte (1986) has written on Aboriginal healing from the point of view of "Psychotherapy". He discusses his contact with a number of Aboriginal people in talking therapies over the years, and sees it as helpful.

Other workers also address needs for counselling – for instance in Alcohol and substance abuse programs. Hunter (1993a) describes the contribution of health workers working with bereaved people in providing care and support. However he goes on to suggest further aspects, such as exploring family support, being able to listen to the grieving person and allow their tears. There may be a need to help them express ambivalent feelings about the person who has died, or anger. It may also involve being there for the person when they need to talk and helping them to "let go". He also describes the work of a mabarn man in the Kimberley, a talking and touching treatment for a grieving woman. These approaches clearly contribute forms of bereavement counselling.

Presentations to the National Aboriginal Mental Health Conference frequently addressed the needs for counselling, and models that had developed. Rosemary Wanganeen in her presentation (published in Aboriginal Health Workers Journal, March 1994) described a seven phase model of "self-healing" and spiritual reconnection, which suggested a basis for elements related to counselling processes. These phases were: Phase one – Aboriginal History, cultural and spiritual; Phase two – the Aftermath of the invasion; Phase three – Identifying past physical experiences and origins in childhood, adolescence, adult life; Phase four – Identifying emotional legacies and connecting them to past physical experiences (including earlier generations); Phase five – Working with and through phases 3 and 4, with grieving processes and forgiveness processes; Phase six – The journey to find the real you and your purpose in this lifetime. Phase six involves releasing "negative energy"; Phase seven – making your connection to your spirit and our spiritual ancestors (Wanganeen, 1994, p9–15). This presentation emphasises the importance of positive self healing and each person's responsibility for this. The model, the journey, and the personal ownership are the essence of many good counselling models. Pat Lowe, at the same meeting, talks of the common emotional needs of all peoples and that while there is a need for professional counsellors

(Aboriginal) the natural abilities of some people should also be used for roles as lay counsellors.

This model was used in Broome to support Aboriginal people in custody. She emphasises too, the need for Aboriginal people to be involved in counselling, to preserve Aboriginal people's own cultural way.

Recommendations from the National Aboriginal Mental Health Conference (Report, Swan and Raphael, 1994) also addressed counselling needs (see Appendix A also).

- "That the money promised by the Commonwealth Government and ATSIC to the families of Aboriginal people who have died in custody for grief counselling be released immediately."
- "That Aboriginal Children's Services be resourced to provide culturally appropriate mental health and counselling services to their client group."
- "That funds become available for existing Early Child Care Centres for:
- counsellors for child/parent and staff needs"
- "That Aboriginal ways of counselling, Aboriginal ways of healing be identified."
- "That the Federal and State Governments acknowledge the trauma and grief that has been caused to Aboriginal people and provide resources to Aboriginal people to develop healing and counselling for the trauma and grief policies to prevent further trauma and grief."

- **"That Aboriginal mental health workers be educated to work with children and adults alongside existing services e.g. Aboriginal School Counsellors."**

- "That Aboriginal people working in the Aboriginal community and doing counselling as part of their duties (specified or unspecified) be entitled to attend counselling skills courses and receive any ongoing training they feel they need to perform their job adequately. LINK UP (NSW) be involved in educating Aboriginal and non-Aboriginal mental health workers (on effects of removal)."
- "That there be an injection of funds into all levels of training/education in Aboriginal mental health, i.e.. lay counsellors and Aboriginal health visitors, undergraduate health disciplines and graduate/post-graduate specialty education in Aboriginal mental health."
- "That relevant State and Commonwealth funding authorities be informed about the urgent need to fund courses that enable Aboriginal people to gain qualifications in psychology that are approved by relevant State Registration Boards and the APS."
- "That Aboriginal women's refuges be resourced to provide culturally appropriate counselling and mental health problems to their client group."

Aim

To develop, test and implement a range of effective counselling models and programs for Aboriginal people.

Policy initiatives

There is a need for Centres as above and other groups to be supported in their Educational Service and Research contribution to the development of Counselling for Aboriginal people.

Strategies and targets

1. Support be provided for Counselling education programs as part of Aboriginal Health Worker Education. (see Section 15)
2. Research to explore counselling models and their effectiveness be developed by and with Aboriginal people and appropriate researchers and be supported by special initiative funding through NH&MRC, RADGAC or other groups.
3. A National Workshop to develop a resource on Aboriginal and Indigenous counselling and to explore its parameters be coordinated by end 1996.

5.   *Suicide and self harm*

Suicide and self harming behaviours are complex in their aetiology. While not generally described in traditional Aboriginal society (apart from ritual behaviours) these behaviours are on the increase and have been identified in both remote and urban communities. These problems appear to be related to the social changes facing communities; to substance abuse; especially alcohol; to mental health problems and disorders such as depression; to violence; and to trauma and loss.

Evidence clearly indicates rising rates of these behaviours in those communities where they have been studied, or in terms of other indicators of their occurrence (mortality and morbidity statistics).

Aims

To reduce the rates of suicide and self-harming behaviours in Aboriginal communities.

Policy initiatives

Many of the policy initiatives outlined in other sections should also have implications for the lessening of suicide and self-harming behaviour – for instance the holistic and specialised specialist mental health programs outlined, the programs addressing trauma and loss and those dealing with substance abuse and violence, as well as young people's, men's and forensic programs detailed below.

However there is ample evidence in the broader community that there is also a need to address all possible opportunities to reduce suicide and self-harm.

Clinical policies, protocols and programs

Clinical services should have specific policies and programs aimed at dealing with suicide and self harming behaviours.

Aboriginal Health and Mental Health Services in each community as well as general mental health services should provide
- Assessment and support for Aboriginal people in Police custody particularly within the first few hours of being taken into custody, but also at all other times as appropriate (see Recommendations of Royal Commission 127, 130, 133, 138, 150, 151, 152 etc.).
- Mental health support and services for people with a past history of suicidal ideation/behaviour or attempts.
- Contact and support for acutely intoxicated people who may be particularly vulnerable if there is a history of recent loss or relationship disruption, or with evidence of perceptual or hallucinatory experiences, or paranoid ideation.
- Mental health care for young men and young women with self-harming histories and self-mutilation.
- Social support and community intervention programs for communities with high rates of self harm or clusters of suicide.
- Counselling and bereavement support for families who have experienced the death of a family member from suicide, whether in custody or the community.

Community oriented prevention programs

These need to address specific issues in each social context or community. For instance if a certain set of behaviours is associated with self-harm, such as rituals, drinking, drugs, these contexts may need to be dealt with by attempting to change attitudes or social structures (e.g. alternative goals or activities). Elders, significant community leaders, or youth leaders may be able to facilitate such a process. This component of programs addressing suicide is particularly relevant in that there is evidence of regional variation in rates (reviewed Reser, 1991), as is also found in some other indigenous populations. While self-harming behaviours must be assessed and dealt with in the social context in which they occur, it is also clear that

they may reflect a range of psychological processes and morbidity including low self-esteem and poor self-worth through to depression. Thus education of the community to help, especially those despairing or depressed, and the setting up of support networks or links to the Community Mental Health Program above, should be part of the response.

In addition community enhancement activities aimed at strengthening communities, increasing work and meaningful activity, strengthening culture and cultural connections, enhancing personal and community identity, and lessening sanctions for negative behaviours and substance abuse; should also be developed. Structural responses might also include dealing with welfare dependency, trauma cycles, self help groups for those with past trauma, and abuse or self-harm, or past problems with the law and so forth.

Rationale

Studies have delineated the increase or high prevalence of suicide and self-harming behaviours among Aboriginal people in specific areas such as the Kimberley (Hunter, 1993) or urban communities such as Adelaide (Radford et al, 1990).

Hunter (1993) summarised findings to date concerning suicide amongst Aboriginal people noting that prior to the Royal Commission most reports were anecdotal and often interpreted in terms of the frames of reference of those writing about them. However Kamien's study of Bourke (Kamien, 1978), and Burvill (1975) reported on serious suicide attempts among Aboriginal people.

Radford et al (1990) reported that in a study of 88 heads of households in Adelaide, of the 72 women interviewed, one third reported suicidal thoughts in the past and 20% had made at least one suicide attempt. Unemployment of self or partner or caregiver, living on government pension or benefits, other aspects of social disadvantage, problems with the law, experience of violence, and family disruption in childhood (lack of knowledge of at least one parent and foster home by age 12) all correlated with such suicidal behaviour.

Frequent feelings of anger, and the feeling of being not able to have reasonable control of one's life also correlated with suicide attempts, as did being raped or sexually assaulted, and a personal perception of non-acceptance by the rest of the society. These researchers concluded that a large minority of the women in this urban sample, as a result of past traumas and present stress, contemplated or attempted suicide. The second stage of this study examined factors associated with suicide attempts among Aboriginal and non-Aboriginal single parents (supporting mothers) (Radford et al, 1991). In the total sample (Aboriginal $n = 52$ and non-Aboriginal $n = 45$), twenty five percent of Aboriginals and 42.2% of non-Aboriginal women had attempted suicide. Within the Aboriginal community having 4 plus children in one's care, having ever been sexually abused, other drug problems (self), past history of self-harm, distinguish the group.

Socioeconomic disadvantage (e.g. housing, pensions, lower education, crowding) contributed to risk as did high morbidity. Isolation in the form of no close friend, or being without any vehicle, were found to be independently associated with suicide. The authors indicated the urgent need for community development approaches such as: breaking the welfare dependency spirals; caring and empathic staff rostered through welfare and law enforcement agencies; child care and weekend respite; stopping violence as far as was possible; community development strategies such as support persons, "therapeutic community effects" and so forth.

Reser (1991) reported on his own research where he interviewed 45 suicide attempters and found that alcohol was involved in nearly all the males, and half for females (heavy regular and binge drinkers were 18 times more likely to be at risk of attempting suicide).

The investigation of the Royal Commission into Aboriginal Deaths in Custody (1991) reported on 99 Aboriginal deaths in custody. The majority of deaths occurred in police custody (2 x that of prisons). While not all these deaths were suicide (however 30 were hangings) they highlighted the need for a duty of care. Those more at risk were the young (< 30 years), being under the influence of alcohol, and those who were confined alone.

Hunter (1988, 1990, 1991, 1993) reported on suicide deaths in custody in the Kimberley and then went on to study 100 Aboriginal people in the police lock-up, by visiting there and interviewing each day. Forty

six percent had a history of hospitalisation for alcohol related conditions and the current arrest was alcohol related for 92%. This population was generally young (mean 32 years). They were likely to have a history of past suicidal ideation (25%) and suicide attempts (12% of males and 30% of females) with a history of at least one of these experiences in 57% of the sample. Nine percent had suicidal ideation in the previous 24 hours. Alcohol precipitated disorders of ideation and perception e.g. paranoid ideas and hallucinatory experiences, and panic were not uncommon (30% or so). In examining the suicides that occurred he identified similar and other factors, namely: heavy drinking; disorders of ideation and perception; recent disruption to interpersonal relationships; and for some, childhood disruptions. A family history of heavy drinking was also prominent. Hunter hypothesised (p157) that as young people they, the young adult males who suicided, had experienced widespread drinking, especially by men in their parental generation; high rates of imprisonment of parents; reliance on other caretakers for those young men as children. Powerlessness, threats to relatedness (particularly the networks of interpersonal relationships that sustain identity), psychological insecurity, depression, interpersonal loss, and disorders of ideation and perception, all related to alcohol and thus to suicide.

Impulses to self harm were also researched by Hunter (1993) and in those less than 35 years of age (the majority) there was a higher level of anxiety and depression in those with self-harming ideation, and to a lesser degree self-harming history, than with the broader population of this age: Alcohol, "jealousing", and relationship disruption were found to be factors. Again Hunter highlights the social contexts, the place of social stressors, and as well issues of identity particularly for Aboriginal males. He also clearly identifies suicide, parasuicide and self-mutilation in the context of violence as well as alcohol abuse.

Thus there is ample evidence of suicide and suicidal and other self-harming behaviours, although more detailed general population estimates are needed. In a recent review of available data, the Australian Institute of Health and Welfare (November, 1994) reported that suicide and homicide account for 5% of Aboriginal male deaths and 3% of Aboriginal female deaths, in comparison to less than 2% of deaths in the total population. From 1985 to 1992 suicide was the recorded cause of death for 121 Aboriginal male deaths in New South Wales, South Australia, Western Australia and Northern Territory. An additional 124 males died of the injuries inflicted by others. Deaths in custody contributed to these high numbers but reflected as well the disproportionately high rates of imprisonment of Aboriginals.

Reports

The importance of specific policy initiatives is supported by these findings, and by the recommendations of the Royal Commission into Aboriginal Deaths in Custody (see above). [especially Recommendations 127, 130, 133, 138, 150, 151, 152 etc.]

The Recommendations of the National Aboriginal Mental Health Conference included specific reference to Aboriginal suicide and deaths in custody. These include: the need to provide for the Indigenous children of men who have died in custody, financially, emotionally and culturally; recognition of both the personal grief of family members and the multitude of problems of health, mental and spiritual well-being and financial difficulties; the need for support for Aboriginal organisations to provide preventive programs to strengthen Aboriginal family life and then to begin a healing process for families who have suffered these losses; immediate services to address the suffering and grief and to provide opportunities for healing, planned with families to meet their individual needs (Aboriginal Mental Health Conference, Redfern, Swan and Raphael 1994). It was also emphasised that the deaths in custody should not be used politically. It was further recommended "that the money promised by the Commonwealth Government and ATSIC to the families of Aboriginal people who have died in Custody for grief counselling to be released immediately" (p24). (see Appendix A)

Other Indigenous mental health programs have also addressed the "Suicide Epidemic among First Nation Youth" (Bodnar and Devlin, 1994). These workers have adapted European models of grief counselling to promote healing in programs for Indigenous people in Canada. They note that present day "suicide survivors groups" are founded on the old tradition of the "healing circle". The programs reported by these workers deal with communities having many of the same problems as are faced by Aboriginal people (e.g. housing, overcrowding among populations, poor water supplies, welfare dependency). The Suicide

Bereavement Program was developed in response to the high numbers of clients presenting with grief issues as their main reason for requesting mental health counselling. These workers also found 50% of the completed suicide and suicide attempts were made by survivors of suicide (either immediate family or friends). The program developed clinical assessment and treatment plans. It also developed a community assessment framework to identify the community's history of loss, the impact of those specific losses on that community as they perceived and the community's preferred bereavement practices. In their studies of these communities, they reported on the widespread affects of grief, the unresolved grief that was likely in suicide families where there were likely to be patterns of severe dysfunction, and the shock and trauma associated with suicidal deaths.

They noted also the problems of "suicide pacts" amongst some groups of young people such as "blood brothers" and this may represent an allegiance and wish to be with the dead rather than the living. High levels of suicide attempts and suicides affected small communities so that suicide became seen as a "normal" way to deal with pain.

Bodnar and Devlin (1994) also provide a clinical assessment for suicide survivors which encompasses demographic information, personal history (physical and psychosocial), Mental Status assessment, and Circumstances and Reactions to Death and Current Functioning.

Part IV regarding Circumstances of Death, Reactions and Current functions is seen as the most important and the basis for treatment planning and subsequent functioning. (See Attachment to this section.)

However such initiatives in addressing suicide and self-harm are also specifically supported by the National Goals and Targets for Mental Health (1994) with specific targets reducing the rates of suicide in males 15–34 (a group vulnerable in the Aboriginal population). Strategies identified in this report include primary prevention dealing with high risk situations and secondary prevention through treatment of depression, schizophrenia and related disorders in primary care.

The Consultancy Report identified problems of self-harm behaviours as frequent and disturbing. Furthermore, concern about the ongoing impact of suicide, but particularly deaths in Custody, was seen as having significant negative effects on the mental health and well-being of all Aboriginal people. The symbolic effect of suicide deaths, and the multiplicity of losses of young lives contributed to adverse outcomes.

Strategies

1. Educational programs in the detection and management of risk for suicide and self harm should be provided in courses to all primary care providers including Aboriginal Health Workers, Aboriginal Mental Health Workers and Medical, Nursing and other staff working in Aboriginal Medical Services and in regions with significant Aboriginal populations. These education programs should include circumstances of risk as identified above, how to ensure support and protection, and referral when appropriate to mental health professionals.
2. Educational programs of community leaders about suicide risk and support and how to gain assistance should be developed.
3. Education of police, correctional staff, welfare staff, alcohol providers about suicide risk and its management should be developed.
4. Protocols for assessing and responding to suicide risk in clients presenting to health, mental health, custodial and alcohol services should be part of all such services.
5. Specific identified personnel in each Mental Health Team should ensure local programs of support and outreach/followup of those with histories of attempted suicide and self-harming behaviour. These programs should include positive support and access at times of need. These should include outreach and early support to Aboriginal people immediately they are taken into custody.
6. While some initiatives have been identified and attempts have been made to provide some counselling for families, these attempts have been fragmented. A network of grief counselling programs including those with specific expertise with respect to suicide bereavements is

encompassed in strategies with respect to Trauma and grief. Suicide bereavements need to be specifically addressed in identified provision of these and it is essential that they make positive outreach over time to families so bereaved, including those bereaved in the past through deaths in custody. Workers will require education for these programs.

7. Community initiatives in non-Aboriginal communities have proved generally supportive ranging from community meetings, to youth support, to special prevention initiatives for particular regions, towns etc. These methods have not been tested in Aboriginal populations; however they are supported by reports from Indigenous programs in Canada (see above). There is likely to be a need for programs for young men and women (for self destructive behaviours and suicides). In the former, programs should be linked to men's programs, substance abuse programs and violence prevention, while the latter group, women's support and group programs in communities are likely to be effective. It is appropriate for all communities of approximately 3000 Aboriginal people to have specific community/group initiatives to address these issues, with recognition of the need for gender based programs where required, and special programs in communities with recent suicides or higher rates of self-harm or suicidal behaviours.

Targets

1. Education programs on suicide and suicidal ideation and behaviour and other self destructive behaviours and their management should be developed and implemented both as part of mental health education and for workers as noted above, and as independent programs under the auspices of the Education and Personnel Working Party by end 1995.

2. General community education programs concerning suicidal behaviours, their recognition, responses and prevention should be provided to communities >3000 by end 1996 and evaluated by the Education and Personnel Development Working Party.

3. Intersectoral programs should be developed with police, welfare, correctional and other services which include education, referral systems by end 1996, both in local community settings and centrally in each state. These could be linked to Watch Committee proposals.

4. Protocols for assessing suicidal behaviours, and risk should be developed by Aboriginal Community Mental Health Programs building on current knowledge and community needs and should be required for all services by end 1996. (See Protocol in attachment to this Section.) This should be developed and coordinated in association with the Data and Information Systems and their effectiveness evaluated/monitored by the National Aboriginal Mental Health Advisory Committee by end 1998.

5. Personnel responsible for suicidal and self-destructive behaviour management should be identified in each Aboriginal Community Mental Health Program and provided with appropriate educational programs plus support/debriefing by end 1995, and the competencies and knowledge of all health workers increased in this regard.

6. Suicide bereavement counselling programs should be developed in association with trauma and grief program development above and be identified and in place by end 1997.

7. Community Development programs to address the risk factors for suicidal and self-destructive behaviours be developed in a major urban, and major rural and one remote area in each state by end 1996 with evaluation by end 1998.

6. *Aboriginal children, young people and families – "Our Children, Our Future"*

Mental Health Program

There are significant problems facing children and young people in the general Australian community with rising rates of youth suicide, significant levels of antisocial behaviours, and indications that 10 to 18% at least of young people have a diagnosable psychiatric disorder. Services in Child and Adolescent mental health are poorly resourced generally and an area of major need for the Australian community generally. There are virtually no specific specialised services for Aboriginal children and young people with mental health problems and disorders, despite significant recognition and attempts to provide support (except the Koori Kids Mental Health Network).

Therefore, it is essential that programs address issues of mental health problems and mental disorders with young people as an urgent necessity.

In the face of the lack of any major mental health services for Aboriginal children and young people there is a need for both:

i)   Program development accessing all available sources in primary care and specialised mental health care systems, as has been done in some areas. (e.g. Koorie Kids Mental Health Network in Victoria, 1993)

ii) Preventive mental health initiatives building on all available knowledge of effective programs for children and young people, particularly those known to be effective with indigenous and disadvantaged populations.

iii) Collaboration at every level with Aboriginal programs for Children, Aboriginal Children's Services, MACS, AICCA's etc., Child Protection, Child Care, SNAICC, AECG, NACCHO, AMS, Juvenile Justice, Aboriginal Legal Services etc. Intersectoral collaboration should involve extensive networking to achieve optimal outcomes for Aboriginal children and young people.

Programs need to be innovative, creative and developed with and by Aboriginal people, meeting the principles outlined above.

In addition, a developmental perspective is critical in both program areas, as well as identifying appropriate interventions at individual, family, and community levels.

A life span developmental perspective is in keeping with the most up-to-date views of prevention and promotion of mental health for young people (Mrazek and Haggerty, 1994, Rutter and Rutter, 1993), as well as service provision. To ensure optimal mental health, the approaches of promotion, prevention and program development are usefully applied when little or no systematic specialised services exist. This life span developmental approach also incorporates the social contexts of the health and well-being of children and young people. These issues are incorporated into the following Program for Aboriginal Children, Young People and Families.

Aim

To promote the development, mental health and well-being of Aboriginal children, young people and families, to prevent mental health problems and mental disorders, and to provide the most effective and appropriate treatment for such disorders when they occur.

Policy initiative "our children our future" mental health program

1.   Promoting child development: antenatal care, childbirth and post natal care initiatives

The health and well-being of Aboriginal babies and young children is inextricably interwoven with high quality culturally appropriate antenatal care, birthing practices, and post natal care.

  •   **Child-birth Programs** Such care is essential for both ensuring the child is born with optimal chances of survival and the basis for physical and emotional health. High levels of

Aboriginal maternal mortality, perinatal mortality and morbidity and infant mortality, (even though there has been some improvement in these indices) mean that on a continuum with this, many infants start life with considerable vulnerability. Low birthweight is far more likely for Aboriginal babies. Specific issues include nutrition during pregnancy, infections during pregnancy, maternal smoking, and maternal alcoholism and potential abuse of the mother and foetus (Webster et al., 1994). Risks for infants include prematurity, low birth weight, foetal alcohol syndrome, minimal brain damage to name a few. Recent studies have indicated that even in urban populations where there is access to conventional medical services, Aboriginal women have adverse pregnancy outcomes at one and a half to two times the rate experienced by non-Aboriginal women (Najman et al, 1994). There were increased risk factors in terms of higher rates of smoking and alcohol use, and poorer antenatal care attendance. In terms of the births there were low APGAR scores, more delay in establishment of respiration, greater frequency of need for mechanical resuscitation and higher levels of low birth weight births, as well as increased neonatal deaths. Support for the mother in culturally appropriate ways may also be a critical factor to her own adjustment, especially if she is separated from family and homeland (e.g. to hospital from remote community). Language, cultural requirements, fear of alien practices, separation from women and family, and alienation, may all contribute to significant levels of distress during pregnancy and especially during the birth process, leading to greater risk of complications, adverse outcomes for the baby, or problems of mother and infant relationship and parenting.

Congress Alukura has identified the importance of proper birthing practices and places to support Aboriginal women through this process. They also provide a support program for Aboriginal women and when women come from remote communities. There are also many other birthing programs developed by Aboriginal women to meet their cultural needs.

Specialised mental health programs as well as this supportive prevention approach may be necessary in this early period. They include

- **Parenting support programs** These are particularly likely to be necessary for very young mothers, young women without family supports, or those vulnerable because of adversity, and those with history of family separation. Parenting programs will be considered in detail later, but may need to be implemented from the earliest time. They should be developed and run by experienced Aboriginal women.

- **Young mother programs** are seen as an area of special need and require specific development directed toward enhancing the outcomes for these young women and their children.

- **Aboriginal Home Health Visitor Programs** There is adequate evidence from a wide range of studies (Reviewed in Mrazek and Haggerty 1994) that such visitor programs can achieve improved outcomes in vulnerable and disadvantaged new mothers, those with low-birthweight babies, and those at risk with abuse and parenting failures.

- **Treatment of Post Natal depression** Post Natal depression among Aboriginal women has been reviewed by Druett (1993/94). She suggests that identification of post natal depression should be through general questions covering the woman's feelings after the birth of her baby. Education of Aboriginal women would be helpful so that women could identify what was happening to them and not blame themselves. Health Worker Education was also important. (These issues are specifically dealt with below).

    The detection and treatment of Post Natal Depression is critical for mother and baby. Studies in the general population indicate that depression may continue for a year or more in a large proportion of mothers and the mother's depression is known to have an adverse effect on infant development as well as mother-infant relationships. (Raphael and Martinek, 1994)

These program elements, while building on understanding from non-Aboriginal communities, have valuable elements which can be developed by Aboriginal women, and in line with culture and need. They should link to other family support programs and parenting, and build on the strengths of Aboriginal women's networks. However this program should focus on special mental health outcomes for infants and

young children, and their mothers and families in terms of emphasising the opportunities for positive relationships, mothering and secure development.

2.   Young children at risk

A significant number of young Aboriginal children may be, as with the general Australian population, at high risk of abuse, failure to thrive or early disruptive behaviours, conduct disorder, traumatisation symptoms, failure of attachment and so forth. Risk may be associated with Loss and Trauma, many young children having experienced recent multiple disruptions, separations, fostering and so forth. Programs need to support and enhance positive parenting for the young child, by support in child care placements, in foster care, or in homes with vulnerable parenting. Parenting support networks, of Aboriginal women, including mothers, grandmothers and aunts and specific Parent education programs such as the Triple P program modified for Aboriginal culture could be utilised. Because of the need for men's involvement also, Fathering programs and support may also be considered where appropriate.

Parenting programs for the descendants of the Stolen Generation Because grandparents or parents may have been taken from their families, there are many instances where parenting models and skills will have been lost to those who have not experienced adequate parenting themselves because of these separations. Family breakup, violence, alcoholism, parental incarceration, as well as high levels of demoralisation may all have a negative effect. Special parenting skills development programs are needed for this vulnerable group.

3.   Aboriginal places of family

Aboriginal places of family, special places for parenting and family support could form a focus to enhance and develop skills where there are such difficulties, to use experienced, supportive aunts, grandmothers, elders and others to support and rebuild relations between parents where there is discord. The need for this focus on family is also in line with Aboriginal views of holistic health, and needs to address views from a family point of view. These Aboriginal Place for Family settings can provide the focus for family health education, enhanced parenting, family development, and a wide range of interventions to promote health, prevent violence, and to strengthen culture.

4.   Prevention of child abuse and neglect

While the above programs provide a basis to contribute to the prevention of Child Abuse and Neglect, there is a need for specific national initiatives as presented to the National Council for Child Protection by the Secretariat of the National Aboriginal and Islander Child Care Committee (see review). This places emphasis on prevention as a priority with strategies addressing community awareness and education, parent education, child education; early intervention; and preventive and support networks at local and community levels. There is a need to involve men as well as women in this process and to alter community denial and promote attitude change, action and responsibility. There is also the need for counselling and support programs for those affected, and which may link to the initiatives related to Trauma and Grief. This initiative while operating from a mental health point of view needs to be part of the National Plan of Action, confirming and supporting it. It also needs to operate on a strong intersectoral base.

5.   Healthy schools programs

There are major National initiatives to promote healthy schools (Health Advancement Standing Committee, NH&MRC, 1994–95). This program should identify a specific component for Aboriginal Children as well as for non-Aboriginal Children to enhance mutual understanding. The mental health components of such programs need to specifically focus on difficulties faced by Aboriginal Children in such settings, for instance low self-worth, conduct disorder, depression, learning difficulties. Educational interventions for vulnerable Aboriginal young people, should complement structural change in schools, and work with teachers, parents and communities in multicomponent enrichment programs, which have been demonstrated to be effective in other disadvantaged groups (e.g. Headstart). For schools in areas where Aboriginal families and children have a large population base, or Aboriginal schools, the cultural ethos of

the school may be the critical component of such enrichment. The cultural basis, understanding and programs of the school need to be addressed.

6.   Young peoples programs

Guidance and counselling workers in schools in areas with significant Aboriginal populations, should be Aboriginal or supported by an Aboriginal school liaison officer. Guidance and counselling officers should be educated to identify and respond to the mental health problems of young people in culturally appropriate and effective ways. For young people already demonstrating problems, there is likely to be value in cultural development programs, for instance special camps like Mt Clump for young people with antisocial problems.

Prevention programs developed for Aboriginal young people should be a major program initiative. They should include substance abuse prevention, social skills development, interpersonal problem solving and other programs of demonstrated effectiveness. A central aspect of such programs should be aimed at assisting Aboriginal young people with their sense of identity and culture, and to develop positive coping styles. The issues for young men and young women are different and are considered in men's and women's mental health programs. However it is essential that educational support and enrichment, sporting and leisure development as well as interpersonal and physical health education form a strong component of mental health prevention programs for young people. Education should help young people to recognise problems and provide opportunities for them to access support for this. Adolescent vulnerabilities related to past or ongoing sexual abuse, violence, and substance abuse may need to be specifically dealt with. Programs facilitating work entry development and accessing appropriate employment will be particularly important for older adolescents. All of these programs must be provided in culturally appropriate ways, must be developed with young people, and be responsive in Aboriginal ways.

At this stage it is critical that access to mental health expertise becomes available, as young people in mid to late adolescence are at a developmental stage where major mental health problems or disorders have their onset. Furthermore there is a risk that acting out behaviour may lead to problems with the law, and the beginning of a criminal career, homelessness, and physical health problems such as sexually transmitted diseases. Thus the Specialist Aboriginal Mental Health Team for the region should have a Young People's Access component and a Young People's Mental Health Program should be the aim for all communities of reasonable size. This program could follow a model of prevention and early intervention and prevention of psychosis and early recognition and care of other disorders, as with the Young People's Mental Health program and Early Psychosis unit in Melbourne (McGorry and Pattern, 1994). This should of course be modified to meet Aboriginal community needs and the particular needs of Aboriginal young people.

7.   Specialised children, young people and family mental health networks

There is a need to identify child and family mental health services in each region and to ensure access and special programs for Aboriginal children, young people and families. The provision of assessment, counselling and other therapies for Aboriginal families should be in terms of extensive understanding of their problems, the effects of history as well as current disadvantage, their social contexts and the impact of violence, substance abuse and other factors. While there is a general shortage of child mental health services in the Australian community, models such as the Koori Kids Mental Health Network provide an opportunity for Aboriginal Medical Services and, as they develop, Aboriginal Mental Health Services, to link to child mental health expertise to develop programs for Aboriginal Children in this field. Such programs can use education of mainstream services ensuring they are informed in cultural practice and need; consultation liaison models to enhance Aboriginal mental health worker skills; and affirmative action to develop a cadre of Aboriginal Mental Health Professionals with specialised training in child and adolescent mental health (e.g. psychologists, social workers, mental health nurses, and eventually child psychiatrists).

8.   Special needs groups

Most prevention and services programs identify responses to groups with special needs. These include

addressing the mental health issues from a prevention and care point of view for children and young people. These special needs groups include those children:

- who have physical illness and chronic disability
- who have learning disability
- who are intellectually handicapped
- who are institutionalised (e.g. juvenile justice systems)
- who are at risk of suicide and self harm
- who have parents with mental illness or substance abuse.

Children of parents with mental illness are a group at special risk. Their parents may have been absent with hospitalisation, abusive, or shown inadequate parenting because of their illness; or have suffered marital discord; or been impaired role models or genetically based vulnerabilities may have occurred. Similarly with substance abuse.

9. Youth representation

It is essential that Aboriginal young people are actively represented in development, planning and management of programs that are geared towards their needs. This has multiple levels of value, including the importance of empowerment in realistic ways and the likely beneficial effects in making programs more accessible, acceptable and effective for their target group.

Rationale

It has been estimated that 40% of Aboriginal populations are aged 15 years or younger. (SNAICC, 1994) There are enormous stresses faced by communities with parental substance abuse, domestic violence, family breakdowns, lack of proper housing and basic facilities, poverty, poor physical health, and great social disadvantage. It is critical that the needs of young people are urgently addressed both in terms of prevention and access to counselling, support and specialised mental health services. While little systematic data exists on the levels of mental health problems and disorders in Aboriginal children in this age group, there is much to suggest it is substantial and increasing. The need to convene programs in this sphere is thus urgent.

Mental health problems of children, young people and families

The review above strongly supports the view that mental health problems and mental disorder may affect at least a third of young people if not more, and may be linked to prolonged adverse effects and consequences, as well as increasing vulnerability to disorders in adult life or reflecting continuity with these. Morbidity is high and mortality, for instance from suicide is also substantial (see review), and may also include other mortality outcomes such as homicide and motor vehicle accident deaths.

In addition it is essential that children and young people must be viewed in their family and community context. Therefore all programs outlined above, although focused on their mental health needs, must also invariably encompass family involvement where this is possible and appropriate. This is the more so because of the powerful bonds of kinship and extended family in Aboriginal society.

A further important aspect is the drawing together of intersectoral contributions, especially children's services, child protection, and education, child care and so forth. A critical role of initial mental health service development is the identification of these intersectoral programs and resources and a clarification of their potential contribution to mental health and well-being.

A review of some of the issues relevant to children's services has highlighted the need for a coherent approach for services for Aboriginal children, one which is inclusive rather than exclusive, and which reflects a collaboration of those elements that are significant, rather than the fragmentation identified in children's services generally in Australia (SNAICC Report, 1994). At the same time any approach must incorporate cultural differences and requirements. It is suggested that Centres for children should be places for community, involving elders in their traditional roles with children (SNAICC, 1994, p23). With respect to Childcare and Early Childhood, it is suggested that early childhood services might have a broader role in Aboriginal communities, with a "national approach to early childhood education". There is also the need to support Aboriginal people's rights and role in the transmission of their culture to their children, and as well a need to protect the processes of developmental transition that were previously protected by rituals and other structures (Hunter, 1993). The need to "harness the various strands of the children's services field" and to ensure mechanisms for monitoring and implementation by Aboriginal people is emphasised (SNAICC Report, 1994). Unfortunately there is ongoing fragmentation in Aboriginal children's services, as in the non-Aboriginal community, reflecting different government funding programs. Aboriginal control over the provision of children's services, including early childhood services is a required element of self-determination. There is a need to consider coordination, policy development with appropriate aims, multipurpose support services (e.g. welfare and family support). Provision of prevention of abuse services should be seen as encompassing both prevention of child abuse and family violence. Housing needs, income security and support into a National System of Indigenous Family and Children's Service (SNAICC Report, p31). Mental health service development for children and families needs to incorporate and fit in with these provisions.

It is concluded (SNAICC Report, 1994) that to better meet diverse mental health needs and support families and communities, there should be "the development of a national policy for Aboriginal children that is underpinned by National legislation" (p33) and a "range of children's services needs to be defined by Aboriginal and Torres Strait Islander people and suited to their needs" (p33). "There needs to be the development of a specific National Plan for the Survival, Development and Protection of Aboriginal Children" (p33). Such proposals encompass this recognition of the ongoing effects of colonisation and history on Aboriginal people, as they are transmitted through generations, in the ongoing effects for instance of forced removal and current high rates of family separation through institutionalisation, fostering etc., and institutionalised racism.

The National Aboriginal Health Strategy (1989) highlights the importance of addressing the problems of Aboriginal children, young people and families and the urgency of approaches to protect their future and also to enhance their survival, development and well-being.

The New South Wales Aboriginal Mental Health Report (Swan and Fagan, AMS Redfern, 1991) also supports the importance of mental health programs recognising addressing the needs of families, and the particular vulnerabilities associated with a history of childhood disruption. It also emphasises the need for research to provide baseline data on mental health problems for instance child abuse and neglect, substance use and abuse, and also to evaluate the effectiveness of early intervention and other programs in these areas.

A wide range of National Mental Health Initiatives has highlighted needs for service equity and access for groups with special needs (e.g. Aboriginal and Torres Strait Islander people) and targeting specific age groups (e.g. children and young people) (National Mental Health Policy and Plan 1992), thus substantiating the importance of programs in this area.

The National Aboriginal Mental Health Conference (1993) has made a number of specific recommendations to address the needs of Aboriginal children, young people and families. These include the following (Report, Swan and Raphael, 1994);

"That Aboriginal Children's Services be resourced by providing culturally appropriate mental health and counselling services to their client group" (p24)

"That there be funded positions within organisations for family support workers and that these positions be designated" (p24)

Child Care and Protection (p28)

That funds become available for existing Early Child Care Centres for
- *educating staff*
- *research into children's needs|*
- *counsellors for child/parent and staff needs*
- *relief staff funding*
- *parents' training in behavioural management*

That there be increased attention paid to mental health issues for young people in correction services, e.g. community based.

That closer attention be paid to the process of young people through the mental health system, especially indigenous young people

That there be National legislation for the protection of Aboriginal and Torres Strait Islander children

Special recommendations for Aboriginal Families (p9)

"That family links be encouraged especially with the extended family by:
- *art and drawing classes for kids*
- *breaking the cycles of kids being placed in care from mothers who were in homes*
- *taking out and resolving family problems after separation*
- *Aboriginal people sticking together*
- *art as therapy for hurting and encourage expression of feelings, using whatever medium the person is good at*

That files or records relating to removed/separated people be available for access to LINKUP staff

That safe places (refuges) for families be established for members of the family where one member has a mental health problem

That putting people back in touch with their families is a priority in achieving Aboriginal well-being and mental health

That the importance of grieving the loss of family caused by forced removal of children be acknowledged."

> Models of Service Delivery emphasise the need for Aboriginal Health Services to develop mental health programs to address (p31)
> - Family Violence
> - Aboriginal Children's issues

- Aboriginal Youth issues
- That culturally appropriate Aboriginal Family Therapy programs be developed by Aboriginal Legal, Medical and Children's services (p31)
- That Aboriginal Children's Services be funded to provide primary prevention mental health services (p31)

Education

- That Aboriginal mental health workers be educated to work with children and adults alongside existing services, e.g. Aboriginal School Counsellors.

It is also suggested that Aboriginal child care workers have special training to help them to deal with children who have experienced/witnessed violence and family disruption.

The Burdekin and other reports also support similar initiatives.

Consultation with communities and individuals

The communities consulted indicated that there were major problems with young people and children. Children were extremely vulnerable to family disruptions and were exposed to abuse and neglect, were often undernourished because of this neglect or became involved in crime or prostitution. Substance abuse was a problem with many very young children. Violence was the norm in many households. Disruptive behaviour was also reported frequently. Overwhelmingly the problems of children were seen as associated with those of parents and families and the historical and social context and the loss of cultural identity. Clearly also high levels of physical health problems, hearing impairments and educational disadvantage constitute significant additional burdens. There was a great need for prevention and services.

In conclusion there is extensive need, identified by Aboriginal consultation and reports, to urgently address the Mental Health needs of children, young people and families. This approach, in the absence of service development, must encompass prevention as the first priority, plus associated mental health service development at holistic, primary and specialist secondary care levels.

Strategies

Strategies should be informed by the guiding principles enumerated above and should recognise individual and community strengths while at the same time acknowledging the extent and severity of the problems being addressed. Here, as elsewhere, self-determination in program provision is critical. This program should be managed as indicated at a local level, but oversighted in its national implementation and evaluated, by the National Aboriginal Mental Health Advisory Committee.

1. Coordinators: young people's mental health

Coordinator positions for Children and Young People's mental health should be established in every community of reasonable size. This position should be a central and significant senior position at managerial level and should be filled whenever possible by an Aboriginal person. This is a key coordinating and organisational role that will initiate, identify and integrate other strategies. This position will be responsible for oversighting, managing and developing the prevention and service initiatives outlined above. This position should not have direct clinical responsibility, but should operate with understanding and expertise relevant to both prevention and clinical issues for children, young people and families in terms of mental health. This position should be responsible for identifying and drawing together existing resources, lobbying for additional resources that are needed, coordinating intersectoral and community meetings, and identifying networks for counselling and specialist mental health services as needed.

Even without specific clinical responsibilities, the work of the Coordinator as outlined is stressful. It is proposed that relief and supervision programs are available, and that a network of workers link together in a group for mutual support in larger geographic regions. Modern telecommunications can optimise this network.

These developments should be initiated in 25 areas, some grouped in larger population bases, as an urgent priority. These programs must be developed with community consultation and communities should have a role in worker selection. Workers should operate through Aboriginal Medical Services as a base linked to Aboriginal Community Mental Health Programs and Aboriginal Children's Services, but with this area as central responsibility, and advocacy for children's mental health and well-being as a primary goal. Specific educational programs to support these workers, the first before each individual takes up this role, would be essential. With local communities, specific goals should be established, providing a focus for activities, and objectives which can be evaluated.

2.   An intersectoral forum for children: "Our Children Our Future"

This forum should be established in each community by the Coordinator identified in "1" above. The aim is to ensure that all resources and programs relevant to the mental health and well-being of Aboriginal children, young people and families are identified. A library with other resource base, bibliography and so forth should be established. This forum should involve local representatives of Aboriginal Children's Agencies, Children's Health Services, Education, Youth Services and so forth, as well as community leadership representation committed to enhancing outcomes for children and young people. It is critical that there is Aboriginal young people's representation on this forum, and other significant groups, and that this representation is active and not tokenistic.

It should be the local or regional focus for education for mental health, mental health promotion programs, interagency development. It should provide a framework for prevention initiatives identified above related to child development, parenting, young children at risk, prevention of child abuse and neglect programs, Healthy Schools programs and all mental health prevention programs. It should support the development of services such as young people's programs, specialised mental health networks (like Koori Kids Mental Health Network Victoria), and services for special needs groups. However these programs are ultimately the responsibility of Aboriginal Health and Mental Health Services. In some communities a single Regional Mental Health Forum may cover all programs, but in others, it will be appropriate to have separate groups because of the different focus.

3.   Aboriginal place of family should be established in communities

This should be a place where parenting support and education programs, family counselling, psychoeducation, family therapy, and other relevant programs for children, young people and families can be carried out. This venue should be available for group and self-help meetings, education, consumer organisations and as a resource, with relevant materials, in the community. Its focus should be children, young people and families: its approach Aboriginal and cultural; its orientation, to education, prevention and early care.

4.   Prevention programs

In view of the potential benefits of a preventive approach at this developmental stage (OSAP, 1989; Raphael NH&MRC, 1992; Mrazek and Haggerty, 1994) a number of prevention programs should be initiated, with appropriate resources to support them. The priorities for these, and their form should be developed at a local level by the Coordinator for Young People's Mental Health and the Intersectoral Forum for the Our Children, Our Future Mental Health Program taking into account policy initiatives above. The elements that could be incorporated include:

- Promoting child development through antenatal, childbirth and post natal care programs including support programs for early parenting, low birthweight babies, and utilising Aboriginal Home Health Visitors.
- Parenting enhancement, healing and support programs including supportive networks,

education and use of traditional practices.
- Community education programs to identify effects of factors that contribute risk for children and the modification of these – for instance alcohol abuse, family violence.
- Local initiatives in a National Plan and program for Prevention of Child Abuse and Neglect.
- Family enhancement, education and support programs.
- Personal skills and interpersonal relationship programs.
- Prevention Programs for Young People with Substance Abuse, Destructive behaviours and Depression.

These are universal types of programs applicable generally for the whole community, and likely to be most effective when "owned" by local Aboriginal groups and shaped to their specific needs. It should be noted that multicomponent programs operating at a number of different levels concurrently (e.g. individual, family, school, community) are most likely to be effective.

However they should be not seen in isolation from the need at a national level to address disempowerment, disadvantage, poverty, housing, health, legal and other problems which may contribute to the risk factors and in their own right impact negatively on mental health.

5.   Specific Programs for those at high risk – prevention and early intervention

(Selective and indicated prevention approaches as well as early treatment)

(Mrazek and Haggerty, 1994)

With the leadership of the Coordinator for Young People's Mental Health, and linked to Aboriginal Mental Health, Health and Aboriginal Children's and Youth Programs, there is a need for specific programs addressing those at high risk. These should be initiated in each Community by the Coordinator after specific local needs have been identified and should be supported by other work (e.g. of Trauma and Grief, Adult Mental Health, Intersectoral approaches in Education, Justice, Welfare, etc.) They could address:
- high risk parenting
- abuse and violence
- disability
- self harm and so forth
- developmental delay, slow learning
- children in families with substance abuse or mental illness

Aboriginal young people's involvement in the development and implementation of such programs is critical from the outset.

6.   Aboriginal children and young people's mental health networks

To support these programs Aboriginal Children and Young People's Mental Health Networks should be established in each community of significant size. These could include:
- Specific Aboriginal Mental Health Workers educated in the area of child and young people's mental health working preferably in local communities.
- Aboriginal Mental Health Professionals such as psychologists, social workers and mental health workers.
- Specific identification of mainstream child and family mental health services and setting up a relationship with them to ensure the appropriate provision of assessment, counselling and other aspects of specialised mental health care, for Aboriginal children, families and young people, in ways that are culturally appropriate, acceptable and accessible.
- Development of responses and where needed, programs for children with special needs, especially those with physical illness or disability or learning disability.
- Identification of and liaison with appropriate inpatient programs when needed.

7. Youth programs within this network of strategies

It is essential that specific youth programs are developed and provided, encompassing developmental, preventive and service approaches. These should fit with the cultural needs of young people, particularly in terms of their identity and Aboriginality and utilise all community supports and resources. Education, men's and women's issues, peer and interpersonal skill development should be developed by the intersectoral forum and community leaders, under the leadership of the Coordinator, and with a significant group of Aboriginal young people involved in planning and development of these programs.

8. Community support programs

Supportive networks of Aboriginal leaders and community members should be developed by the coordinator to enhance the future and positive orientation of the prevention and service program outlined above.

9. Education

There will be a need for initiatives in Aboriginal Health and Mental Health Worker education and professional mental health worker affirmative action to enhance knowledge, skills and attitudes to address child, young people and family mental health needs in terms of risk factors, problems and disorders and appropriate prevention and treatment programs.

Both short courses and specific worker education and qualification initiatives are needed in these areas.

There is a need also for education for mainstream health and mental health workers to appropriate understanding of Cultural issues and practice, including issues of Aboriginal family life and child rearing as well as the impact of colonisation, current disadvantage and stress. Such programs should be incorporated into curricula, required for accreditation, and provided as well in short courses for those in practice. Services dealing with Aboriginal children, young people and families should be Culturally Informed and indicate this in policies and programs to be accredited and funded.

Education should also be provided for the broader community; including other Aboriginal organisations, particularly for those working with children, and young people, concerning mental health needs and problems. These educational initiatives should be evaluated and monitored by the Education and Personnel Development Working Party of the National Aboriginal Mental Health Advisory Committee.

10. Data and information systems

Baseline data should be collected and a national survey of children and young people's mental health linked to the proposed National Mental Health Survey and to the specific initiatives for young people as part of this.

Baseline data about risk factors for mental health problems of children and young people should also be collected, and specifically include those related to Child Abuse and Neglect as suggested in the SNAICC report.

Mental health utilisation information systems should be established for Aboriginal Children, Young People and Family Mental Health Services with the identification of appropriate outcomes.

Prevention and service developments outlined above should be evaluated in terms of agreed outcomes, defined by Aboriginal people for this area of service provision.

These processes should be oversighted and monitored by the Data and Information Systems Working Party of the National Aboriginal Mental Health Advisory Committee.

Targets

1. Children's and Young People's Mental Health Coordinator positions should be established and filled in at least 10 communities (5 urban, 5 rural or remote) by end 1995 and in a further 15 communities by end 1997.
2. Intersectoral Forums for Children and Young People should be established in at least 10

communities identified above by end 1995 and in the further communities by mid 1997.

3. Aboriginal Places of Family should be established in at least 10 communities as above by end 1996, and in further communities by mid 1998.

4. Prevention programs geared to local needs should be established in at least 10 communities by end 1996 and in further identified communities by end 1997 and in additional communities over the ensuing years.

5. Specific high risk and early intervention programs should be established by end 1996 in at least 10 communities as above with further 15 communities by end 1998.

6. Aboriginal Children's and Young People's Mental Health networks should be established in at least 10 communities as above by end 1996 and in a further 15 by end 1998.

7. Youth Programs should be identified within these program frameworks within at least 10 communities by end 1996 and a further 15 by 1998 and other communities subsequently.

8. Community support programs should be identified within these program frameworks within at least 10 communities by end 1996 and a further 15 by 1998 and other communities subsequently.

9. Educational initiatives should be established with short courses by mid 1996, and other programs by mid 1997.

10. Data and Information Systems
The proposed National Aboriginal Survey should be in place by end 1995 and other initiatives by end 1997.

7. Aboriginal women and mental health

There has recently been increased recognition of the particular factors contributing to the mental ill-health of women, and the high rates of mental health problems experienced by them. There is a lack of systematic data for the general Australian population, and a proposed National Mental Health Survey should address this to some degree, providing gender biases do not diminish the full assessment of the spectrum of problems facing women and men. No National systematic data exists concerning Aboriginal women, but what data is available (e.g. McKendrick, 1993) supports the view that the problems they face are at least as prevalent as those of non Aboriginal women, and probably more so, because of their history of trauma and loss, the impact of colonisation and the disadvantage they continue to suffer.

Thus it is important that policy development, as for the non-Aboriginal community, specifically address Aboriginal women's mental health needs.

Aim

To develop mental health responses of promotion, prevention and specific services to enhance Aboriginal women's mental health and to improve upon factors that contribute to their mental ill-health; with special reference also to those disorders that are more prevalent in women or occur only in women.

Policy initiatives

In terms of Aboriginal views of the importance of considering families as an entity, or group with interpersonal connectedness, some issues of women's mental health can be dealt with optimally in conjunction with programs relevant for men, and cannot be considered totally separately. Thus policy initiatives should not be seen as negating those necessary for Aboriginal men, but as complementary. At the same time it is important that some matters linked to women's issues, such as mental health aspects of

women's sexual and reproductive health, should have specific and 'private' levels or initiatives.

Policy initiatives also, importantly, must link to social justice and equity considerations for women. Aboriginal women, as noted above, may have a different perception of the equity issue of relevance from those of the broader community as they have concerns that Aboriginal men may be also grossly disadvantaged in status, socio-economically, and so forth. Thus the wish to stop violence may not be seen as part of the wish to negate men, but is seen often as the result of the shared environment and experience of colonisation, dislocation, and continuing disadvantage. Aboriginal women present significant concern about the problems faced by Aboriginal people, Aboriginal men, and the need to address these problems through a holistic health care model.

1.   Violence and its consequences

Programs to deal with violence against women should be part of an integrated approach to prevention in this field, and involve men's programs (see next section) as well as community wide initiatives. These matters will also be dealt with in the Policy Initiatives for Prevention (see Section 10). A number of community groups have already developed programs for Aboriginal women to help them to prevent and deal with violence and abuse. These are generally healing programs (e.g. Atkinson, 1994, We Al-Li).

Program elements include:

- **Violence is unacceptable.** Community programs need an active educational component that provides the message all aspects of violence are unacceptable, but that violence to women is especially unacceptable (as is violence to children). Sanctions reinforcing that such violence is shameful, encouraged by a decrease of community denial of the violence of Aboriginal men to Aboriginal women (and to a lesser degree vice versa) should be part of this program. It would be of particular importance for each relevant community to seek solutions and support a change in these community attitudes. As violence may be context and time specific – for instance related to drinking and pay or money phases of the week, or after funerals, special programs targeting these times and behaviour that follows them could be helpful.
- **Women's groups.** Groups of women provide relevant support, plus opportunities for specific education/counselling/social networks. These groups may be used to help women to develop ways to prevent violence in some instances, and to support one another to stand up against it in their communities. In such groups it may be possible to develop techniques that are non violent to help resist violence individually as well as generally for communities.
- **Healing programs.** Such programs can specifically address the issues of dealing with past trauma such as child abuse, as well as healing current effects of violence. One such model, the We Al-li program utilises the concept of a healing circle using Dadirri – an "inner depth listening and quiet still awareness"; workshops such as "lifting the blankets", and "recreating the circle" (Atkinson, 1994). Other healing models, for instance that of Rosemary Wanganeen's 7 phases of self-healing may also be appropriate. Communities should develop and use models seen as appropriate by Aboriginal women and the specific culture of their own communities.
- **Sexual assault and abuse.** There is a specific need to address sexual assault and its consequences for women, as this is frequent and traumatic and impacts on all aspects of women's lives. Similarly Abuse, both past and present, should be provided for in a range of programs.
- **Counselling.** Specific counselling for those affected by violence needs to aim at mitigating the post traumatic morbidity, breaking the cycle of violence, and healing those traumatised by it. All this should be provided in culturally appropriate counselling frameworks, and by Aboriginal people who are skilled to respond to these needs.

2.   Women's issues related to reproductive health

There are a number of components that can contribute to enhancing Aboriginal Women's mental Health with respect to their sexual and reproductive health.

- **Young Women's programs** to enhance self-esteem, encourage self-worth and support to develop work and role expectancies that are rewarding, including those that may help delay early pregnancy. These programs include education, group support, cultural programs, Grandmother programs, schools programs.
- **Psychosocial care** for pregnancy, childbirth and post-natally. These elements should be provided through Aboriginal Health, Women's Health and Mental Health program levels and increased awareness of the special psychosocial issues for Aboriginal women, for both Aboriginal and non-Aboriginal care providers. Enhanced opportunities for involvement of Grandmothers and other women, and traditional birthing when this is preferred, should be encouraged.
- **Support, education and parenting support** (e.g. Aboriginal home visiting, linked to enhanced detection of child rearing problems, and problems such as post natal depression) This program should be part of that for children and young people above and include parenting support options, and also linked to the Aboriginal Community Mental Health Program.
- **Counselling.** Special "women's business" counselling provided for Aboriginal women, by appropriate women, should be available for both prevention and treatment of Aboriginal Women's problems in this area.

3.   Other aspects of women's mental health

Problems such as stress related to women's roles in the home, (e.g. lack of money, poor housing, managing large households); caring (for children, the ill, the handicapped, the mentally ill); cumulative stress of women's responsibilities e.g. the "stressed-out granny syndrome"; work stresses of multiple obligations, for instance for Aboriginal Health Care Workers; problems of single parenthood, for instance with young mothers, and the high levels of incarceration of Aboriginal men; past stresses and current effects of history, loss and separations; and many other factors may contribute to mental health problems for Aboriginal women. Most can be prevented or managed by three key program components

- Education about issues and coping
- Supportive networks and groups with other Aboriginal women and perhaps elders
- Counselling oriented to these issues and in culturally appropriate frameworks.

Rationale

The Literature Review identified the fact that mental health problems occur for Aboriginal women and on the limited information available, are at least as frequent, and perhaps more so, than those affecting non-Aboriginal women. Depression is prevalent, in the limited systematic data available, as indicated by McKendrick (1993) and McKendrick and Thorpe (1994) and correlates with experiences of separation and other factors. Radford et al (1990, 1991) report a very high prevalence of self-harming and suicidal thoughts and behaviours which correlated strongly with adverse environment and social factors, as well as early separation experiences. No specific studies appear to address women's mental health issues further amongst Aboriginal women. The limited hospital separations data available, also supports the findings of depression, self harm and to a lesser degree but still frequent, anxiety conditions as significant mental health problems for Aboriginal women.

Some general features of Aboriginal women's health are relevant to their mental health. They have higher fertility and birth rates, but higher infant mortality than the non-Aboriginal population. They have births at a younger age than non-Aboriginal women and there are more young mothers. While they have higher rates of unemployment than non-Aboriginal women, their rates of employment grew more than those for Aboriginal men. The life expectancy of an Aboriginal woman at birth is up to 20 years less than for non-Aboriginal women. More Aboriginal women live in multifamily households. One parent families usually headed by an Aboriginal woman comprise 27% of indigenous families, almost double that of the non-indigenous population.

A higher proportion of Aboriginal women than non-Aboriginal do not drink, but of those that drink a high proportion do so at hazardous levels.

Thirteen percent of Aboriginal babies are low birthweight, more than twice the rate for non-Aboriginal babies. This low birthweight may be associated with higher rates of still-birth and neonatal deaths. There is a much higher rate of foetal alcohol syndromes. The incidence of antenatal complications is higher and STD's more frequent (de Costa et al, 1994). These low birthweight babies constitute an additional stress for the mother. Other differences, for instance in sex – specific mortality parallel the pattern seen in non-Aboriginal people. Post natal depression among Aboriginal women was reviewed by Anny Druett (1994) as part of a consultancy to the New South Wales Health Department. She reports that there is an abundance of anecdotal evidence to support the fact that it affects Aboriginal women, but no systematic data was found. The consultation process found that post natal depression had not been adequately recognised as an issue and that it was often difficult to tell others about depressed feelings, particularly male doctors, as it was considered to be women's business. There was seen to be a need for increased community awareness, and information provided to Aboriginal Medical Services and Aboriginal Health Workers on this issue. It was also seen as difficult to diagnose the nature of distress and other issues that Aboriginal women might face (particularly with perinatal morbidity and so forth). It was seen as necessary to make post-natal depression known not only to childbearing women themselves, but also to grandmothers, aunts, and other community members, as well as women's groups. There was a need for support systems and groups as well as education of Aboriginal midwives and others to deal with it, and the need for more female doctors. There was also seen to be a need to enhance current management practices by cultural awareness programs for those who cared for Aboriginal women through the childbirth period. It was also recommended that there should be special strategies and programs to deal with post natal depression affecting Aboriginal women, including groups and these should be developed by and with other Aboriginal women.

Clinical screening and all mothers being given time and opportunity to discuss their feelings about themselves after the birth of their babies, were seen as preferable to questionnaires such as the Edinburgh Postnatal Depression Scale. Critical to all these developments was the need for culturally sensitive and appropriate educational programs to enhance the detection and management of post natal depression among women in their own communities. This should apply to non-Aboriginal, as well as Aboriginal health workers, including especially midwives, and obstetricians.

Brady (1992) in considering the health of Aboriginal young people, has drawn particular attention to the issue of childbirth among adolescent girls and the social and cultural issues that surround these youthful childbearing experiences. These younger mothers are more often vulnerable to complications, single and sometimes unsupported. They are less likely to attend for adequate antenatal care and more likely to have problems. Their children may be given over to granny-care and the young women themselves may feel they have lost the gain and status that having a baby meant, and are burdened by the reality. Clearly there are profound psychosocial issues for mother and infant in this setting as well.

Other issues of Aboriginal women's health may also be relevant to their mental health, but data is at the present lacking, although a survey in Sydney (McIlwain et al) may provide much needed information, as may the proposed Longitudinal Women's Health Study.

Aboriginal women's experience of violence has been reviewed by Audrey Bolger 1991). She describes "fights" in traditional communities, the majority of which could be seen as taking place for traditional reasons (e.g. children, jealousy, swearing, ceremonial) but others related to Western influences such as money, alcohol.

However reports suggest that much of the increasing violence in communities is directed towards women. While data on prevalence are limited, she quotes a report by Pat O'Shane to the New South Wales Task Force on Domestic violence, who found, on her report, that it had affected nearly every household. Violence experienced by Aboriginal women ranges from child abuse, particularly sexual abuse, to bashing and domestic violence in the home, and to rape. Bolger also notes that while non-Aboriginal women experience domestic violence, there appear to be few Aboriginal women who have not experienced it. Aboriginal women may also be attacked by a wider group of relations, and are more likely to be attacked with a weapon. The perpetrators are usually Aboriginal, and the violence may result in death. Many women do not disclose, both because it has been accepted as part of their lives (until perhaps recently) and

because they do not want their men to go to goal.

Domestic violence in an urban Aboriginal perspective has recently been reviewed by Muriel Lucashenko and Odette Best (1995). These writers suggest that Aboriginal people in urbanised Australian experience violence on a daily basis, which ranges from psychological hostility through to physical brutality. They go on to state that "for Aboriginal women and children this daily violence is not only public but also has a private, Black on – Black dimension" (p19). As these workers state, there is virtually no comprehensive research into levels of women bashing in urban Aboriginal communities, so evidence is either anecdotal or drawn from hospital statistics.

The report of the National Committee on Violence (1990) states that "the level of violence existing in some Aboriginal communities is of a scale that dwarfs that in any sector of white Australia". (p165)

Reports and other initiatives

The National Women's Health Policy identified a number of major areas to be addressed with women. These included women's mental and emotional health; women's reproductive health; women's experience of violence and abuse; status of women issues; and other matters.

The NH&MRC Report, Women and Mental Health (1991) examined the extent of mental health problems of women and gender differences; mental health issues related to: reproductive biology; life cycle and development; including conflicts and stress in adolescent girls and ageing; women and violence; women, work and unemployment; women in a multicultural society; women in their social roles including women as carers; mental health care and health care for women.

The National Women's Health Policy identified Aboriginal women as a special needs group. The report Women and Mental Health, calls attention to the special needs of Aboriginal women (pages 42–43) and the importance of further research to assess their mental health problems and needs.

The National Aboriginal Health Strategy addresses Women's Business, women's health issues (p179–191) from the point of view concentrating on maternal and child health services; sex education; women's business and mainstream services; family planning; infertility; culturally appropriate birthing centres; early first pregnancy; antenatal and postnatal care; cervical and breast cancer screening programs; health awareness education and promotion programs for women. Strategy areas relevant to women include domestic violence, child abuse and neglect, alcohol and other substance abuse. Mental health proposals cover general issues for Aboriginal Mental Health but also place particular emphasis on Domestic Violence and Mental Health. The NAHS indicates the need for support and services designed and provided by Aboriginal people for Aboriginal people who have been exposed to domestic violence and sexual abuse; and to provide safe houses for those who are victims of domestic violence during the crisis; the employment of Aboriginal people in mainstream domestic violence services; counselling including counselling for families; early intervention strategies; relaxation and behaviour self-management programs; communication and assertiveness training; crisis counselling, to be incorporated into the Aboriginal Health Worker education programs; programs to enable women to form mutual support groups; programs to address the needs of perpetrators.

This Strategy makes the particular point that "most Aboriginal women do not accept this culturally alien non-Aboriginal analysis" of the "feminist/separatist" model, and "do not find it helpful in a crisis".(p174)

The National Aboriginal Mental Health Conference (1993) (Report, Swan and Raphael, 1994) made specific recommendations about the mental health needs of Aboriginal women.

> *"That Aboriginal Health Services develop special mental health programs to address:*
> • *Aboriginal Women's Issues …"*   *(p31)*

> *"That Aboriginal prenatal and postnatal classes be enriched through cultural components by Aboriginal elders" (p31)*

"That young women be given support through programs run by Aboriginal women that promote self-awareness, self-esteem and life realities" (p31)

"That safe places are established for women and children with mental health problems" (p35)

"That Aboriginal women's refuges be resourced to provide for culturally appropriate counselling and mental health problems in their client group" (p36)

At this conference a separate and private session was also called, dealing with private matters of women's business, and attended only by Aboriginal women.

The Consultancy Report indicated significant problems faced by Aboriginal women. Those specifically identified included

- **Domestic violence** – this was identified by the vast majority of those consulted, individuals and organisations, to be a major problem facing Aboriginal women. While it was seen as a problem that must be dealt with by having programs involving men to change their behaviour, it was also seen as critical that services were available for Aboriginal women – e.g. refuges, counselling, to be provided and run by Aboriginal women, and other support and outreach. It was closely linked to problems with alcohol abuse. The adverse effect of the violence on women's health was seen as a problem.

  It was considered that shame and cultural issues had encouraged denial and that it was only very recently that this problem was acknowledged in Aboriginal communities.
- Problems for women resulting from sexual abuse in childhood, which were affecting women in adult life, as well as the consequences of neglect, and other forms of abuse, and sexual assault, were all identified as contributing to or constituting mental health problems for women. Specifically it was seen that there were needs for counselling to deal with these problems, services, and support and healing programs for women. There was also an urgent need to prevent further abuse.
- Problems for women who had been separated from their families, by removal and effects for those women and through the generations, of the removal of children were seen as warranting special attention. There was seen the need to be healing programs to deal with these, especially so to do with loss of parenting skills. It was thought that more female children may have been taken initially, to help as domestic servants, and later male children when they were no longer used to the same degree in the pastoral industry. Whatever, all these separations had prolonged and adverse effects.
- High number of young Aboriginal women in Justice Centres – Drug related.
- Young births, young motherhood and associated problems for young women and their babies were identified by some communities. Support programs were seen as necessary, both to deal with the birth and to deal with parenting. Mothers, grandmothers and aunts, and other women should be involved. These were women's business programs and should be linked to birthing programs to ensure traditional births. They were seen as necessary for all women, but more so for very young women who were likely to be more vulnerable. It was thought that these were very relevant to women's well-being and hence mental health for themselves and their children.
- Post natal depression was indicated to be a problem by a smaller group of those consulted – specifically usually birthing centres or programs. It was felt that there were problems diagnosing post natal depression, as it was often confused with women's distress and separation from families, or capacities to have desired birthing processes, or grief if a baby had died. Nevertheless it was considered to be a real problem affecting Aboriginal women and there was a need for special services to deal with it.

Strategies

1. A Working Group for Aboriginal Women's Mental Health should be established in large communities, linking with Elders, with other women's programs, Women's Health workers or groups, and the Aboriginal Community Mental Health program for the area or region through the Regional Mental Health Forum. The purpose of this group is to identify Women's needs and the most appropriate programs to enhance their mental health and prevent mental health problems and disorders. Networks, focus groups and action research provide useful models to assist the process, to identify both problems and potential solutions.

2. A program core could be developed to deal with
   • Violence and Aboriginal Women's Mental Health. This should incorporate elements of
   • education for attitude change
   • support groups
   • healing programs
   • counselling

   These should be linked to other Mental Health programs for the area.
   • Women's Business

   As Aboriginal women's needs are identified, each component can also build and could incorporate elements of
   • Young women's programs, including self-esteem, education
   • Psychosocial care for pregnancy, childbirth and postnatally
   • Support, education, parent and related programs for women
   • Counselling for women related issues
   • Women's roles

   This should link to identification of role stressors for Aboriginal women of the community and ways of dealing with them including
   • Education
   • Support network
   • Counselling

3. Education programs for Aboriginal Women's Health Services and Aboriginal Health Workers and Mental Health Workers should be educated in the area of women's mental health as should all workers working with Aboriginal women. This education should incorporate both prevention and clinical issues (e.g. detection and care of postnatal depression, sexual assault, counselling).

4. Data and Information needs
   The Working Group should identify needs for data on patterns of mental ill-health and factors contributing for women, and affective interventions to deal with these. The Data and Information Systems Working Party should coordinate national proposals in this area for Aboriginal women, including support for Aboriginal women's well-being to be included in the proposed National Longitudinal Women's Study and the proposed National Mental Health Survey.

Targets

1. Aboriginal Women's Working Group for Mental Health should be set up in communities with high levels of violence, or high levels of identified women's health issues within one year of implementation of this program area.

2. Trial program developments in 2 areas of programs should be set up and evaluated within two years of implementation of this program area.

3. Educational programs to ensure knowledge and skills in areas relevant to women's mental health especially psychosocial aspects of care should be established and monitored by the Education and Personnel Development Working Party, within two years of implementation of

this program area.

4. Data and Information development should inform proposed National Research and Data initiatives for women by end 1995 and set other proposals per priority, e.g. postnatal depression research for Aboriginal women within two years of implementation of this program area. These aspects should be oversighted by the Data and Information Systems Working Party.

8.   *Aboriginal men and mental health*

This section was collaboratively written by Aboriginal Men.

The mental health problems of Aboriginal Men have been poorly researched and grossly misunderstood. Many of the mental health problems identified in Aboriginal men are closely interwoven with substance abuse, violence, destructive behaviours, and the loss of a sense of personal worth.

These are profoundly contributed to by high levels of unemployment, loss of traditional structures of Aboriginal Law, discrimination and pervasive social disadvantage. There are few opportunities for personal achievement and recognition. The distress and problems faced by Aboriginal men have too often led to violence.

> *"All Aboriginal people face a burden of illness which is unparalleled in the wider Australian community. The majority of non-Aboriginal people do not understand how hard things are. Aboriginal people are dying in their 20's, 30's and 40's and not many get past 50. While not underplaying the health problems faced by Aboriginal women, Aboriginal men do have even higher risks of suffering physical and mental ill-health. These problems need to be addressed in a holistic framework."*

This statement from Aboriginal men highlights the issues of relevance in developing a policy and programs to meet mental health needs.

Substance abuse and destructive behaviours are often associated with demoralisation, grief and loss, trauma and other forms of mental distress.

The combined affect of these multiple problems substantially increase the risk of conflict in relationships, with families, with communities and with the law. Early and frequent incarceration may set a negative life course.

Aboriginal men's distress is associated with the many stresses faced by Aboriginal communities, and also, as indicated by the evidence before the Royal Commission into Aboriginal Deaths in Custody, by the impact of family separations and loss.

Some Aboriginal men reported they felt that they had little to contribute to their families and communities. Cycles of devaluation, depression and drinking result in (or constitute) major mental health impairment. These issues have been addressed for their relevance to Aboriginal men in currently available data on Aboriginal Mental Health (McKendrick and Thorpe, 1994).

The mental health needs of Aboriginal men as a group are largely undefined, as more often, men tend to ignore their emotional needs, or to respond to emotional distress by acting out or self-medicating with alcohol or other substances. That Aboriginal men do have special needs is evident from indicators such as their high rates of imprisonment, for a variety of offences, in some instances of a minor nature to more serious violence and sexual offences.

During consultations, complaints from Aboriginal communities about the high incidence of

substance/alcohol abuse, domestic violence and unreported sexual abuse of women and children was widespread.

It will be apparent from the nature of these indicators that the main complainants are often women. However, it should be noted that Aboriginal men have also been victims of rape both in the community and institutions causing not only trauma but a great deal of shame.

Men are unlikely to come forward complaining of their own destructive behaviour. Furthermore, some of the underlying causes of such behaviours may be remote from the individual, and are better described as social or systemic. Racism, low educational attainment, high unemployment and discrimination are examples of causal factors that for the most part lie beyond the scope of mental health services to rectify.

While Aboriginal people and others in and outside the mental health field must lobby and advocate for improvement in all these areas, specific mental health services by their nature focus more narrowly.

What follows does not purport to offer answers to the underlying causes of mental ill-health, but looks at the immediate needs of Aboriginal men who experience distress and display disturbed symptoms and behaviour.

Perhaps the most important statement relevant to the health and well-being of Aboriginal Men is that encompassed by NACCHO's 'Manifesto on Aboriginal Well-being'. This is reproduced in full below, because of its significance.

NACCHO position paper on Aboriginal men's health

Aim

For Aboriginal men to regain a state of well-being at least equal to that which existed prior to colonisation and as referred to in the NACCHO definition of health

Introduction

The NACCHO believes that all Aboriginal men should view their health in the context of their social, emotional and cultural well-being. The well-being of Aboriginal men is inextricably linked to our Dreaming, which in essence is our law and culture.

The process of racialist colonisation saw the multifarious emasculation and dehumanisation of Aboriginal men in order that the colonisers could weaken our peoples resolve to defend our rights and in so doing, disenfranchised Aboriginal men of their role and status to which they evolved through law and ceremony and maintained through fulfiling their obligations.

Also, western society brought with it alien values which were violently and institutionally imposed on Aborigines. These values include discrimination on both gender and racial bases; excessive materialism; working for one's self and not the community; disrespect for human rights, the land and our environs; hypocrisy; diseases; drugs; nutritionally corrupt foods; lies, deceit. This list is not exhaustive.

The combined impact of these forces has caused the well-being of Aboriginal men to deteriorate dramatically to a state when their individual, family and community existence is characterised by low self-esteem, violence, poverty, and excessive morbidity and mortality rates including extremely low life expectancy.

Clearly, if Aboriginal men are to ensure their survival and fulfil their potential as Aborigines and help bring about the well-being of their communities, they must be empowered through regaining their dignity, determination, respect and pre-colonial state of well-being.

Goal 1

To restore the Aboriginality, dignity, respect, role, responsibilities, and determination of Aboriginal men

as a first step to achieving their rightful state of well-being.

Objective 1

To get all Aboriginal men to come to terms with their law/lore and culture.

Objective 2

To empower Aboriginal men to reject (walk through) the corrupt and oppressive values such as materialism, sexism, sectarianism, machoism, drug and alcohol abuse, victim blaming, irresponsibility, etc.

Objective 3

To have all Aboriginal community controlled health services develop and provide effective men's health programs as part of their primary health care role.

Goal 2

For Aboriginal men to contribute to the total well-being of their respective communities.

Objective 1

To get Aboriginal men to stop and condemn the violation of Aboriginal women and children

Objective 2

To get optimum involvement of Aboriginal men in family and community controlled activities.

Objective 3

To have Aboriginal men take greater responsibility for the cultural education of Aboriginal children and youth.

Aim

To develop mental health responses of promotion, prevention and specific services to enhance Aboriginal Men's mental health and improve knowledge about and lessen factors that contribute to their mental ill-health.

Policy initiative

Because of the absence of systematic programs addressing Aboriginal Men's Business in Mental Health and the urgency of addressing these problems, there is a need to develop a comprehensive response which includes mental health promotion, prevention, community development and service aspects, in ways consonant with the Guiding principles of Aboriginal Mental Health.

These program concepts and the themes identified below or other appropriate responses could be developed into specific initiatives in ways relevant for individual communities. Programs should be managed within communities by Aboriginal men.

Wherever possible programs should be holistic and linked to Aboriginal Community Controlled Health services. There should be required links to current or proposed Family Health programs, substance abuse programs and prevention programs.

While men suffering from psychoses almost inevitably come into contact with mental health services, we have little information about how Aboriginal men experience those services, nor how suitable they are. Aboriginal men with emotional disturbances or in crisis seldom seek counselling, even when it is available. It seems likely that, were counselling services appropriate for Aboriginal men made available, and were men to make use of such services, the incidence of extreme crisis leading to serious outcomes

such as injury, homicide and suicide would be reduced.

It should be noted here that the notion of counselling may need to be interpreted broadly and flexibly, to include situations and experiences beyond the classic sit-down-and-talk model.

While ideally, service development should be based on a knowledge of morbidity patterns and risk factors, the need for response is urgent. Thus programs will be proposed in key areas, but it is essential that they are linked, at the same time, to a review process which encompasses the following:

- what projects directed at Aboriginal men's mental health (broadly interpreted) have been undertaken to date
- what projects for indigenous men have been successful in other countries
- **which ones show promise or a measure of success**
    - what mental health services for Aboriginal men already exist
    - the extent to which existing services are used by Aboriginal men
    - the perceived value of these services to users and providers
    - what Aboriginal men consider to be their mental health needs (broadly interpreted)
    - how these needs might be met (based on men's views and on the experience of people working on successful projects).

Coincident with this review, a number of pilot projects, based on what is known, should be set up or linked to, initiatives listed below, trialed and evaluated. Since disempowerment is a prime factor in Aboriginal mental ill-health, the essential starting point in such projects must be that they are driven and controlled by Aboriginal people. (Note that some projects may include members of both sexes, e.g. New South Wales Aboriginal Family Health Strategy.)

Building health: strong bodies, strong people

There is much to suggest, as is a major part of Aboriginal health concepts, that physical fitness and well-being will contribute significantly to mental well-being, and may even mitigate depression. Involvement in sport has been for men a socially positive form of competition and achievement, also allowing an outlet for aggression in play.

Achievement in sport has been a source of pride generally and many Aboriginal men have demonstrated community leadership in this way. It has been suggested that promoting the involvement of Aboriginal children and youth in Sport is likely to be beneficial for young people, and communities.

Sports and fitness programs are an important part of general community development, particularly for young people. Sports and fitness development programs as part of a community health approach are generally likely to contribute to the emotional well-being of men.

Specifically however, health promotion programs with youth in non-Aboriginal communities, have used popular sportsmen as leaders of groups which have the aims of improving sports skills, but also enhancing self-worth and positive coping styles (W.A. Health Promotion Foundation 1993). Such programs developed by Aboriginal communities are likely to have substantial benefits for well-being and mental health.

The concept of physical fitness affecting mental health is appropriate to Aboriginal concepts of holistic health. Thus this area is important for men's well-being, and may also form a focus for active life skills as opposed to negative coping in substance abuse and destructive behaviours. These programs could be developed by communities linked to family health programs in AMS's and other Aboriginal controlled programs.

Strong minds, strong men

The spiritual strengths, intelligence and creativity of Aboriginal men should be promoted, recognised and rewarded. These attributes need to be valued, a concept of strong minds being equivalent to power and a source of pride and masculinity.

Strong Minds programs should also have aims of strengths in saying "No" to substance abuse and destructive behaviours; to enhance strong thinking for the protection of family; mind strengths of concentration and commitment; mind strengths of spiritual values; and mind strength of Law.

There is a need for community education generally for a "strong mind, strong man" value/attitude change and specific skills programs in schools, men's groups, and elsewhere to develop "mind strengths" through learning, creativity, art, problem solving and Aboriginal Men's Business and ways. Aboriginal men must be in control of any such programs.

Brother care

Aboriginal men have a strong commitment to their brothers. This specific program area should involve education of Aboriginal men about the symptoms, distress, mental health problems and mental disorders such as substance abuse, destructive behaviours, and serious mental illnesses such as Depression, Anxiety disorders, and less frequently Schizophrenia and Bipolar disorder. A model of "Brother Care" rather than "shame" can assist other Aboriginal men to seek/accept help for their mental health problems or disorders, or when they are otherwise stressed. This program could also provide Aboriginal men's support groups for men for men in crisis to provide self help to prevent violence and to develop adaptive coping skills. It could also link through Aboriginal Medical Services to the Community Mental Health Programs above and to Family Health programs.

This self help program could mobilise men's skills for both prevention, as well as care, recovery and rehabilitation. Art and other creativity as defined by men should form a special part of this work.

Specific components of this program could be developed in terms of identified needs. Some potential areas could include the following:

- **Brother care and trauma healing**

  There is much to suggest from broader knowledge, that trauma and loss may lead not only to depression and post traumatic stress disorder symptoms, but also to substance abuse and unacceptable behaviours. As trauma, separation and grief have been such pervasive experiences for Aboriginal people, yet often ignored and go unrecognised in Aboriginal men, because of the coping mechanisms often used as outlined above, it is essential that programs addressing these are developed. Specific trauma and grief programs are outlined above and these should be available to Aboriginal men. Self-help has however proved to be a very effective form of trauma help and counselling for men, for instance with veterans. This suggests that a self-help program may have particular value, and in addition because of its educational, positive networking and empowerment aspects.

- **Brother care and men's business**

  There may be other aspects of Aboriginal men's private lives and functioning, for instance with respect to sexuality and traditional men's roles and law. A specific program addressing the mental health aspects of men's business may be appropriate. This program could also contribute to the further understanding and development of strong men's/male identity and role models, which are important for men's well-being, and may be spiritually relevant for Young Aboriginal men.

- **Brother care and forensic mental health**

  Specific mental health assessment and support programs are a major priority and will be addressed subsequently. Because of the ongoing problems of deaths in custody, and the high rates of incarceration of young Aboriginal men, there is a need for specific initiatives in this area linking to such forensic programs. In this also there is a need for preventive approaches, support for those in custody, and support for rehabilitation afterwards. The concept of Aboriginal lay counsellors and Visitors links to this initiative. This may also be developed in connection with the forensic programs outlined in this report.

  There may be significant other aspects of a Men's Mental Health Program. These should be determined by Aboriginal men. Because this area has been very underdeveloped, it is essential that Aboriginal men take a major initiative in this field generally and in their communities. It is

likely that initiatives in this area will have positive benefits for men themselves not only in terms of their mental health and well-being, but also physical health. It could well contribute to diminishing their levels of ill health, decrease vulnerability and prevent mortality. It is also highly likely to contribute to the health and well-being of their families and communities.

Rationale

There is no systematic information on the special mental health problems faced by Aboriginal men except that delineated generally in the Literature Review above. Of specific interest are the high prevalence of violence, self harm, suicide, injury, substance abuse including hazardous levels of alcohol, and criminal and antisocial acts. Differential levels of morbidity for depression were not identified in the McKendrick's review (1993), and it is clear that Aboriginal men are vulnerable in the same ways of Aboriginal women – i.e. through disadvantage, history, trauma and grief, as well as the impact of colonisation. Higher rates of unemployment, racism, loss of traditional male roles, lower incomes in terms of welfare (compared to Aboriginal women with children), have all contributed to disempowerment. Hunter (1993) on suicides, describes these aspects of Aboriginal health and history and their impact for Aboriginal men, as well as his own research which deals with aspects of violence, self harm and alcohol. The only review of available data (McKendrick and Thorpe in press, 1995) highlights the lack of information and need for further research.

Brady (1992) has described some of the conflicts and stresses facing young Aboriginal men and their psychological vulnerability. As well as the stresses of a group in transition, they may face many negative interactions with police, including harassment. Other stresses include illness, early deaths and loss affecting the parental generation; loss of strong adult male role models. The "drastic alteration of adolescent rites of passage into adult status" (p26) have adversely affected them - so that they may experience cycles of despair and conflict, with hopelessness.

Reports from a range of sources have failed to identify any special issues for Men's mental health needs, as opposed to Women's. This difference in and of itself demonstrates the need for further information and programs which are evaluated.

The Recommendations from the Royal Commission into Aboriginal Deaths in Custody highlighted issues relevant for Aboriginal men generally in terms of mental health but much more specifically in relation to forensic settings. These are indicated above.

The National Aboriginal Mental Health Conference held a closed forum for Aboriginal Men.

General recommendations emphasise the following:

> "That Aboriginal Health Services develop mental health programs to address inter alia
> • *Aboriginal Men's Issues*
> • *Family Health.*

The Consultancy Report identified high priorities for a number of areas relevant to Aboriginal Men's Mental Health although not specifically identifying these as mental illnesses, but rather, problems.

They included:
- Alcohol problems and short and long term effects
- Incarceration and imprisonment and Problems with Law
- Family breakups and relationship problems
- Loss of culture an traditional Law
- Trauma and Loss
- Unemployment
- Disempowerment and loss of personal worth
- Violence and its effects for the communities

However as with the coordination of issues of importance to Aboriginal women, the Aboriginal view

prefers to consider people in a family context rather than from a separatist perspective. This should influence policy and implementation, and the specific development of issues such as those outlined.

Strategies

1. Aboriginal men's groups link to the Regional Mental Health Forum to identify particular issues and needs for Aboriginal men of the region in terms of mental health and to form a Working Group for Men's Mental Health. Programs relevant for men such as Substance Abuse programs should be involved in joint discussions to identify the major needs of Aboriginal men and ways in which problems may be solved. This should lead to a Working Group for Men's Mental Health.

2. The Working Group for Men's Mental Health should plan and develop relevant programs encompassing the key elements outlined above plus other initiatives required. These should include, for the community
    *   Building Health: Strong bodies, Strong people – linked to local sporting developments. This could include Health Festivals such as that held at Belyuen (1994), or coaching of schools or teams, through a network, and links to sporting leaders as community or youth mentors.
    *   Strong Minds: This program needs to link to community development proposals, to education, to cultural developments and should have a National base. It could be developed and maintained by the National Aboriginal Mental Health Advisory Committee.
    *   Brother Care: These programs should be strongly linked to Community Mental Health programs in the area or region, and for the specific community. They could be developed in liaison with the Working Group.

3. Educational Programs to develop expertise in men's mental health to back this program development will be needed.

4. Data and Information on Men's Mental Health should be developed urgently. Programs should be evaluated, a network of those developing special initiatives for Aboriginal men established, and a data base gathered. The proposed National Mental Health Survey should also address these issues in its Aboriginal Mental Health components. Aboriginal men from Rural, Remote and Urban communities should be extensively involved in identifying important areas and needs.

Targets

1. Aboriginal Men's Working Group for Men's Mental Health should be set up in all larger communities within the first year of this area of program implementation.

2. **Trial program developments in two areas of programs including Building Health, should be developed in these communities within two years of implementation of this program area.**

3. Educational needs for Men's Mental Health programs should be identified and programs developed to support these within two years of implementation of this program area. This should be oversighted by the Education and Personnel Development Working Party.

4. Data and Information development should be a special initiative area, developed with Aboriginal men in liaison with the Data and Information Systems Working Party, within one year of this area of program implementation.

9.   Elders and mental health

Older people have significant status in Aboriginal communities and are respected and highly valued for their wisdom, their roles as Elders, teachers and leaders, and their knowledge of Tradition, Law, Culture and life skills. Older Aboriginal people are few in number, the identified population over 55 being only 16,379 (see Review). This relates to high mortality rates for Aboriginal people in adult life. Many have suffered significantly from the impact of colonisation and earlier policies, but have clearly enduring strengths to deal with adversity, physical and psychological and social, and those strengths have contributed to their survival. Aboriginal elders are likely to be affected by problems of physical health and require care for these, and may suffer distress or depression in association with such conditions. They may also suffer dementia and other psychiatric disorders and may require care for these in their own communities. There is much to suggest that nursing homes and places for the elderly that follow Western models are unacceptable to Aboriginal people, and will not be utilised. Aboriginal elders need places that are in their own communities, so that they can be with families and kin, and die on their own land.

The definition of "older person" within Aboriginal society should also be considered as life expectancy is 17–20 years less for Aboriginal people. It has been suggested that being "old" in Aboriginal communities may mean being 45, or 50 years, particularly as life expectancy relates to high mortality in 25 to 44 age bands. More relevant, of course, is the prevention of premature mortality. In this proposal older Aboriginal persons will be taken as aged 55 years or more.

Aims

To enhance the mental health and well-being of older Aboriginal people and to prevent or treat mental health problems and mental disorders that affect them.

Policy initiatives

Because of the small numbers of elderly people and their presence in many different communities, programs for their mental health need to be integrated through the Regional Mental Health Forum for that area, and also with any programs through Aboriginal Health Services or Aged Care services that are addressing their needs. Clearly it is most appropriate for local communities to develop their own special initiatives to deal with those issues that are most relevant locally. A coordinated National linkage can help to add expertise and support to this as well as enhancing knowledge about the nature and extent of problems and what will be helpful to deal with them.

Policy elements that may be relevant include
- Housing and supported accommodation for those disabled, near to families and communities and outreach mental health support for mental health problems of those needing such special care.
- Respite care for stressed elders (caring for children and others) as well as full carer support programs.
- Specialised mental health care for older Aboriginal people with depression, or other disorders through the Aboriginal Community Mental Health Program.
    . Valued roles for older Aboriginal people in their community to enhance self-worth and well-being – e.g. cultural education, Groups and Elder Councils can contribute in this way.
- Dementia care Difficulties often arise with the diagnosis and management of dementia in older Aboriginal people. Links to local agency services can help with both provision of care and support for community caregivers as well as education.
- Psychosocial care for those with physical illness or disability through counselling, education and care provided through Aboriginal Health Workers who are educated to deal with their needs.
- Support for carers of elders

Rationale

The Literature Review revealed a lack of studies which could provide any information on the specific mental health issues of older Aboriginal people. Anecdotal evidence and general reports indicate that they do suffer dementia and some other problems of elderly people such as depression. Seru (1994) reports on mental health issues for older Aboriginal women, "grannies" and notes negative factors stressing them to include: "pension cheques being taken; babies being left in their care; alcohol abuse; men not playing their role; white men's processed food causing diabetes and heart disease etc." (p13)

Reports

A New South Wales workshop on Older Aboriginal People identified the need for nutrition programs; training for home carers; respite care; and time out with other older people from the same area with whom to share past experiences and memories. Isolation was seen as a problem and there was a need for drop-in centres in larger communities; or funding to link up families that were dispersed. History, story telling and maintenance of culture are seen as important; as were self-expression through song, dance, song-writing, sewing and cooking. Culturally sensitive and flexible housing design, respite resorts, liaison with the consultative committee on ageing, and education of health care workers for the needs of the elderly were all seen as important.

The National Aboriginal Mental Health Conference reported on similar issues affecting elderly Aboriginal people but made no specific recommendations.

The Consultancy Report. A number of individuals and communities described the stresses faced by elderly Aboriginal people, including what they had survived, and the enormous losses they had experienced. However this area was infrequently reported because of the proportion of youth and the small numbers of older people.

Particular problems were seen when older people's memory was severely impaired, for instance from Dementia, as they would sometimes speak the names of those deceased who should not be mentioned or speak of other taboo matters or relationships. These factors might also complicate their care, making it difficult for those who cared for them.

Strategies

1. Community Mental Health Programs should, through the Regional Mental Health Forum, identify particular needs and problems faced by older Aboriginal people in their communities:
2. Programs for older Aboriginal people's mental health should be developed and include prevention and health promotion approaches and elements such as the following (proportional to local need):
    *   Housing and supported care accommodation
    *   Carer support and respite
    *   Specialised mental health assistance
    *   Valued Role Enhancement
    *   Dementia Care
    *   Psychosocial care for physically ill and disabled elderly
3. Data and Information should be gathered about the mental health of older Aboriginal people both at a community level with action research and nationally. A resource of data about problems and effective programs for older Aboriginal people should be developed through national networking coordinated by the Data and Information Systems Working Party.

Targets

1. Regional Mental Health Forums should identify problems in older Aboriginal people in the communities within one year of implementation of this program area.
2. Program elements for older Aboriginal people should be developed as needed including those

relevant from the above elements, within two years of implementation of this program area.

3. Data and Information Networks about older Aboriginal people's programs and their effectiveness should be developed within two years of implementation of this program area, oversighted by the Data and Information Systems Working Party.

10. Promotion and prevention in Aboriginal mental health: violence, the first priority

The extent of mental health problems and mental disorders affecting Aboriginal people, is, in terms of the limited systematic data substantial, and risk factors for this morbidity are prevalent and excessive. Any approach to Aboriginal mental health based simply on direct treatment programs, is unlikely to impact significantly on outcomes for Aboriginal communities. Many of the policies above, particularly those for Aboriginal Children, Young People and Families, have a significant prevention component. The National Mental Health Policy (1992) recognises the importance of prevention and promotion and indicates that indigenous populations are at risk (p24). Objectives with regard to prevention include: programs to educate the public on mental disorders; development and evaluation of primary, secondary and tertiary prevention programs for those at risk of mental disorders; encouragement of research and the development and evaluation of primary prevention interventions in response to emerging scientific knowledge.

Clearly an element of prevention should be incorporated into mental health care wherever appropriate. As there is not yet a critical momentum for prevention, focus on specific areas is likely to be more effective. Aboriginal communities identify the need for prevention in the mental health field (see below). Violence has been described as one of the most serious problems affecting the mental health and well-being of Aboriginal people. It is therefore proposed, that in addition to prevention components in other areas of policy proposed in this report, that a specific prevention program be developed, implemented and evaluated. This program should focus on violence and those underlying factors that contribute to it. Such an initiative is also important for the broader Australian Community and it is proposed that developments in this area should link to similar current or related initiatives Nationally.

Aim

To lessen the levels of violence affecting Aboriginal people and the adverse consequence of violence for their mental health.

Policy initiative

Policies to prevent violence must encompass a number of levels. As Mrazek and Haggerty (1994) indicate, interventions may be universal, directed towards the whole population for instance education or structural programs, selective, targeted to groups or individuals at heightened risk for problems, for instance those in a violent peer group, and indicated, for those who are already violent or experiencing violence. Prevention initiatives are thus on a continuum with treatment and rehabilitation.

- **Education community programs** for attitude change should be developed within local regions lead by Elders or other senior community members. These programs need to examine those factors of relevance to the particular community be it remote, rural or urban, and factors which contribute such as drinking patterns. The Aim should be to develop a community view that violence is not Aboriginal, and is perhaps shameful. Specific links to men's programs are important but should not be part of separatist approaches. Rather violence should be seen as a community issue and community responses should be an agreed set of developed beliefs and actions negating violent behaviour. Specific emphasis should link to programs against

domestic violence, violence against women, violence against men, child abuse, and violence against children.

Targeted aspects of this program should encompass particularly young men in their adolescent years and seek to develop alternative behaviours to aggression.

- **Conflict resolution and social skills programs.** Skills programs in schools or community settings in the form of socially sanctioned and rewarded programs, may help young people at risk, particularly young men, to develop appropriate coping responses. These may also be linked to sports programs, personal development initiatives, and youth leadership with popular role models. Young Aboriginal people should be involved in the shaping and development of these programs within their communities.

- **Programs to prevent unacceptable behaviour and its antecedents.** These programs would be usefully oriented to schools of later childhood and early adolescent settings where high risk behaviours have appeared and could build on effective approaches such as those developed to prevent bullying (Oluens, 1991) or a Violence Prevention Curriculum for Adolescents model, with T-shirts, television and so forth (Hausmann et al, 1992) or other models such as those for conduct disorder (e.g. Sanders, 1994). "Programs to combat Youth Violence" are likely to be specific elements of this prevention approach.

- **Programs for young people with challenging behaviour.** It would be important for some programs to be specifically directed towards those who have already been convicted for violent acts, or in Juvenile Justice Centres/prisons where violence may be enculturated. These problems affect both young women and young men.

- **"Breaking the Cycle".** Because of the cyclical nature of violence, within communities and across generations (parents who have suffered violence as children may themselves be violent to, or abuse their own children). One program component should specifically focus on "breaking the cycle". This concept is well recognised in communities and provides a positive focus and aim for dealing with violence.

- Programs for those who have suffered violence need to provide counselling, support and care, as indicated in the trauma and grief policy described above. This contributes also to breaking the cycle. It may need places of safety and protection, as well as counselling, with special places for family members.

As violence so intimately relates to substance abuse, alcohol, it is essential that prevention programs specifically address this area also. And all programs should be shaped and developed by Aboriginal people to meet their communities' needs. It is also essential that programs are multifaceted.

Rationale

The Literature Review indicated the severity and extent of violence and violent outcomes affecting Aboriginal people. The contribution of this violence to mental health problems and mental disorders is identified to some degree, although the specificity of this problem amongst a range of generic risk factors is not delineated. Mrazek and Haggerty (1994) identify "violence as a major public health problem" in the United States.

These authors note that violence is linked with mental health in 3 main ways: it causes mental health problems such as PTSD; mental disorders may cause violence such as suicides, or even homicide; and alcohol and drugs are frequently associated with violent behaviours.

The Centres for Disease Control in the United States now conduct a multifaceted community based research effort devoted to youth violence prevention (Rosenberg et al, 1992) and have developed a guide book to such programs "Prevention of Youth Violence: A Framework for Community Action" (C.D.C., 1993). This spells out some relatively simple action plans for communities. Other programs aim at violence prevention, and many are similar to those aimed at reducing substance abuse: most rely on changing norms about violent behaviour; providing skills to solve problem without violence; and school based curricula dealing with social competence promotion in problem solving and developmentally

appropriate social interaction. The "Violence Prevention Project" is one such program (Mrazek and Haggerty, 1994, p273–4).

As is clearly established in recent reviews on prevention in mental health, programs need to be multicomponent, multifaceted and owned and developed within frameworks appropriate for the particular community (Raphael, NH&MRC, 1992; Mrazek and Haggerty, 1994; OSAP, 1989).

Reports and policy

Prevention of violence in the broader Australian community has been identified as a priority (e.g. National Committee on Violence; Violence: Directions for Australia, 1991) and this must apply also for Aboriginal communities.

NH&MRC Report 'Scope for Prevention in Mental Health' (1992) identified Prevention programs for Aboriginal Mental Health as a major priority to be addressed (p177) and "Violence and Abuse" as another major priority area (p175).

The Report on the Aboriginal Family Violence Awareness Program (Baldini and Nelson, 1992) made a series of recommendations about family violence and its prevention, many of which are encompassed in the policy initiatives described above.

The National Aboriginal Mental Health Conference made a number of significant recommendations about prevention in the mental health field, many of which are encompassed in other policy elements in the current proposal. These include the following: (see Appendix A)

> *"That Federal and State Governments provide appropriate resources at a high level for prevention of problems for mental health to be developed by and for Aboriginal people within the next (2) years with continued funding to follow."*

> *and "Aboriginal Children's Services be funded to provide primary preventative mental health programs" …. "preventative programs to strengthen Aboriginal family life."*

> *"That Aboriginal Health Services develop mental health services to care for:*
> • *"Primary Preventative Programs".*

Others dealt with the importance of prevention of further dislocation and separation because of adverse effects on Aboriginal Mental Health; cycles of welfare dependency and disempowerment; reunion of families; spiritual life.

The National Goals and Targets for Mental Health also emphasise the need to address mental health problems for Aboriginal and Torres Strait Islander peoples in a prevention framework to achieve goals and reducing the "loss of health, well-being and social functioning associated with mental health problems and mental disorders" (p258).

The Consultancy Report indicates that Aboriginal people gave high priority to the violence experienced by Aboriginal communities and the very destructive effects on the mental health and well-being of Aboriginal people, their families and communities. Domestic violence, and child abuse were seen as frequent and central both as problems and causes of problems. Fighting and violent episodes arising in association with alcohol, "jealousing", "pay back" or anti social and uncontrolled behaviour were seen as major problems. There was a strongly identified need to do something to prevent and address these issues.

Strategies

1. The Regional Mental Health Forum or Aboriginal Community Mental Health Program work with the Regional Councils, and community leaders to develop a program suited to local needs. These programs should be networked across communities and while shaped by the local group should be part of a Nationally coordinated approach. This National Violence

Prevention Program should be closely linked to other National initiatives in Violence Prevention. This is essential as violence is a problem for the whole community and not just among Aboriginal people. It should also have a very strong intersectoral base. It should be oversighted and monitored by the National Aboriginal Mental Health Advisory Committee.

2. Program elements encompassing some of the dimensions outlined above should be developed as relevant to local communities. National and local education campaigns to change attitudes to violence should be one element and need to link to Substance Abuse Prevention programs. Targeting young men in vulnerable situations is also a priority component, and could involve a national linkage over school based interventions. These elements should be linked to the Education Working Party.

3. Interventions aimed at "Breaking the Cycles" of violence should be developed in the Aboriginal Community Mental Health Programs of each community region, and could involve self-help and support groups and networks as well as trauma and grief related counselling and workshops and education.

4. Clinical programs of early intervention and counselling for individuals and families should be developed by and for Aboriginal people to help those who have experienced trauma. These could be developed by the Aboriginal Community Mental Health Program to prevent as far as possible adverse mental health outcomes of violence as it affects individuals.

5. There is a need for sound data bases to monitor the impact of specific interventions as well as overall prevention programs. This data development should be oversighted by the Data and Information Systems Working Party in collaboration with Aboriginal communities.

Targets

1. Regional Mental Health Forums to develop a plan for Violence Prevention in communities within two years of program commencement.

2. Programs of Attitude Change to violence to be initiated locally and nationally within three years of program commencement.

3. Interventions aimed at "Breaking the Cycle" be developed in at least one major region in each State and 3 remote regions nationally within three years of program commencement.

4. Clinical counselling and related programs be developed alongside trauma and grief and related programs within three years of program commencement.

5. Data needs be identified and developed within two years of program commencement.

11.   Alcohol and other drug use and abuse and Aboriginal mental health

The problems of substance abuse are addressed in many different initiatives in Aboriginal communities, and nationally through a range of programs. Consultative processes are addressing this, as are initiatives in mainstream services. Communities have many different approaches including those that aim at being alcohol free. This review will address the mental health issues associated with Substance Abuse for Aboriginal people.

Brady (1991) has reviewed drug and alcohol use among Aboriginal people, and the conceptualisation of it that have been used to explain problems of harmful use and negative outcomes. Setting apart diagnostic categorisations of "Alcoholism" or "Substance Abuse" problems as automatically being seen as mental disorders, she suggests that rather descriptions such as alcohol dependence syndrome or specific description of the substance and its patterns of use may be more relevant. Reviewers have suggested that intrapersonal factors (such as low self-esteem, lack of social values) and interpersonal factors (influence of

family and peers) may be major contributors to the initiation of drug use and abuse in the general population. Other influential factors that have been described include depression, delinquency, non-conformity and stressful family circumstances with sociodemographic factors adding some explanatory power. These factors are not generally identified in conceptualisations in Aboriginal studies, although many of the early reports have been more ethnographic and from anthropological points of view. Explanations have encompassed historical and social contexts, for instances with the award of citizenship and the right to drink coinciding. Other values described include creation of conviviality, social exchange, action. Kamien's work (1978) suggested group psychological pressures rather than individual psychological need were predominant. And there is debate as to the degree to which earlier studies failed to identify the extent and severity of alcohol problems such as "the agonies men's drinking may involve for women and children" (Room, 1984, p172).

In terms of patterns of drug and alcohol use, there are a number of studies with Aboriginal people which contribute. For instance a Northern Territory Study (Watson et al, 1988) examined 3 regions for patterns of use of alcohol and other drugs. Watson found 76% used analgesics and benzodiazepine, more women than men. Eighty percent of females surveyed were non-drinkers, compared to 35% of men. The proportion of female drinkers increased steadily to above 24% in the fourth decade while the proportion of male drinkers increased from 59% of those 15–20 to 75% of those in their third decade, decreasing slowly to 47% thereafter (Hunter, 1993, p107). At least 68% of females and 69% of male drinkers drank to harmful levels. Broad categories of drinking patterns were constant drinking (almost every day); intermittent (regular e.g. weekly or fortnightly cycles); and episodic. Another large survey was carried out in Queensland. It found 77% of Aboriginal males were drinkers and 45% of Aboriginal females. Similar patterns were found. About 85% of male drinkers and 64% of female drinkers were consuming at least 7 standard drinks per day, well above the hazardous level. (Quoted by Hunter 1993 from Merilyn Gascoyne).

A Western Australian study (Sambo, 1988) showed that drinkers ranged from 83% (15–17 years) to 53% (31–40 years) with more than half drinking at hazardous levels. These and other studies indicate that while there is a high proportion of non-drinkers among Aboriginal people, there are nevertheless problem levels of drinking, with drinking being almost universal in young adult males, and most drinkers starting at a young age and consuming at hazardous levels.

Similar patterns appeared in Hunter's Kimberley study (Hunter, 1993). Urban studies tend to replicate these findings. Perkins et al. (1994) concluded in their study of drug use in urban Aboriginal communities that "the health implications with respect to hazardous alcohol use and the high prevalence of smoking within the communities" should be addressed as a matter of urgency.

There are many questions about whether substance abuse may arise as a result of mental distress, mental health problems, or mental disorders. Whether people "self-medicate" to deal with distress and despair, or abnormal mental experiences, is the central issue. The strong association between high levels of alcohol use with distress related to colonisation, dislocation, trauma and loss as described by Aboriginal people must suggest that this effect may be one aspect of substance abuse, as might be the sense of identity and conviviality mentioned above. These factors may also be explained by traumatisation syndromes such as PTSD where alcohol and other substances have been used to dampen arousal. Thus there is a need to identify the interplay between such stresses, outcomes and processes of the use and abuse of psychoactive substances. Substance abuse may be both a result of despair and a cause of further despair.

With respect to the relationship between Alcohol use and psychiatric morbidity there do not appear to be specific studies of these mental health issues in Aboriginal populations. However the recent Survey of Aboriginal Admissions to Bloomfield Hospital, New South Wales, (Bert Prusiak, 1995) show alarming rates of dual diagnosis. Studies in non-Aboriginal populations indicate, however, high levels of comorbidity (Hancock et al., 1992). Data supporting comorbidity with mental health problems and disorders as important also appears in Hunter's study where increased frequency of alcohol consumption was associated with current depression and anxiety scores. Severe psychological reactions were not uncommon and related to alcohol quantity. Self-harmful impulses and acts were also related, with constant drinkers being 13 times more likely to have self-mutilated. Frequency of drinking also correlated with

suicide attempts. Abnormal perceptual experiences such as hallucinations, paranoid ideas and reactions of panic were also correlated with drinking (Hunter, 1993).

As well as correlations above, there are indications that alcohol use may be associated with many adverse outcomes for mental health. For instance alcohol is implicated in high levels of deaths from injury and poisoning among Aboriginal people, and in terms of the findings of the Royal Commission into Aboriginal Deaths in Custody, was implicated in a high proportion of accidental deaths and suicide (Brady, 1991, p203). A study of hospital admissions in Bourke showed that 25.4% of all Aboriginal admissions were directly or indirectly alcohol related compared to 4.8% of non-Aboriginal, trauma being the most common reason for admissions (Harris et al, 1989).

Violence is one of the major adverse correlates that is alcohol-related. Aboriginal women may be subject to violence with men's drinking and the increased rates of alcohol related homicide of Aboriginal women indicate these consequences (J. Lawrence, Broome, September 1994). Hunter has also indicated the strong association of alcohol and violence and adverse outcomes in his extensive work in this field. These connections have also been reviewed in terms of the impact on children, young people and families, both with trauma, disruption and antisocial outcomes of violence in families, most often perpetrated by men under the influence of alcohol.

While it must be acknowledged that social factors and contexts come into play with Aboriginal alcohol use, it must also be accepted that it is associated with significant negative health outcomes in terms of both mental and physical health. These issues also include the whole range of organic syndromes, from intoxication to delirium, from alcohol induced psychotic disorder to alcohol induced amnestic syndromes and dementia.

The use of other substances and their mental health implications warrants further consideration. For instance petrol sniffing and other volatile substance abuse, especially amongst young people, has been reported especially in Northern Territory, Central Australia and Eastern Goldfields region of Western Australia, but also in urban settings, although data on these is less clear (Brady, 1991). Euphoria and hallucinations are often associated with its inhalation, as well as antisocial behaviours.

Kava use increased in some communities but adverse health effects are poorly understood.

With respect to illicit drugs, data is also problematic. A study in New South Wales of young Aboriginal people indicated that 17% knew someone using cocaine, and 19% knew someone using heroin. It is indicated also that heroin has been a significant problem for Aboriginal communities in Sydney for at least a decade, with number of users growing steadily (National Aboriginal Health Strategy Working Party 1989). Marijuana use is widespread especially in urban and country areas. It is often associated with the precipitation of psychoses or other mental states.

In all these instances the complex interrelationship of substance use and misuse with depression, anxiety and other disorders is not well established. However relationship to adverse outcomes is clear both in terms of direct effects on mental health of many of these substances when used to hazardous levels, and effects through social and health outcomes, especially violence, injuries, accidents and organic syndromes. Substance abuse and mental health are closely interrelated and service response in mental health must address this area.

The National Aboriginal Health Strategy (p193–206) states the urgency of addressing these issues

> *"The need to create and place strong emphasis on preventative and public awareness type programs is considered essential" (p196)*

A whole range of treatment and rehabilitation programs are proposed.

This report also suggests that psychoactive drug use should be addressed, including known stimulants, sedatives and hallucinogens. They consider destructive psychoactive drug use does not appear in isolation, but is related to problems such as low self-esteem, inadequate relationships, cultural disruption, disempowerment and so forth. Heroin is seen as the major source of concern in this respect. All these behaviours are associated with adverse outcomes in terms of spiritual, emotional, mental and physical

well-being for Aboriginal people, families and communities.

Substance abuse and Aboriginal mental health

The high, and in some instances rising rates of hazardous drinking, the pervasive use of marijuana and other drugs, the heroin dependence in some communities and the morbidity and mortality associated with these behaviours indicate very significant problems for Aboriginal communities. Strategies to address these have been and are being developed. Yet most are separate from and not integrated with mental health programs and the high level of interrelationship between substance abuse and mental health is not addressed. There is a need to link developments, policies and programs in these two areas, as part of the holistic relationship, that is integral in Aboriginal health, and because of the extent of the interrelatedness of the problems they represent.

Aims

To lessen the levels of hazardous alcohol and other drug use among Aboriginal people of all ages; to diminish the adverse consequences; and to lessen associated mental health problems and mental disorders.

Policy initiatives

These policy program directions represent a general synthesis of some of those found to be of value and suggested by those working in this field. It should be noted at the outset however that they should only complement, when appropriate, many of the excellent programs developed by Aboriginal people. Amongst these are the Karpu, Doongoch, New South Wales, the Aboriginal living with Alcohol Program in the Northern Territory, a harm reduction model, the Central Australian Aboriginal Alcohol Planning Unit program, the Community Mobilisation for the Prevention of Alcohol-related Injury (COMPARI) from Western Australian and many others. However specific attention is necessary for both cognitive and organic aspects and the strong relationship to mental health problems. The proposals below cover alcohol and other substances, including heroin and injecting drug use.

- **Education of the community.** These programs could link to existing substance abuse programs but incorporate a recognition of the relationship to distress, and the option for other ways of coping with stress that will be less harmful.
- Information – for instances about hazardous drinking and its outcomes, or about mental health aspects, or mental disorders related to it, and about effective interventions. Brady (1994) has suggested that this material may need to be collated and disseminated to reach Aboriginal Medical Services and Communities.
- Intervention programs for those at risk may be developed through Aboriginal Medical Services, for instance for heavy drinkers with explanatory modes developed relevant to cultural understanding.
- Special Programs for Young People should be developed through schools, communities and family involvement, including education, and skills for other social behaviours and coping, as well as identity formation, and if appropriate with youth leaders. Cultural aspects should be a strong component.
- Clinical programs should be developed through Aboriginal Community Mental Health Programs and Aboriginal Medical Services to ensure that there is diagnosis of comorbid or associated mental health problems, and treatment for both conditions.
- Alcohol Related Brain Damage There is a need for education of communities and health services to deal with this, both in terms of presentation where possible and appropriate care.
- Prevention of Foetal Alcohol Syndrome There is a need for education and antenatal programs to lessen hazardous drinking (and substance use) in young Aboriginal women, and to prevent foetal alcohol syndrome. Aboriginal Medical Services and Midwives will, as Women's health programs, need to specifically address this issue.
- Prevention and Programs for I.D.U. There is a need for special programs, especially for

young people, in areas of heavy use of I.D.U./ cocaine and heroin etc.

Overall, these elements should fit in a harm reduction model, developed by Aboriginal communities, in ways appropriate to their needs and coordinated within regions and nationally.

Rationale

The Literature Review and the earlier overview highlight the nature and extent of substance abuse problems and the importance of addressing them because of their profound adverse effects on the mental health and well-being of Aboriginal men, women, children, families and communities.

Dunlop (1988) in her presentation of The Rama Rama Mob highlighted the fact that disturbed behaviours, mental disorders and substance abuse were inseparable in both her findings and in the eyes of the community.

Brady (1994) writes that "As with any other segment of the population, alcohol and other drug use both masks, and is exacerbated by, existing mental health problems". She goes on to point out that from her experience in this field "the two areas seem to intertwine so closely that it is difficult to disentangle them". Also many mental health problems requiring treatment remain untreated because they are hidden by alcohol or petrol sniffing.

Numerous other studies and reports indicate this close relationship.

Reports including the National Aboriginal Health Strategy all urge prevention and treatment programs. Numerous reports on Substance Abuse, especially Alcohol, but also other drugs, have advised the need for care.

In the mental health field, the National Aboriginal Mental Health Conference recommended

> *"That Aboriginal Health Services develop mental health programs to address:(see Appendix A)*
> * *Substance Abuse"*

> *"That substance abuse be recognised as only one symptom of other mental health problems, and treated holistically".*

The Consultancy Report indicates that alcohol abuse was identified both as one of the major mental health problems affecting Aboriginal people and one of the principal causes of mental health problems for them.

The inseparable nature of substance abuse and mental health problems was clearly conveyed by the majority of respondents. It was seen as essential that services address both. Furthermore violence, sexual abuse, accidents, injuries, deaths, and ill-health generally were also seen as connected in a very adverse picture for many communities.

Strategies

1. The Regional Mental Health Forum should develop a program to deal with substance abuse/mental health as these interrelating problems affect the particular community. This program should result from consultative processes and collaborative working parties linked to Aboriginal programs in the region. Program elements should encompass the relevant aspects of those components outlined above.
2. Program development of linked programs for mental health and substance abuse should be carried out related to regional problems and priorities, but should encompass at the least education, information, and clinical components. These should include too, education/intervention to prevent foetal alcohol syndrome and alcohol brain damage.
3. Educational programs for Aboriginal Health Workers, Mental Health Workers and Substance Abuse Workers need to be developed and provided in both short and longer course formats, as part of training curricula for these workers and as part of continuing education. Programs need to emphasise the interrelationship of mental health problems and substance abuse, and the educational, clinical and other intervention skills necessary to deal with them. These

educational developments should occur through and be monitored by the Education and Personnel Development Working Party.

4. Data needs to both identify patterns, extent and nature of mental health problems and substance abuse, and their interrelationship. Effective interventions should be established by appropriate collaborative research carried out by Aboriginal people and coordinated by the Data and Information Systems Working Party.

Targets

1. Regional Mental Health Forums should identify specific problem profiles and plan programs relevant to substance abuse and mental health as a high priority within the first year of program implementation.
2. Program development in selected areas including education and clinical should commence in at least 10 regions within two years of program implementation.
3. Educational programs should be developed and oversighted by Education and Personnel Development Working Party within three years of program implementation.
4. Data needs should be identified and funding sought for research to address these by relevant Aboriginal groups and coordinated by the Data and Information Systems Working Party within three years of program implementation.

12.   Forensic issues in mental health

The high rates of incarceration of Aboriginal people, the history of repeated incarceration; of adverse experiences with the criminal justice system; the relationships of younger Aboriginal people to the juvenile justice system; the tragedy of Aboriginal deaths in custody; reports of stressor experiences in encounters with the police system; the extra separations and family disruptions that result; the violence and substance abuse; the differences of Aboriginal Law and non-Aboriginal Law: All these factors have significant mental health implications in that they impact negatively on the mental health and well-being of Aboriginal people. In addition there is ample evidence that Aboriginal people may suffer significant mental health problems and mental disorders that require treatment when in custody and that they need appropriate mental health assessment and preventive care. These matters are covered in detail in the Recommendations of the Royal Commission into Aboriginal Deaths in Custody (1991) (see Policy Background) and in supporting reports and documents since that time.

Aims

To prevent or manage mental health problems that contribute to problems with the law and incarceration for Aboriginal people; to contribute to lessening high rates of incarceration of Aboriginal people; to provide appropriate prevention and treatment to Aboriginal people in custody, so as to lessen the mental health problems or disorders they experience and to prevent suicide.

Policies

Numerous initiatives are in place following the Royal Commission into Aboriginal Deaths in Custody ranging from Aboriginal Prisoner Health planning programs to Aboriginal Visitor programs for those imprisoned.

All these are of great value. However there is also a need for prevention programs at both a structural level to prevent incarceration in the first place and to develop other mechanisms to address the underlying issues that will lessen antisocial behaviour. Clearly many of these rest with changes to the justice system, early

intervention and prevention programs with young people, and development of systems linked directly to Aboriginal Law. These matters are most appropriately addressed by Aboriginal people and communities as part of social justice processes. However, from the mental health point of view several program elements are likely to be helpful.

- Education and Early Intervention programs with a strong orientation to preventing problems with the justice system and incarceration. These might include prevention for high risk youth in terms of disruptive behaviours.
- Youth Programs There is an urgent need for programs to prevent young people going into justice institutions or to provide support and positive outcomes if they do.
- Provide Mental Health Outreach Services to all Aboriginal people in custody. This outreach should be provided by Aboriginal Mental Health Workers or Mental Health Professionals and should be a component of the Aboriginal Community Mental Health Program, linked to regional Aboriginal Medical Services.

Workers should have specific educational input for forensic mental health issues and support and supervision for this specific role and should also link to Forensic Mental Health Services or conventional Mental Health Workers generally.

These outreach services should:
- provide early assessment or contact for Aboriginal people in custody
- identify mental health problems and mental disorders
- provide counselling as appropriate, especially in situations of crisis, trauma, loss, withdrawal
- ensure assessment and management of alcohol and drug problems also affecting Aboriginal people in these settings
- develop mental health promotion and maintenance programs, e.g. relaxation, stress coping strategies, assertiveness
- apply appropriate referral and follow up.

These services may need also to provide special support and counselling for families of the person in custody. Special Aboriginal Mental Health Workers positions for Correction and Health Services Work may need to be established. Such people may function for instance as an integral part of the Crisis Intervention Team for a prison complex to assist health staff with the mental health assessment/intervention and to provide advice, assistance and liaison with Aboriginal support groups, in regard to mental health issues affecting Aboriginals in custody. Services should include a link to "Watch" Committee initiatives in the response of preventing deaths in custody and protocol for a counselling service for family members if a death does occur.

Overall this Aboriginal Mental Health Outreach Service needs to ensure follow up, general support, and that early support is available at the vulnerable period when a person is first taken into custody.

Family Support Program

As part of mental health outreach it is essential that there are family support programs to deal with family mental health needs and to prevent cycles of ongoing problems with the law. This component also needs to provide counselling, for instance following deaths, or to prevent incarceration if possible.

Court reporting and assessing

These Services should be developed as appropriate. All of these and other proposals need to link to current initiatives through Aboriginal Legal Services, Aboriginal Medical Services and Justice and Correctional systems in each state. Special emphasis should be placed on Juvenile justice initiatives for Aboriginal young people because of the prevention and early intervention opportunities.

Rationale

The Literature Review above indicates the high level of psychosocial morbidity generally, and the specific vulnerabilities of those incarcerated as indicated by Hunter's study (1993). Radford et al. (1990) indicates the stressor effects of repeated police contact. The reports contributing to the evidence for RCIADIC also indicates the extent of mental health problems. Mental health and substance abuse problems clearly interrelate in this context also. The suicidal deaths, reflecting mental health problems in many instances, indicate the need for urgent action. Clearly also there is a need for further research.

Reports of particular significance are the Royal Commission into Aboriginal Deaths in Custody. Recommendations 122–167 address these issues, but the urgent need for forensic mental health is particularly highlighted by the following Recommendations:

150. That the health care available to persons in correctional institutions should be of an equivalent standard to that available to the general public. Services provided to inmates of correctional institutions should include medical, dental, mental health, drug and alcohol services provided either within the correctional institution or made available by ready access to community facilities and services.

151. That, wherever possible, Aboriginal prisoners or detainees requiring psychiatric assessment or treatment should be referred to a psychiatrist with knowledge and experience of Aboriginal persons.

152. The Corrective Services in conjunction with Aboriginal Health Services and such other bodies as may be appropriate should review the provision of health services to Aboriginal prisoners in correctional institutions and have regard to, and report upon, the following matters together with other matters thought appropriate:

    a. The standard of general and mental health care available to Aboriginal prisoners in each correctional institution.

The National Aboriginal Mental Health Conference included a number of significant presentations on this issue and emphasised the need for prevention and other early action (see Report, Swan and Raphael, 1994).

Recommendations included the following:

> *"That there be increased attention paid to mental health issues for young people in correction services, e.g. community based."*

A recent report of the Juvenile Justice Advisory Council of New South Wales "Aboriginal Over-Representation and Discretionary Decisions in the N.S.W. Juvenile Justice System" (Luke and Cunneen, 1995) reported on the extreme, high apprehension rates and probably bias in decisions. While representing only 1.9% of New South Wales youth, Aboriginal youth represent 25% of those in custody. It is important to note the younger ages and high numbers of Aboriginal young people and the relatively higher percentage of young women for formal intervention.

The Consultancy Report indicated a high level of concern in this area in terms of Aboriginal people's culture and needs not being understood by non-Aboriginal police and correctional services; that it was felt that racism and scapegoating contributed adverse outcomes for young Aboriginal people in contact with the law; that parent absence created further problems in Aboriginal families when either was incarcerated; that Aboriginal people went to prison at higher rates because of the impact of colonisation and social factors and that has had very adverse effects on them and related to their mental health; that many families of those who had died in custody had still not received adequate appropriate counselling for their grief.

Mental Health Review Tribunals were most often inappropriate to clearly assess the mental state of Aboriginal forensic patients.

Strategies

1. Regional Aboriginal Mental Health Forum groups or Aboriginal Community Mental Health programs coordinate a meeting to identify current initiatives about forensic mental health as it affects Aboriginal people and future needs. These groups need to ensure:

   That Mental Health Review Tribunals include Aboriginal members when Aboriginal people are reviewed.

   That Aboriginal people are members of Guardianship Boards when dealing with Aboriginal clients.

2. Planning processes should be undertaken with relevant state leaders from Government, non-government and forensic services with Aboriginal Mental Health groups and community leaders to plan programs covering
   - Education and Early Intervention for the Region
   - Mental Health outreach programs

   Necessary resources should be sought and the workforce necessary to carry out these programs developed and educated in necessary competencies.

3. Educational program needs should be identified and incorporated in the programs and curricula for relevant workers, particularly specialised Aboriginal Mental Health Workers working in correctional Services. Non-Aboriginal Mental Health Workers who are called upon to deal with Aboriginal clients should also review such programs in addition to those covering Aboriginal culture and history. This should be identified by the Education and Personnel Development Working Party.

4. Data and Information Systems should be established locally and coordinated nationally with respect to Aboriginal Forensic Mental Health issues and oversighted by the Data and Information Systems Working Party.

Targets

1. Regional Aboriginal Mental Health Forum groups should establish collaborative meetings and review local initiatives and need within one year of this program implementation.

2. Aboriginal Mental Health Outreach Forensic services should be established with at least one worker in major regions within two years of program implementation.

3. Educational programs to meet needs for Aboriginal Forensic Mental Health education should be established within one year of program implementation.

4. Aboriginal members on Mental Health Review Tribunals and Guardianship Boards receiving Aboriginal people within two years of program implementation.

5. That Aboriginal Medical Services and Aboriginal Legal Services have resources to employ suitable Professionals for forensic assessments within two years of program implementation.

6. Data and Information Systems for Aboriginal Forensic Mental Health should be established within one year of program implementation.

13. Intersectoral programs and mental health

There has been an increasing recognition of the importance of addressing intersectoral programs in terms of the mental health issues that interact with them. Programs in other sectors may encompass the needs of people with mental health problems or mental disorders, for instance housing, employment, social security, community services, welfare and so forth. Mental health problems and mental disorders may also

present in other program sectors – for instance education, justice, general health and so forth. In addition there may be conditions or disorders in the mental health field that fall between sectors of health or health and other: these are often specifically situations of comorbidity, or dual diagnosis. Two classic areas are substance abuse and mental health; and developmental disability and mental health. Substance abuse is addressed with mental health in this current set of proposals but developmental disability or disability has not. The aim of this program element is to specifically identify relevant intersectoral issues, and processes whereby they may be addressed so as to enhance the Mental Health and Well-being of Aboriginal people.

Aims

To identify intersectoral issues relevant to Aboriginal Mental Health and to develop mechanisms for intersectoral collaboration so as to promote positive mental health outcomes for Aboriginal people.

Policy initiatives

It is essential that intersectoral issues are recognised at the outset and incorporated into the mechanisms for policy management at national and local levels and for particular case focus where this is required, for instance by interagency collaboration. Policies in each of the areas identified in this report, Sections 1–16, will have intersectoral aspects and these should be addressed in each instance. Specific groupings will be relevant for particular areas (e.g. Education, Youth and Family Services for Children's and Young People's Mental Health programs). Developing these intersectoral collaborations can achieve the goal of enhancing their contribution to positive mental health outcomes for Aboriginal people, as well as achieving more efficient resource utilisation.

Consultation frameworks for intersectoral programs should be developed

- National Consultative frameworks for intersectoral programs should be identified and developed both generally and for each policy area, through the National Aboriginal Mental Health Advisory Committee.
- State Tripartite Forums on Aboriginal Health
- Regional Mental Health Forum responsibility in local regions should also provide a framework for intersectoral collaboration at a Regional level.
- Interagency committees or groups can be developed to manage cases where cross sector management is essential at a local level.

Specific intersectoral programs

Specific Intersectoral Programs of Relevance to Aboriginal Mental Health should be identified. These are likely to include:
- Aboriginal Affairs
- Disability Services
- Accommodation services/Housing
- Aged care
- Children's services
- Youth services
- Employment and training
- **Income Security – Social Services**
  - Family and Community Services
  - Justice and Forensic Services
  - Education
  - Transport

It is important that a review or survey establish the potential aspects of relevance in policies and programs and specifically address these through a range of mechanisms including complementary policy and

program development, intersectoral linkages, cross sector programs and so forth. Such initiatives may generally assist mental health program development.

It is also important that sectors within health are addressed – for instance child health and mental health, chronic mental disorder and rehabilitation.

Specific programs in dual diagnosis areas may need to be explored – for instance with intellectual handicap and mental illness and the heightened need.

Rationale

The Literature Review while not specifically addressing intersectoral problems, notes these in some contexts, e.g. mental health problems in the justice system, suicide and deaths in custody; health service funding.

Reports in a number of areas address the importance of intersectoral issues for mental health in general and thus their relevance for Aboriginal mental health and in related areas.

The National Aboriginal Health Strategy (1989) discusses the significance of intersectoral collaboration (Chapter 6, p102–114). It described the nature and importance of intersectoral collaboration for Aboriginal Health generally .. "Vital to the efforts to improve health and well-being are the contributions of a variety of sectors ..." (p.103). It notes that health agencies have a pivotal role in intersectoral collaboration efforts, and that health and national development strategies are linked. It describes mechanisms for establishing intersectoral collaboration, and the barriers to them; the need for cultural and sociopolitical considerations; and specifically addressing the housing, environmental and public works areas; education; and employment.

The National Mental Health Policy (1992) describes the need to link mental health service to other sectors in collaboration frameworks, particularly for those with severe mental illness (e.g. supported accommodation, income security, etc.). It makes recommendations aimed at enhancing intersectoral collaboration and interagency links to adequately address the needs of those with severe mental health problems and mental disorders (p19–20).

The NH&MRC Report Scope for Prevention in Mental Health (1992) notes the critical nature of intersectoral approaches to address prevention in the mental health field in all areas.

The National Health Strategy (Issues paper number 5, 1993 – Help where Help is Needed) emphasises the need to develop intersectoral levels to address the needs for care for people with chronic mental illness.

The National Aboriginal Mental Health Conference (1993) comments frequently on intersectoral areas e.g. children's forensic services, accommodation and housing and highlights their importance.

The Consultancy Report provided repeated examples of the problems for Aboriginal people with mental health problems and mental disorders in their interaction with other sectors, specifically forensic and justice, education, housing, aged care, youth services and so forth.

Strategies

1. The National Aboriginal Mental Health Advisory Committee should identify intersectoral issues relevant to Aboriginal mental health, provide a resource on these and facilitate the development of consultative mechanisms to address these rationally through its own operations and regionally through the Regional Mental Health Forum. (Section 3)
2. Specific intersectoral program areas should be identified and whenever appropriate complementary programs or consultative mechanisms established between these (nationally and/or locally).
3. Specific intersectoral programs should be established from within health sector collaboration.

Target

The National Aboriginal Mental Health Advisory Committee should progressively develop and establish

intersectoral collaboration and program identification from the time of inception of the general program, but specific programs from two years after this area is separately and additionally addressed.

14. Research and evaluation

The absence of adequate information on Aboriginal mental health, the lack of understanding of the processes which influence it and of risk and protective factors, the need for Mental Health Outcome Indices, and methods to evaluate the effectiveness of health interventions, all attest to the need for a research and evaluation Policy initiative.

Aims

To determine research priorities and frameworks, and to identify resources so as to promote culturally appropriate and sanctioned research in mental health, to be carried out for and by Aboriginal people.

Policy initiatives

Research development in Aboriginal mental health should be driven by priorities of need, but should also be able to explore the basic service elements of Aboriginal mental health if this is considered an area of need or relevance by Aboriginal people. Research policy development needs to link to data and information development, where appropriate; to pursue ethical guidelines for research with Aboriginal communities as identified by the NH&MRC and NAHS; to deal with mental health priority needs; to provide both basic and health service research components including program evaluation; to be responsible to Aboriginal communities in terms of the return of findings to communities; to build a research career structure and workforce for Aboriginal mental health researchers; to develop an academic base for Aboriginal Mental Health.

Promotion of mental health research for Aboriginal people

The National Aboriginal Mental Health Advisory Committee should take an active role in promoting Aboriginal Mental Health Research. This should include developing a relationship with the Aboriginal Health Advisory Committee of NH&MRC to urge the Medical Research Committees to lobby for Aboriginal Mental Health research as a Special Initiative area for Research Funding. The National Aboriginal Mental Health Advisory Committee could also provide, in consultation with NACCHO and Aboriginal communities, priority areas for research. These could include the following:

- National Survey of Aboriginal Mental Health
  There should be support and backing for this Aboriginal Mental Health initiative, and its development by Aboriginal Mental Health researchers.
- Research into priority areas for Aboriginal Mental Health
- Trauma and Grief as they affect Aboriginal people, and the processes and mechanisms contributing to impairment of mental and physical health and the nature and consequences of past traumatic morbidity amongst Aboriginal people and its relation to substance abuse.
- Children and young people's mental health and the interaction between child rearing and child development and mental health, as well as the impact of disrupted parenting.
- Social and cultural factors that influence the nature of psychosocial morbidity and mental disorders amongst Aboriginal people.
- Counselling frameworks, their nature and significance.
- Other areas as relevant.

- Mental Health Services Research and Evaluation
  This area is essential in several aspects including the following:
- Effectiveness or otherwise of therapeutic interventions for Aboriginal people with Mental Health problems and mental disorders, including counselling, community mental health care, psychotropic medication, and traditional healing.
- Effectiveness or otherwise of preventive approaches to mental health among Aboriginal people.
- Mental Health Outcomes

  It is essential, as noted previously, that mental health outcome assessments for Aboriginal people are developed in consultative frameworks. Special research initiatives developed by Aboriginal people should urgently address this area, and link to the Data and Information Systems Working Party in this regard, as well as to National Mental Health Policy Initiatives.
- Research Development in Aboriginal Mental Health should be encouraged in several ways. There should be Research Fellowships and Traineeships in Aboriginal Mental Health linked to established research teams or academic departments (e.g. Psychiatry) working in Aboriginal Mental Health research. Specific research proposals and programs should be supported to provide such development. Models of consultative research development as in McKendrick and Thorpe's model at Rumbalara, which encompasses educational and experiential components for collaborating Aboriginal researchers is one such model of great value. A number of Centres nationally could receive development grants through consultative frameworks initiated with local communities to research mental health areas of priority need. Research career structures for Aboriginal Mental Health researchers should be developed.
- Research Methods and Programs

  The National Aboriginal Mental Health Advisory Committee should encourage a review and development of a range of qualitative and quantitative methodologies appropriate to addressing the needs for Mental Health research with Aboriginal people. A resource base, a research network and a working party to address these matters could be developed using available expertise. This framework should also link to establishment of priorities for research areas, ensuring support in project submissions and their review and identifying specific resources for research funding (e.g. RADGAC, NH&MRC).
- Ethics and Consultation in Aboriginal Mental Health Research

  There are specific requirements in NH&MRC guidelines for research with Aboriginal communities and processes identified by the National Aboriginal Health Strategy. These overall guidelines include: Obtaining Ethical approval; Consultation process; ongoing Review of Ethical Standards; addressing Social, Gender and Cultural issues; communication and consent; employment of local people; ownership and publication of materials; exploration of community resources; priority being given to those proposals that address the most important and achievable goals. The importance of the relationship with local communities cannot be overemphasised. There is also a need to recognise the particular sensitivities of issues of gender – parenting, family and community structures and responsibilities; personal and collective relationships; invasions of the body; handling of human specimens and products.

  In addition to these general cultural and ethical considerations, there will be particular issues relevant to mental health: the stigma; informed consent; cultural interpretations of behavioural patterns; cultural prescriptions regarding what can be discussed; and many other factors. These need to be identified nationally, but also specifically locally, and must be addressed in the development of culturally sensitive research proposals.

Rationale

The Literature Review highlights the many deficiencies in Aboriginal Mental Health Research and the needs for extensive development in this field. The most up to date contributions such as those of Hunter (1993) and McKendrick and Thorpe (1993) provide indicators of both methods that have been utilised

effectively and successful outcomes. But there is a need for research to identify the nature and extent of mental health problems and mental disorders among Aboriginal people.

Reports from a number of sources also support the need for research development.

The National Aboriginal Health Strategy discusses Aboriginal Health Research at length (Chapter 11, pages 207–217) and also addresses some concepts of both Data and Information Systems and Evaluation in its Chapter covering Monitoring and Evaluation (Chapter 12). With respect to Aboriginal Health Research, a number of matters are raised relevant to mental health research:

In drawing particular attention to the relevance of cross cultural research to psychiatric/mental health research, including issues of diagnosis, it is suggested that researchers "own complexes" and culture may influence research.

> *"These factors have an impact on the conclusions researchers reach, and help to explain why mental health/illness research has had little success in exploring, in usefully describing and defining, the Aboriginal situation" (p.208).*

The report goes on to indicate in general for Aboriginal Health Research.

> *"Aboriginal research, rather than reflecting the fancy of the individual researcher, needs to become problem oriented and Aboriginal people should be defining the problems. Underlying issues will be better understood and the way towards prevention and treatment made clear."*

> *"The research should clearly specify the issue under consideration, and the community should be involved in framing the questions so that the research is relevant to their needs." (p.208)*

> *"The Aboriginal community must actively participate in the research process, be kept fully informed, and have some say in how the research findings are publicised and used. Only when research projects are subject to Aboriginal community influence, will they be both relevant, and of benefit, to the community." (p.209)*

The review also recommends:

> *"That the paper 'Report on the National Workshop on Ethics of Research in Aboriginal Health' be adopted as the basis for considering Aboriginal health research proposals" (p212). "The NH&MRC should annually set aside a fixed proportion of research monies it administers, for research projects in Aboriginal Health." (p.212)*

Research areas identified social health and specific health issues. The latter made particular reference to the following areas of mental health research which it specifically recommended (amongst others)

> *"development of appropriate strategies to deal with mental health problems, especially alcoholism" (p.216)*

> *"development of effective means for reducing the prevalence and effects of child abuse" (p.216)*

In addition

> *"The Working Party recognises that there should not be an imbalance towards areas of research in specific diseases. Rather it is recognised that there should be a swing towards a balancing emphasis on Social Health and the socio-economic and consequent mental stress basis for illness with Aboriginal communities." (p.217)*

Monitoring and Evaluation section of NAHS identified a range of indices and data collections necessary including morbidity and mortality; service provision and utilisation; physical (objective) state of health; self reported (or subjective) state of health; behaviour has implications for health; and environmental factors that influence health. (p.221) It also recommends indicators be established covering: Sentinel Health Events (SHE) (provider based); family health (consumer based); health systems infrastructure; environmental conditions; intersectoral collaboration; Aboriginal and Islander vital statistics (births, deaths, maternal/perinatal collections, hospitalisations/ separations); and cultural and social well-being (cultural integrity, attitude to health and well-being, racism) (pages 229–230). These dimensions should thus be taken into consideration for the development of Aboriginal Mental Health Outcomes or Indicators.

The Royal Commission into Aboriginal Deaths in Custody also made recommendations about the need for Aboriginal health statistics (p.270).

The National Enquiry into the Human Rights of People with Mental Illness (Burdekin, 1993) specifically recommends research into Aboriginal Mental Health.

> *"Joint research projects should be undertaken by Aboriginal communities and other mental health professionals to determine the Nature and Extent of mental illness among Aboriginal people."* *(p938)*

The National Aboriginal Mental Health Conference (1993) (Report 1994) recommended that (p.35):

> *"The Conference demanded that research into all aspects of Aboriginal and Torres Strait Islander Communities be undertaken only within Aboriginal and Torres Strait Islander guidelines, including community participation and only with full consent of the particular community, with whom research is to be undertaken."*

> *"National Aboriginal Mental Health Needs Survey."*

The Consultancy Report identifies both the needs for information and data in many areas, but the importance of addressing these in culturally appropriate ways, with specific programs developed with local communities. A consultative group of Aboriginal women planning proposals for the Longitudinal Women's Health Study, was able to identify culturally appropriate frameworks and processes to address such research development. The potential value of research, but also the exploitation that has occurred, with many researchers' work, and the misunderstandings that were particularly likely in mental health were also discussed. Generally there was support, particularly for research identifying Aboriginal Mental Health needs and relevant local issues.

Strategies

1. The National Aboriginal Mental Health Advisory Committee should coordinate the development of a Research strategy for Aboriginal Mental Health including the following:
   • Research in priority areas and identifying need
   • Health services research and evaluation in Aboriginal Mental Health
   • Development of Mental Health Outcome measures and indicators
   • Resource base and network for research development in Aboriginal Mental Health
   • Research methods and program funding
   • Consultation and Ethics

   In so doing, it should link with NH&MRC, RADGAC, Data and Information Systems Working Party, National Centres in Mental Health, Australian Institute of Health Welfare and other groups as relevant.

2. An Aboriginal Mental Health Research Workshop should be held, to develop a resource base (i.e. current or past mental health research projects, publications, methodologies, and so forth) and to discuss these issues in depth with the goal of formulating an ongoing Research

Network in Aboriginal Mental Health, encompassing researchers and academic institutions as relevant. All proposed research projects in Aboriginal Mental Health should be registered with this network.

3. Research Working Groups linked to the Data and Information Systems Working Party should
   • Inform and manage the proposed National Aboriginal Mental Health Strategy
   • Submit proposals for funding for the development of Mental Health Outcome Measures and Indicators in Aboriginal Mental Health

These two matters should have urgent priority and link to current National Mental Health Policy initiatives in both areas, and be funded alongside these programs.

Targets

1. The National Aboriginal Mental Health Research Strategy should be developed as outlined within two years.
2. Special research proposals should be identified and submitted for funding within two years.
3. Research Workshops and Seminars in Aboriginal Mental Health Research should be held in 1995 and 1997 with the establishment of an Aboriginal Mental Health Research Network within two years.
4. Priority research in Aboriginal mental health should be carried out in two areas and the proposals for these established and implemented.
   • National Aboriginal Mental Health Survey by end 1995
   • Aboriginal Mental Health Outcomes Measures and Indicators by end 1997
5. Aboriginal Mental Health should be identified as a special initiative area for NH&MRC funding by 1996.

15.   Education and personnel development

Critical to the implementation of any Policy Proposals for Aboriginal Mental Health, including those outlined above, is the provision of a skilled and educated workforce, encompassing appropriate numbers and placement of qualified and competent personnel. A strategy for policy implementation must ensure that such workforce development runs alongside and fulfils the requirements of the strategy. Personnel development must encompass both education for care tasks and competencies, of those already in the workforce who may be challenged by new roles and functions; and programs for new staff. Brief courses as well as professional education are relevant, and there is also the need to ensure continuing education frameworks. The value, numbers and disposition of personnel required need to be identified and progressive evaluation of this workforce planned in terms of priorities, need and resource development.

Aims

To facilitate the development of a skilled workforce to respond to priorities and needs for the provision of mental health care for Aboriginal people, in line with the principles outlined above.

To ensure that all health care professionals working with Aboriginal people and specifically Aboriginal Health workers have appropriate education to ensure that they achieve core competencies in terms of skills and knowledge with respect to Aboriginal mental health.

To ensure that all Mental Health Professionals and specifically Aboriginal Mental Health Workers have appropriate education to achieve required levels of competency in Aboriginal Mental Health.

To ensure that education to achieve required competencies in Aboriginal Mental Health is provided in multiple forms and media, including courses, professional qualification and continuing education.

To ensure that, through appropriate means, including affirmative action, appropriate numbers of Aboriginal people are educated for the mental health workforce at all professional levels in mental health.

To support position development and position numbers for all areas of Aboriginal Mental Health so as to ensure an informed, competent and skilled workforce.

To enhance awareness for Aboriginal people and communities about Aboriginal Mental Health.

To ensure the coordination, development and monitoring of skills, education and personnel development initiatives for Aboriginal Mental Health Care provision and that management and human resource management processes are synchronous with this development.

Policy initiatives

There is a need to ensure a coordinated national approach linked to State and local initiatives in workforce development in Aboriginal Mental Health. This approach needs to include the following:

Identification of workforce and workforce need

The recent review for the National Evaluation Strategy has examined Community Controlled Aboriginal Health Services and the workforce of Aboriginal Health Workers (Wronski et al., 1994). This review has examined characteristics, roles and functions, but did not indicate numbers. Minimum numbers seen to be necessary for the provision of mental health care for Aboriginal people in a range of communities and settings, and numbers of different personnel have not yet been identified. Many Aboriginal Health Workers are multiskilled. It is also known that numbers of specialised Aboriginal Mental Health Workers are small, and the mental health education and skills of Aboriginal Health Workers in the field of mental health seen as needing to be increased, and perceived as inadequate in many settings. With respect to specialised Aboriginal Mental Health Workers, data on numbers of other such professionals (e.g. psychologists, social workers, occupational therapists) did not appear to be available. While data on Aboriginal and Torres Strait Islander nurses was available from the recent Nursing review, it did not provide any indication of those with mental health training or expertise.

There are 431 Registered Nurses and 780 Enrolled Nurses identified as Aboriginal and Torres Strait Islander, meaning that 2 in every 1000 Indigenous Australians are Registered Nurses compared to 9 in every thousand non-Indigenous Australians. And there are approximately 3 indigenous compared to 12 non-Indigenous who are Enrolled Nurses, indicating a higher proportion in the Enrolled category (which may reflect disadvantage, costs etc.). (Nursing Review, pages 294–295). Of students enrolled in nursing courses (at Bachelor level) there are 0.07% of the total Aboriginal and Torres Strait Islander population, compared to 0.13% of all Australians. The review states

> *"Whatever the reason, there is a need for more Aboriginal and Torres Strait Islander students in nursing and a more Aboriginal and Torres Strait Islander oriented curriculum." (p.296)*

This review also endorsed the importance of Aboriginal and Torres Strait Islander people as health professionals as "an important part of any overall strategy for the achievement of better health outcomes".

Elsewhere the report notes the need to strengthen the mental health component of general nursing curricula and to strengthen and make more attractive with special initiatives, post-graduate mental health nursing opportunities. These issues must also apply for the role of nurses in Aboriginal communities, especially as nurse practitioners, and ways they can be educated for the provision of Aboriginal Mental Health Care.

With respect to other professionals and their roles, e.g. psychologists and social workers, it is known that there are Aboriginal people working in such professions, and as well, non-Aboriginal people, who provide mental health care. These workers and their roles (both Aboriginal and non-Aboriginal

professionals) need to be identified and further educational opportunities provided to increase their numbers and enhance their capacity to work in the field of Aboriginal Mental Health. This would also apply to other workers who may have professional basis in mental health, for instance Occupational Therapists.

Medical personnel work in larger Community Controlled Health Organisations, either for the organisation or sessionally and will vary in their expertise in Aboriginal Mental Health. An increasing number of Aboriginal Medical Graduates are bringing specific contributions and most have had reasonable undergraduate experience in this field. Affirmative Action proposals (see Consultancy Report) should enhance their numbers. There is a need for educational input to postgraduate education of psychiatrists both in Aboriginal Mental Health and Culture. It is said that there is at least one Aboriginal medical practitioner in the training program for the Fellowship of the R.A.N.Z.C.P.

The review and monitoring of workforce needs and personnel development is an essential component of the Aboriginal Mental Health Policy and Strategy.

Educational programs for Aboriginal health workers and mental health workers

Educational Programs for Aboriginal Health Workers and Mental Health Workers should be developed and accredited nationally and oversighted, monitored and evaluated as part of the National Aboriginal Mental Health Policies and strategy. Curriculum content and educational requirements should be identified and should include:

> Core Curriculum components for Aboriginal Health Workers
> Curriculum for Aboriginal Mental Health Workers.

Educational programs for mental health professionals

Educational Programs for Mental Health Professionals should encompass the following: the professional qualification and education of these professionals; affirmative action programs to enhance the number of Aboriginal people involved in such professional qualification streams; education in Aboriginal Culture and History so as to be Culturally Informed in the practice of mental health care for Aboriginal people; and education in Aboriginal Mental Health and Health Care.

- Educational programs for updating, continuing, education, and skills development need also to be encompassed within the educational strategy supporting Aboriginal Mental Health Program development.
- Personnel Management, Human Resource Management and Support System/Healthier Worker Programs. Within Management structures and educational programs, there needs to be an acknowledgement of the stresses involved for Health Workers particularly those working in Aboriginal Health and Mental Health. Courses in Management processes need to ensure skills in self-care, supervision and healthy organisational practice.

These developments need to be coordinated and developed nationally with a resource base, accreditation and standard requirements and regular processes of review.

Education and community awareness

There should be education and support for the community generally to ensure community awareness about Aboriginal mental health, the prevention of mental ill-health and effective forms of care. This should link to general program initiatives in other policy segments.

Rationale

The Literature Review previously identified the extent and severity of Aboriginal Mental Health problems and mental disorders. The need for these problems to be dealt with in a wide range of settings, rural, remote and urban, and the special expertise required were identified in literature reviews and reports, as well as the shortage of personnel and relevant expertise. The wide range of problems; the interrelationship of alcohol abuse and mental disorders; the impact of history, colonialisation and disadvantage, the

pervasive significance of trauma and grief; the problems of domestic violence and sexual abuse, were all incorporated by Aboriginal people in their contextualisation of mental health problems and identified similarly in those studies of their mental health that were available. Thus there is a need for an educated and skilled workforce to deal with these issues.

Reports

The Draft Review of Aboriginal Community Controlled Health Services (Wronski et al., 1994) identified mental health, alcohol, child sexual abuse and neglect as central problems dealt with by their services, with social and behavioural factors ranking high in remote and rural services (pages 7–8 Draft report). There was perceived to be little capacity to provide mental health programs in remote areas, and this, with domestic violence, was highly ranked by staff as conditions they felt ill equipped to handle (p.12). Furthermore Community Controlled Health Services identified mental health as a major area of service need, and also with Aboriginal Health Worker training (p.15). Mental health was so rated, but other mental health areas were also seen as important, including substance abuse, domestic violence and sexual assault, youth health, and grief and loss counselling.

Overall mental health was ranked first among issues the health service must manage, but was ill-equipped to do so. (p.19) Furthermore perceived inappropriateness of mainstream services made referral to and use of them, a further difficulty. The absence of mental health referral services was a major concern in addition, especially for rural communities.

Personnel and education needs were also examined in this review. It was stated that Aboriginal health workers played a "central role in the provision of health care and held a pivotal position in the future development of health care strategies for indigenous communities" (p.36). The review surveyed 49 Aboriginal Health Workers from non-desert communities (from 16 Community Controlled Aboriginal Health Services) and found educational experience included one year enrolled or registered nursing, Aboriginal Health worker programs, either from Community Controlled Health Services or TAFE based programs. There were a number of workplace based programs providing such educational programs. A further survey covered 55 Aboriginal Health Workers working in desert-based communities. Programs in these settings appeared to use both workplace and modular teaching.

It is also significant that Aboriginal Health Services considered that their clinical staff such as doctors and nurses also needed to have special education in Public Health and Aboriginal Health. There was also an identified need, especially for nurses, for cultural awareness programs. Current postgraduate programs in public health and related fields were also seen as important, but despite the lack of skills in the mental health area noted above, these needs for Aboriginal Mental Health education were not addressed. However counselling skills were specifically identified. Lack of funds, resources and relief staff were seen as ongoing problems.

The National Aboriginal Health Strategy had addressed "Training and Education Issues" (NAHS 1989, Chapter 5, pages 85–101 incl). It notes the primary health care focus and the wide range of skills that are necessary "within Aboriginal health services, the Health Worker (Aboriginal) will be exposed to and participate in the full range of programs." (p.85) These are specifically described as including mental health services, and assessment, management, prevention and promotion activities generally.

Objectives of Aboriginal Health Worker Education Programs should be broadly based and encompass cultural awareness as well as clinical skills and administrative requirements, so as to meet the needs of Aboriginal people. In review of the core curriculum in four states, it reports that there is core covering of mental health in New South Wales, Queensland, the Northern Territory and Western Australia. This report recommends the need for adequate resources for Aboriginal Health Worker Education, and the need to encourage uniform accreditation standards; the need to address secure employment and career opportunities; and ongoing funding for professional development.

The NAHS Working Party also makes recommendations with respect to the education of health professionals generally, covering curricula and skills development, registration requirements, funding for clinical practice components; community based education; specific needs in terms of medical and nursing education. There is also recognition of the need to educate other professionals in related spheres. It

emphasises the need for "the study of Aboriginal distress, history, and health issues" (p.100) for all other relevant health and related professions.

Royal Commission into Aboriginal Deaths in Custody (1991) described not only the needs for specific initiatives in Aboriginal Mental Health Education, but also workforce development, with incorporation of the particular needs relevant to Aboriginal people in custody, including

> *".. a substantial expansion in Aboriginal mental health services" (Recommendation No. 264)*

> *"That as an immediate step towards overcoming the poorly developed level of mental health services for Aboriginal people priority should be given to complementing the training of psychiatrists and other non-Aboriginal mental health professionals with the development of a cadre of Aboriginal health workers with appropriate mental health training, as well as their general health worker training. The integration of the two groups, both in their training and in mental health service delivery, should receive close attention. In addition, resources should be allocated for the training and employment of Aboriginal mental health workers by Aboriginal health services." (Recommendation No. 265)*

The National Mental Health Policy (1992) addresses the needs for the mental health workforce, including the needs for specific education in mental health. There are also initiatives attempting to address the workforce distribution in mental health. None of these addresses Aboriginal Mental Health workforce needs specifically.

The Human Rights (Burdekin) Enquiry (1993) reports extensively on Aboriginal Mental Health needs in its findings. Recommendations included:

> • *"Tertiary courses for non-Aboriginal Mental Health Professionals particularly psychiatrists and nurses should include material on Aboriginal history and contemporary Aboriginal society."*

> • *"Priority must be given to training Aboriginal Health Workers and other Aboriginal community-based resource people or mental health workers."*

The National Aboriginal Mental Health Conference (1993) placed major emphasis on education and workforce development, with a larger number of recommendations relevant to these. These are as follows:

Training

Training for Aboriginal workers

That more Aboriginal people receive training and be employed in mental health.

That Aboriginal child care workers have study leave provisions to enable skills development and training in order to be able to better deal with children who have experienced/witnessed violence and family disruption.

That workers need training in protective behaviours that recognise that abusers will be from the family and community.

That scholarships be made available for Aborigines to study Psychology Therapy.

That Aboriginal mental health workers be trained to work with children and adults alongside existing services e.g. Aboriginal School Counsellors.

That Aboriginal people working in the Aboriginal community and doing counselling as part of their duties (specified or unspecified) be entitled to attend counselling skills courses and receive any ongoing training they feel they need to perform their job adequately.

Significantly more (2:100 population) Aboriginal people should be properly trained in health issues in all

areas of health, in all disciplines and employed at all levels of the health system immediately.

Training for non-Aboriginal workers

That the education of the psychiatric profession on the historical factors that lead to mental health problems of Aboriginal people, be a key elementary component of any training of these professionals.

That psychiatrists be educated in Aboriginal culture.

That the Australian Psychologist Association (APS) and the Australian College of Psychiatrists ensure/set a requirement that a students in psychology and psychiatry programs have Aboriginal Studies/Issues as a core part of curriculum(s).

That mainstream/white organisation which employ Aboriginal workers recognise their different style of working and have policies which validate and acknowledge these. This may include leave provisions to cover after hours work and family commitments / pressure – Stress Leave?

That all mental health workers learn cultural awareness and Aboriginal notions of health and well-being in their curriculum.

That the larger issue be looked at in regards to books in the area of sociology, anthropology discussing specifics of men and women's law be banned.

That non-Aboriginal people must learn to listen to Aboriginal people.

That all teachers learn something about Aboriginal history, culture, and issues in their training courses.

All health professionals in this country should effectively learn the political and interracial realities and cultural imperatives in their training curricula along with an understanding of the Aboriginal and Torres Strait Islander philosophy of health care undefined by the NACCHO definition of health. This should be undertaken immediately.

Administration of training

Recommendations to the Aboriginal Mental Health Conference that the Government of Australia and non-Aboriginal Health Professionals include representatives of the NACCHO at all levels in deliberating concerning, training participants and resource allocations for Aboriginal Health in equal participation.

Recognition of prior learning and experience

That Aboriginal health workers skills and knowledge be recognised by the health care system and that systems of support and adequate resources be provided.

Curriculum and accreditation

That there be the creation of undergraduates and post graduate courses designed to train Aboriginal persons to become psychologists to the standard required by the relevant State Psychological Registration Board and the Australian Psychological Society.

That this conference advises the APS about the recommendations and asks them to disseminate information about the development of Psychology courses for Aboriginal persons as a matter of urgency.

That this conference raise the issue of accreditation for Aboriginal workers with the universities.

An Aboriginal Reference Group be set up to writing of the curriculum of the Aboriginal mental health and to be accredited and supported and owned by Aboriginal people.

Worker support

Cultural strategies and techniques be developed and implemented to ensure the well-being of the worker in mental health related areas.

That Aboriginal community controlled services ensure that all workers are supported and that steps are taken to prevent burnout.

That all Aboriginal mental health workers should be adequately resourced and supported in their work to reduce burnout.

The importance of mental health Workers well-being must be recognised regardless of employment setting i.e. community, hospital or elsewhere and should not be assumed to be entirely self-regulating.

Resources should be provided (determined by the number of workers and setting) that are available solely for health worker mental health issues. These are in addition to traditional means of mental health self-management. Resources might include:

- opportunity for supervision
- opportunity for peer support
- education
- skills development opportunities, e.g. stress management
- plus other projects or tangible resources that might assist workers to maintain and foster their own mental health
- such resources and processes must be formally recognised and stated as policy
- workers should be made aware of such resources and be involved in their modification and development for future mental health workers, such provisions are made in consideration of the Aboriginal or Torres Strait Islander setting.

The Nursing Review, The Service of 'Nursing'– Nursing Education in Australian Universities (1994) as noted above described the shortfall in Aboriginal nurses and the need for action to address this (pages 293–298). It separately acknowledges that there appears to be a need to enhance the mental health component of nursing generally and makes recommendations on both the importance of mental health within the undergraduate curriculum and "the provision of appropriate post-registration courses to prepare comprehensively educated nurses for specialist mental health practice" (p.278), plus the need for particular initiatives to enhance workforce development. These two issues come together to highlight needs for Aboriginal Mental Health education relevance as part of general and postgraduate education for nurses.

It was also found that there were relevant lower numbers of Aboriginal and Torres Strait Islander nursing students and that there should be affirmative action processes to address this imbalance, including support, recognition of other experience and training and articulation with other Aboriginal health worker courses.

Thus there is extensive evidence in current reports of the need for particular initiatives in Aboriginal mental health, health education and workforce development at all levels.

The Consultancy Report (see Consultancy Report, Review of Education for Aboriginal Mental Health). This review found initiatives in many areas relevant to Aboriginal Mental Health generally, but overall there was no identified resource describing these programs and no coordination of their objectives or outcomes.

The review also indicated that there were programs of relevance in New South Wales and the Monaro/Queanbeyan Certificate for Aboriginal Mental Health Workers; the Diploma in Aboriginal Mental Health proposed through the Faculty of Nursing, UTS, Sydney; some limited coverage in health science and nursing courses; a small input in Aboriginal Health education and mental health to a lesser degree in medical curricula, apart from the initiatives of the University of Newcastle Medical School and the University of Melbourne which had a specific input. Apart from the first two specific programs – Aboriginal Mental Health and some health worker courses through health services, there was a significant deficiency in educational programs at all levels with respect to Aboriginal Mental Health. In the Northern Territory there were a number of courses of relevance; a Graduate Diploma in Mental Health through the

Northern Territory University and other courses with some valuable review "Aboriginal Mental Health Training: Identifying the Need" (from Northern Territory Department of Health and Community Service) proposes both increased mental health input into Health Worker Education, and the development of courses/programs for Aboriginal Mental Health Workers; on the job educational programs also make some contribution but overall there is extensive urgent need.

In Queensland there are several developments and programs including: a Certificate of Aboriginal and Torres Strait Islander Primary Health Care through TAFE in Cairns, Hervey Bay and Rockhampton, which encompasses a limited coverage of "Mind" and mental health; an Associate Diploma of Health Sciences including a mental health option; the Bachelor of Applied Science (Indigenous Primary Health Care) through the University of Queensland which offers significant mental health components; specific Masters and Diplomas and other courses including Public Health through James Cook University and potential development of a Bachelor of Indigenous Mental Health program. There is also an Aboriginal Mental Health Worker program being run through Cairns and possibly similar approaches in other centres. Thus there are a significant number of developments, but no coordinated approach, and a need for future specialised mental health components.

In Western Australia there are: programs through Curtin University with a particular Counselling course; an Aboriginal Health Worker Education program in environmental health; and an Aboriginal Health Worker College. There is some coverage of Aboriginal Health in the other Medical Course at University of Western Australia, but specific mental health issues may or may not be encompassing.

In Victoria there are some options covering Aboriginal Health with some input in Aboriginal Mental Health, for instance in the Nursing Faculty at Monash, and the Centre for Mental Health with some coverage in the medical curriculum of Aboriginal Mental Health. While workplace programs for Aboriginal Health Worker Education and other community initiatives are of value, there is a lack of and need for specific mental health data input.

In South Australia no specific University courses were identified, although a Master of Primary Health Care and Master of Science both had options for Community Mental Health, but not specifically Aboriginal Mental Health. Health worker programs for mental health were not identified, although special programs such as a counselling course, were seen as potentially relevant.

In the ACT no programs in Aboriginal Mental Health were reported.

In Tasmania the Institute of Adult Education provided some courses for Aboriginal people and a course on Aboriginal Health Care is supposed to be offered through TAFE.

Thus there are very significant deficiencies in educational programs relevant to Aboriginal Mental Health even for Aboriginal Workers or others and extensive need in this area. This need was also identified in the consultation process with Aboriginal communities and Health Services. The need for Aboriginal Health workers to be educated in mental health, the need for Aboriginal Mental Health Workers; the need for courses for these workers; the need for appropriate career structure and remuneration; the need for Aboriginal psychologists, nurses (in mental health), doctors and psychiatrists; the need for recognition and remuneration for traditional healers; the need for accreditation and coordination of education and qualification processes.

One recent and important development is the General Practice National Initiative funded through the Commonwealth, the "Aboriginal Primary Health Care Project". This operates through the North Queensland Clinical School and seeks to establish effective integration of general practice with other elements of the health care system. The conceptual basis is described in the Consultancy Report.

It does not deal with Mental Health as a separate stream but is dealt with in the clinical decision making, encompassing diagnosis and management of psychosocial health. Further development of the Aboriginal Mental Health aspects may occur as this course evolves.

Additional education and program development to enhance or extend Aboriginal Mental Health Care provision, including increased numbers of positions for Aboriginal Mental Health Workers, have come through National Mental Health program initiatives such as Mental Health Worker positions in the

Northern Territory services, initiatives in Broome; Victoria; New South Wales and elsewhere. Rural initiatives such as RESET have also given opportunities for Aboriginal Mental Health programs and primary care development. However there is still no National or coordinated evolution of an Aboriginal Mental Health workforce to meet needs.

Strategies

A number of strategies are necessary to develop an appropriate, competent and qualified Aboriginal Mental Health workforce, and as well, adequate personnel numbers with appropriate range of expertise.

1. To examine, develop, coordinate, monitor and evaluate education and personnel development for Aboriginal Mental Health, it is proposed that a working party of the National Aboriginal Mental Health Advisory Committee be established for this purpose: The Education and Personnel Development Working Party.

2. The nature and extent of the Aboriginal Mental Health workforce should be further established building on the current and other reports, including the Draft report on Community Controlled Health Services (recognising that not all Aboriginal Health Workers will work in these services), the Northern Territory report on Aboriginal Mental Health Training, Nursing Review, and the State and relevant data from Aboriginal Health Services as they come to hand. There should be a data base developed of workforce, including Aboriginal Mental Health professionals. This further examination by survey and consultation should provide particular information and a basis for monitoring workforce need.

3. Education Programs for Aboriginal Health and Mental Health Workers should be developed and linked to and building on current initiatives.

   Accredited courses for Aboriginal Health Workers encompassing Mental Health, and full courses for Specialised Aboriginal Mental Health Workers, need to be developed in each State and in appropriate central as well as rural/remote educational venues.

   a) Aboriginal Health Workers

   The majority of individuals and groups consulted identified a specific need for Aboriginal Health Workers to be educated in Mental Health. This involves both basic knowledge and skills, how to identify more serious disorders and situations of need, and when and how to refer to more specialised mental health services.

   b) Aboriginal Mental Health Workers

   The majority of individuals and groups consulted also identified the need for Aboriginal workers specifically educated in mental health. Such workers would need to be specifically skilled in the management of mental health problems and mental illness.

In building such programs prior experience and skills of Aboriginal people should receive recognition.

These courses need, where possible, to be developed and taught by Aboriginal people and to encompass both formal knowledge and skills development, possibly in an Apprenticeship model (e.g. Hunter, 1994).

Training programs for Aboriginal Health Workers and in some instances Mental Health Workers exist or are being developed in most States, for instance in the following settings: Curtin University; Bachelor College; James Cook University; University of Queensland (Indigenous Primary Health Care Course); UTS (Sydney), Wollongong; Queanbeyan; Cairns and many other places (see Consultancy Report).

It is essential that Mental Health Care Modules covering the following matters be present in all these courses and that they encompass as a minimum 15% of course content.

- Historical and Sociopolitical issues as they affect Aboriginal People's Mental Health
- Substance Abuse and Mental Health
- Trauma Loss and Grief as they affect Aboriginal people
- Symptoms of Severe Mental Illness in Aboriginal people
- Management of Mental Illnesses and how and where to refer
- Suicide risk: how to detect and how to respond
- Depression as it affects Aboriginal people

- Counselling for Aboriginal people
- Special issues for:
  - Children
  - Young people
  - Women, Men
  - Elders

Specific Mental Health Training for Aboriginal Mental Health Workers is provided in both formal settings, with courses as above, but incorporating as well, further content or a specific focus for Mental Health, or a specific program.

The course content needs to cover the items identified above plus the following:

- Family counselling, e.g. Narrative Therapy (S.A.)
- Specialised counselling for trauma and loss
- Psychotropic Medications used for mental health problems and mental illness, their dosage, side effects etc.
- Referral Systems for more specialised services for mental health problems and mental disorders
- Trauma and Stress Debriefing, and Crisis Intervention
- Sexual and other Abuse
- Community Development and Mental Health
- Assessment of children and young people and their mental health problems
- Assessment of women's mental health problems and their management
- Assessment of men's mental health problems and their management
- Assessment of elder problems and their management
- Carers and their needs
- Systems and places for Mental Health Care
- Relating to Non Aboriginal Mental Health Services
- Forensic Mental Health
- Traditional Healing and other healers
- Preventive Mental Health

To achieve these requirements, the following strategies should be used in addition:

i) DEET funding should be sought to support places in a range of Tertiary Sector systems for shorter and longer courses and continuing education and update programs in Mental Health for Aboriginal people.

ii) Funding support through ATSIC to Aboriginal Medical Services should be provided to enable present staff to undertake Mental Health education in their chosen field, thus retaining their wages to support them during these further studies.

iii) Each program should meet required standards for accreditation and funding (e.g. 15% of general health course should be devoted to mental health and there should be course objectives concerning issues identified above and encompassing skills, and knowledge).

iv) There should be a minimum of 20 funded places in each Institution providing such courses as specific places for Aboriginal Mental Health.
Career Development, appropriate education and qualification as an Aboriginal Mental Health Worker should be accepted entry to other mental health professional streams for Aboriginal people wishing to extend their skills, with appropriate credit. Articulation with other areas should be supported. There should be specific positive career development options for Aboriginal Mental Health Workers.

4. **Educational Programs for Aboriginal Mental Health Professionals** for Professional Qualification should be encouraged by a range of strategies to encourage and

support Aboriginal people to enter these programs.

Nursing. Nursing curricula in tertiary institutions should be reviewed and specific course modules to an adequate level be developed to ensure educational programs in nursing for Aboriginal people with a proportion of these courses and post basic courses providing specific programs in Aboriginal Mental Health.

It would be critical to examine the curricula of nursing programs to ensure that generic programs adequately address Aboriginal Health and Mental Health. This is relevant for both non-indigenous nursing practitioners, for their understanding of Aboriginal people who may present to their systems of care, and indigenous students. However, the level of input for workers who will work in Aboriginal and Torres Strait Islander communities would need to be significantly greater and could be met by the numbers of electives or modules required to build the courses to an optimal coverage of these issues. Such electives and modules would then constitute, with the core nursing curriculum, an appropriate professional course and qualification for Aboriginal and Torres Strait islander people.

The specific recommendations of the nursing review concerning Aboriginal and Torres Strait Islander nursing education are supported (Recommendations 14.5 and 14.6) and those for mental health nursing (14.1). It is suggested however that specific initiatives to address Aboriginal Mental Health should be included.

The value of Nurse Practitioner roles for Aboriginal people providing Community mental health care in Aboriginal communities should be emphasised in nursing education programs. To achieve the appropriate educational programs it is suggested that the following strategies be followed:

i)   DEET funding to be sought to support a specific program of nursing practitioner education for Aboriginal people with a specific proportion of basic training covering Aboriginal Health and Mental Health and specialised programs in Aboriginal Mental Health Nursing (community based particularly).

ii)   Each nursing program should have required standard for accreditation in terms of availability of Aboriginal nursing qualification places, and Aboriginal Health and Mental Health modules in general programs and specific Aboriginal Mental Health Nurse Practitioner options.

iii)   There should be a minimum of 5 places available in such accredited institutions with such accredited programs for Aboriginal people. At least 50% of Institutions offering nursing courses should be required to offer options such as this for Aboriginal people.

Psychology

It was recommended at the Aboriginal Mental Health Conference (1993) that there "should be creation of undergraduate and post-graduate Courses designed to educate Aboriginal persons to become Psychologists to the standard required by the relevant State Psychologists Registration Board and the Australian Psychological Society" (p34).

It is difficult to identify the exact number of Aboriginal people formally trained as psychologists. Significant achievements by such workers highlight the value of bringing Aboriginal understandings to this disciplinary base and its potential to contribute to the development of Aboriginal models of Counselling (e.g. Collard& Garvey, 1994).

Initiatives through the Australian Psychological Society led to the Board of Community Psychologists and the Centre for Aboriginal Studies at Curtin University holding a Conference in December 1993 on Aboriginal Psychology. A stated aim of this conference was to examine the need for "a conceptually separate Aboriginal Psychology". It was considered that there was the need for a large increase in the number of indigenous people entering the profession of Psychology. An Aboriginal Psychology Interest Group has received $25,000 from the A.P.S. over 5 years to encourage indigenous people to enter psychology. The first activity of this process was to try to identify all indigenous students in Psychology courses throughout Australia and to arrange further conferences etc. N.S.W. Correctional Services has also agreed to sponsor Aboriginal Psychology students.

Psychology Curricula providing training in **Clinical Psychology** should be reviewed to ensure adequate coverage of Aboriginal Mental Health. Specific course modules should be provided so that psychology graduates are informed in Core Knowledge and skills in Aboriginal Mental Health. Additional course components for Electives and Honours projects should be provided, particularly in regions where there are significant Aboriginal populations. Continuing and Post-Graduate modules should also be developed.

Education and Qualification for Aboriginal people in psychology should be supported by the following strategies:

(i)   It is clear that strategies to increase psychologists' understanding and competence in this sphere have commenced as have some programs of affirmative action to increase the numbers of Aboriginal psychologists.

(ii)   Further support should be provided for those initiatives. DEET and other support should provide special places for Aboriginal people to be educated as Clinical Psychologists.

(iii)   There should be accreditation for Educational programs in Clinical Psychology that require education in Aboriginal Mental Health, with requirements determined by the A.P.S. in liaison with the Education and Personnel Development Working Party.

(iv)   There should be a minimum of 20 places nationally for Aboriginal people to be educated in psychology, especially Clinical Psychology.

Social Work

Social work courses should be reviewed nationally in collaboration with Professional Associations and Tertiary Education institutions (Universities) to estimate numbers of Aboriginal social work Professionals working in Mental Health, and students who are training in areas relevant to mental health care provision. Curricula for Social Work Education should also be reviewed for educational content in Aboriginal Health and Mental Health.

Specific strategies include the following:

(i)   DEET or other support should be sought to ensure specific opportunities for Aboriginal people to obtain professional education in the mental health aspects of social work.

(ii)   Curricula should be accredited in terms of Aboriginal Mental Health content for social work clinical professional education.

(iii)   There should be a minimum of 20 places nationally for Aboriginal people to be educated in social work for Mental Health Care.

(iv)   Workforce need should be explored by the Education and Personnel Development Working Party, as should education programs.

Occupational Therapy – similar processes should be applied in terms of Psychology and Occupational Therapy.

Medical Practice initiatives in Medical Education such as those at the University of Newcastle, Faculty of Medicine should be supported and further developed so as to ensure there are adequate numbers of Aboriginal Medical Practitioners and further students enrolled nationally (1994 report). It should also be the aim of undergraduate and post-graduate and Continuing medical education to ensure competency of medical practitioners in Aboriginal Mental Health. Specific initiatives such as the Aboriginal Primary Health Care Project should be supported and encouraged, and should have a strong mental health component in Aboriginal Mental Health.

Strategies to address this could include:

(i)   Accreditation programs should require that mental health course content also includes core knowledge and skills in Aboriginal Mental Health.

(ii)   Further programs should be developed in all medical schools to provide opportunities and support for Aboriginal people to be educated as medical practitioners.

Psychiatry

It should be necessary for all psychiatrists as Specialised Medical Practitioners to have education in Aboriginal Mental Health. Training requirements could require this and training programs accredited in terms of it.

To address these needs the following strategies are suggested:

(i) *Accreditation programs should review current content and require a component of training in Aboriginal Mental Health.*

    (ii) Supportive programs should be developed by RANZCP and State Health Departments to promote opportunities for Aboriginal medical practitioners to be educated as Specialists/Psychiatrists.

    (iii) Special electives during the elective year should be encouraged in the field of Aboriginal Mental Health.

    (iv) Programs to update those in practice in terms of Aboriginal Mental Health should be developed through Continuing Medical Education frameworks.

Specialised education programs in Child Mental Health/Child Psychiatry for Aboriginal people should be supported as well as professional training for Aboriginal people in these areas.

All the above initiatives should be coordinated through collaborative processes, limited to and oversighted by the Education and Personnel Development Working Party.

The key elements of the above are:

- curricula in Aboriginal mental health for all mental health professionals
- professional education and qualification for Aboriginal people in the full range of mental health professionals

5. **Other Educational Programs and Courses**

There is a need for extensive education on mental health in the form of shorter courses, both covering the general area, and for specific issues – for instance Trauma and Grief, Elders and Mental Health, and so forth. These are important both for new knowledge and to update knowledge and skills and should also link to continuing education initiatives that are part of workplace requirements.

    (i) Each local area Aboriginal Community Mental Health Program should have an identified budget for Continuing education and related requirements. A program for each year should be determined by the local group linked to a consultative approach, and in response to identified needs as well as knowledge developments. Video, television and related resources should form part of this ongoing and continuous education process and there should be an identified time set aside for this each week.

    (ii) Regional conferences and seminars to develop mental health knowledge and expertise should be provided on a twice a year basis as a minimum. These should involve formal content, and travel, speakers resources and accommodation should be provided. This contributes to support, networking and the development of a positive approach to mental health.

    (iii) National initiatives should ensure the development of Educational resources to support these programs and should work in partnership with NACCHO to ensure availability of resources to meet their short term and ongoing educational needs. There should be the development of a Distance education network in association with one of the established tertiary sector systems working in this area to ensure remote and rural access.

    (iv) Rural health education councils and programs should be contacted to ensure adequate coverage of Aboriginal Mental Health in their training programs, through RAGCP Rural Health Education Centres and Councils and other service providers such as the Royal Flying Doctor Service.

    (v) A Central Resource or Library in Aboriginal Mental Health encompassing formal, video and other Educational resources should be developed to link to a Central unit with responsibility for educational development for Aboriginal Mental Health.

(vi)   These initiatives should be further developed, implemented, monitored and evaluated under the auspices of the Education and Personnel Development Working Party of the National Aboriginal Mental Health Advisory Committee.

6.   Educational programs for non-Indigenous mental health workers on Aboriginal History, and Cultural issues should be required so as to ensure that such workers are Culturally Informed in practices related to Aboriginal Mental Health.

7.   Community Education and Awareness. Expertise from the Education and Personnel Development Working Party and Resources should support the development of community awareness programs and general public education programs relevant to Aboriginal Mental Health.

Targets

1.   The Education and Personnel Development Working Party of the National Aboriginal Mental Health Advisory Committee be established by mid 1995.

2.   Workforce needs for Aboriginal Mental Health be addressed in general terms by end 1996.

3.   Education Programs for Aboriginal Mental Health for Aboriginal Health Workers and Aboriginal Mental Health Workers be reviewed with a minimum of 20 places in educational programs for Aboriginal Mental Health Workers established with a minimum of 20 places in each state by end 1996.

      There should be a target of 2 Aboriginal Mental Health Workers for every larger Aboriginal region or community (greater than 3000 approximately) with a minimum of 60 such workers by end 1996 and for all groups to the level of 2 Aboriginal Mental Health Workers per 400–500 people by end 1998.

      There should be targets for Aboriginal Mental Health Education Modules in all Aboriginal health education programs by end 1996.

4.   Educational programs for Mental Health Professionals and for general health workers working with Aboriginal people should include

      Aboriginal Mental Health in all curricula by end 1997.

      Professional qualification educational institutions should aim to increase numbers of enrolled Aboriginal Mental Health Professionals by end 1997.

5.   Educational programs in Aboriginal Mental Health in short forms, and resource development, local education and other programs should be established in all Aboriginal Health Services and nationally by end 1997.

6.   Education programs in Aboriginal History and Culture and relevant aspects for Aboriginal Culturally Informed Health and Mental Health Practice should be introduced into all Health curricula by end 1996.

16.   Data and information systems

Data is needed at a national level on Aboriginal Health generally and Mental Health in particular, both in terms of providing appropriate preventive and other interventions and judging their effectiveness. Not only is there a need for national Baseline Data on mental health, mental health problems and mental disorders, but there is also a need to examine risk and protective factors and access to treatment services. As well there is a need for health service information systems which can allow the monitoring of the nature and extent of mental health problems presenting for health care and the patterns of mental health service utilisation. Such baseline data and information systems are critical to Aboriginal Mental Health Policy and

strategies of implementation, and should be coordinated and monitored nationally.

Aims

To establish baseline data in Aboriginal Mental Health

To establish Aboriginal Mental Health Information Systems which will encompass also health service utilisation patterns.

Policy initiatives

A data and information system base is essential to the implementation of National Mental Health Policy and Programs for Aboriginal people. Several policy elements are relevant in this regard.

- A **coordinating mechanism** for the development of baseline data, and mental health service information systems should be developed nationally and linked to the National Aboriginal Mental Health Advisory Committee which will oversight policy implementation.

- A **National Survey of Aboriginal Mental Health** should be carried out to provide baseline data on Aboriginal Mental Health problems. This should be developed by the Data and Information Systems Working Party in consultation with Aboriginal Communities and Organisations. It should link to other proposed or current national health and mental health studies. An action research component to identify local problems and needs should be built in a network approach with core shared data elements, so as to enhance understanding of regional factors contributing either to Aboriginal well-being or mental ill-health. This survey should be carried out in a framework similar to that of the proposed national survey, linked to it in ways indicated, yet formatted and carried out in a culturally appropriate framework. White ford (1994, p.4) has indicated the possibility of such a framework – i.e. as one of the "parallel studies" dealing with Aboriginal and Torres Strait Islander communities. Clearly any such survey would need to be developed in consultation with Aboriginal communities to meet their identified needs, to ensure adequate coverage of mental health issues they deemed as important, and to be delivered in culturally acceptable as well as appropriate formats. Work involving community members, at the same time providing education and feedback to communities, as for instance in the model of McKendrick and Thorpe (1994) could be useful in this regard. Such a survey would have to be developed with a National Aboriginal Steering Committee, perhaps the Data and Information Systems Working Party, to ensure core data was uniformly gathered, that variables and domains were agreed upon, and that measures were reliable and valid, and the format of value to Aboriginal people. This would allow the development of a national data base for morbidity monitoring and evaluation of strategies, as well as holistical to address specific local issues.

- **Mental Health Information Systems** are an essential basis to health system monitoring, both in terms of record keeping and addressing patterns of utilisation, cost and effectiveness. There is a need for specific formats for information recording; an agreement on basic information that will be recorded; some standardised record; infrastructure and technology (e.g. computing); record access; information analysis, synthesis and reporting.
  Some Aboriginal Medial Services have gathered systematic data on health problems of those presenting to the service. In general however, formats do not provide for systematic gathering of mental health data. Nor are resources available to analyse this data on either a centre of national basis (and much may not be nationally comparable). This problem is similar to that found in primary care/general practice settings generally, and many mainstream community health (and mental health) programs. While some data formats are becoming available to analyse occasions of service, these do not provide adequate information on diagnosis, comorbidity and impairment or well-being of those presenting. Nor would they, as currently developed, be able to provide adequate information on Aboriginal mental health problems and outcomes. The Aboriginal Data and Information Systems Working Party proposed above could oversee the development of a core format for service utilisation assessment in Aboriginal

Community Controlled Health Services, to cover mental health problems presenting primarily, or secondary, to other significant medical illness. Such a core format should be brief, able to be computer-utilised and allow for add-ons relevant to particular communities.

- **Mental Health Outcomes and Indicators**

  There is a need to identify health outcomes and indicators relevant to Aboriginal Mental Health. This problem is complex, the more so as satisfactory Mental Health outcomes and indicators have not yet been developed for the general Australian community. Any such measures must encompass Aboriginal concepts of health and mental health in holistic frameworks (see Guiding Principles) and must be agreed upon through consultative frameworks. These issues have been discussed generally (see Attachment to this section) and should link to national initiatives of these are appropriate (e.g. Andrews et al., 1994, Consultancy in Mental Health Consumer Outcomes).

- **Quality Assurance Standards and Program Monitoring**

  It is necessary to ensure specific information and data is gathered to provide for quality assurance. Policy elements must provide or progressively develop a basis which can allow for monitoring of the quality of mental health services for Aboriginal people, and encompassing this, for instance, requirements for meeting standards for Mental Health Care provision.

- **Aboriginal Mental Health Data Management**

  Education and other considerations should take into account the following matters in data and health information management. These issues are of concern to Aboriginal people and should be adequately and appropriately addressed in this policy initiative.

  There is some sensitivity about the accumulation and use of Aboriginal health data. This arises because of the following:

  - Data is often gathered but no change results.
  - Data may provide for others' research careers, but contribute little to the health and well-being of Aboriginal people.
  - Data is often reported in the negative and used to create negative images of Aboriginal people, often with graphic and racist media coverage.
  - Data may be used to validate practice for Aboriginal as opposed to non-Aboriginal people, e.g. vaccination of Aboriginal people for Hepatitis B.
  - Data is often not focused on projects likely to be of use to communities
  - Researchers may frame questions in ways which do not get valid answers because of language usage and interpretation.
  - Particular problems arise for mental health data as mental health has been a source of stigma and discrimination in its own right and not culturally appropriate.

These issues have also been addressed in the National Aboriginal Health Strategy (p. 208).

Aboriginal people are aware of health data linkage to priority determinations of funding, but also to negative outcome (e.g. restriction of activity, disempowerment, forced treatment in alien settings and incarceration). For these reasons there is naturally reluctance to participate in data gathering exercises in which Aboriginal people have not had an active part in determining or the purposes and use of which, are poorly defined.

Another issue is the methodology of quantitative work e.g. counting, which may be seen as inappropriate in Aboriginal ways of doing things. While these matters can be addressed with consultative frameworks such as those outlined, there is a need to ensure they are recognised from the outset in any data development frameworks with Aboriginal communities.

A further matter deserves particular note. Many communities may not have English as a first language, or even second or third. Any assessment of health or mental health would have to be not only sensitive to the cultural requirements of different communities, but to the language issues as well. And reading the written word in communities reliant on oral traditions would make this inappropriate for survey formats. These matters highlight the importance of supplementing any health assessment with qualitative assessment synchronous with Aboriginal requirements; or the need to develop new data assessment methods.

- **Dissemination of Mental Health Data and Information**
  The ways in which data will be made available to Aboriginal people, the form and value of data dissemination, and its appropriate format should be addressed.

Rationale

The Literature Review indicates the inadequacy of baseline data on Aboriginal Mental Health. The National Health survey also indicated the absence of adequate data on mental health generally. There are only National Health Survey data on self-reported prevalence of mental ill-health, and a general survey cannot expect to yield information or specific illness. There are no data or incidence of mental disorders, or on the welfare of mentally ill people in the community. Data on the use of mental health services are sparse. This data has not been analysed for Aboriginal people.

The reviewed studies often failed to use standardised or comparable measures. Rates varied. Risk factors were rarely assessed, apart from recent studies of particular groups (e.g. Clayer et al., 1990; McKendrick and Thorpe, 1993).

Reports

The National Aboriginal Health Strategy reports "The lack of a National data base upon which policy and program planning can be based, and by which outcomes can be assessed was of great concern".

Recent reviews such as Scope for Prevention in Mental Health (NH&MRC, 1992 and the Activity Scan Mental Health in Australia, 1993) have drawn together available mental health data and health Service Information, and make clear the absence of adequate baseline and utilisation data in Aboriginal Mental Health.

The National Aboriginal Mental Health Conference (1993) highlighted the deficiency of information and health data and recommended as follows:

> *"National Aboriginal Mental Health Needs Survey" (p.35).*

Other reports including the Burdekin Enquiry addressed the needs for mental health data and research."

A major National Epidemiological survey in Mental Health is proposed (Mental Health Survey Workshop 12 December 1994). Even though a sample frame in the vicinity of 10,000 is proposed, it is recognised that "the design of the survey, including case finding instruments may be culturally inappropriate for Aboriginal and Torres Strait Island respondents in some geographical areas." (Whiteford, H., paper for Workshop p.3). In other documents for the same workshop, Henderson (p.2) notes that if the National Mental Health Policy and its associated Plan is to be carried through "high quality epidemiological information on the country's mental health will be needed". This is necessary also for the fulfiling of National Goals and Targets strategies for mental health. He notes too the emphasis on the need for mental health data as indicated in the recent report "Australia's Health 1994".

These developments are in line with the recommendations of the National Mental Health Policy (1992) (p28–29) in terms of the lack of consistent mental health data and the need

> *"To develop a National Mental Health Data Strategy" (p29).*

Thus the proposed Aboriginal Mental Health Data Strategy should link to this.

The Consultancy Report indicated that there was a need for mental health data, as reported by those counselled, and a lack of national data base for mental health services, plus a range of findings from State Mental Health Reports.

Aboriginal Health Services almost invariably indicated that they did not have adequate resources to fully identify the mental health problems of clients. Services were often without guidelines to develop these systems. Some records were kept and these were client files. Nevertheless systematic data collection had

yet to be developed in these community based organisations. It must be noted that many health systems and community mental health systems do not as yet have adequate data and information systems and a number of different approaches are currently being trialed.

Infrastructure was also absent in terms of the data gathering mechanisms, computing resources and expertise and so forth. (The need for further computing skills was also noted by staff in the report to the NAHS Evaluation.) Resources to gather data were also seen as vital, including personnel time.

Concerns exist for Aboriginal people as to the nature of data gathered, the outcomes for which it will be used. There is ongoing anxiety about it being used to further negatively stereotype Aboriginal people. The need for Aboriginal people themselves to determine the nature, utilisation and access to data and information systems and their potential benefits was seen as critical. Issues of privacy and access are seen as very important.

The value of information in terms of lobbying for resources, and its political uses in a positive sense have been acknowledged but it is believed that Aboriginal people need more support and expertise to be able to achieve such ends.

Ethics of health data information systems for Aboriginal people must be considered, particularly with relevance to the nature and utilisation and Aboriginal people's cultural needs and understandings.

State Mental Health Data was irregularly available and agreed by States and National Mental Health grants to be inadequate.

Health data does not always provide adequate identifications of Aboriginality, or people are not asked, or are hesitant to use these because of fears they will be adversely affected if they do so. Nevertheless some State data is available and has been provided in the relevant sections. Further data from these services should continue to be available and should be improved, and hopefully, linked in the National Mental Health Information Strategies.

Thus there is ample evidence of both inadequacy and need for a national approach to Aboriginal Mental Health Data and Information Systems.

Strategies

To support and deliver the National Aboriginal Mental Health Policy and Plan the following strategies are necessary:

1. To develop, implement, oversight, monitor and evaluate the National Aboriginal Mental Health Policy and Plan and to develop an Aboriginal Data and Information Strategy, the Data and Information Systems Working Party should be established, reporting to the National Aboriginal Mental Health Advisory Committee. This Working Party should also include in its membership representation from the Australian Institute of Health and Welfare, and the Australian Bureau of Statistics, so as to ensure optimal linkage to all major health data exercises in the future.

2. The Data and Information Systems Working Party, or a Steering Committee nominated by it, should link to the working group for the National Mental Health Survey to establish a framework, basis and mechanism for the Aboriginal Mental Health Survey to be linked to this. This group should also inform the broader national survey. It is essential that this process is rapidly established, in view of the proposed Timeline of the National survey and is expected to collaborate, consult and steer the Aboriginal component of this project.

3. In consultation with Aboriginal Community Controlled Health Services and in interaction with National Mental Health Policy initiatives in developing a Data Dictionary and Minimum Mental Health Data Set the Data and Information Systems Working Party should develop a practical and acceptable Mental Health Recording and Information System. It is essential that this is part of, and compatible with, general health information recording and systems but with a separate mental health component and identifiers. This is essential both because of holistic concepts of health and mental health, and because of the extensive interrelationship of the two.

4. Mental Health Outcomes and Indicators should be developed through a consultative process by the Data and Information Systems Working Party. These should include as a minimum some measures of: well-being or health; symptomatic distress or mental suffering; impaired interpersonal, social or other functioning (work may be less relevant because of very high unemployment levels); social indices such as violence, disadvantage, and abuse as negative and community achievements as positive. These processes should have a sound scientific basis, quantitative and qualitative, and be firmly grounded in Aboriginal perceptions and experience, with emphasis on dimensions appropriate to Aboriginal cultural norms (e.g. kinship). It should link to AIHW initiatives in this area.

5. Quality Assurance Mechanisms and the methods for ongoing data gathering and mental health information systems provide necessary quality indices (e.g. protection of rights of mentally ill Aboriginal people, equity in clinical assessment and management). This process should be progressively evolved coincident with service development and as an essential part of each mental health service element, and should be the responsibility of the Data and Information Systems Working Party.

6. Mental Health Information Dissemination

    The Data and Information Systems Working Party, in collaboration with regional Aboriginal Health and Mental Health Services, and relevant community groups including regional Councils, should develop a dissemination program to provide valuable and useful mental health data or matters relevant to the mental health and well-being of Aboriginal communities. Data Dissemination strategies should include both dissemination to health system workers and to the community.

Targets

1. The Data and Information Systems Working Party (see Terms of Reference and Objectives, Section One) should be established by mid 1995.

2. The Working Party should link to the proposed National Mental Health Survey, and other proposed development (e.g. Longitudinal Women's Health Study) to provide the basis for and management of the Aboriginal Mental Health component of this survey by mid 1995.

3. The Working Party should commence the development of relevant negotiations and basis for the Aboriginal Mental Health Information System by end 1995, with a system in place that is acceptable to Aboriginal Health providers, links to Physical Health indices, and national mental health initiatives to be piloted by end 1996 and in place end 1997.

4. Aboriginal Mental Health Outcomes Measures should be developed under the guidance of the Data and Information Systems Working Party, linked to general developments in Mental Health Outcomes and Health Outcomes, through an Aboriginal Mental Health Research Initiative for this specific purpose. This Research Initiative should commence by mid 1996 and be completed end 1997 to allow testing alongside Information Strategies.

5. Quality Assurance Indicators should be determined in basic forms and tested alongside program developments by end 1997.

6. Mental Health Data and Information Management Systems should be developed by the Data Monitoring Group identified above. This group should be established by end 1995 and include a basis for ethical review.

7. Mental Health Information Dissemination should be determined by a strategy developed and oversighted by the Data and Information Systems Working Party by end 1997.

Attachment

Clinical assessment for suicide survivors

(from Bodnar and Devlin, 1994)

Part IV

Circumstances of death, reactions and current functioning:

    A.   Circumstances of the Deaths
    B.   The Nature and Meaning of the Relationship and what has Been Lost
    C.   Do you Feel you have any "Unfinished Business" with _____?
    D.   Mourner's Reaction to the Death and Coping Attempts
    E.   Reactions of Others in the Mourner's World and Perceived Support
    F.   Changes in the Mourner and the Mourner's Life Since the Death
    G.   Mourner's Relationship to the Deceased and Memories Associated with the Deceased
    H.   History Status, and Influences of Prior Loss Experiences, Including Mourner's Method of Coping
    I.   Mourner's Self-Assessment of Healthy Adaptation to the Loss Now and in the Future
    J.   Mourner's Degree of Realistic Understanding of and Expectations of Grief and Mourning
    K.   Open Topic

It is important that the local Aboriginal Cultural Practices and Law are respected in death and bereavement counselling.

Relationship of Aboriginal mental health policy development to national mental health policy initiatives (1992 a, b; 1993)

Extensive Federal support and State support has been drawn together for the National Mental Health Policy and Plan (1992). While some consultation with Indigenous people and some representation in policy development occurred, the policy refers to Indigenous people only in general, for instance in the National Mental Health Policy (p20) under the heading of Service Mix as follows:

> *"Adequate resources must be made available to meet the needs of special 'at risk' groups, such as older people, children and adolescents, people from non-English speaking backgrounds, Aboriginal and Torres Strait Islanders, people living in remote and rural areas, and offenders with a mental disorder."*

Both in terms of the policy and in terms of social justice and equity, it is thus essential that the needs of Aboriginal people with respect to mental health be fully addressed.

The **N.S.W. Aboriginal Mental Health Report (1991)** emphasised the need for National Mental Health Policy "to include a section that specifically addresses the needs of the Aboriginal Community" (p.11). The Report went on to identify that

> *"The particular disadvantage that characterises Aboriginal people's position in Australian society today leads to an increased vulnerability to the development of some categories of mental health problems" (p.11)*

and that

> *"mental health services fail to meet Aboriginal people's needs" (p.11) and that*

> *"It is important that the National Policy acknowledges and addresses these issues." (p.11)*

The **National Mental Health Policy** also states with respect to the varying needs of particular groups

> *"It is important that mental health services be planned and delivered in a manner which is sensitive to the needs and expectations of different groups in the community. In this regard, the recommendations of National Policies which have been developed for a number of "special needs groups", clearly need to be acknowledged in the planning and operation of services." (p.13)*

The **National Mental Health Plan** (1992) 10 (p.14–15) indicates the importance that

> *"People of all ages with mental disorders, and their carers, should have the same access to the range of public and private health care and community services enjoyed by other members of the community. It is important that mental health services are planned and delivered in a manner which is sensitive to the needs and expectations of different groups in the community."*

> *"It is recognised that some groups in the community have special needs, and an underlying principle is that the mental health service system should be responsive to the varying needs of particular groups."*

> *"In this regard, the policy acknowledges the recommendations of the National Aboriginal Health Strategy and the National Women's Health Strategy."*

It is reported in Terms of the National Mental Health Plan that

Within the life of the Plan, the States/Territories will:

Report on the development of the most appropriate service models to meet the service requirements of identified special needs groups across different regions.

This plan, like the National Mental Health Policy, does not address issues of Aboriginal Mental Health significantly, despite the emphasis on equity and social justice.

In a review of the National Mental Health Policy from an Aboriginal point of view it is suggested that this policy also fails in that it does not adequately incorporate the concepts of mental health (as opposed to illness), the social, cultural and socio-economic influences in the promotion and maintenance of mental health, and in its failure to address the role of primary prevention (Wright, 1994). These omissions are seen to have "considerably reduced the possible benefits of the National Mental Health Policy to underprivileged minorities and especially to the Aboriginal and Torres Strait Islander community." (p7)

Within the First National Mental Health Report there is little acknowledgement of the special needs and resources required for Aboriginal Mental Health.

The First National Mental Health Report acknowledges that Aboriginal Mental Health is identified as one of the priority areas (p.105) in terms of the NH&MRC Report – Scope for Prevention in Mental Health (1992).

The Report goes on to identify the current consultancy and "the importance of services which are responsive to the diverse needs of people with a mental illness or psychiatric disability". It notes that funding for the consultancy was provided and some support for the National Aboriginal Mental Health Conference. (p.117, also table 119)

Further funds have also been allocated to specific mental health projects for Aboriginal people through special initiatives funding.

The National Aboriginal Health Strategy (1989)

The National Aboriginal Health Strategy Working Party prepared a very significant report on Aboriginal Health and made specific recommendations with respect to the organisation and structure as well as objectives, necessary to advance Aboriginal health.

The National Aboriginal Health Strategy discusses Mental Health in the context of overall health. It states

> *"Mental distress is a common and crippling problem for many Aboriginal people and appropriate services are a pressing need." (p.171)*

It indicates that the advances in understanding and treatment for mental health problems have not yet benefited Aboriginal people, and it noted that, at the time of writing, services for Aboriginal people in the mental health area were "virtually non-existent" (p.172). Furthermore mainstream services were seen as being in Western biomedical models, and in that they did not adapt to Aboriginal beliefs and law, as "causing a huge gap between service provider and user". Thus much mental distress in the Aboriginal community was seen as undetected and neither diagnosed or treated. The strategy report goes on to state:

"It is clear that Aboriginal people suffer the same major psychiatric disorders as others, though culture will influence the presentation and treatment. However a major part of the mental distress that exists in the Aboriginal community falls outside of these categories, and is related to reality factors."

'There is a need to identify more clearly the nature of mental health problems among Aborigines." *(p.172).*

Aetiological factors should be seen in the context of Aboriginal history (200 years of Unfinished Business) and are seen as including overt and covert discrimination; isolation; powerlessness; loss of land; forced dependence; poverty; childhood separations; and other factors which are also seen as contributing to the violence in Aboriginal communities.

Domestic violence, child abuse and neglect (including sexual abuse), and alcohol and other substance abuse are all seen as having interrelated in the mental health context.

Specific recommendations cover Aboriginal health workers and mental health workers and needs for education and support and strategies as follows:
- mental health services which are culturally appropriate and accessible to Aboriginal people are required: ways of making this possible include:
  - employment of Aboriginal liaison officers whose role is communication between psychiatric ward and units, and Aboriginal Health Service staff and community; and
  - employment of specialist psychiatric Aboriginal Health Workers working in the area of mental health in their communities and who also can provide domiciliary care;
- adolescent services must be specifically designed to address the needs of this "at risk" group;
- establish specific Aboriginal community controlled psychiatric services;
- that traditional healers be recognised and employed in Aboriginal mental health programs;
- resocialisation and enculturation services along the lines of the Aboriginal organisation "Link-up" an organisation established by Aboriginal people to trace and reunite the stolen generations." (p.173)

This report thus identifies the needs as follows (p.172–178), and these are reiterated in the recommendations of the National Aboriginal Mental Health Conference for

- **Aboriginal Health Worker advanced education in mental health**
  - Education of non-Aboriginal health workers, on Aboriginal culture and history
  - Development by Aboriginal people of a framework for understanding mental health problems
  - Development of Community based and controlled Aboriginal Crisis teams
  - Mental Health Services which are culturally appropriate and accessible
  - Adolescent services for Young Aboriginal People at risk
  - Recognition and employment of traditional healers
  - Specific Aboriginal Community Controlled Psychiatric Services
  - Domestic Violence and Mental Health
  - Child Abuse and Neglect – including sexual assault and incest

It also deals extensively with alcohol and other substance abuse. (p.192–206)

The recent Evaluation of the National Aboriginal Health Strategy (December 1994) highlights its failure to be adequately implemented, and thus to change the inequities in health generally for Aboriginal people. As mental health was only addressed to a limited degree it is clear that the N.A.H.S. response could not have encompassed an adequate development to meet mental health needs either.

The Evaluation highlights the failure of this Strategy and as it states (p.2) "found only traces of where the

strategy had been", and minimal gains in the appalling state of Aboriginal health".

Its major findings include the following:

> • *"The National Aboriginal Health Strategy (N.A.H.S.) was never effectively implemented.*

> • *All governments have grossly underfunded N.A.H.S. initiatives in remote and rural areas if the objective of environmental equity by the year 2001 is to be attained.*

> • *There has been a lack of accountability for the implementation of the June 1990 N.A.H.S. Joint Ministerial resolutions and inadequate program management information where Commonwealth N.A.H.S. funds have been applied"* (p.3)

and…

> • *"The provision of housing and essential services should be accompanied by strategies for improved maintenance of facilities and appropriate education, including health services and promotion, to equip individuals to achieve a lifestyle and level of economic stability which permits health choices." (p. 3)*

and…

> • *"Local community involvement as espoused by N.A.H.S. is critical not only to improving quality of life, but also the attainment of an experience of health and length of life to be expected in a technologically advanced nation." (p.4)*

> • *"Public health providers need to create meaningful coalitions with Aboriginal and Torres Strait Islanders so that communities and individuals can make informed choices regarding health;"*

> • *"Health providers need to be focused on outcomes and health gains, and not the process of health care organisation and financing";*

> • *the Commonwealth objective of "achieving equity of access for Aboriginal and Torres Strait Islander peoples to health services and facilities by the year 2001" is unattainable at both current and projected levels of funding;*

> • *"health statistics show that Aboriginal and Torres Strait Islander peoples are so far behind the rest of the Australian community, that equity considerations demand national large scale affirmative action programs in environmental health."*

Major organisational options described include: (p.4)

> • *"a workable, expert National council for Aboriginal Health involving NACCHO, State/Territory governments, ATSIC and the Commonwealth, oversighting the implementation for the development of the National Aboriginal Health Policy and Strategy;*

> • *agreement between the Commonwealth and State/Territory governments to achieve a common needs assessment and resource allocation process agreement involving ATSIC and relevant*

Aboriginal organisations including NACCHO at the State/Territory and regional levels instead of continuing to operate independently of each other;

• partnership between State/Territory health providers and Aboriginal Health Services to achieve an integrated approach to health services delivery to Aboriginal people at the local and regional levels."

Performance indicators are seen as essential:

"A national plan through to the year 2001 is essential to ensure a strategic approach to implementation, and framework for measuring the impact of interventions, recognising that improvements to access to health services and facilities will take much longer to translate into improved health status."

and…(p. 5)

"It is critical that program performance management be improved and closely monitored to ensure public accountability and transparency so that all governments, as well as non-government agencies, fulfil their responsibilities."

and…(p.5)

"The National Council of Aboriginal Health would be responsible for monitoring and reporting on the performances of all governments and service providers.

Outcome measures must be designed to demonstrate that what is being done is what is needed and to assess the impact of the national effort."

This report also identified mental health as an important issue.

It highlights the need for improved information for (p. 7) "identification of health and welfare problems and at-risk groups; setting priorities for interventions and policies.
- planning programs and policies
- monitoring changes over time
- evaluating the effectiveness of interventions

It recognises the diversity of local Aboriginal community needs, but also the need for greater emphasis on some program areas such as: (p.27)
- men's health problems;
- substance abuse programs;
- smoking;
- youth programs;
- domestic violence; and
- mental health care programs." (p.27)

Thus there is a specific recognition of the failure of past initiatives in Aboriginal health generally, including mental health (both in the holistic view and in terms of special needs) and a clear statement of the need to address these issues.

It should be noted that the Evaluation takes a strong public and environmental health approach and this orientation is also relevant for mental health, both in terms of holistic effects on mental well-being, as sources of stressor experiences, and in recognition of the external and environmental factors that contribute

to morbidity in terms of mental health problems and disorders. The structural and organisational issues are also relevant to mental health policy and implementation.

Its major recommendations as follows stand also as critical for mental health. (p.2–3)

> *1.   That the Commonwealth reaffirm its commitment to the principles underlying N.A.H.S. including:*
> *acceptance of Aboriginal people's holistic view of health;*
> *recognition of the importance of local community control and participation; and*
> *intersectoral collaboration.*

> *2.   That the achievement of equity, by which is meant equal access to equal care appropriate to need in comparison with non-Aboriginal Australia remain a major goal.*

> *3.   That there be a partnership in the pursuit of this goal between the Commonwealth State and Territory Governments, ATSIC and NACCHO at the national, state/territory and regional levels.*

> *4.   That a human rights based approach to funding be adopted with major increases for all aspects of Aboriginal health to achieve comparable standards with that of non-Aboriginal Australia. As much as $2 billion would be needed in funding just to meet the backlog in processing and essential services in remote and rural communities in Australia, including the Torres Strait.*

> *5.   That the Commonwealth take a leadership position for all Australians by declaring its resolve to achieve health gains."*

The Royal Commission into Aboriginal deaths in custody (1991)

The Royal Commission addressing the problems of Aboriginal deaths in custody made many recommendations relevant to mental health.

They recommended:

> *"That, wherever appropriate, governments make use of the services of Aboriginal organisations in implementing such recommendations;"*

> *"Ensure that local Aboriginal organisations are consulted about the local implementation of recommendations and then services be used when feasible." (p69–70)*

The report goes on to make recommendations with respect to the deaths and post-death enquiries; the adequacy of information and need for statistical systems; Aboriginal society today and the social issues affecting Aboriginal communities and in particular the importance of establishing family links and support for family reunions; the prison experience (p107–111); relations with the non-Aboriginal community.

The report specifically identifies issues in the criminal justice system and the disastrous repercussions of the high rates of involvement of Aboriginal Young people in the juvenile justice system, as well as the harmful effects of the excessive use of alcohol and other drugs. It pointed to the need to address the use of Alcohol and other drugs (p83–85, Recommendations 63–71 incl.) and these recommendations significantly involve health and mental health services. Strategies for Coping with Alcohol an other drugs are dealt with. (p130–132, Recommendations 272–288)

Infrastructure issues such as education, housing (also p142–144), roads, local government, and related issues are also covered, as is the critical role of self-determination (p85–86). A specific section addresses The Way to Self-Determination (p111–115, Recommendations 188–204 incl.). The critical importance of addressing land Rights (p145–146), the process of Reconciliation (p146) and conforming with international obligations (p144–145) is also identified.

Alternatives to Policy Custody; imprisonment as a last resort, are seen as important components of an overall approach to prevention.

Recommendations concerning Custodial Health and Safety have significant implications for Aboriginal mental health policy and services and need to be specifically addressed. These include the following. (p95–127, Recommendations 122–167)

124. That Police and Corrective Services should each establish procedures for the conduct of de-briefing sessions following incidents of importance such as deaths, medical emergencies or actual or attempted suicides so that the operation of procedures, the actions of those involved and the application of instructions to specific situations can be discussed and assessed with a view to reducing risks in the future. (3:194)

127. a. The introduction of a regular medical or nursing presence in all principal watch-houses in capital cities and in such other major centres as have substantial numbers detained;
     b.   In other locations, the establishment of arrangements to have medical practitioners or trained nurses readily available to attend police watch-houses for the purpose of identifying those prisoners who are at risk through illness, injury or self-harm at the time of reception;
     f.   The development of protocols for the care and management of Aboriginal prisoners at risk, with attention to be given to the specific action to be taken by officers with respect to the management of:
           i.   intoxicated persons;
           ii.   persons who are known to suffer from illnesses such as epilepsy, diabetes or heart disease or other serious medical conditions;
           iii.   persons who make any attempt to harm themselves or who exhibits a tendency to violent, irrational or potentially self-injurious behaviour;
           iv.   persons with an impaired state of consciousness;
           v.   angry, aggressive or otherwise disturbed persons;
           vi.   persons suffering from mental illness;
           vii.   other serious medical conditions;

130. That:
     a.   Protocols be established for the transfer between Police and Corrective Services of information about the physical or mental condition of an Aboriginal person which may create or increase the risks of death or injury to that person when in custody;

133. That:
     a.   All police officers should receive training at both recruit and inservice levels to enable them to identify persons in distress or at risk of death or injury through illness, injury or self-harm;
     b.   Such training should include information as to the general health status of the Aboriginal population, the dangers and misconceptions associated with intoxication, the dangers associated with detaining unconscious or semi-rousable persons and the specific action to be taken by officers in relation to those matters which are to be the subject of protocols referred to in Recommendation 127;

138 That police instructions should require the adequate recording, in relevant journals, of observations and information regarding complaints, requests or behaviours relating to mental or physical health, medical attention offered and/or provided to detainees and any other matters relating to the well being of detainees.

150. That the health care available to persons in correctional institutions should be of an equivalent standard to that available to the general public. Services provided to inmates of correctional institutions should include medical, dental, mental health, drug and alcohol services provided either within the correctional institution or made available by ready access to community facilities and services.

151. That, wherever possible, Aboriginal prisoners or detainees requiring psychiatric assessment or treatment should be referred to a psychiatrist with knowledge and experience of Aboriginal persons.

152. The Corrective Services in conjunction with Aboriginal Health Services and such other bodies as may be appropriate should review the provision of health services to Aboriginal prisoners in correctional institutions and have regard to, and report upon, the following matters together with other matters thought appropriate:

   a. The standard of general and mental health care available to Aboriginal prisoners in each correctional institution;

   b. The extent to which services provided are culturally appropriate for and are used by Aboriginal inmates.

   c. The involvement of Aboriginal Health Services in the provision of general and mental health care to Aboriginal prisoners;

   d. The development of appropriate facilities for the behaviourally disturbed;

   g. The development of protocols detailing the specific action to be taken by officers with respect to the care and management of:

      i. persons identified at the screening assessment on reception as being at risk or requiring any special consideration for whatever reason;

      ii. intoxicated or drug affected persons, or persons with drug or alcohol related conditions;

      iii. persons who are known to suffer from any serious illnesses or conditions such as epilepsy, diabetes or heart disease;

      iv. persons who have made any attempt to harm themselves or who exhibit, or are believed to have exhibited, a tendency to violent, irrational or potentially self-injurious behaviour;

      v. apparently angry, aggressive or disturbed persons;

      vi. persons suffering from mental illness;

      vii. other serious medical conditions;

      viii. persons on medication; and

      ix. such other persons or situations as agreed. (3:278)

The Report goes on to identify the importance of Breaking the Cycle with Aboriginal Youth (p122–125, Recommendations 234–245). These are also extremely relevant in terms of Mental Health and Prevention Policy for Young People.

The section of the report deals with Towards Better Health (p125–130, Recommendations 246–271). These are all relevant in terms of holistic concepts of health and mental health:

246. That the State, Territory and Commonwealth governments act to put an end to the situation where insufficient accurate and comprehensive information on inputs to and activities of Aboriginal health programs is available.

247. That more and/or better quality training be provided in a range of areas taking note of the following:

   a. Many non-Aboriginal health professionals at all levels are poorly informed about Aboriginal people, their cultural differences, their specific socio-economic circumstances and their history within Australian society.

   c. The primary health care approach to health development is highly appropriate in the

Aboriginal health field, but health professionals are not well trained in this area.

259. That Aboriginal community-controlled health services be resourced to meet a broad range of functions, beyond simply the provision of medical and nursing care, including the promotion of good health, the prevention of disease, environmental improvement and the improvement of social welfare services for Aboriginal people. (4:261)

264. That:
   a. There be a substantial expansion in Aboriginal mental health services within the framework of the development, on the basis of community consultation, of a new national mental health policy;
   b. There be close scrutiny by those developing the national policy of the number of models that exist for such expansion; and
   c. Aboriginal people be fully involved in the policy development and implementation process. (4:262)

265. That as an immediate step towards overcoming the poorly developed level of mental health services for Aboriginal people priority should be given to complementing the training of psychiatrists and other non-Aboriginal mental health professionals with the development of a cadre of Aboriginal health workers with appropriate mental health training, as well as their general health worker training. The integration of the two groups, both in their training and in mental health service delivery, should receive close attention. In addition, resources should be allocated for the training and employment of Aboriginal mental health workers by Aboriginal health services. (4:262)

266. That the linking or integrating of mental health services for Aboriginal people with local health and other support services be a feature of current and expanded Aboriginal mental health services. (4:263)

270. That:
   a. Aboriginal people be involved in each stage of the development of Aboriginal health statistics; and
   b. Appropriate Aboriginal health advisory bodies (such as the proposed Council of Aboriginal Health) consider developing an expanded role in this area, perhaps in an advisory capacity to the Australian Institute of Health, and that the aim of this involvement should be to ensure that priority is given to the collection, analysis, dissemination and use of those Aboriginal health statistics most relevant to Aboriginal health development. (4:263)

Finally the Report addresses two major areas of great significance for the future health and well-being of Aboriginal people, and ultimately for their mental health: Educating for the Future (p132–135, Recommendations 289–299); and Increasing Economic Opportunity (p135–142, Recommendations 300–320).

National Aboriginal Community Controlled Health Organisation (1993)

The National Aboriginal Community Controlled Health Organisation at its meeting in Cairns in September 1993 specifically addressed draft policy recommendations for mental health.

1. That the community be empowered to address social/mental health problems and psychiatric disorders and resources be made available to develop and provide culturally appropriate policies, prevention strategies and treatment services.
2. That social/mental health problems, psychiatric disorder be given a high priority in addressing Aboriginal Health in Australia.

3. Identifying the extent of Social/Mental Health problems in the community and strategies to address these problems.
4. That mainstream services acknowledge and recognise the needs in this area and provide culturally appropriate policies, preventive strategies and treatment services.
5. That mainstream services incorporate Aboriginal social/mental health issues in all relevant professional curriculum and staff development programs.
6. That Aboriginal staff working in social/mental health of psychiatric services should be given appropriate education.
7. That the special needs of children, youth and elders are recognised and addressed and appropriately resourced.
8. Overall, more effective co-ordination of service delivery for above identified problems which must include the involvement of Aboriginal Community Controlled Health Services and adequately resourced.

The National Aboriginal Mental Health Conference (1993)

In 1979 an Aboriginal mental health group was formed with a Steering Committee for what was called the National Aboriginal Mental Health Association. This Association produced a declaration:

> *"We declare that mental health problems in Aboriginal society are at least as common and as serious as in any of the society in Australia.*
>
> *We declare that Aboriginal society does not enjoy the services for the relief and care of mental illness enjoyed by other groups.*
>
> *We hold that psychiatric services planned to assist people of European descent are not suited to relieve the distress of Aboriginal people.*
>
> *Therefore*
>
> *We express the need to develop with urgency Aboriginal services to meet the needs of Aboriginal people suffering from mental illness.*
>
> *We maintain that these services should be conducted for and by Aboriginal people with proper links to other health services.*
>
> *We recognise that services are provided for Aboriginal problems of the body, but that mental health problems go overlooked and ignored.*
>
> *Therefore we pledge ourselves to the National Aboriginal Mental Health movement, designed to promote professional and vocational development in this field."*

At the inaugural Aboriginal Mental Health Conference held in 1979 the declaration was supported and those who attended indicated the extent of need and the inadequacy of services for mental health. The need was seen as urgent.

In 1980 a second Conference was held on "Aborigines and Mental Health" (sponsored by the Australian National Association for Mental Health and the National Aboriginal Mental Health Association). The theme of this Conference was "Hitting Our Heads Against a Brick Wall". Although these meetings demonstrated both interest and need, little advance had occurred and it was only with the "National Aboriginal Mental Health Conference" Sydney, November 21–23, 1993 that the need which had been evident more than a decade before, became comprehensively addressed and documented, drawing together more than 900 people from around the country.

Details of the recommendation of the First National Aboriginal Mental Health Conference are extensive and can be assessed in detail p24–36 (see Report – Appendix [2]. (Recommendations only)

Key Recommendations from this include the need for:
- Aboriginal Mental Health Workers positions to be funded and for these workers to be employed in both Aboriginal Community Controlled Medical Services and State Government Services
- Grief counselling and support for programs dealing with grief, e.g. LINKUP, Aboriginal Deaths in Custody Watch Committee and other NGO's and for family loss and separation
- A network of support services providing psychological and welfare services similar to that of community health services (which are seen as being largely inaccessible to Aboriginal people)
- Children and Young people should be a special focus of attention with programs taking into account cultural factors, early child care centres, child abuse, young people in correction services, but particularly and above all else, the protection of Aboriginal and Torres Strait Islander children and young people from removal from their indigenous families and communities.
- Support for families both in protection from separation, support of culture, supporting family reunion, acknowledging family grief and specific support for families with a mentally ill member.
- Recognition of the importance of land, land rights and their impact on health and mental health. In addition to addressing land rights, there is the importance of provision of healing places on the land.
- Recognition of the specific importance of Aboriginal cultural practices with respect to death and grief, including the need for ceremonies, attendance at funerals, importance of burial in one's own country, and cultural sensitivity in all areas of grief and loss.
- Self determination, both generally and in all matters to do with Aboriginal life, health and mental health
- Models of service delivery which are
- developed and controlled by Aboriginal people
- Programs addressing Family violence, substance abuse, sexual assault, Grief and loss, special programs for Men, Women, Children and Youth.
- Prevention programs.

These are attached in Appendix 2, but also addressed in detail in relevant sections of this report and policy development.

National Enquiry into the Human Rights of People with Mental Illness, 1993

The Report of the National Enquiry into the Human Rights of People with Mental Illness (Burdekin, 1993) specifically addresses Aboriginal and Torres Strait Islander people (Chapter 23, p.692–722).

It comments on the historical experience

"The underlying causes of the physical and emotional ill-health prevalent in Aboriginal communities lie in the continuing social, political, and economic disadvantage that Aboriginal people experience." (N.S.W. Aboriginal Mental Health Report, 1991, p.9)

It identifies colonisation, disruption of traditional customs and lifestyles, forced removal from families, and socio-economic disadvantage as contributing.

Cross-cultural perspectives and the social context of Aboriginal Mental Health need to be taken into account, including symptom expression, grief, poor self-image and the problems of suicide.

Problems in the diagnosis of mental illness, as are identified in this Report, both because of interpretation of disturbed behaviour in different cultural contexts, the lack of appropriate services, substance abuse and mental illness were often combined and exacerbated each other.

There was a great need for adequate data in the prevalence and nature of mental health problems and mental disorders among Aboriginal people.

Witnesses to the Inquiry identified the need to distinguish two overlapping areas of difficulty
- people with mental disorders as they are usually understood
- a very large group of people with symptoms of distress, mental distress (including depression), which needed to be understood in a social context (Hunter, E., 1993).

Special groups were identified as having particular needs
- Elderly people
- Young people
- Women

Service problems for rural and remote areas were also seen as a particular issue.

The need for culturally appropriate services was seen as a critical issue.

The particular problems of "Wilsons Patch" were also discussed.

This chapter concluded emphasising the importance of Self-determination.

General findings and recommendations addressing Aboriginal mental health

Findings

- Not enough is known about the incidence or prevalence of mental illness among Aboriginal and Torres Strait Islander people.
- The removal of children from their families, the dispossession of Aboriginal and Torres Strait Islander people and their continuing social and economic disadvantage have contributed to widespread mental health problems. However, mental health services rarely deal with the underlying grief and emotional distress experienced by Aboriginal people.
- Mental health professionals have little understanding of Aboriginal culture and society. This frequently results in misdiagnosis and inappropriate treatment.
- Existing mainstream mental health services are inadequate and culturally inappropriate for Aboriginal people.
- Aboriginal communities do not have access to the knowledge or resources to care appropriately for many of their own people.
- Many Aboriginal and Islander people are denied the right to adequate mental health services because they live in isolated areas.
- The removal of Aboriginal people from remote communities for treatment in town can be

extremely destructive to their mental well-being. This is particularly so for elderly people.

Recommendations

- Governments must provide funding and resources to enable Aboriginal community-controlled health services to develop and deliver appropriate mental health services to their client group.
- Joint research projects should be undertaken by Aboriginal communities and other mental health professionals to determine the nature and extent of mental illness among Aboriginal people.
- Governments should ensure that mental health policy, planning and program delivery is developed in consultation with Aboriginal people.
- Tertiary courses for non-Aboriginal mental health professionals (particularly psychiatrists and nurses) should include material on Aboriginal history and contemporary Aboriginal society.
- Mental health professionals should acknowledge the role and significance of traditional healers in Aboriginal communities.
- Priority must be given to training Aboriginal health workers and other Aboriginal community-based resource people as mental health workers.
- Health departments should identify positions for Aboriginal mental health workers in areas with significant Aboriginal populations.
- Aboriginal liaison officers should be employed by relevant mainstream service providers to improve communication and consultation at all levels of the mental health system.
- All government and non-government mental health services should provide cross-cultural education for staff.
- Mental health services for Aboriginal people should be expanded to include community development, mental health promotion and primary prevention, and crisis intervention services for individuals and families.
- Mental health workers must consult with family and community members before deciding that any individual affected by mental illness requires care or treatment away from the community. Community members should be kept informed about the treatment, progress and likely return of anyone removed from their community.
- Health and community services departments should, in consultation with Aboriginal representatives, develop guidelines for the care of elderly Aboriginal people in remote communities.

Goals and targets for mental health

An interim draft General Health Goals and Targets for Aboriginal and Torres Strait Islander health was developed from a Commonwealth consultancy funded through the National Better Health program in 1991. This report covered illness, risk factors, environmental health, education, training and employment, and a range of other issues. This report was rejected and it was decided to develop more realistic goals and targets. In terms of mental health issues it dealt with suicide, substance abuse, domestic violence, child abuse and neglect and the need for a mental health survey.

Some states have gone on to develop specific Goals and Targets for Aboriginal Health. These as a rule address mental health only minimally.

For instance **Aboriginal Health Goals for New South Wales** (NSW Health, November 1993 specifies Mental Health as priority number 7 (p.12).

Goal 7.1   Substantially reduce mortality and morbidity associated with Mental Disorders.

    7.1.1 Reduce the prevalence of mental disorders and emotional ill-health among adolescents and adults

This goal is also cross referenced to Priority area No. 5, Injury and Morbidity (p.14)

5.2 Reduce incidence of suicide and attempted suicide in the community

5.2.1 Reduce deaths from attempted suicide

5.2.2 Reduce the number of those deaths in custody that occur through suicide

5.3 Reduce mortality and morbidity from injury caused as a result of interpersonal violence

5.3.3 Reduce morbidity resulting from sexual, physical and emotional abuse and neglect among children and Young people less than 17 years

5.3.4 Reduce morbidity resulting from domestic violence among women 17 Years or more

5.3.5 Reduce morbidity resulting from sexual assault of women 17 Years or more

There is also a cross reference to Priority Area 8 – Substance Abuse, particularly alcohol (p.18)

8. Minimise harm associated with the use of alcohol

Western Australian Strategic Plan for Aboriginal Health

The plan includes mental health goals and targets

Population targets: All

Main strategies:

- Regional Aboriginal mental health teams.
- Train primary health care staff in the detection, referral and community management of mental illness.
- Reduction of admission to mental institutions through use of community treatment alternatives, medication maintenance in community, and access to appropriately supervised and supported accommodation.
- Research into mental health needs, intervention, and service delivery strategies.
- Utilise the cultural skills of Aboriginal elders and traditional healers.

Goals and Targets are also provided for Alcohol and Drug Abuse.

The National Goals and Targets for Mental Health (1994) identify goals for Mental Health as

- Reduce the loss of health, well-being and social functioning associated with mental health problems and mental disorders (p.248)
- Reduce the rate of suicide among people with mental disorders (p.249)

This report notes that factors which contribute to inequalities in mental health status, and availability of and access to services include

- Indigenous status.

A specific segment of the National Goals and Targets Report addresses Aboriginal and Torres Strait Islander Peoples. It notes the current consultancy and consultation process and goes on to state

> *"A key objective of the National health goals and targets general implementation strategy is the reduction of the gap between health outcome of Aboriginal and Torres Strait Islander peoples and those of the wider Australian community. It is essential that mental health issues facing indigenous people continue to be debated within the National goals and targets process in conjunction with local indigenous communities" (p.256)*

It also notes that in the implementation of the specific strategies described, agencies such as Aboriginal and Torres Strait Islander Community Controlled Health and other service agencies, should be involved.

Targets for goal 1

Reducing Loss of Health and Well-Being were established for two groups of disorders: depression and related disorders; and schizophrenia and other psychoses.

Priority populations for depression include post-trauma and bereaved populations, amongst which, of course, Aboriginal people are significantly over represented.

Strategies recommended:

- funding of studies which identify pathways to care and help seeking, addressing cultural and other barriers to primary health care.
- the development of a research network to facilitate establishment of baseline prevalence rates for depression and related disorders in the Australian general population, in young people, and in specific groups such as older people, and Aboriginal and Torres Strait Island peoples.
- development and evaluation of methods of measuring consumer outcomes.

Primary Prevention is addressed in this report in terms of

- school-based mental health promotion and mental disorder awareness programs
- community programs to increase community awareness of the mental health impact of Child Abuse and Neglect
- clearly identified and effective interventions for disruptive behaviour disorders in children and adolescents
- education for the early identification in antenatal and early childhood care of mothers at risk for depression and related disorders
- outreach services for post-trauma and bereavement counselling following violent episodes, domestic violence, rape, traumatic events and bereavement, and disasters.
- provision of information, respite and support for carers and relatives and friends of those affected by mental disorders
- enhanced service utilisation by those most in need, especially those with social and economic disadvantage

Secondary Prevention strategies include

- school-based assessment and counselling services that are culturally appropriate and accessible
- school-based programs to support and assist children experiencing grief, trauma, loss, parental and relationship discord and separation and parental mental disorder
- training of general practitioners for early and effective treatment and relapse prevention, (and for instance Aboriginal Health Workers)

Tertiary Prevention strategies include

- best clinical practice for management of depression in primary care
- community awareness programs related to depression and its effective treatment

Strategies with respect to Schizophrenia and Psychoses are also described. The principal aims are early effective intervention aimed at recovery and improving recovery, with programs to meet consumer and carer needs, and also to decrease stigma and lead to more positive attitudes in the community. Here too there is identified the need for baseline data on prevalence.

Targets for goal 2

Reducing rate of suicide among people with mental disorders – include males 15–34 and 65 and older as priority populations.

The need for data strategies is also identified for this goal.

The strategies include

- Primary prevention dealing with high risk situations.
- Secondary prevention with the informed recognition and treatment of depression in primary care, emergency departments, depression awareness campaign and best practice guidelines for the care of those with mental disorders.

The particular issue of Aboriginal suicide is not addressed, nor is other self-harming behaviour.

In terms of equity principles, at the least, all of these goals and targets are also relevant for Aboriginal and Torres Strait Islander people.

These are some of the key recent initiatives relevant to Aboriginal Mental Health, and set a separate policy background for the present report.

Literature review

The Aboriginal and Torres Strait Islander population

The following summary presents a broad analysis of the most recent national statistical data relating to the Aboriginal and Torres Strait Islander population from a report from Aboriginal and Torres Strait Islander Commission, February, 1994. However as the report outlines, there are limitations in the availability of data on the Aboriginal and Torres Strait Islander population as well as the comparability of that data over time. This places some significant restraints on its analysis, and should be taken into account in considering the following findings.

The report states that the statistical definition of an Aboriginal or Torres Strait Islander is based on descent and self-identification. The report also states there has been a substantial increase mainly in urban areas in the willingness of people to identify as Aboriginal or Torres Strait Islander since their first inclusion in the Census in 1971. Further there has also been a tendency towards under-enumeration in remote areas. And other complications include significant levels of non-response to some questions by Aboriginal and Torres Strait Islander people and in many cases no information is available because applicants/respondents have not been asked whether they are Aboriginal or Torres Strait Islander.

It should also be noted that in instances such as 'births and deaths and hospital admissions', information on Aboriginality may be available for some States and Territories but not others and there may be differences from State to State between methods and coverage of data collection. Further statistical information on the Aboriginal and Torres Strait Islander population was expected at the end of 1994 following the Special Survey due to be conducted mid-1994, but was not available at time of writing.

The "Key Features" of the statistical analysis outline the growth of the Aboriginal and Torres Strait Islander population and the enduring pattern of Aboriginal and Torres Strait Islander disadvantage in important socioeconomic areas such as employment and income; education; health and housing; and law and justice. These "Key Features" are presented below.

Population

At the time of the 1991 Census, the Aboriginal and Torres Strait Islander population:

- comprised about 1.6 per cent of the overall Australian population; (265,458) – 131,446 males and 134,012 females
- others were 238,575 Aboriginal persons and 26,883 Torres Strait Islander persons
- had increased, in the preceding 5 years, at double the rate of the overall Australian population, reflecting both an increasing willingness to identify and also higher birth rates;
- was significantly more youthful than the overall population. The median age in 1991 was under 20, compared with 32 for the Australian population as a whole. About 41 per cent were under the age of 15;
- displayed an age profile indicative of higher birthrates and lower life expectancy compared to the wider population;
- had a significantly different pattern of geographic distribution, with only 27 per cent living in major urban areas compared with 63 per cent of the total population.

In the 5 year period to the next census, in 1996, the Aboriginal and Torres Strait Islander population has been projected to increase by 13 per cent, to 303,000.

Employment

The overall picture is of rapid growth in working age population, and some comparative improvement in employment:

- **the unemployment rate in the Aboriginal and Torres Strait Islander labour force was 30.8 per cent in 1991, down from 35.3 per cent in 1986;**
    - over the same period, unemployment in the total Australian labour force increased, from 9.2 per cent to 11.7 per cent;
    - while Aboriginal and Torres Strait Islander unemployment rates in 1991 were 2.6 times the levels for other Australians, this was a considerable improvement on the 1986 ratio of 3.8:1;
    - the indigenous working-age population (aged 15–64) grew 2.4 times as fast as the non-indigenous working age population between 1986 and 1991;
    - the rate of Aboriginal and Torres Strait Islander participation in the labour force increased from 48 per cent to 51 per cent between 1986 and 1991. The national participation rate in 1991 was 61 percent.

In large measure, the intercensal growth in Aboriginal and Torres Strait Islander employment was due to the rapid expansion of the Community Employment Development Projects (CDEP) Scheme, under which participants have the opportunity to work on community projects funded by foregone unemployment benefits. Much of the employment is part-time.

Employment grew proportionately more for women than for men, and more in rural and remote areas than in urban areas.

Income

There was no change in relative income status, with the mean for Aboriginal and Torres Strait Islander people remaining under two-thirds of the national figure.

Education

Participation levels are improving, though the gap between indigenous and non-indigenous rates remains wide.

Between 1985 and 1993, the retention rate to year 12 of indigenous students rose from 14 per cent to 25 per cent. Rates for other students in the same period, however, rose from 58 per cent to 76 per cent.

Aboriginal and Torres Strait Islander enrolments in TAFE are growing more rapidly than other enrolments. In 1992, indigenous students comprised an estimated 1.3 per cent of total students.

In higher education, Aboriginal and Torres Strait Islander students were just over 1 per cent of total enrolments in 1993, but comprised 1.5 per cent of new enrolments. There has been a significant shift away from enrolments for diplomas to enrolments for degrees.

Housing

In 1991, the average size of indigenous households was 4.6 persons, compared with 2.6 for non-indigenous households, and up marginally from the 4.5 recorded in 1986. In 1986, an estimated one third of all Aboriginal and Torres Strait Islander family dwellings were over-occupied, compared to only 8 per cent for the total population.

It has been estimated that around 44,000 Aboriginal and Torres Strait Islander people living outside urban areas live in such overcrowded conditions that they require additional housing. About 40 per cent of the houses in these areas require major repair or replacement.

Health

The limited available data shows that health continues to be a major problem area, with:

- infant mortality rates, while declining at around 4 times the national rate;
- more frequent admissions to hospital than other Australians;
- disproportionate incidence of certain diseases, including diabetes mellitus, circulatory system disorders, respiratory disorders, renal system diseases, ear diseases, eye disorders, hepatitis B, and sexually transmitted diseases;
- age specific death rates between two and seven times those of the total Australian population; and
- life expectancy at birth for an Aboriginal woman up to 20 years less than for a non-Aboriginal woman. For Aboriginal men, the gap was up to 18 years.

Law and Justice

Aboriginal and Torres Strait Islander people continue to be heavily over-represented in the criminal justice system. Surveys in 1992 found that they were over-represented in police custody by a factor of 26, and in prisons by a factor of 14. (Aboriginal and Torres Strait Islander Commission, Feb, 1994).

A further and detailed review of sociodemographic factors of relevance to Aboriginal Health and Well-being was provided to the Aboriginal and Torres Strait Islander Commission by region by the Australian Bureau of Statistics in 1994. Regional populations are identified, plus their features. These population figures are indicated in Attachment A to this section of the report.

This report supports and extends the above data. For instance it shows the population is youthful, and there are more infants (0–4 years), children (5–14 years) and young people (15–24 years) in the Aboriginal and Torres Strait Islander population and fewer adults, and many fewer elderly (only 16,379 people 55 years and over). This youthful population profile is further highlighted by the median age differences – 19 for Aboriginal and Torres Strait Islander people compared to 32 for the total Australian population. The Roma Region with half the population less than 18 years of age had the lowest median age and Cooktown the highest. The three largest regions are Sydney (22,905 people), Brisbane (16,261 people) and Coffs Harbour (15,876 people).

Forty two communities lacked formal land tenure to the land on which the community was located. Home ownership rates were 28% which was less than half that of the total Australian population. And 4% lived in improvised accommodation compared to 0.2% of the non-indigenous population.

Health parameters included the lower life expectancy (17 years for male and 15 years for females), higher fertility (40% for Aboriginal and Torres Strait Islander women) but higher infant mortality (3 times).

Environmental health parameters are also described and are significant. For instance with respect to water supply more than three hundred discrete communities did not meet NH&MRC guidelines, with water deficiencies affecting 14,616 people, and many others affected by inadequate or unreliable water systems. With respect to waste disposal 137 communities were without sewage disposal with many others with unsatisfactory systems and nil or poor garbage disposal. Electricity supplies were inadequate or absent for over 300 communities.

One hundred and seventy nine centres lacked local medical services; 418 centres had no local health program; 729 no local women's health program; and 759 centres had no health buildings within the centre (p11). One hundred and forty centres also lacked locally available medical examination services.

Education statistics showed that, as would be expected for such a young population, 30% of Aboriginal and Torres Strait Islander people were attending some form of educational institution. Even so 378 centres surveyed in 1992 did not have local educational facilities available for the use of the community. Three hundred and eighty centres were over 30 kilometres from the nearest primary school and 784 from the nearest secondary school. Tertiary participation was lower for Aboriginal and Torres Strait Islander youth: 9% compared to 22%. While more females were currently in tertiary education, more males currently held tertiary qualifications. Sydney and Wangaratta Regions have the highest qualification roles. Male qualifications were usually in the areas of engineering, agriculture, and architecture and building, with women being more in the areas of education, health, society and culture and business and administration. (p14)

Employment

This was a significant field with the need to consider participation rates, unemployment and matters such as the CDEP program (Community Development Employment Program) – there being at the time of the report 235 CDEP schemes with 23,000 participants.

The workforce rose from 66,287 in 1986 to 82,185 in 1991 – an 18% increase. The total participation rate for the Australian population was 62% (1991 figures) with that for Aboriginal and Torres Strait Islander people being said to be 52%. The reports suggests lower participation related to more women in childminding, and a younger population not in the workforce but at school, and as well the unavailability of employment.

Unemployment figures showed that of the 82,185 people participating in the workforce 25,288 were unemployed, with Sydney having the most unemployed people, followed by Coffs Harbour. The unemployment rates for Aboriginal and Torres Strait Islander people were 31% compared to 11% for the total Australian population (1991 figures), and this figure would have been higher but for CDEP programs as people with lower rates were those with high CDEP participation. Employment rates at this time were 36% compared to the total Australian population rate of 54%. Community service industries provided almost a third of the jobs, and a substantial proportion of these were CDEP. Twenty eight percent of Aboriginal and Torres Strait Islander workers were employed in unskilled operations compared to 13% of non-indigenous workers.

Income also shows the disadvantage experienced by Aboriginal and Torres Strait Islander people. Mean individual income in 1991 was $8,900 which was $5,100 below the mean individual income for the total population, and this lower level is related not only to the youth of the population, but also lower paying occupations and higher levels of unemployment. The median household income was $27,000 compared to $31,000 for the total population, but it should be remembered that Aboriginal households average 4.6 persons compared to 2.6 persons in non-indigenous households. The median family income was $24,600 which was $10,200 below the total population figures.

Households not only average higher numbers of people (4.6 compared to 2.6) but multifamily households are more common (12% compared to 2%). Lone person households are less common (3% compared to 7%). It is of interest to note that according to the 1991 census report 52% of households with Aboriginal and Torres Strait Islander people present also had a non-indigenous person who had not identified as indigenous when surveyed for the census night.

Thus there is a picture of significant economic, housing, health and social disadvantage, as well as negative environmental influences. All these are risk factors for poor physical health and likely to adversely affect the mental health and well-being of Aboriginal people.

The physical health and well-being of Aboriginal people

The National Aboriginal Health Strategy (1989) highlighted the extent of inequities in Aboriginal Health and proposed an appropriate strategy to deal with these.

Increasingly however it was recognised that Aboriginal health indices showed continuing inequity and fourth world health outcomes. Political pressures also demanded recognition, and scientific publications, as well as epidemiological data, repeatedly indicated the extent of the problems.

Mathews (1993) provided an overview of Aboriginal health outcomes from a wide range of studies to that time to the then Federal Minister for Health, Senator Graham Richardson. His analysis reported that:

Aboriginal disadvantage starts from birth with maternal malnutrition and other factors leading to as many as one in five Aboriginal infants being born with low birth weight (less than 2.5 kgm) (3–4 times the rate for other Australians). High maternal mortality existed for Aboriginal women both in the Northern Territory and nationally, Aboriginal women being more than 30 times more likely to die giving birth than other Australian women. Even though improving from rates in the 1960's, infant mortality rates were 3 times the rate for non-Aboriginal infants. This heightened mortality persisted through childhood, resulting from infectious conditions such as diarrhoea and bacterial conditions, accidents and deficiencies in available services for prevention and primary care. The nutritional status of Aboriginal children was considered to be deteriorating rather than improving with 20% satisfying a WHO definition for malnutrition, a factor likely to adversely affect physical and intellectual growth and development. This is also likely to increase vulnerability to some diseases in adult life, such as diabetes, heart disease and hypertension, the prevalence of which is already high, and even rising in some Aboriginal communities.

Mortality rates in adult life were also described as being far worse for Aboriginal adults, with life span being reduced by some 20 years compared with other Australians. As many as fifty percent of premature deaths, in Aboriginal adults, were reported as being directly or indirectly due to alcohol abuse. Death rates were also greatly increased from diabetes, heart disease, lung disease and kidney disease. Many of these problems resulted from adverse environments and their outcomes in childhood and through to adult life, as well as risk factors such as high alcohol intake and smoking. The impact of infectious and bacterial diseases, including otitis media, respiratory diseases, diarrhoeal diseases, and sexually transmitted diseases is seen in their outcomes and is also influenced by the fact that many are not adequately recognised or treated.

Mathews (1993) saw there were problems with health service provision varying from the failure to adequately involve Aboriginal people in planning, through to inappropriate models of health care delivery. Problems included training and availability of Aboriginal health workers, inadequate accountability for Aboriginal health with division of responsibility, lack of information, and lack of resources. These same themes have been reflected in more recent reports and findings, both in terms of current health data and the problems of proposed strategies not being effective.

These same issues have been reiterated in the most recent reports from Mathews' unit (Menzies School of Health Research 1993–1994, Annual Report).

A range of other reports have addressed regional health data or have reviewed Aboriginal Health (e.g. Reid and Trompf, 1991).

Reid and Trompf's volume examines not only data on Aboriginal health status but sets this in context; for instance it examines: the history and politics of Aboriginal health; the current status of Aboriginal health; the decline and rise of Aboriginal families; food, nutrition and growth in Aboriginal communities; drug and alcohol use among Aboriginal people; the conflicting cultural perspectives of Aboriginal mental health; the sociocultural context of Aboriginal well-being, illness and healing; contemporary issues in Aboriginal public health; and the policy and practice of Aboriginal health. Thompson's contribution (1991) in reviewing Aboriginal health status documents a very similar picture to those earlier reports, but sets them in clinical contexts. Reid and Trompf's volume is the only review to that time to include mental health within the health status report. Furthermore Reser's chapter (see this review) contributes significantly with

mental health data review to that time. Neither of these writers however, integrates the physical health and mental health elements, the possible comorbidity, and their interactive contribution to adverse outcomes for Aboriginal people. Mobbs (1991) examines the sociocultural context of Aboriginal well-being, illness and healing in the same volume, and in this sense provides a more holistic approach. She also looks at illness behaviour, the sick role, and explanations of illness causation including natural, introduced, environmental, direct supernatural and indirect supernatural "causes". Nevertheless mental health and its relation to physical health require further consideration, both from the holistic point of view, and also mutual effects of comorbidity.

The most recent review of physical health differentials indicates the high levels of morbidity and mortality and adverse health differentials that continue to be experienced by Aboriginal and Torres Strait Islander people (Bhatia and Anderson, 1994). This review of the most recent data indicates that:

- Aboriginal death rates greatly exceed those of non-Aboriginal people at all ages.
  - For the Aboriginal boy, the expectation of life at birth is between 16–18 years shorter.
  - For the Aboriginal girl, the expectation of life at birth is slightly wider than this.
- Preventable communicable diseases contribute disproportionately to high mortality and high hospitalisation rates.
- There is a growing impact of non-communicable diseases – particularly cardiovascular disease and diabetes. Adult prevalence rates of diabetes exceed 30% in some communities, and leads to age standardised mortality rates of more than seven times that of non-Aboriginal people with this disease.

It should be noted however that data did not derive from all States – mortality data derived for instance from data from death registrations in South Australia, Western Australia, Northern Territory, while specific disease data came from New South Wales, South Australia, Western Australia and Northern Territory. However most of the population comparisons are made between Aboriginal and total Australian populations. Self assessment data in terms of self-reported health and illness are national figures, derived from the 1989–90 National health Survey by the ABS. It should be noted that provision now exists for the identification of Aboriginality in all vital statistical collections including recently Queensland. While Queensland data was not included in this report a recent review from Queensland " The Health of Indigenous people of Queensland" (Runciman and Ring, 1994) confirms that "indigenous Queenslanders have similar health profiles to those of Aboriginal people in other parts of the country" (p. 17). Mental health data is also limited with no national collection available at time of writing (see State data) and thus it is difficult to gain a comprehensive picture of Aboriginal mental health, the more so because of the potential influence of regional factors and variations, and because of a likely under-reporting of Aboriginality in health data generally (and mental health data in particular).

Examining this general health data in greater detail is helpful as it highlights the pervasiveness of ill-health, and points to the potential influence of such factors on mental health and well-being.

Mortality

It is noted that improvements in Aboriginal life expectancy over the past two decades have been achieved mainly through reductions in infant mortality. But high death rates in younger and middle adult life are likely to produce ongoing impact, in terms of years of life lost, on families and in terms of personal and social role fulfilment. Even though infant mortality has declined in recent decades, Aboriginal infant mortality rates are 2–3 times those of the broader Australian community, accounting for instance in 1993 for 73% of all infant deaths but only 38% of all births in the Northern Territory. Aboriginal death rates are consistently higher at all ages, typically 2–8 times those of non-Aboriginal populations. The least favourable ratios are in the 25–34 year age range. Males have a higher death rate at all ages, but particularly aged 15–44. Causes of death are cardiovascular diseases, external causes such as accidents, poisoning and violence, respiratory problems, neoplasms, endocrine disorders. Deaths from motor vehicle accidents, fire, drowning, poisoning, violence and other injuries, were the second largest contribution to Aboriginal mortality and Aboriginal injury rates were four times those of non-Aboriginal people.

Suicide and homicide account for 5% Aboriginal male deaths and 3% Aboriginal female deaths, compared to 2% of such deaths in the total population, including Aboriginal deaths in custody. Trends in mortality do indicate there is some decline in mortality rates – but it should once more be noted that Aboriginality was poorly identified in most States death registrations prior to 1989. Male rates showed a decline from 1989 to 1992. But patterns indicate increased SMR (Standardised Mortality Rates) for Aboriginal males have arisen over time for acute myocardial infarction. And even though violent and vehicular death rates have decreased this is not so great as the decrease for non-Aboriginal males. While some lowering of mortality has occurred for Aboriginal females, this was less than for Aboriginal males and the gap widened in comparison to non-Aboriginal females.

Deaths associated with alcohol misuse have declined and there has been a steady decline for deaths from external causes, including fatal transport accidents and violence. Yet despite such trends, mortality from suicide and self-inflicted injuries remains high among Aboriginal males, and may have risen in Aboriginal females.

The traumatic and untimely circumstances of death that are so defined are clearly much more frequent in the Aboriginal population, contributing to the overwhelming trauma and loss described by Aboriginal people. Bereavement such as this has, in its own turn, profound adverse effects on health and well-being. And the frequency, numbers and traumatic nature of the losses that must result from this premature mortality must impact on mental health and well-being, if Aboriginal people have the same psychological, social and biological vulnerabilities that follow such a stressor, as have been demonstrated in studies of non-Aboriginal people, and there is no reason to believe they do not (Raphael, 1994).

Furthermore the trauma associated with many such causes of death, as well as the extent of injury and violence which does not necessarily end in death, is likely in and of itself to contribute as well to psychiatric morbidity, for instance post traumatic stress disorder.

Patterns of illness

Self-reported illness patterns defined in this report should be viewed with some caution because of the differences in population structure, culture and perceptions of Aboriginal and non-Aboriginal people.

In the ABS National Health Survey 66% of Aboriginal people responding reported themselves to be in "excellent" or "good" health, as compared to 79% of the total Australian sample. The proportions of those rating their health as excellent was markedly smaller (18% compared to 29% of the non-Aboriginal population).

More than a third of Aboriginal respondents rated their health as poor or fair.

Respiratory diseases were the most common major illness conditions reported, followed by arthritis, digestive system diseases and asthma. Important causes of ill health include diabetes, trachoma, renal disease, and cardiovascular disease. However half of the Aboriginal respondents, compared to two thirds of non-Aboriginals respondents, reported long-term illness. Metabolic, endocrine and immune disorders were frequent in those over 55. The authors suggest that these patterns differ from acute hospitalisation and mortality data, reflecting the accumulating impact of chronic health problems of low severity in the non-Aboriginal population.

Acute hospitalisation data show that for Aboriginal males rates were 70% higher than the total population and for females 57% higher (including childbirth hospitalisations). Aboriginal standardised hospitalisation rates were higher at all age groups, but especially 25–54 year old males, but for older female age groups. Respiratory diseases then injury and poisoning were commonest causes for males, with similar pictures but lower rates for females. Infectious diseases were also responsible for frequent hospitalisations.

The second and most up-to-date review in the evaluation of the National Aboriginal Health Strategy (December 1994) repeats the findings of adverse health status described above. For instance this report states: (p. 6)

> *"Hospital discharge rates are well over the national average – 70% higher for males and 57% higher for females."*

> *"Age standardised mortality rates for infectious diseases are 12 times higher among Aboriginal and Torres Strait Islander people."*

> *"Chronic diseases are a serious health problem*
> *- diabetes affects 30% of people in some Aboriginal and Torres Strait Islander Communities which is four times the non-Aboriginal rate;*
> *- trachoma continues to be a significant cause of blindness and visual impairment in remote communities;*
> *- chronic ear disease is common in many communities; and*
> *- chronic renal failure is far more common in Aboriginal than in non-Aboriginal people"*

> *"At any age, Aboriginal and Torres Strait Islander people are more than twice as likely to die as are non-Aboriginals. Aboriginals aged 25–44 the risk is five times greater than the National average."*

While this report goes on to document some improvements in health status, these are relatively few and it goes on to state (p. 7):

> *"But the health of Aboriginal people has not improved as much as it should. The health of indigenous populations in other industrialised nations has improved significantly in recent decades to the point where they are approaching the average health of those nations. The same cannot be said for Aboriginal and Torres Strait Islanders."*

The report further indicates that on some measures the health of Aboriginal and Torres Strait Islanders has declined even further, for instance deaths from diabetes, communicable diseases, including HIV/STD's, are seen as further complicating problems already present.

And this report, unlike those before it, acknowledges mental health as an important issue.

In conclusion it states: (p. 12–13).

> *"The overwhelming weight of the information from consultations and submissions confirms the desperate living conditions and poor health status highlighted in many previous reports about Aboriginal and Torres Strait Islander communities."*

Disability among Aboriginal people

Information on disability and handicap is limited, but described elsewhere in this report, as there is limited (or unanalysed) National data. A recent report (Gething, 1994) highlights the importance of understanding more about the levels of disability experienced by Aboriginal people. Disabilities may include both mental disorders and physical conditions and a person is considered disabled when he or she has experienced one or more disabilities or impairments lasting six months or more. A person is considered handicapped when their disability limits their capacity to perform tasks in one or more practical areas.

No provision was made for the identification of Aboriginality in earlier surveys of disability and handicap conducted by the Australian Bureau of Statistics. The 1993 survey did include Aboriginality. Its findings have not yet been analysed for this data subset (Bhatia and Anderson, 1994).

A more detailed study has been conducted in the Taree region of New South Wales with the Aboriginal people of that area and this provides important information on disability and handicap generally, and that relating to mental disorders. The total population (n=907) was surveyed, and 25% were found to have one or more disabilities; 13.7% being handicapped by their disability, and 5.1% severely handicapped. After appropriate adjustments for differences in the age structure of this group compared to the total Australian population, the level of disability among the Aboriginal people of this region was found to be 2.5 times higher for males and 2.9 times higher for females. The level of handicap was 1.7 times higher for males and severe handicap 2.4 times higher and 2.3 times higher respectively.

The most frequent disabilities were hearing loss and loss of sight (19%) followed by musculoskeletal (16%), circulatory systems disorders (15%) and respiratory system 13%. These disabilities produce significant handicap to mobility, employment and education.

Unspecified mental, nervous or emotional disorders were the third most frequent cause of disability in women, with a prevalence of 4.3% and constituting 10.9% of primary disabling conditions.

Slow learning or developmental delay was the most frequent disability for men with a prevalence of 5.1% and for women of 3.0%.

Some questions must be raised however about identification of mental disorders and the disability associated with them, in such a survey, as only one male with a psychosis other than senile was detected – and no females. Questions of literacy, the ways in which questions are framed, lack of sensitivity to Aboriginal culture, distrust of Government organisations and services, as well as reluctance to disclose mental disturbances may all bias the data on mental disorders. Nevertheless this information is important in highlighting further the need for research on this matter. For instance anecdotal reports noted by Gething (1994) suggest that CES officers and Aboriginal liaison officers had reported the majority of Aboriginal people with disabilities had some form of psychiatric disability, and substance abuse (particularly alcohol) was thought to be a disability effecting a large number of Aboriginal people. However as most people with disability were not constantly ill, it is important for any programs developed to deal with this focus on well-being as well as dealing with the problem.

Risk factors presented in this report included alcohol and tobacco misuse. Aboriginal people who drink are reportedly more likely to do so at levels seen as hazardous and there is significant mortality from alcohol cirrhosis, and alcohol dependence syndrome. Alcohol contributed also to transport related deaths, and deaths from other causes including falls, interpersonal violence, suicide and homicide. Alcohol also contributes to acute hospitalisation, for example from alcohol related injuries. Foetal-alcohol syndrome is also more prevalent (almost three-quarters of cases in Western Australia notified 1980–93 occurred in Aboriginal infants).

Smoking and chewing tobacco is high with the rate being nearly twice that of the total population. Lung cancer and airways disease, and other respiratory problems are associated with this risk factor, and it is suggested that there may even be a contribution to suicide risk, although small. The small relative risks nevertheless translate to a significant number of Aboriginal deaths.

Implications for mental health may be found in the high rates of acute illness and hospitalisation, injury and violence related problems and substance abuse. These factors in and of themselves are risk factors for mental health problems and mental disorders, and may contribute significantly to the milieu of ill-health experienced by Aboriginal families. These may be further complicated by poor access to health resources and more adverse outcomes for illness. Studies show high rates of depression and other mental health problems and disorders in association with physical illness and hospitalisation, with rates in some studies exceeding 60% but others in the vicinity of 40–50% (Raphael, NH&MRC, 1992). This vulnerability, with associated social adversity that surrounds Aboriginal people, especially if ill, and the alien and stressful experience of Western medicine for many people, may add to psychological vulnerability for those reasons alone.

The contribution of stress in high levels to Aboriginal ill health needs to be considered, both from its identified impact in psychological well-being, and its potential impact on physical health. An interesting contribution to this debate comes from the work of Sibthorpe (1988). She examined Aboriginal Health and

diet in a small rural New South Wales community, Kempsey. She found that Aboriginal Health was extremely poor when compared to that of other Australians, but contrary to the hypothesis of her research the composition of the diet of the Aboriginal people studied was not as poor as predicted and did not substantially differ from that of the broader population.

Sibthorpe, after examining all the potential variables concluded that there was much to suggest that stress, per se, contributed significantly to the ill health of Aboriginal people. The social distribution of disease (and associated multiple stressors of disadvantage), the physiological reactivities associated with psychological arousal; the established evidence for the effects of stressors such as bereavement or immune function; as well as the affects of other emotion or the immune system, all indicate possible pathways. Stresses faced by Aboriginal people as indicated in her work included: dispossession and institutionalisation; separation and loss; unemployment; alienation and inequity. In addition Aboriginal concepts of health in holistic frameworks mean that such physical ill health will inevitably impact on and impair mental health and well-being.

Communicating about adult mortality in an Aboriginal community is an issue that has been considered in some depth by Weeramanthri and Plummer (1994).

This study described a classificatory framework for addressing the underlying causes of disease, namely: Land (physical environmental causes such as water, pollution, infections, disease causes); Body (such as nutrition/exercise or lifestyle diseases); and Spirit (social/mental such as stress, disadvantage, alcohol, trauma etc.). This moves understanding from the Western medical explanatory models to those relevant for the Aboriginal communities living in traditional ways. These workers carried out a study using this explanatory model to discuss with communities causes and possible responses to premature deaths. They felt such a model was not only useful in communicating with people concerning such deaths, but could be useful for prevention and health promotion. And it was also seen to be a helpful way of having Aboriginal people understand better the nature of ill health, and its impact, and to facilitate talking about the "sorry business" of deaths in helpful ways. It provides an initiative which may be valuable both in its ultimate health impact as well as more positive management of the trauma and grief of such premature deaths.

While there are a number of initiatives attempting to address Aboriginal health problems and inequity as identified above, the failure of these to impact adequately on the major indicators of ill health is clear. This has been documented in the recent evaluation of the National Aboriginal Health Strategy and amply supported by submissions such as that of Mathews (1993 – see above) as well as presentations at the Summit held by the Australian Medical Association (Canberra, 1994). Nevertheless none of these submissions apart from the recent evaluation of the National Aboriginal Health Strategy has adequately recognised or addressed the mental health needs and inequities. And none has recognised the effects of the physical health problems outlined above on the mental health and well-being of Aboriginal people, the comorbidity likely to be involved, and, the ultimate contribution of both to adverse outcomes.

Some recent recognition appears in the evaluation of the National Aboriginal Health Strategy with recognition that greater emphasis is required on men's health problems; substance abuse programs; youth programs; domestic violence; and mental health care programs (p. 27). Nevertheless mental health is still not identified as a central issue for Aboriginal people's well-being, as it is seen by the Aboriginal community.

Another critical aspect of the high levels of physical morbidity and mortality is that many communities become so overwhelmed with dealing with these health issues that mental health needs get set aside as a secondary issue. This may lead to problems becoming more chronic and entrenched, contributing further to health risk behaviours such as substance abuse, and violence; or such problems may only come to attention when extreme and disruptive to the community as with severe violence or suicide.

Mental ill health as understood in Aboriginal communities

Interpretations of "mental health" or "mental illness" are Western, framed from Western medicine. Distress and disturbed behaviour are recognised in most cultures, but their causes and meaning may be understood in many different ways. And how members of any cultural group or society respond to or deal with the distress or "different" behaviours may vary from tolerance to punishment, "treatment" to exclusion. Concepts of "deviance" are also critical to this issue. As Reser (1991) notes such conceptualisations may certainly not conform to Western Diagnostic Manuals or psychiatric explanations.

With respect to mental health as opposed to mental illness, the holistic concept of well-being has been described and is agreed to in terms of the concepts noted above, i.e. emotional, cultural, spiritual, physical, mental well-being, rather than simply the absence of distress or deviant and disturbed behaviour. It seems clear that these holistic concepts of well-being have been a longstanding theme in Aboriginal culture and interpretation of personal states.

Reid (1982) states "The Aboriginal approach to both prophylaxis and curing is a holistic one. It recognises the physical, personal and spiritual dimension of life and health" (p91). She notes that in many ways it is closer than that of Western medicine to the WHO's definition of health – "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (p91).

Early researchers such as Cawte (1972, 1974), Cawte et al (1968) and Eastwell (1982) tried to describe the nature and extent of disturbed behaviour, as mental illness, found in traditional communities. They described both syndromes similar to those of Western medicine, such as schizophrenia, depression, and culturally derived explanations of these such as sorcery. They highlighted the difficulty of both defining and diagnosing these differences, and the postulated issues of management. Cawte was said to have an "ethno- psychiatric agenda" in describing these issues and proposed that there were two groups of illnesses – those characteristic of traditional life and those of communities in transition. Eastwell used dynamic explanatory models. However these explanatory frameworks have not been in recent or current use. Kahn (1982) like Cawte (1972), drew attention to the effects of loss of traditional lands, gross disruption of culture, with the resulting social disorganisation or stress. In a range of cultures where indigenous people have experienced these same stressors similar patterns of emotional problems and disturbances appear: alcohol abuse, suicide, accidental death, homicide increases, child abuse, domestic violence and family breakups.

Kleinman (1986) draws attention to the concepts of illness experience, as distinct from disease entity and this conceptualisation has greatly enhanced the cross-cultural approach to psychiatry. His work and that of others contributing to the field of cross-cultural psychiatry have helped recognition that sociocultural factors influence almost every aspect of mental health and illness: aetiology, onset, course, personal experience, outcome, and systems of care. Even though there are enormous individual differences between people, and great similarities, cultural factors are likely to dominate expression and understanding of behaviours, even those of organic origin. These issues must set a background for considering Aboriginal mental health.

On the other hand Biernoff (1982) has highlighted the difference between psychiatric and anthropological interpretations of "Aberrant" behaviour in an Aboriginal community and examined the role of social control mechanisms in mobilising negative sanctions against the "antisocial". Many of these early studies failed to take into account the subjective reality of the Aboriginal people. He concludes, both from his reviews of the work of psychiatrists in this field and from his own study, that the majority of Aboriginal people do not in fact show psychopathology but rather resilience and remarkable coping skills in adjustment to the world in which they live, with the majority showing "well-integrated adult personalities" and leading a "valuable and meaningful life" (p152).

Aboriginal languages demonstrate acknowledgement of the Aberrant or "silly" behaviour, and the longstanding nature of this recognition. Dunlop (1988) for instance reports the word "arerte" -being used

to refer to a person who is really mad, or in another language "Rama rama" – silly, stupid, mad (Warlpiri) and "Walpanalpa" – mad or crazy, "Warungko", "arengkw", "pina pati", or "kawa-kawa" – thoughtless, silly and here too "rama rama" silly (Dunlop, 1988, p42). Morice (1977 a,b,c,d) has also written in this sphere and points out the important subtleties of language that distinguish between certain types of emotion and mental disorder. His work also shows that there are precise usages which define whether a reaction is normal, for instance grief, or illness such as depression, and whether it might be seen as resulting from some socially justifiable context (e.g. some anger) or a personality trait or "disorder" (for instance, aggression). Morice's work is valuable in describing and identifying the much more subtle distinction in Aboriginal language and understandings. Furthermore this use of terms may also give clues as to how the behaviours are viewed and reacted upon by that group. There are, of course, many other words and languages, some of which are covered in the recent volume "Aboriginal Words" from Macquarie Press.

Dunlop (1988) "All that Rama Rama Mob" in response to a "crisis in coping with the behaviourally disturbed" (p.ix) carried out research to address this issue for Congress (the Central Australian Aboriginal Congress, the Aboriginal Medical Service, Alice Springs). This was particularly valuable as a research initiative in that it was a community controlled consultative research project, and was undertaken to ascertain Aboriginal perceptions of disturbed behaviour. She found that in general there were people in the community willing to participate in the research, although discussions were sometimes constrained because of the personal nature of what was being considered, or family or other connections. In reviewing different language terms and these associated concepts she found that in all the languages of the areas she researched, the term used for "madness", also applied to "deafness", and as well there were a multitude of other words which referred to abnormal or disturbed behaviours.

It was found that where local services considered someone to be mentally ill their communities also perceived them as abnormal, and that this was differentiated from violence or substance abuse, even though these behaviours might be seen as serious problems. There was, in general, a high degree of acceptance of abnormal behaviour. Communities would start to complain if the disturbed person's behaviour was extremely violent; if the person caused difficulties constantly so that families could not get a break; or if there were not enough people to care for the person on a shared responsibility basis.

In describing the patterns of disturbed behaviour, Dunlop found that the sample could be divided roughly into three groups: non-disruptive cases; disruptive cases with little violence; and cases that were both violent and disruptive. It is interesting to note that it became obvious it was impossible to completely separate the issues of substance abuse from the other aspects of disturbed behaviour.

Communities also usually described the behavioural problems as chronic, with only one fifth of cases believed to be improving or having the potential to improve. Furthermore there was no one Aboriginal concept to cover globally the nature of the behaviourally disturbed, and people used a range of interpretations.

It was found that disturbed behaviour was usually attributed to some problem in the head, with a variety of causes corresponding to physical, "spiritual" and psychological and social factors. People were often seen as affected by external causes and not held responsible for their actions in that, as Dunlop says, they could not "see" or "hear" when acting in a disturbed way. Behaviour was often given a number of explanations, operating at different levels. The severity of the behaviour (as well as context) was likely to be the best indication of community views on the likely need for treatment. "Spirit" causes were most often applied to the most severe cases. There was also a tendency to attribute the disturbance to a period in the intermediate rather than distant or immediate past.

Responses to disturbed behaviour were described at many levels. In general there was a strong sense of family responsibility with people seeking outside assistance only when there were extreme problems. The community tended to be very tolerant as well, unless problems were severe, disruption incessant, or demonstrated significant aggression and violence.

Dunlop vividly describes how, within communities and families, one or two people may take on a large burden of care including in their responsibilities "sniffer grandchildren, senile parents and a disturbed individual as well" (p.xxiv). However these methods would fail if too much burden was placed on individuals or family care networks, or if family networks were dispersed or ruptured, or if alcohol added further disruption.

The typical disturbed person was male, unmarried, 16–25 years old and was more often violent, while females were more often seen as "ill". Most of these abnormal cases had never married. Cases reported in the town were seen as more problematic than those in bush communities, and alcohol was associated with one half of these town cases.

Examining further the nature of the disturbed behaviour Dunlop reported on a total sample of over 200 people said to be problematic by their communities because of disturbed behaviour. The findings resulted from extensive community discussion among Aboriginal research officers and in community languages, with community leaders; traditional healers (ngangkari); health workers; close family of problematic individuals; "carers" of these individual problematic individuals themselves; other concerned community members. There was no attempt to make diagnostic assessments in a clinical context, although those involved in care were asked their views and perceptions of the nature of the problems. There was also exploration of current forms of assistance and perceived need.

While clearly the worst of the behavioural problems discussed were those of severe violence and aggression there were other primary behaviours seen as "abnormal" or "mad".

As noted previously there were a number of main groupings:
- i) not disruptive (38%). This group of people demonstrated a range of mild problems; had a few "odd" traits; were or were not able to communicate verbally; ranged in capacity of looking after themselves; and were often problematic for themselves and carers.
- ii) Disruptive behaviours included those that
  - a) were disruptive with low violence (30%); they ranged in severity, constancy of problems, burden to the community and their capacity to communicate with others.
  - b) those both disruptive and violent to others (30%); these people could communicate with others, and were angry, disruptive and at times violent to others; and a burden of care.

Behaviours described as disturbed included: walking around the camp all the time; talking incessantly; sleep disturbance; hearing voices; frequently moving between communities or heading out bush; keeping out of normal social interactions; sleeping anywhere; being naked. These were activities, as Dunlop suggests, that other people found "generally pointless, possibly worrying, and often irritating". (p49)

Personality traits were often part of the description of disturbed individuals: they were seen as angry (more than 50%); upset; restless or frustrated; mistrustful; bored; and lonely.

Almost half the group had at least one physical problem and the majority of these directly related to the disorder of definition of abnormality, for example fits, headaches, or other forms of physical condition including mental retardation.

It should be emphasised that substance abuse was closely interwoven with these problems and perceptions of them and in the descriptions and understandings provided, it was not possible "to distinguish between behaviour which was substance induced and behaviour with other causes" (p65). Dunlop suggests that ignoring the compounding effects of substance abuse on behavioural disorders (especially for instance, alcohol) "may lead to misdiagnosis and ineffective treatment" (p68).

Causes examined in this respect include immediate causes which showed repeated assumptions that part of the body was affected (e.g. by an object inside, "must be a stone inside"). Longer term causes were seen as:

"Spiritual"
- ghost, devil, resulting from damage to a sacred object, being "sung"

"Physical"
- either from damage assumed to have happened in childhood, physical effects or from direct or specific injuries such as a head wound

Substance Abuse
- for instance these causative explanations related to the damage or abnormal behaviour caused by alcohol or petrol sniffing

Lifestyle causes

- these were causes such as worries about family, stresses and pressures of children, the effects of jail, mental stress of "too much thinking", old age, or an interaction of such factors.

Inherent factors
- for instance inherited madness seen as relating to a family history of madness and strange behaviour

Exacerbating factors were seen as including both these elements and possible upsetting and unsettling influences. For the most part, causes were viewed as interacting, and understanding came in terms of multiple and mutually influential variables in the types of categories outlined above; or in some instances more "nebulous" for instance, "just born like that". (p79)

In terms of the **care needed** while families traditionally take responsibility for care of the disturbed individual, additional help was often needed. Dunlop found that there was generally faith in Aboriginal primary health care systems, but people were willing to use the non-Aboriginal care systems to: relieve symptoms; cope with things outside the sphere of traditional medicine; or as another source of assistance for serious problems (see Dunlop, Chapter 6). People were however, reluctant to interfere in the lives of others unless there were family responsibilities to do so. There were also sometimes problems in that this not only meant difficulties in acting to provide care, but it might also prevent people from protecting those who are disturbed from others giving them a hard time, for instance, by teasing.

Traditional healers or **ngangkari** were called upon and bush medicines were also used. Traditional healers were seen to deal with certain 'spirit' causes, and some cases of extreme punishment and rejection; but it was considered that there were a large number of disturbed people for whom there was no traditional coping strategy because their problems had arisen from factors outside traditional times, or traditional coping mechanisms were no longer effective for them. For instance, with respect to substance abuse and other factors associated with modern lifestyle changes, community members felt that they should receive external support to deal with these issues. Traditional healing was seen as involving the work of the ngangkari which was to deal with: foreign objects in the mind; infected brains; thought disturbance; pain in the head; blocked ears; lost spirit. The healer might "sing" people to make them well; trips to the bush and gathering bush foods; bush medicine; traditional care; traditional restraints; and some modern adaptations. However the limitations of the traditional healing programs were recognised and acknowledged; for instance with substance abuse, or because such skills were more for physical problems, or were seen as fading. However, belief was strong in bush communities, and it was often considered that the ngangkari should be consulted first, and brought in if other healing was ineffective. There were descriptions of bush medicine used for disturbed behaviour (see Chapter 7, p129–134 and Table 2, page 131). Rock fuschia, Bush banana, Bush current, Lemon grass, Quondong, were amongst those identified for madness, headache and so forth.

The report indicated that agency support available for disturbed people and their families was extremely limited, with some disturbed people ending up in jail because there was nowhere else for them. The only community based treatment available in many cases was medication. Health services felt that they had very limited resources to deal with these problems, and there was criticism of the ways patients were diagnosed (for instance with schizophrenia which was seen as over diagnosed), and the reliance on medication (often at high levels and with significant side effects). While community care was seen as the ideal, there were many criticisms of how it operated at that time. There was seen to be poor communication between agencies and the community and between differing agencies involved in care. There was often a failure to adequately consult with or inform family members of proposed care, as well as gaining their views on problems. There was little support for families attempting to care for a disturbed member. Community workers had a strong desire to be involved in the decision making processes for systems of care as well as individual care within their community.

Principal recommendations for the future included the following (General) recommendations (p.xiii–xviii)
  i.   Aboriginal people must continue to be involved in developing services.
  ii. Aboriginal people must be involved in designing and applying specific treatment strategies for particular individuals.

iii. In formulating management strategies, Aboriginal traditional methods and community initiatives should be given equal status to non-Aboriginal medical practices.

iv. These recommendations should be followed as closely as possible, and should be seen in the context of the whole report.

Specific recommendations relate to the client group, including Aboriginal people with disturbed behaviour associated with organic, psychological or emotional disorders or is the result of long term substance abuse, that is dangerous or disabling. The service should cater for these individuals, their families and communities, and should not only meet the needs of those with mental disturbance, but also chronic substance abuse. It was recommended that the service should encompass a formal body to coordinate referral, assessment and management and should be the first point of contact for those who are disturbed, and coordinate and liaise with others to provide appropriately for their needs. It should involve support of disturbed people and their management in their own communities wherever possible and it should aim to prevent crisis situations as well as respond to them rapidly. It should be backed by a variety and network of residential placements and short term, respite, and long term care, and purpose-built facilities with an appropriate caring therapeutic milieu. Optimal communication at all levels should be a priority including the use of interpreters, and Aboriginal people from appropriate language groups, as well as full assessment of other sources of information and communication between agencies as well as individuals and communities. The service staff should have appropriate management, and training as well as support, to ensure optimal clinical care provision.

Education should involve Aboriginal and non-Aboriginal staff to enhance awareness of cross cultural issues, and skills for appropriate response. Above all, services should build on existing Aboriginal care systems and be guided by principles of self-determination.

The contribution of this report by Dunlop and her Aboriginal co-workers was enormous. Videos were also developed from it. The recent consultation in Alice Springs indicates that it is widely still used and an enormously valuable guide and educational resource. In addition, it provides a context for linking into other Aboriginal Mental Health needs, and problems as will be described below.

Since this report, other researchers have gone on to link Aboriginal understandings and experience to findings in the mental health field and to expand conceptualisation. Hunter (1993) has perhaps contributed most widely and his findings and concepts are discussed in the next section. In addition, workers such as Kunitz (1994) have compared affects on Aboriginal health and social and mental health of European colonisation with that found in other indigenous communities, showing clearly the common themes, as indicated above and subsequently. These concepts merge into a growing, but still vastly inadequate data base on Aboriginal experience of mental health, and mental health problems and mental disorders.

Studies of Aboriginal mental health and mental disorders

As noted above early studies of Aboriginal mental health were often anecdotal or case studies and faced the difficulties of applying Western diagnostic modes and concepts to the understanding of the mental well-being and problems of Aboriginal people.

Adult disorders

Cawte (1964, 1972), Nurcombe and Cawte (1967) reported on a study in the Northern Kimberley and concluded that 1.7% of the Aboriginal population were affected with mental disorders, although Cawte's later studies with colleagues suggested higher rates. His early work and attempts to produce models was followed by that of a significant number of other workers who produced estimates of the levels of psychiatric morbidity in those communities they researched. These studies were usually of remote communities, and the methods used were variable and lacked systematic measures; and reports showed figures ranging from 3.8 to 10%.

Kidson and Jones (1968) and Jones (1972) reported rates of 6.8% in Western Australia and Northern

Territory 8.8%. Jones and Horne (1972) found 2.7% in Western Desert and Kimberley communities. Jones and his colleagues as a result of their series of studies concluded that, among the Aboriginal population studied, dementia, depression, schizophrenia, hysterical conversion states and personality disorders existed and that in essential respects they were similar to those conditions found in non-Aboriginal populations, but mode of presentation might differ. Possession states were also found. These writers considered overt anxiety and suicide to be rare at that time. The prevalence rates of psychiatric conditions ranged from 2.7 to 9.2% for total populations and up to 14.3% when the adult population only was considered.

The most comprehensive survey at the time was that of Eastwell (1977, 1982). His findings indicated psychiatric problems similar to those found in non-Aboriginal communities occurred. The population studied was of 10,500 – 11,000. Depression was the most common presentation, both depressive neurosis as described at that time and manic depressive illness. He indicated that shame was a dominant phenomenon in the depressive neurosis category. Dissociative and hypochondriacal conditions were also observed and were not infrequent.

As Eastwell himself indicated, and as highlighted by reviews such as those of Reser (1991) and Kyaw (1993), there were significant problems methodologically which included: lack of specifics with regard to method or procedure; reliance or perceptions of non-Aboriginal staff; reliance on another culture's classification and diagnostic scheme; a failure to take into account differing cultural responses.

Kamien (1978) carried out studies in a rural town, Bourke, and reported a very high prevalence of disorder in the adult population, of 31.9%. This may reflect improved methods e.g. systematic measures and records, better access, or a higher level of problems in terms perhaps of the impact of acculturative stress.

Kahn (1982) reviewed Aboriginal health from a cross cultural perspective and compared Australian Aboriginal and Native American mental health problems and highlighted the similar patterns of problems, with high rates of psychosocial disorder.

The limitations of these studies are obvious: for the most part they lack standardised measures, defined diagnostic criteria and sampling prerequisites, as well as the invalidity likely to be associated with response rates and content in terms of cultural appropriateness. Nevertheless they allow for some prevalence estimates. Kyaw (1993), drawing all these together as he has done in the review, shows that prevalence rates reported were similar to those of other studies, i.e. 3.8 – 31.9% – mean 13.5%, (compared with say Dohrenwend's findings at the same time (Dohrenwend, 1979)) of 14.1% of the population suffering mental health problems and mental disorders. At that time Dohrenwend also indicated that at least an additional 10% of the adult population would suffer significant psychological distress in the form of demoralisation, likely to impair their quality of life and well-being. It is highly likely that at least a similar level of psychosocial morbidity would have been found in many Aboriginal populations, and perhaps even more in view of the high levels of stress faced by communities in transition and the presence of other risk factors.

In terms of the types of problems identified in these studies Kyaw (1993) in his review reported the following (p35)

"Information from the studies listed provided prevalence estimates of disorder categories which included: Schizophrenia 0.2–4.2%; Paranoia states 0.8–2.3%; Affective psychoses 0.2–1.3%; Depression 0.2–5.6%; Anxiety Disorder 0.1–5.0%; Hysteria 0.5–1.7%; Hypochondrias 0.3–2.6%; Situational reaction 0.2–0.9%; Possession Syndrome 0.3–1.3%; Personality disorders 0.2–16.2%; others 0.1–1.7%.

Reser also carried out a critical review of adult prevalence of other psychiatric studies of Aboriginal people (Reser, 1991). He sets this out in terms of conflicting cultural perspectives and argues the need to appraise research findings such as those listed above in terms of the problems of portraying "conflicting cultural perspectives", as well as the methodological inadequacies noted. He states "the issue of Aboriginal mental health is embedded in a large set of questions relating to culture and cultural differences, historical events, social and cultural change, and coping" (p218). He goes on to point out that contemporary problems such as violence, substance abuse, physical health problems have also increased concern about Aboriginal

mental health. He believed however that many conceptualisations of Aboriginal mental health had been formed in ethnocentric terms.

There is an inadequate understanding of psychopathology and what is psychopathology in other cultures, and in this context the "causes, meanings and consequences of disturbed behaviour" (p221).

Reser emphasised this in terms of his own studies of the anxieties and coping mechanisms that may be generated for Aboriginal people in Western housing settlements away from their own lands.

In this review Reser goes on to discuss both the way in which mental health may be viewed as a "qualitative index of the integrity and strength of an individual's relationship with his or her natural, spiritual or social world" (p222); the forms psychological problems and disorders may take; and the presence of culture bound syndromes, such as "Malgri" (a spirit invasion syndrome). Sociocultural factors are likely to influence or shape the aetiology, appearance, expression, experience, course, outcome and aetiology of mental disorders.

Reser emphasised that it was critical to examine the indigenous perspective on mental health in terms of causality, abnormality, notions of sorcery and notions of healing.

In examining Aboriginal Mental Health, Reser goes on to describe factors of "Emotions, Coping and Well-being", and their relevance.

He suggests that simplistic models cannot explain the relationship of acculturation, to mental distress and mental illness. There is a need, rather, to take into account vulnerabilities of various types through the life cycle; the decrease of social support and social networks traditionally present and likely to mitigate the effects of stress; the loss of identity from shared values and identifications; particular stressful situations; and major socioeconomic disadvantage.

Reser suggests that "Aboriginal coping strategies appear to rely more on the expression and communication of feeling, and a reliance on a collective coping response" (p248). He suggests that one reason for reliance on alcohol may be its facilitation of such coping. He proposes that in "the more psychological and emotional Aboriginal world view, feelings are primary", "social intercourse takes place 'with feeling'" – "communication of how a person is feeling is usually of paramount importance" – not to show proper feeling to others may "threaten a severing of connectedness which is critical to the sense of self and well-being" (p252–253).

Furthermore feelings such as grief, melancholy, happiness, shame, worry, homesickness, anger, may all be seen as not only sources of distress but potential crises of illness. Relatedness influences the construction of self in an Aboriginal way. "Self" in an Aboriginal context is seen to incorporate one's family and extended clan group; with a complex of relational bonds and reciprocal obligations. These factors are relevant then, to Aboriginal Mental Health and well-being, and their loss or fragmentation will lead to mental ill health.

Reser also reviewed earlier studies and shared the previously noted methodological criticisms of them, agreeing that the quality of epidemiological data in these studies was poor. He went on to emphasise the need for "more systematic, comprehensive and valid data". However any such data must also, to be useful, be informed by the social, cultural, physical and psychological contexts in which Aboriginal people exist.

Clayer and Divakaran-Brown (1991) conducted a study of mental health and behavioural problems in an urban Aboriginal population (adult) (n=530). They reported high rates of disorder, not dissimilar from Kamien's study, i.e. 35%, their study of an urban population in Adelaide. This study used the B.S.I. (Brief Symptom Inventory), the 12 item G.H.Q. (General Health Questionnaire) and a lifetime Alcohol and Drug use measure in addition to the structured interview and attempted to cover at least some potential risk factors. They found that 31% of those studied had been separated from their parents by the age of 14. Absence of a father and traditional teachings in the first fourteen years correlated significantly with suicide attempts. On G.H.Q. estimates 35% were distressed to the level equivalent to a psychiatric case, although only less than one in five of the people so delineated had ever sought or received professional help for mental health problems. A high proportion of the respondents, 16% of males and 15% of females, had

made at least one determined suicide attempt in their lives. Thirty five point seven percent of the sample used non-prescribed drugs and 76.4% of the population used alcohol; both these trends were more marked in younger age groups. Factor analysis of responses to the B.S.I. showed several groups of symptoms: somatoform; phobic anxiety; and depression. While mental health problem rates were roughly equivalent to those of the general population, attempted suicide rates were much higher.

A finding of interest was that there were eight questions that emerged as an important factor from the Brief Symptom Inventory. These questions enquired into: feeling lonely even when with people; feeling worthless; feeling no interest in things; feeling that often people will take advantage of you; never feeling close to another person; feeling sad; feeling most people cannot be trusted. These variables have a depressive component, but may reflect the demoralisation noted by Dohrenwend (1977 op. cit.) or Durkheim's concept of "Anomie". They correlated significantly and independently with attempted suicide, drug usage and alcohol usage. It should be noted however, as will be considered subsequently, they may also reflect significant outcomes of trauma and grief, PTSD or unresolved loss.

Radford et al (1991) carried out a study in Adelaide in the late 1980's examining stress and self-destructive behaviours. In a random sample of those in greatest socioeconomic need, and after consultation with the Aboriginal community, a semi structured interview was developed. There were 88 heads of households (82% of whom were female heads living in government rented housing). Over 50% of this group had been assaulted or bashed, two thirds of these on many occasions. Forty-two per cent assessed themselves as having at least one major health problem and 18% currently had alcohol problems. Anxiety was assessed on the Spielberger anxiety scale. High anxiety was associated with an "unhappy" housing situation, low frequency of talking with a close friend, high frequency of anger, feelings of lack of reasonable control over one's life, leaving school at 15–16, experience of violence and having considered suicide. Thirty one percent of respondents reported having serious thoughts of suicide, and 25% had deliberately hurt themselves at one time.

The New South Wales Aboriginal Mental Health Report (Swan and Fagan, 1991) included a Mental Health Survey gathering information on those presenting to medical clinics in Aboriginal Medical Services. In the survey 1501 consecutive adult patients at Redfern and Taree services were assessed for the presence of mental health problems. There were 349 or 23.3% at Redfern (22.2–24.4%) and 19.6% (16.8–22.4%) at Taree. These were amongst the most common clinical problems presenting to doctors working at AMS's. Amongst these drug problems were also frequent. Of all the patients during the survey period 25.1% were diagnosed as having a mental health problem. Nearly 47% were associated with stressful life situations. Crisis counselling and medication were the common treatments as well as referral. In a case control comparison there was a very strong association between a history of childhood disruption, and employment difficulties in adult life, and having a mental health problem. A childhood history of separation from biological parents (Odds Ratio 1.8), neglect (O.R. 3.0) and institutionalisation (O.R. 1.7) were important predictors for mental health problems and with both neglect and institutionalisation the Odds Ratio was 9.4. Employment difficulties added both independent and further risk. This survey was significant in defining potential risk factors as well as prevalence in a health care setting.

McKendrick's work in Victoria has provided valuable further information and for the first time utilised systematic diagnostic criteria measures adapted to the requirements of the setting in an Aboriginal community. Furthermore the research was carried out and continues in a consultative framework and has already provided valuable feedback to the communities involved. McKendrick (McKendrick et al, 1992) conducted a systematic study of psychological distress among urban Aboriginal people at the Victorian Aboriginal Health Services in Melbourne. This group found that among the 112 individuals over 14 years selected at random, the level of psychiatric "caseness", i.e. likelihood of having a psychiatric disorder, on the Present State Examination was 54%. A further 16% of the sample had at least 10 non-specific psychiatric symptoms. There was no sex difference and in this study no relation of caseness to average daily consumption of alcohol which was also assessed. The most common psychiatric disorder, both on the systematic measures, and on clinical assessment, was depression. A high proportion of the respondents (46% of men and 22% of women) consumed more than 100gms of alcohol daily with those in the 30–44 age group being the highest consumers. Forty-five percent stated they currently used marijuana with 22% smoking it on most days. At least one in five took benzodiazepines or non-narcotic analgesia

daily.

In terms of sociodemographic factors 67% were between 15–29 years and only 4% over 60: there were 57% women and 43% men. Socioeconomic statistics showed low employment levels, low income and housing with 77% receiving less than $12,000 per year. Only 4% said they lacked a close confidante. Childhood experiences were assessed. It was found that many respondents had been separated from their families for significant periods before the age of 14 years, with 49% being separated from both parents and 19% from one. Twenty percent had been brought up in children's homes and 10% adopted or fostered by non Aboriginal parents. The presence of psychological distress was assessed over time. It was found that a higher proportion of men, of those aged 30–39 years, of those not in paid employment, of those with a forensic history; and of those whose main caregiver had not been Aboriginal, were significantly psychologically distressed at each time period. A higher proportion of those who were heavy users of alcohol and had ever used marijuana and amphetamines were significantly psychologically distressed throughout the study period. However a significantly lower proportion of respondents who grew up within their Aboriginal families, who learned their Aboriginal identity early in life, and who regularly visited their traditional country, were psychologically distressed throughout the study period (McKendrick, 1993; McKendrick and Thorpe, 1994). In addition to this contribution, McKendrick has provided a valuable review of other studies of Aboriginal mental health in her doctoral thesis (McKendrick, 1993).

Numerous studies have also addressed suicidal behaviours. These have been reviewed elsewhere (see below Policy Rationale with respect to suicide – section 5) and are well covered by Hunter's comprehensive examination of "Aboriginal Health and History" (Hunter, 1993).

Studies of suicide among Aboriginal people have indicated rates of 14.5% for suicide attempts in the population studied by Reser (1991), and 6% for males and 21% for females in Radford et al's study (1991). (These are life time prevalence rates.) Hunter (1991) reported a one year prevalence of 2.1% for suicide attempts. While findings from the Royal Commission for Aboriginal Deaths in Custody highlighted high levels of prison suicides, these related principally to very high incarceration rates. National mortality data is only recently providing some information on deaths from external causes and these have been much higher in Aboriginal populations though the rate appears to be no longer escalating. Hunter's detailed dissection (1993) provides some basis for identifying risk factors (e.g. loss, alcohol, disrupted relationships) but clearly there is a need for much further data.

Substance abuse is a very significant problem for mental health, both in its own right, and in terms of its high comorbidity with mental health problems. Hunter has provided the most comprehensive and in depth account of Alcohol in Aboriginal communities (Hunter, 1993, Chapter 5). He summarises the available data from other studies to the time of his writing. Between 32% and 65% of males in these studies (New South Wales, Northern Territory, Western Australian and Queensland) were drinking at harmful levels (>40gm per day), and between 3% and 51% of females. Hunter's own study of the Kimberley found 76% of adult Aboriginal males were current drinkers and 46% of Aboriginal women. Using the NH&MRC criteria for hazardous drinking, 74% of episodic drinkers, 84% of intermittent drinkers, and 94% of constant drinkers were consuming to harmful levels. Consequences of substance abuse include organic syndromes acute and chronic, alcoholic hallucinations, delirium, dementia as well as devastatingly high comorbidity with anxiety and depression, and possibly other disorders. As clearly indicated from the studies described above, and from the communities' views indicated in this report, substance abuse is intricately linked to mental health.

Mental health risk factors and interventions

There is ample evidence presented above of the high level of disadvantage faced by Aboriginal people and communities. Research into risk factors for mental disorders has repeatedly identified generic indices such as poverty, social disadvantage, violence, family discord, abuse, substance abuse, life stress, separation in childhood and so forth. The above review has highlighted the greater prevalence of all these negative factors for Aboriginal people. Data supporting risk factor identification is available in a number of preventive reviews (OSAP, 1989; Raphael, NH&MRC, 1992; Mrazek and Haggerty, 1994). There is ample evidence that at least some of these may form targets for effective prevention approaches, and

indeed some have been specifically identified with indigenous minority groups.

The particular additional impact of colonisation and historical factors needs to be taken into account, as well as extensive adverse physical health outcomes. All of these may also need to be the target of prevention initiatives.

With respect to effective interventions or treatments for mental health problems and disorders, no reports of program evaluations for Aboriginal mental health could be found. Until such studies have been carried out, the principal need must be for programs which have a sound scientific basis, with modifications so that these can be implemented in culturally appropriate ways.

There is very clearly a need for systematic data on the extent and nature of mental health problems and mental disorders in Aboriginal people, and effective prevention and treatment interventions. Research and evaluation are essential.

Mental health problems of Aboriginal children, young people and families

The demographic profile of Aboriginal people highlights some essential differences from the general population. For instance over 40% of the Aboriginal population is below the age of 15 and almost 15% below 5 years. The comparable figures for the total population are 22% aged less than 15 and 7% less than 5 years. There are comparatively fewer old people with only 6% of Aboriginal people over the age of 55 compared to 20% for non-Indigenous people. The population mobility is similar with above 45% with a different address on census night. Multifamily households are more common with almost 12% of Aboriginal families living in such settings compared with only 1.5% of the non-Aboriginal population. Average household size is almost double (4.6 persons compared with 2.6). There are more than double the number of single parent families (27% compared to 12.6%) and more families with dependents (73% compared to 53%). These issues are highlighted in a valuable report from SNAICC (1994).

This report also documents some of the social and economic disadvantage experienced by Aboriginal families, but highlights as well the disempowerment that comes from identifying Aboriginal problems just in the context of "Disadvantaged" families, rather than recognising the effects of Indigenous status, historical effects of colonisation and institutional racism (SNAICC, 1994). Income levels are low with almost two thirds of the population aged 15 and over reporting income levels below $12,000 compared to 45% of the non-indigenous population. Only 2.2% of the Indigenous, compared to 11% of the non-Indigenous earn greater than $35,000. Unemployment levels range from 30% perhaps as high as 70% if CDEP programs were not in place (CDEP – Community Development Employment Program).

There is also a very high proportion of long term unemployed and it is stated that 60% of all those registered as unemployed and waiting placement are Aboriginal. Thus Aboriginal families, because of high proportion of young people and low levels of employment, have high dependency ratios which make them very vulnerable in terms of policy changes and disempowered in terms of their relationship with Government. This is further added to by the fact that single parent families are in high proportion. All these factors contribute to the vulnerability of children, young people and families to the effects of these factors on mental health, an influence well established in other settings. (Raphael, NH&MRC, 1992)

Children, young people and families

There is little systematic information about the mental health problems and mental disorders affecting Aboriginal children and young people. However it is recognised that there are significant problems facing children and young people in the general Australian population with at least 10 to 18% of young people having a diagnosable psychiatric disorder (Connell et al., 1982, Sawyer et al., 1990). There is also much to suggest that such problems are increasing in young people (Brandenburg et al., 1990). What is known in the general population is likely to also be relevant for Aboriginal populations, although clearly differing family structures and culture are likely to influence the nature and form of problems presenting.

Delinquent and antisocial problems and conduct disorders are disruptive and prevalent, and while there are no national studies, available evidence from New Zealand data (Anderson et al., 1987) indicates that rates of 3.4% for conduct disorder are likely. Conduct disorder not only leads to problems in childhood, such as disruptions of learning and social development, but is also associated with an increased vulnerability to disorders in adult life, with considerable continuity with antisocial personality disorder in adolescence and adulthood. The high rates of incarceration of young Aboriginal people (25 times the rate of non-Aboriginal young people (Dodson, 1994)) may be only in part a response to such behaviours, but may also represent the legal system and enforcement agency responses to stereotyped views of the meaning of such behaviours. The degree to which young men seek an identity on such "antisocial" acts (in terms of rebellion against white stereotypes and rules) is also important (Hunter, 1993). The critical issue is the need for understanding of the sources of such behaviours, their level and significance in Aboriginal contexts and identification of social and psychiatric contributions that require attention. A further matter that is of relevance is the relation of such antecedents (for example behavioural problems in childhood) to substance abuse in adolescent and adult life.

This needs to be put in context when examining problems such as petrol sniffing, alcohol and elicit drug use among Aboriginal young people.

Kosky (1992) describes the way in which Aboriginal young people do badly in the juvenile justice system. For instance in Adelaide, they make up about 2% of the adolescent population, yet in the 5 years 1979–84, they formed 7.8% of those apprehended, 13.9% of Children's Court appearances, and 28.1% of detention orders, and in 1989, 15% of inmates (Kosky, 1992). In New South Wales where Aboriginal young people aged 5–19 make up 1.8%, they constitute just under a quarter of those detained. In Queensland, they are 3.8% of the 5–19 age group and a third of those detained; and in Western Australian, 4.1% of 5–19 years old and 75% of juveniles in detention (Hunter, 1992). Hunter goes on to point out that these outcomes may be the result of class but there is also race bias, as evidenced by the reports of physical maltreatment in custody (85% of Aboriginal juveniles reported physical mistreatment in custody or detention in one study (Cunneen, 1990). This whole area is one of enormous importance from a preventive and service point of view in terms of mental health. Firstly there is the impact of these separations. Then the suggestion that such detention replaces other ritual as a rite of passage to manhood. And finally there is the beginning of a "criminal" identity which may seem the only available option and develop a status of its own. Then these young people, usually young men, become absent fathers, with implications for their own children, especially sons.

Depression is a significant problem in adolescence for young women in the broader society with rates increasing during the adolescent years to 20%–25% compared with about 10% in young men (Pattern et al, 1994). How this affects young Aboriginal women is unknown although the high rates of self-harming behaviour (Radford et al, 1990) and low feelings of self-worth suggest it is also a problem for them, mixed complexity as it is in the non-Aboriginal population with social constructions such as those related to the roles and value of young women. It seems likely that young women may deal with bad feelings by self-harm, or may become pregnant at a young age, gaining status and esteem, but perhaps also difficulties because of early child bearing and problems for the infant. There must also be concern about the impact of depression on learning, development, and the capacity for achievement as well as potential relationships to substance abuse at least for males (Hunter, 1993) and eating disorders and substance abuse for girls (Pattern et al, 1994.)

The prevalence of other disorders in childhood is unknown in the Aboriginal population and the levels of problems such as Attention Deficit Disorder, those associated with Developmental delays etc. not in any way established. This also applies to anxiety, obsessive compulsive disorders and problems such as autism.

Risk factors for disorders in childhood and adolescence are prevalent in the general community and also in Aboriginal communities. There include parental discord and violence, parental alcoholism, child abuse including childhood sexual abuse, as well as failed parenting, family breakdown, parental separation and losses (Raphael, NH&MRC, 1992). Vulnerabilities associated with poor obstetric outcomes and their effects on infants, severe acute and/or chronic illness in childhood, are all more frequent in Aboriginal

communities (AIHW Report on Aboriginal Health Differentials, 1994). Thus it is extremely likely that at least the levels of problems found in the general population of Australian children and young people are likely to be present in Aboriginal children.

Significant disruptions of learning and learning problems, if not disorders, are likely to be prevalent, particularly in association with reported levels of learning impairment through high rates of middle ear infection, and eye disease may also contribute.

Childhood abuse presents a major problem in the general Australian community. Although levels of abuse are not established in National surveys a number of studies suggest that sexual abuse is reported to occur for up to 10% of boys by age 16 and 28% of girls, figures substantiated by findings in other communities such as New Zealand and the United States of America (Raphael, 1994). The Australian Institute of Health and Welfare's report Child Abuse in Australia 1990–1991 (Angus and Wilkinson, 1993) reported 4,032 cases of abuse and neglect of Aboriginal children of which 2,089 were substantiated (these levels are not likely to include all cases because of differing reporting and other requirements in States). Of the Aboriginal children notified this included 42% for neglect, 14% for sexual abuse, 20% for emotional abuse and 24% for physical abuse. This highlighted the higher levels of neglect as a cause compared to the non-Aboriginal population (approximately 25%) and may reflect the effects of impoverished conditions. For the year 1991–92 the AIHW found there were 3,418 substantiated cased of Child Abuse and Neglect in Aboriginal and Torres Strait Islander communities for that year. The proportion of Child Abuse and Neglect was higher at 8% than the representation of Aboriginal people in the general community (less than 2%). There was also a higher "At Risk" population, 60% compared to 49% in the general population, and neglect here too was high, 40% compared to 24% of all children. These facts indicate the high burden of problems and care for Aboriginal and Islander Child Care Agencies (AICCA's). It is considered that the effects of poverty, drug and alcohol abuse, family violence, high stress levels and low self esteem, particularly as a consequence of lack of access, opportunities and control as well as historical experience, contribute to these problems.

The Secretariat of National Aboriginal and Islander Child Care (SNAICC) has recently provided a discussion paper for: A proposed Plan of Action for the Prevention of Child Abuse and Neglect in Aboriginal Communities. This discussion paper makes a very strong case for prevention as the priority, pointing out that it is currently impossible to meet needs for care with demands increasing. Thus there must be action to stop abuse occurring. It is believed that successful prevention strategies must be grounded in principles associated with: the impact of colonisation and historical context; the right to self-determination; recognition of Aboriginal child rearing practices; taking a holistic approach to Child Abuse and Neglect; holistic measures for Prevention of Child Abuse and Neglect. There is a need for healing processes and prevention addressing the effects of removals, separation and abuse as they have affected Aboriginal families as a result of colonisation. There is a need to value and have recognised the positive contributions of Aboriginal Child Rearing practices, the kinship and elder roles, as these may contribute to prevention of Child Abuse and Neglect. The discussion paper highlighting these issues is proposed to be used as a basis for State-wide and Territory workshops, which would in turn lead to a final report with recommendations and strategies for the prevention of Child Abuse and Neglect in Aboriginal Communities. It is also suggested that such Strategies should include ways of improving mainstream services and their consultation with Aboriginal communities and use of Aboriginal non-Government services (e.g. Aboriginal Child Care Agencies and Aboriginal Medical Services). The Report of the Royal Commission into Aboriginal Deaths in Custody, and the National Aboriginal Health Strategies should also be linked to the Plan of Action. This proposal was linked to the National Child Protection Council Initiatives and, like these, emphasised a number of components: community awareness, including establishing state-wide Child Abuse and Neglect prevention networks; development of information packages and a media campaign; skills and knowledge development and provision of information and advice through education of children and parents; policy development; community based initiatives and services such as early intervention, support and locally based prevention.

A Working Party Report on Child Protection and Aboriginal Communities in New South Wales highlights further issues and the need for: intervention to provide immediate protection of children; immediate action against known paedophilia, prostitution and pornographic activities; action against perpetrators within

Aboriginal communities; support for Aboriginal women to assist them to protect their children; counselling services and protective behaviour programs for children; foster placements with Aboriginal families which are safe, well-resourced and where the foster parents are well-supported by the placement agency/department; Aboriginal group homes staffed with appropriately trained Aboriginal people; comprehensive awareness strategies around STD's including HIV/AIDS; prompt notification of all cases and coordination.

Useful initiatives addressing these issues are also being developed in other States (e.g. Western Australian pamphlet on "Take Care of our Kids. Listen to Them. Sexual Abuse Happens. Stop it Now.")

The National Prevention Strategy on Child Abuse reviewed initiatives at a State level (July, 1994) and noted initiatives such as Local networks and state-wide prevention networks (Tasmania, Western Australia, Queensland, Victoria, New South Wales, Australian Capital Territory, Northern Territory). Parent education protective behaviour program, early intervention programs, public awareness and education, home visitor programs, support program telephone services, policy and legislation initiatives, have all been identified, but a coordinated national strategy does not yet appear to be in place and implemented. Initiatives in relation to Aboriginal communities (and workers to address these) are described only in some instances (e.g. Northern Territory) though seen as part of most state responses. The effects of media intervention have been positive in increasing awareness of these issues, but need much further development and specificity, as well as linking to other comprehensive multifaceted approaches (Donovan, 1994).

Issues of relevance in Aboriginal childhood have been described by Hunter (1994). He suggests that there was a consensus that early childhood has few controls so that children were little prepared to be subjected to the authority of others as they grew up. Girls were gradually introduced to adult roles by maternal figures, participation in women's activities and seen as mature with the onset of menstruation. Boys moved to the world of men from the world of women and thus to a new set of relationships, previously by specific initiation rites. These traditional matters have been significantly impacted on by social change. The focus of these changes and the intergenerational tensions is usually adolescence.

Amongst the studies that provided some information on the problems of Adolescent children and adults, the early work of Kidson, who reported psychiatric disorder in 2.6% of population aged 15 years and younger in a remote community in central Australia, and identified sociocultural change and marginal situations as contributing. Gault, in the late 60's, surveyed Aboriginal adolescents in Victoria and the Kimberley town of Derby and found high levels of disturbance of delinquency and antisocial behaviour as well as social maladjustment (both reviewed by Hunter, 1994). Nurcombe's research in the late 1960's and early 1970's with John Cawte emphasised the adverse social experiences of Aboriginals in the processes of change and effects of poor housing, unemployment, loss of roles, cultural loss and trauma as contributing to the problems of Aboriginal young people, including petrol sniffing. They questioned the appropriateness of European models of assessment (e.g. of language and cognitive skill development) and diagnostic categorisation and for instance social processes that supported internalisation rather than freedom, from early childhood. They found of 280 children surveyed on Mornington Island at that time, 10% were believed to have some form of psychogenic disorder and that these disorders arose following the social and economic and ecological impact of external acculturative pressures.

Kamien (1978), in his study in Bourke, found substantial behavioural problems in just over one quarter of Aboriginal males and one third of Aboriginal females between 5 and 14 years (n = 250). Anxiety symptoms and enuresis were more common among girls. These girls were also sexually active at an early age. This may well have been associated with abuse, although this was not identified at that time. Childhood separations were frequent having occurred for a third of the adults studied within community survey.

Webber (1980) examined mental health problems amongst Aboriginal children in north Australia by establishing a register of child mental health cases from tribal communities in the north of the Northern Territory. It was found that there were a preponderance of serious learning difficulties in the children presenting, with a preponderance of male cases. Behaviour problems were also frequent at 19.4%, with learning difficulties 26.3% and mental retardation 17.1%. Brain syndrome constitutes 16%.

In his review, Hunter goes on to emphasis the ongoing separations experienced by Aboriginal children, with them seven times more likely to be placed in foster care, as well as the excess detention in juvenile justice institutions.

Maternal and paternal roles have been compromised in Aboriginal families. These factors, disadvantage, and separations, impact adversely, as do educational and developmental disadvantage, creating high risk burdens in terms of mental health, and little opportunity for those factors likely to promote resilience and resistance. Hunter concludes that Aboriginal young people "experience at least the same rates of most mental health disorders as children elsewhere, but have less access to professional services. They are far more likely to manifest a range of behaviours that reflect social realities of Aboriginal disadvantage." (p24) Many articulate their anger and construct their identity through behaviour, including violence, that signifies resistance to perceived oppression." (p22) Others, with opportunity have found more positive outcomes, but he concluded "resistance without opportunity will both further disadvantage Aboriginals and lead to escalating conflict" within the modern society (p22).

Young people and problems

Hunter (1992) has reviewed the problems of Aboriginal adolescents, particularly those in remote communities. He emphasises the impact of social factors, including the pressures of social change, social dislocation and intercultural pressures. He notes that they may experience more economic disadvantage than urban Aboriginal populations, and may live in "settlements" established by processes of forced centralisation "which meet neither their cultural nor economic needs." (p79).

Such remote communities may be further disadvantaged by high costs of basic items, and by lack of services and facilities for health, work and leisure activities.

Young people may be impacted by the forced removal of children from their parents, leaving an ongoing legacy. As well Hunter suggests, as do others, that in some ways the removal continues with the high numbers of Aboriginal youth in detention centres. It is thought that earlier separations resulted in more girls being taken away (impacting on parenting) and more recently on boys (delinquency). The imprisonment of many adult Aboriginal men even if transiently, has meant that male role models have been compromised (through father absence or incapacity e.g. through alcohol). Hunter believes that this, coincident with welfare (money) support for mother and children, has lead to an increasingly matriarchal family structure. All these factors may have damaging consequences for the identity development of Aboriginal young people.

In these remote communities, there are even more likely to be developmental impacts of physical illness. For instance, children in the Kimberley are more likely to be born underweight and remain underweight throughout childhood, to be undernourished, and to have a range of other health problems such as hearing problems (Hunter, 1992, p87). All these not only affect development, but also education through absenteeism and other factors.

Alcohol problems affecting young Aboriginal people have been described in urban, rural and remote communities, with peer pressure a factor in early and hazardous use. While many Aboriginal people do not drink, studies quoted by Hunter (1992, 1993) indicated that rates are high, especially for young people in terms of current drinking (60% of females and 87% of males aged 15 to 20 years in the Kimberley). These young people also consumed, as an average well above the hazardous levels, averaging 88 gms per drinking day for females and 169gms for males (Hunter et al, 1991, p28). Kava has been used in some Northern Territory communities and has also been associated with problems (Mathews et al, 1988, p67).

Petrol sniffing has also been a problem in a number of regions (Brady, 1991, p71). In a national survey of 837 communities, 56 (6.7%) were reported to have petrol sniffing which may be associated with lead intoxication and death. It is of interest that communities with a history of Aboriginal involvement in the pastoral industry were protected, perhaps because of the capacity for work in a productive economic enterprise. (Brady, 1991)

Other issues reviewed by Hunter as affecting Aboriginal young people include violence, childhood physical and sexual abuse, self-harm behaviours and stresses of parenthood. Young age of parenthood for

both males and females is a specific factor with the fertility rate for Aboriginal females aged 15–19 years in Western Australia in 1987 being 8.5 times greater than for the same age group generally. On the other hand high STD rates bring significant problems including infertility for some. These issues will be discussed further with the consideration of women's mental health, although it should be noted that pregnancy may have positive and protective outcomes for young women at least initially.

However as Hunter states, there is totally inadequate information about urban Aboriginal youth and a need to urgently address their problems. These are likely to be similar to those in rural remote centres, although access to mental health and health services may be greater, if these are used, which they frequently are not.

There is, according to Hunter's review, an urgent need to address the issues of above, including psychological and social problems, drug and alcohol use, physical health, and the dangerous morbidity and mortality from behaviour that is related to substance abuse, related to depression, anger and frustration. There is an urgent need for programs for Aboriginal children and youth. In particular there is also a need for programs to avoid the criminalisation of Aboriginal youth. Finally there needs to be an addressing of the social, transgenerational and economic factors that impact on the health and well-being and mental health of Aboriginal Young People.

The health of young Aborigines

A thorough review of the health of young Aboriginal people aged 12–25 was edited by Brady (1992). This report provides information on the distribution of Aboriginal young people and relevant sociodemographic variables.

There were 30,277 Aboriginal young people aged 10–14; 29,106 aged 15–19; and 24,044 aged 20–24, across Australia according to the 1986 Census. Of these 22,564 were in Queensland; 22,035 in New South Wales; 13,676 in Western Australia; 12,409 in the Northern Territory; 5,191 in South Australia; 4,608 in Victoria; 2,499 in Tasmania; and 455 in the Australian Capital Territory. In the Northern Territory the Aboriginal population is chiefly rural (69%) and in Western Australia and Queensland about 35%. The major urban components are Victoria (48%) and New South Wales (36%).

Only 21% of young Aboriginal people aged 15–19 are employed and only 37% of those 20 to 34 according to the 1986 census. According to this review less than 2000 Aboriginal and Torres Strait Islanders are engaged in some form of post-secondary education. Aboriginal people generally are in low status jobs, regardless of how long they stayed at school and as noted elsewhere, severely disadvantaged on average earnings.

Significant physical health problems affect Aboriginal young people as well as Aboriginal people as a whole and the prodroma of disorders such as diabetes may be present at this time. However they are generally the healthiest age group of the Aboriginal population.

However it is reported that mortality in this age group is usually related to external causes of injury and poisoning with some deaths also due to "mental disorders" associated with alcohol and drug use. Suicide accounts for increased deaths in the 15–19 age group of both Aboriginal and non Aboriginal males, with hanging the commonest method.

Social factors contribute significantly to the ill-health of Aboriginal young people. Brady examines in this context sexually transmitted diseases which are prevalent among Aboriginal young people. Although some have declined, especially with the condom campaigns related to AIDS risk, rates are still high –for instance of chlamydia, herpes. HIV infection has been found in some communities and there have been some deaths. With the high rates of ulcerative STD's this is an area of major risk. Pelvic inflammatory disease is a cause of infertility and appears to be rising in the general population.

There is a high incidence of youthful pregnancy among Aboriginal women, and as with all pregnancies under 16 years, these are likely to be higher risk. These young mothers are also less likely to have adequate antenatal care, one of the risk factors for perinatal morbidity. Lack of antenatal care may be aggravated by many cultural and social aspects of Aboriginal life, and particularly the need for this process to be women's business. As Brady notes the higher level of youthful pregnancies may relate to the fact that having a baby provides young women with interest, someone to care for, social network, and a new social

position within their community. However they may need the support of mothers, aunts, grandmothers and others to care for their babies. And there is much evidence to suggest that education (of these young women) will be one of the strongest influences on the health status of these mothers and their infants.

Hearing problems resulting from childhood ear disease may result in cultural and educational defects. Blindness, for instance from trachoma, may have similar effects.

Psychosocial health issues were substantial among young people, according to Brady's review. There is a comprehensive account of the nature of alcohol and drug use in terms of available data; but most is descriptive and there is little quantitative data for this age group across different communities. Alcohol use in a Northern Territory Survey was reported in 36.6% of 15–20 year olds and 48% of 21–30 Aboriginal people in one survey, with males predominant. The only urban survey suggested levels of 56% (by asking levels of other drinkers) These young drinkers are vulnerable in terms of accidents, deaths (e.g. deaths in custody) and so forth. Tobacco use is also frequent, as was marijuana. Petrol sniffing was a group experience strongly influenced by peer culture.

The desire to be part of the peer group was probably the main factor in this drug use; in addition there are heavy drinking role models of parents and other adults. In addition extra social problems arise for parents and community because of their inability to control this disturbed behaviour of those drinking heavily in the younger petrol sniffers. Drinking and petrol sniffing are also used to facilitate social interaction and action.

Stress is a significant factor of the lives of Aboriginal young people. Bereavement, including the deaths of parents prematurely, is a feature of the high Aboriginal mortality rates. Furthermore there are high levels of self-harming intent and behaviour. These feelings are often connected to loss of hope. Hunter's work suggests that the high levels of anxiety and depression in the young men he studied resulted because they had born the brunt of rapid social change in Aboriginal communities. In urban communities young Aboriginal people may experience stressful and frequent contact with the police.

Interpersonal violence, accidents and poisoning, which are among the leading causes of death of young Aboriginal people, arise from many sources including stress, alcohol and norms of violence as in male to male fighting. Domestic violence and child abuse, as well as sexual assault, are further stressors and sources of mental ill health. These behavioural outcomes reflect the impact of historical factors, colonisation and disadvantage, but require further research to clarify the complex sources of violence and effective interventions.

Social factors may also affect the health and well-being of young Aboriginal people in other ways – for instance lesser access to and opportunity with respect to housing, education, diet and health services. The access to resources for sport and recreation should also be considered in this context, as well as places of living and their consequences, urban, rural and remote.

Brady concludes this valuable and wide-ranging review by comparisons with the Kaui long term study of high risk children (related to the ill-health and social stresses being experienced) and the resilience of some young people that emerged. She makes a series of recommendations linked to improving health services and programs for these young people including holistic health care, community controlled health services for young people, programs to prevent substance abuse, intersectoral collaboration, programs for young mothers and the children of young mothers, special support for those lacking social bonds, enhanced access to meaningful activity and work for young people. Of special significance are recommendations for the involvement of young people in determining priorities and programs, conferences, drop-in centres, health promotion and prevention and community awareness and in representation on all relevant formal and informal bodies.

Aboriginal families

Children and young people frequently present difficulties which reflect the impact of parental or family problems. For instance the physical development of infants and children may be severely affected by poor nutrition, a result of low family income, or diversion of family resources into gambling or substance abuse (SNAICC Report, 1994; Hunter, 1993). Physical illnesses such as repeated infections associated with

adverse physical environments and understanding of and access to services for families may interfere further with development and education.

Family violence has profound and adverse effects on the mental health and well-being of children, as indicated above, both through the environments of violence that becomes a norm for behaviour, and the personal effects of abuse and assault.

The strong association of family violence and mental health has been identified in the New South Wales Aboriginal Mental Health Report, and in repeated reports to the National Aboriginal Mental Health Conference (1993).

The New South Wales Family Health Strategy (1994) also reinforces the importance of addressing family violence and sexual assault in Aboriginal communities and the coalescence of mental health and family health. The overall objective of this Strategy is to "reduce family violence and sexual assault in Aboriginal communities" (p5). There is emphasis on the importance of breaking patterns of denial and acknowledging the incidence and unacceptability of family violence. It is seen that solutions to family violence and sexual assault within Aboriginal communities are Family Health solutions, with education and follow-up a priority. Furthermore it is seen as critical that men participate by acknowledgement and taking responsibility for their violence and taking an active part in solutions. For instance Aboriginal communities are demanding that "men accept traditional responsibilities and participate in men's business, taking responsibility for the reworking of spiritually strong masculine roles". (p6)

The strategic aims of this Family Health Strategy encompass both lessening denial and increased criminal reporting on action, as well as to

> *"increase personal and community self-esteem through a community controlled infrastructure of education and service provision related to Family Health." (p10)*

> *"increase knowledge, skills and experience in dealing with Aboriginal Family Health issues by Aboriginal communities and health and other service professionals." (p10)*

> *"extend the provision of existing Health services to Aboriginal people to include Family Health services which are:*
> *• directed at well-being*
> *• place as much emphasis on preventative and follow-up programs as on crisis care and criminal prosecution*
> *• maintain family structures within a strong culture*
> *• link with other health issues such as substance abuse and mental health." (p10)*

Strategies suggested include: locating Aboriginal Health Service provision within existing services and support current work in communities; establish a network of safe houses in Aboriginal communities for the immediate protection of all Aboriginal people seeking care and safety; initiate the development of a range of community controlled Aboriginal Family Health Projects including preventive programs, crisis care and flexible formats for diverse needs; encourage integrating family health projects; and establish coordinator mechanisms to support Family Health Infrastructure and other proposals including for instance establishing a category of Aboriginal Family Health Workers; and the need for family health education.

Critically here, as in other areas there is a need for baseline data relating to family violence and sexual assault in Aboriginal communities (p18) highlighting the need for resources to address these issues. There is also a need for data on family problems, their prevalence and potential solutions.

The responses to this consultative document highlight the multiplicity of approaches, but also the critical need to consider intersectoral issues in all problems to do with family, children and young people, in Aboriginal as in non-Aboriginal communities. Responses come from Education, Youth Affairs, Legal services, Women's Policy areas, regional health services, sexual assault services. Thus it is central to any

development of services for Aboriginal children, young people and families that intersectoral resources and involvement are mobilised.

The decline and rise of Aboriginal families has been described by Gray, Trompf and Houston (1991). After describing the impact of "dislocation, desecration, and destruction" through colonisation, the taking away of the children, disease, policy and environmental factors such as housing, these authors provide a hopeful conclusion on the renewal of the family with communities "strong and getting stronger" (p118).

O'Shane (1993) also highlighted the problems facing Aboriginal families in the plenary address to the Australian Family Therapy Conference which was titled "Assimilation or Acculturation: Problems of Aboriginal Families". She details the enormous problems facing families and concludes "There needs to be a proper recognition of the fact that many Aboriginal families are in crisis as a direct consequence of colonisation; that those circumstances give rise to very particular needs; and that those needs can only be addressed by carefully, and deliberately, designed programs of empowerment and therapy" (p198, 1993).

Further emphasis on families is highlighted by Dodson (1994) in his discussion of the rights of Indigenous people in the International Year of the Family. He states that in indigenous societies, "the extended family traditionally managed virtually all areas of social, economic and cultural life" (p34), but that the authority of the family has gradually given way to that of the State. The family in contemporary Australia has roles for procreation, cohabitation, private and intimate relationships, but "the transmission of culture has historically been, and largely remains the responsibility of the family." (p35) This results from the role of parents in passing on to their children, beliefs, knowledge, language, customs, attitudes and so forth. He emphasises that in terms of Human Rights everyone has such rights and that Aboriginal and Torres Strait Islander families should not be prevented from transmitting their culture, and should be supported to do so. The adverse effects of colonisation on indigenous families occurred at every level: uprooting from traditional lands; eliminating traditional means of survival; separating people within kinship groups; removal of children; starvation; massacre; rape; disease. These factors prevented families surviving and reproducing, and intervention of institutional systems of law, welfare, education, interference with kinship obligations and the education of children by parents and law, and the transmission of culture, language, law and so forth. Conflict and other consequences including the disproportionate level of intervention in Aboriginal families strongly supports the need for special protection of Aboriginal children and their families. There has been a call for "culturally relevant" National legislation relating to Aboriginal and Islander child development for more than a decade, without this resulting. Self-determination is seen here too as a critical issue, with a sound "social, economic, cultural, and political base which will ultimately support our families and our ability to care for ourselves and each other from the inside" (p39, Dodson, 1994). Thus our aim should be for Indigenous families to enjoy the "security, health and cultural integrity" which is their right.

The health status of Torres Strait Islanders
Draft Report (Flower, 1995).

It was difficult to research this topic as there are no statistics readily available to use as a reference except those from the Health Workshop held on Thursday Island last year. Those of us fortunate enough to be in attendance were stunned by the realisation that the health status of Torres Strait Islanders is far below that of Aborigines.

We were informed among other things that:
- women die at an earlier age than men
- many young women die after giving birth
- many babies die at birth or are born dead
- so many of our people have diabetes and peripheral vascular disease leading to amputation
- many people have high blood pressure and heart trouble.
- alcohol abuse leads to cultural breakdown, domestic violence, sexual abuse, trauma, brain damage
- drugs of addiction are being introduced to population

Strategies were formulated and are in the process of being implemented in order to introduce new services and bring about a qualitative change in the existing health services.

While this information was revealed about those residing in Torres Strait, very little information is released about those of us living on the mainland.

Statistics

Academic papers written on the health of indigenous people usually bear the title Aboriginal and Torres Strait but a close examination reveals that the statistics refer to Aborigines. Torres Strait Islanders may or may not be included.

Mental health

Contained in the report from the Workshop are a few lines indicating the existence of mental ill-health and the need for research and subsequent action.

It is not known to what degree people suffer from:
- genetic disorders
- schizophrenia
- organic brain syndrome
- stress
- neuroses
- psychoses
- dementia
- brain damage due to: substance abuse; nutritional disorders; trauma; occupational hazards (nitrogen narcosis due to diving)

It is also not known if people suffering from mental ill-health are cared for by family, institutionalised or incarcerated. It is only now that the health status of Torres Strait Islanders is being observed and it is essential that mental health be included and not treated as a separate issue.

Social

Torres Strait Islanders have for generations lived in the area between Cape York and Papua New Guinea, known as Torres Strait.

Surveys have been performed on Torres Strait to assess the possibility of setting up economically viable projects. The outcomes have indicated that the only resource available to the people is the ocean. Limited economic flow into the area has meant that unemployment amongst the Islanders is high. (It is said that Torres Strait Island workers would send a hotel "broke" as they would be obliged to give free drinks to their relatives.)

Since the implementation of the workshop there has been an influx of non-Torres Strait Island workers in all capacities: nurses, carpenters, plumbers and other occupations. Commercial enterprises are in the process of being set up by non-TSI people.

It would appear that once again service providers are non-TSI and TSI people are once again on the unemployed list.

Grief and bereavement

Due to the lack of specialist services in the far north of Queensland, specifically TSI, clients requiring services of a specialist nature are sent to Cairns, Townsville or Brisbane away from their immediate families and friends, some never to return, or to return with a new baby.

Some Islanders have family members in the southern cities who do their best to care for those in need.

Many have diabetes mellitus accompanied by peripheral vascular disease leading to amputation, so imagine

the bereavement when a limb is amputated and the spouse/brother/sister etc. comes home minus a leg, sometimes two, and in a wheelchair.

There is an acceptance of diabetes as being inevitable.

Funerals are a costly business as they are so many in number. It is also the custom to take people back to their home islands to be buried. In days gone by, the body of the deceased used to be with the family for a week prior to burial. Family and friends would visit regularly and sit up all night singing hymns and talking about the deceased for the week. They would bring food to be served by the daughters of the house who would be busy making guests welcome.

This practice has ceased to exist due to health regulations, and the people have had to adapt their culture to the regime of Health Departments.

In Torres Strait due to the lack of a holding area bodies were wrapped in plastic bags and piled one on top of the other until the burial (usually the day after death), and has caused much distress to the families. This is in the process of being changed.

The size of the funeral is an indication of family (clan) wealth and status. The richer and more important the family the bigger the funeral.

Twelve months following the funeral people come together again for the "Tombstone Opening" (dedication). A tombstone is erected on the grave and on this occasion is decorated (it is said that this is the deceased person's new home). Prayers are said and hymns sung and we remember the deceased person who stays with us for this time.

The family (clan) provides the biggest and best feast with all members of that clan present as well as those closely associated. Dance teams are made up of the clan members as well and guests may join in after the family has performed its duties.

Many families are in the position of not being able to afford the spectacular ceremonies expected of them and this loss of status in the eyes of people causes embarrassment and stress at "having lost face in public".

Children

Traditional adoption

Families were and still are given babies to rear as their own. This used to be restricted to babies who were born into the particular family (clan) but in recent times has involved those born outside the family.

Children have always been told who their biological parents are and recognise their adoptive parents as their own. They are entitled to inherit from their adoptive parents only.

Recently the Queensland Department of Community Services has ruled that this is now to be called adoption, departmental rules apply, and all "transactions" are to be registered and legalised.

Some births were not registered with the relevant government department but with the catholic church on Thursday Island, so people have had to research records to find proof of their identity.

Sexual abuse

This is a topic which is known to exist but which is seldom referred to. Culturally this behaviour is not acceptable, not even to be talked about, but is being faced squarely now. At a recent National TSI Workshop, this topic was highlighted and strategies discussed to inform and prevent.

Torres Strait people have to come to terms with a form of sex being "abusive" and it was realised that abuse of all ages and sexes takes place. The workshop decided that prevention was the people's responsibility.

Substance abuse

For such a small population there are numerous hotels which do a thriving business on Thursday Island (e.g. a slab of beer costs $45.00 at one hotel as opposed to approximately $22.00 on the mainland).

Hotels are a place where all comers are equalised and the non-TSI service providers sometimes mix with the locals. Hotels offer entertainment and are a place where people go to meet their friends and have a good night out. Unfortunately the good night out may finish at sunrise or may go on for days at a time:

- ending possibly in a jail term
- injury
- rape
- taking drugs
- committal of crime
- possibility of being a victim in hospital
- no money.

Alcohol abuse leads to cultural breakdown and isolation, and subsequent family poverty. While no one starves in Torres Strait the nutritional status of alcohol abusers and the many families who are the victims of alcohol abuse is questionable.

It is a sad state of affairs when an uncle buys his favourite young teenage nephew or niece a slab of beer instead of giving a traditional gift as would have happened in the past. In other words in many instances alcohol has become a ready substitute for culture; a sub-culture. We see this also on the mainland.

Torres Strait in is in close proximity to Papua New Guinea and the islands of Asia. It is known as the gateway to Australia not only for shipping, but also as a drug route. The use of drugs is becoming more common amongst the young and this is in keeping with the increase in crime in The area. This also applies to the mainland.

Life on the mainland

Torres Strait Islanders living on the mainland have made it known that they make no claim to land title on the mainland, but support the struggle by Aborigines to obtain ownership of their lands.

Since the beginning of this century there has been a steady migration of families to the mainland in search of work, housing and education for their children.

In many areas Torres Strait Islanders have adapted to life on the mainland, while in others conflict has arisen. This conflict is caused by:

- efforts to preserve culture in an environment dominated by Anglo-Saxon norms.
- the changing nature of communication between youth and aged.
- the adoption of the foreign culture.
- being classified as Aboriginal (meaning the culture).
- lack of recognition of Torres Strait Islanders as belonging to a distinctive culture separate to Aboriginal.
- lack of representation in policy making areas.
- lack of awareness that there is no TSI representation.
- discrimination in employment.
- ignorance on the part of service providers.
- difficulty in obtaining proof of identity in southern States.
- hostility from Aborigines and others when Torres Strait Islanders attempt to access services.
- denial of essential services on racial grounds.
- failure to identify TSI as indigenous Australians.
- the education system failing to acknowledge and make provision for Torres Strait Islanders and culture.
- lack of recognition of July 1st as being Torres Strait Island National Day.
- Culture taking second place to Government Departmental rules (e.g.. Traditional Adoption).
- break-up of family groups.

- changing roles of men.
- changing roles of women.

Since the advent of ATSIC those of mixed parentage are going through a harrowing stressful experience as pressure is put on them to decide whether they are Aboriginal or TSI. Many say they are both and are determined not to choose but continue to be involved in working for both groups.

Recommendations

- There is a need for research into Torres Strait Island health including mental health nationally.
- Recognition and respect by service providers of Torres Strait Islanders as a distinct cultural people.
- The need for awareness of mental health amongst Torres Strait Islanders -mental ill-health is something not to be ashamed of.
- The need for consultation with Torres Strait Islanders re input into programs.
- The need for participation by Torres Strait Islanders in the implementation of such programs.
- The need for Health Workers including Torres Strait Island Health Workers to acquire counselling and other skills to recognise and deal with mental ill-health.
- Recognition of Torres Strait Island cultural methods of healing.
- Recognition of Torres Strait Island cultural healers.

Consultation report and processes

Communities and individuals were consulted in a wide range of ways and settings. Consultation took place as follows:

National Aboriginal Mental Health Conference, November 1993

Discussions were held with those attending this conference during the conference, and in a special forum to identify key issues with conference participants.

The focus of this conference was on the mental health of Aboriginal people and their needs. The themes and recommendations are incorporated in the report "Our Way: National Aboriginal Mental Health Conference 1993" (Swan and Raphael, 1994). The themes identified and recommendations are identified generally as a background to this report, and specifically incorporated into relevant sections (see summary in Attachment A; Recommendations Appendix 2).

National Aboriginal Community Controlled Health Organisation

Three major meetings of NACCHO were attended, namely September 1993 (Cairns), March 1994 (Darwin) and February 1995 (Executive Canberra). Meetings were also attended in Coffs Harbour and Townsville. The major themes for Mental Health were considered and discussed in depth at both these meetings and support given for the consultancy process. Numerous members of this group have been consulted individually on a regular basis to the present and their ideas and contributions included in the present proposals. (Reports of meetings are included – see Attachment B).

Surveys and Contacts with Organisations

Aboriginal and Torres Strait Islander Council

The Council and many regional representatives were contacted to obtain views on Aboriginal Mental Health, needs and future directions. These views have been noted and incorporated as suggested by the Council in its response to the consultants, in particular its suggestions of contact to Regional Councils and to Aboriginal Health services. (see Attachment C)

State Health Departments

were contacted for information on Aboriginal Mental Health and Mental Health Services in each State. The details of state response are summarised in the attached report. (see Consultancy Report State Department Reports)

N.S.W. Aboriginal Health Resource Co-op

were contacted for information, attendance and discussion at meetings held in Sydney and Gosford.

Educational Institutions

Universities, Colleges and other bodies were contacted to explore teaching and educational programs relevant to Aboriginal Mental Health, and programs addressing Aboriginal Mental Health Workers, and any programs of affirmative action for the Professional education of Aboriginal people in spheres relevant to mental health.

A detailed report of these findings is attached (See Consultancy Report – Education).

Data and information systems providers

A range of reports were used and groups were contacted to explore available information on Aboriginal Mental Health or any proposed or current initiatives in this field.

There is a profound shortage of any adequate data base to form indicators or by which to satisfactorily monitor the extent of mental health problems, mental health service utilisation, or outcomes.

State Health Departments are currently attempting to enhance their data in their own health information systems linked to proposed national initiatives under National Mental Health Policy for a National Minimum Data Sets and Data Dictionary.

The Australian Institute of Health and Welfare was consulted with respect to data information gathered on Aboriginal Health generally, and Aboriginal Mental Health in particular. The contact indicated a great shortage of National Mental Health data generally, and a virtual absence of data on Aboriginal Mental Health. What limited data is available is indicated in appropriate sectors. (see Attachment D).
Health Outcomes and indicators were identified as a significant area in terms of mental health development. Professor B. Raphael is a member of the Quality of Health Care Committee of NH&MRC, which is pursuing issues of outcome measures. In addition she attended the first Health Outcomes Conference in New South Wales. The Consultants and Mrs N. Mayers prepared a paper on Aboriginal Health Outcomes at the request of the AIHW, and this has been published. (see Policy Section 16 – Data and Information Systems).

Aboriginal community controlled health services

A large number of Aboriginal Medical Services and Health Workers were contacted for their views. A list of these Aboriginal Health Care services is attached. Their views were obtained in both verbal and written submissions and responded to a set of key questions. The areas reviewed were as follows:

- Data, Health Information and Statistics systems (to be dealt with above)
- Current Mental Health Services provided and personnel, and perceived needs
- Perceptions of main causes of mental health problems for Aboriginal people in their region
- Main types of mental health problems experienced by Aboriginal people in their area
- What they perceive would be helpful in way of services to address mental health needs
- Helpful and unhelpful aspects of mainstream mental health services
- Proposals or new developments
- Views on education/training needs for those working in field of Aboriginal Mental Health (see Education review)
- Healing programs perceived that it would be helpful to have for Aboriginal people with mental health problems in their area
- Views of highest priority for Aboriginal Mental Health Services generally
- General views and comments

A detailed report is provided below identifying the principle themes and priorities presented by Aboriginal organisations in response to these issues and the groups and individuals consulted. (See Consultancy Report).

Visits to and detailed consultation with Aboriginal health and mental health service providers in each state

A number of Aboriginal Health Services were visited in each State. This small number of direct visits related to funding and time limitations but provided representative and in-depth views to complement the more extensive data provided above.

A summary report of these Centres and the findings of this aspect of the consultative process is provided below, with key themes identified and needs defined. This report also deals with interrelationships with Regional, State, Commonwealth and general health matters impacting on Aboriginal Mental Health.

Other organisational involvement

Consultants met or communicated with the following organisations on matters of relevance and sought

their views, or presented matters relevant to the consultancy or made other contributions and reviewed input with respect to Aboriginal Mental Health.

AMA Summit on Mental Health

The President of the AMA was consulted on Aboriginal Mental Health. The views of those attending were elicited and key issues discussed at this forum. These are included as appropriate.

National Health Goals and Targets Group for Mental Health

The Consultants actively participated in this process and sought views from related bodies and those consulted on Aboriginal Mental Health. These matters are referred to in appropriate places.

National Health and Medical Research Council

The Consultants were actively involved in the National Health and Medical Research Council's Mental Health Committee (to end 1993) and prepared a paper on "Aboriginal Mental Health -Everybody's Business".

This paper is currently under review with the restructured NH&MRC process through the National Health Advisory Committee.

The consultants are further making contributions through the proposed Health Advisory Standing Committee of which Professor B. Raphael is a member, on a National initiative in Child Abuse, especially Child Sexual Abuse, in line with needs identified in the Mental Health Goals and Targets, but also identified extensively as a priority for Aboriginal Mental Health during this consultancy process.

Aboriginal Women's Health Group

The consultants have consulted with Aboriginal women with regards matters of relevance for their mental health and well-being in a number of contexts.

Ms P. Swan is the Consultant to a study on Women's Health being conducted in Consultation with the Aboriginal Health Service at Redfern.

Ms P. Swan and Professor B. Raphael consulted with a number of Queensland and National Groups on Aboriginal Women's Mental Health at a Women and Mental Health Conference held in Brisbane on 30 and 31 August and presented papers at this meeting, as well as liaising with Aboriginal Women's groups in the Mental Health consumer area, Women's Prison group, and about Domestic Violence.

Ms P. Swan and Professor B. Raphael are active collaborators in the proposed Longitudinal Women's Health Study. As part of this consortium they were involved in the development of a Consultative model, for a national study of Aboriginal Women's Health and well-being as an aim of the proposed Longitudinal Women's Health Study.

A detailed report of these consultation processes and workshop (chaired by Professor B. Raphael) plus a list of the Aboriginal women involved, is available on request. This study will be led by Aboriginal Women and is oriented to women's well-being and will help to develop systematic assessments of Aboriginal women's mental health and well-being, as well as relevant aspects of reproduction and physical health, violence and so forth. The work to date demonstrates the feasibility of the approach to work with Aboriginal communities.

National Mental Health strategy developments

The Consultants have been involved with response to initiatives regarding Aboriginal Mental Health in a number of frameworks.

They have been involved in the development, review and support of funding proposals for Aboriginal Mental Health Initiatives, under National initiatives.

Professor B. Raphael has been involved in developments for the proposed National Mental Health Survey and is responsible with respect to the necessity for a National Aboriginal Mental Health Survey as part of this; and the Young People at Risk Program: Access, Prevention and Action.

The consultants have also made representation, or contributed with respect to proposals on Promotion and Prevention, Consumer Involvement and Counselling, Workforce etc. (A list of funded Commonwealth initiatives is attached. See Attachment I)

Royal Australian and New Zealand College of Psychiatrists

The consultants have been involved in active liaison with the RANZCP in terms of Aboriginal Mental Health. They attended and actively participated in a conference of the Section of Social and Cultural Psychiatry held in Broome (September 1994) and presented on matters relevant to Aboriginal Mental Health. In addition they liaised with psychiatrists and other health and mental health workers for further information on key needs and issues on Aboriginal mental health. (Attachment K)

Rural Health Support, Education and Training Program (RHSET)

A number of grants have been made to Aboriginal communities or people who work in Aboriginal communities with regards to Education and services – many of these are directly or indirectly relevant to mental health. They are listed for information and should be followed up for their outcomes by the proposed Organisational Grant and at a required basis. (see Attachment K)

International meetings

Professor B. Raphael attended two international meetings and workshops at those relevant to Indigenous Mental Health (American Psychiatric Meeting Philadelphia, May 1994), Fourth International Meeting of Grief and Bereavement (June 1994). (These meetings were independently funded and were not part of consultancy funding.)

Issues of particular interest such as a suicide prevention and bereavement program in remote Canada, are noted in relevant sections of this report.

Consultees

List of those individuals and organisations consulted are attached. However it should be noted that this list is not necessarily total or all inclusive, as many discussions were also held informally and people did not necessarily provide names.

State reports

Northern Territory

Total indigenous population   46 000 (ABS,1995)

Proportion of total state population 24.0%

Northern Territory Mental Health Services

Darwin Rural District: There is an innovative program of Aboriginal Mental Health Workers supported by a non-Aboriginal Community Worker (Senior Psychiatric Nurse), Mr Glen Norris. Three workers have been appointed to health worker positions:
- Mr Henry Moreen (F.T.) Belyuen Community;
- M. Pius Tipunguruti and Mr Matthew Wonaemiri share a fulltime position with Milikapiti Community Council.

Their major role is "Cultural Counselling" as they work within existing family and community networks using law and traditional knowledge. There are senior people in their own communities. Further positions were sought to a total of 6, plus clinical nurse, counsellor and Aboriginal Mental Health Workers in Darwin to provide liaison support and funding for a full network.

This model is seen positively, perceived as impacting to provide better resources for communities resolving conflict, etc., decreasing evacuations for psychiatric disorder. However, final evaluation is yet to be carried out.

East Arnhem District

1	Community Psychiatric nurse
1	Aboriginal mental health worker
0.2	psychiatrist

These staff are reported by N.T. authorities. A meeting held with staff serving the East Arnhem district also identified innovative programs utilising community views and models of mental health, and community resources.

Alice Springs

Meetings with Territory Mental Health Service staff established that many Aboriginal patients are admitted to inpatient beds in the acute health unit of Alice Springs Hospital. While there is an Aboriginal Liaison Officer for the hospital as a whole, this person is not always able to provide support for patients in the psychiatric unit. Problems with patients were identified in terms of: people from remote areas separated from families; lack of English as a first, or even second or third language; need to provide for families and others who come with the patient; provision of medication and compliance; high overlap of alcohol problems with psychiatric problems; problems of follow-up; problems of reintegration into the community; stigma both within the hospital and without for psychiatric patients. It was also noted that the mental health services within the community could not always provide necessary support, even though many Aboriginal patients were seen. There was poor liaison between these services and the Aboriginal Community controlled Health Services.

Alice Springs and the Territory Mental Health Services report one community psychiatric nurse and an Aboriginal mental Health worker positions allocated to Mental health Services, with mental health worker positions vacant at the time of reporting. Other staff, including two psychiatric staff do, however, look after Aboriginal patients and clients. Maintenance review and medication is provided to some patients by District or Visiting Medical Officers on their routine visits, or on occasion by regional community nurses.

A further service model of interest was the development of Critical Incident Stress Debriefing in Aboriginal communities in response to incidents of violence, accidents, death etc. (Norris, 1994). This model appeared to facilitate community and individual discussion and working through.

Aboriginal Health Services

Congress (Aboriginal Community Controlled Health Service) had one (temporary) Aboriginal Mental Health Worker in position. She was operating in a generic mode with clients who presented or were refused, attempting to estimate need and providing outreach (e.g. to Hermensberg).

Other Aboriginal Medical Services from Darwin and elsewhere report extensive mental health needs but no specific personnel or services.

General counselling on stress, family, alcohol, and related matters many presented through AMS and other services with need for specific mental health training. Expertise is seen as a very high priority.

Separations and Utilisation

Data provided to the consultancy was a copy of the 1993/94 Annual Report on the Mental Health Act and it was noted that no data was available for the Darwin Rural and Alice Springs Rural Districts which have almost exclusively Aboriginal clientele. Aboriginal and Torres Strait Islander people were admitted to a Mental health ward in Darwin and Alice Springs (1993/94 N=168, 80 to Royal Darwin (16%) 88 to Alice

Springs (33%)). Katherine, Gove and Tennant Creek Hospitals also admit psychiatric patients to non specialist wards although breakdown x ethnicity data was not available.

Current diagnosis were residual or paranoid schizophrenia; prolonged depressive anxiety reaction, unspecified adjustment reaction; anxiety reaction; reactions to alcohol.

New South Wales

Total indigenous population   80 500 (ABS,1995)

Proportion of total state population 1.3%

State Mental Health Services

Report from the Director of Mental Health

There is no one person responsible for heading Aboriginal Mental Health in New South Wales, as organisational structure determines that responsibility is held at Area/District basis with Central Administration fulfilling policy, planning, standards and performance monitoring. The Director is responsible for carrying out the role of Central Administration in respect of State Mental health service planning and provision and monitoring mental health activities. Within Central Administration of the NSW Department there is an Office of Aboriginal Health, as well as the mental Health Branch.

There is a New South Wales Strategic Plan for Mental health entitled "Leading The Way" the Mental Health Branch is working with the Office of Aboriginal Health on the development of a New South Wales Aboriginal Mental Health policy.

Provision for Aboriginal people through the mainstream mental health services are being addressed through planning processes. There are a number of Aboriginal liaison workers employed by the Health Department to facilitate access to mainstream services.

Funding has been allocated to the following Areas/Districts for the development of Aboriginal Mental Health Services and/or employment of an Aboriginal Mental Health Liaison Officer. These include Aboriginal liaison and Mental Health Workers both urban and rural and Aboriginal supported accommodation.

- Central Sydney Area Health Service – received funding for the development of a comprehensive Aboriginal Mental Health Service.
- South Western Sydney Area Health Service – received funding for the development of the Area's Aboriginal Mental Health Service for the Campbelltown Local Government Area and adjacent area.
- Corrections Health Service – received funding for the employment of an Aboriginal Mental Health Liaison Officer. (Positive recently advertised).
- Central West/Evans/Lachlan Health Districts received funding for the establishment of Aboriginal Mental health services for the three Districts.
- Macquarie Health District – received funding for the establishment of an Aboriginal Mental Health Service.
- Orana Health District – received funding for the establishment of the Aboriginal mental Health counselling positions in Bourke and Walgett.
- Barwon Health District – received funding for the establishment of an Aboriginal Mental Health Service.

Other proposals in process include a Mental Health Working Group established to develop a NSW Strategy for Mental health Services for Aboriginal People which will hold its first meeting on 1 February 1995. Membership of the group is broad and includes representatives from Aboriginal groups, consumer groups, the Department of Health, and Area and District health services.

Aboriginal Medical Services

While Aboriginal Medical Services and Aboriginal community controlled Health Organisations look after Aboriginal clients who may present with a range of mental health problems, very few have specialised mental health components.

As noted above, there are substantial initiatives which have been proposed, or are underway many linked to Aboriginal Health Services in Regional areas.

At the time of the consultation there were limited numbers of Aboriginal Mental Health Workers and these were chiefly in training, for instance through the scheme at Queanbeyan. A few medical services have received some support from visiting services with psychiatrists, or links with services, and this is not consistent, for instance in Durack, and more recently one session by a child psychiatrist to the Aboriginal Medical Service at Redfern. (since the consultancy was completed). The most recent review indicates, however, that there are few trained Aboriginal Mental Health Workers in positions in the state, although positions are planned and no consistent provision of mental health services to Aboriginal people in the State in Aboriginal Health Service frameworks.

Initiatives proposed in Centre Sydney include a Koori Mental Health Residential Facility and model for an Integrated Mental Health Service for Aboriginal people (Professor M. Bashir).

Central Sydney Mental Health Service
Koori Mental Health Residential Facility

(Jan Yow Yeh, AMS Redfern and Christopher Dunn, Adult Mental Health Team, Redfern Community Health Centre).

The establishment of long term residential facility aims to provide for homeless Aboriginal people with Mental Disorders.

"The orientation of the residential program is teaching with reinforcement of necessary self-care and community skills so that residents are able to achieve their optimal level of functioning in the community."

The aims are specifically

"i) to establish a culturally appropriate and sensitive, long term accommodation, for Aboriginal people who live in the Sydney metropolitan area and are restricted due to a mental disorder"

"ii) to provide accommodation for homeless Aboriginal people who are restricted by mental disorder, or become isolated from their families due to illness"

"iii) to provide short to medium respite care for Aboriginal people affected by mental disorder and who live in the Sydney metropolitan area with their family".

Development of a Model for Integrated Mental Health Service for Aboriginal People: A Partnership Approach between local Aboriginal Medical Services and the Department of health. (Professor M. Bashir)

This proposal provides for a special service to address Aboriginal client needs linking together the following components:

(a) acute care either inpatient or 24 hour crisis care in the community with support of an Aboriginal Liaison Officer (A.L.O.) who would have substantial involvement in discharge planning.

(b) Post acute care and rehabilitation including needs assessment, provided from cottage-ward accommodation staffed jointly by Aboriginal and non-Aboriginal staff with input and support from the A.L.O.

(c) Post discharge supported accommodation in a community based dwelling administered by an

Aboriginal Community Controlled NGO to support continuing rehabilitation.

(d) Community reintegration support via contact with family and significant others, with Aboriginal organisations addressing grief, loss and trauma issues (link-up, Correction Services, Juvenile Justice and/or training/paid work opportunities). (C.D.E.P., DEET, TAFE and Land Councils).

(e) Consultation/Liaison to community clinics by the designated A.L.O.

It was encouraged that this would support a substantial minor city Aboriginal population (N=2000 approximate). This project is funded and currently in process of development and implementation.

However, to date these projects have not been funded, apart from one project officer to develop a handbook on the ideal Integrated Mental Health service for Aboriginal people. There has also been the appointment of an Aboriginal Liaison Officer to support inpatient programs.

Rural Regions

Mental Health Services in Rural Regions are attempting to provide for Aboriginal clients. There have been a number of Aboriginal Mental Health Worker appointments in the frameworks outlined above. Specialist outreach teams have also attempted to provide special mental health input, e.g. from Royal North Shore hospitals in Sydney and other centres.

Separations and Utilisation

Separations for 1992/93 were 1447. Principal diagnoses were alcohol related conditions (delirium, psychosis, acute intoxication, other alcohol and other drug abuse, schizophrenia (paranoid), disorder, brief reactive and other depressions, anxiety and personality disorders.

Tasmania

Total indigenous population   10 100 (ABS,1995)

Proportion of total state population 2.1%

Tasmanian State Mental Health Services

There is no specific Aboriginal Mental Health Service in Tasmania and no person representing or employed in such a way.

A specific objective in Tasmania's Health Goals and Targets includes mental health as a goal area, namely

> *"In consultation with the Aboriginal community, examine the special mental health needs of Aboriginal people and establish culturally acceptable programs to meet these needs."*

An issues paper was developed in 1992 to this end but had not been progressed to consultation with Aboriginal people.

There was acknowledged to be a general paucity of information available on Aboriginal Health, and mental health. Aboriginality is infrequently identified in mental health data collections. There are no specific provisions for Aboriginal people within Tasmania's mainstream mental health services. It was noted that there were Aboriginal Health Services in each of the three regions in the State with dedicated Aboriginal Health workers. It was considered likely that these services would fulfil a need in this area.

Current development of mental health information systems is proceeding with tenders having been advertised and evaluation now proceeding for a client activity system. Aboriginality is included in core information to be collected.

Cross cultural training (part of the development of culturally acceptable programs) is occurring and training in Aboriginal Studies at tertiary level is being undertaken by the forensic psychologist on assisted study from the program. Mental health is represented on the Royal Commission into Aboriginal Deaths in

Custody Monitoring Committee and regular meetings are held between the Senior Policy Officer, Aboriginal Health and the State Program Co-ordinator.

Aboriginal Medical Services

Consultation with the Aboriginal Medical Services revealed significant problems accessing psychiatric care. There were limited counselling services provided generically across the state. There were problems for patients admitted to inpatient services as they were usually poorly understood in terms of family issues and alcohol problems. There were major difficulties accessing services for young people, and particular problems for suicidal young people. There are problems with patients who are seen to be violent and great difficulties getting care for young people like this.

Separations and Utilisation

Current data indicates that from 1989 to May 1994, 11 Aboriginal people were treated in general hospital units. It is suggested that these low figures reflect the general paucity of data on Aboriginal Health in Tasmania.

Victoria

Total indigenous population   19 200 (ABS,1995)

Proportion of total state population 0.4%

Victorian State Mental Health Services

Report from the Director of Psychiatric Services.

A number of initiatives have been developed in Victoria with respect to Aboriginal Mental Health Services and these include:

- The Aboriginal Mental Health Housing and Support Project.
- The H&CS Northern Region (NEMPS) is currently exploring ways of transferring the full management and funding of the two Aboriginal Mental Health Workers attached to the Aboriginal Mental Health Network to VAHS.
- Psychiatric Services Branch has carried out a preliminary mapping exercise in order to identify the range of mental health services for Aboriginal people in Victoria.

The mapping exercise is the first stage in a program development project on services for Aboriginal people with mental illness.

There is also consideration for the possibility of developing a Victorian policy on Aboriginal Mental Health, that perhaps draws together the programs currently being made. And at present there are four Aboriginal workers employed by mental health services specifically supporting Aboriginal people with serious mental illness. This includes the two workers with the network.

Victorian Aboriginal Mental Health Services

In 1988 a collaborative network was formed between Psychiatric Services and the Victorian Aboriginal Health Service (VAHS). The state wide Victorian Aboriginal Mental Health Network has five designated Aboriginal beds at the Bundoora Campus of the North East Metropolitan Psychiatric Services (NEMPS). The Network also includes two Aboriginal mental health liaison workers based and managed from the Victorian Aboriginal Health Service but employed by NEMPS. The North East Metropolitan Psychiatric Services will advertise for the position of Consultant Psychiatrist for the Aboriginal Mental Health Network after the EOI process is complete. The job description is being developed jointly with VAHS. At present the staffing for the Network includes 0.5 Consultant Director, 0.2 Medical Officer and 2 Psychiatric Service Officers.

The Koori Kids Network is also based at VAHS. The network is made up of staff from VAHS, the Victorian Aboriginal Child Care Agency, regional child and adolescent psychiatric services and school

support centres. The network offers:

- Direct consultations for Aboriginal children with mental health or emotional problems.
- Secondary consultations to staff of VAHS and ACCA.
- The education of the Aboriginal community regarding childhood emotional development and emotional problems.

An Aboriginal Mental Health Liaison worker is based in Mildura and together with a psychiatric nurse from the community mental health service, offers education and secondary consultation to Aboriginal Cooperatives in the area.

St. Vincent's Hospital together with the University of Melbourne employs a consultant psychiatrist, Dr. Jane McKendrick as a Senior Lecturer in Psychiatry (Koori Mental Health). Dr. Jane Mckendrick provides some consultation to workers at VAHS and is also working on a research project at Rumbalara.

The Aboriginal Cooperative at Rumbalara has also recently employed a part time Koori Mental Health Project Worker.

Psychiatric Services Branch, VAHS, and the Department of Planning (Office of Housing) have jointly developed a Koori Housing and Support Project. This project offers stable housing with accommodation support for up to ten Aboriginal people with psychiatric disabilities. The housing has been purchased by the Office of Housing, and the disability support is supplied by VAHS through Commonwealth State Disability Agreement funding from Psychiatric Services Branch. VAHS have also applied for funding from ATSIC for a live-in house keeper for this project.

Also, within some Health and Community Regions there are discussions occurring between mental health service staff and Koori communities regarding strategies to make services more accessible to Koori people.

The Victorian Aboriginal Mental Health Network

This network currently (at the time of writing) encompasses inpatient, outpatient and community components. There are five designated beds for Aboriginal people who require inpatient care. (moving from Lorundel to St Vincents Hospital – it should be noted that there are estimated to be 10–12 patients in the whole of Larundel).

There is one full time Psychiatrist (half the University of Melbourne and half Victorian Health funding); halftime Psychiatrist; 2 sessions OPD medical officer; medical officer looking after the inpatient unit; two Aboriginal Mental Health workers (getting training on the job) and one worker (Graham Thorpe) from the Aboriginal Medical Service; one drug and alcohol worker (Lawrence James) and a range of sessions (5) for supervision etc. There is an advisory committee with regular monthly meetings.

The Koori Kids Mental Health network has a full time Aboriginal coordinator; a child psychologist providing up to three sessions, and one session from a child therapist and an adolescent therapist, plus other limited intervention.

Other Areas of the State and Rural Areas reported very limited access to specialised Mental Health Services.

Separations and utilisation

There were a total of 6124 community contacts made by Aboriginal and Torres Strait Islander clients in 1993/94. Two hundred and thirty two clients were responsible for these separations.

In total, Aboriginal and Torres Strait Islanders had 132 formal separations in 1993/94. Eighty eight clients were responsible for these separations.

In total, 253 individual clients received service during 1993–94. Nineteen clients were inpatients only, 165 were community only and 69 received both inpatient and community care.

Bed days were a total of 4013 for 1993/94.

The most common causes of separation are :schizophrenia; no diagnosis recorded; personality disorders; acute stress reaction; acute alcohol intoxication and withdrawal. Personality disorder and other drug abuse and dependence were the commonest morbidity after no discharge diagnosis.

The vast majority of all clients were in the 5–40 age range.

South Australia

Total indigenous population   18 400 (ABS,1995)

Proportion of total state population 1.2%

South Australia Mental Health Services

There is no single point of responsibility for Aboriginal Mental Health Service provision. Policy development and discussions are underway. There is however an Aboriginal community representative on the consumer advisory group. Currently there are no separately identified services for Aboriginal people.

While there are no separate services for Aboriginal people there are Proposals in process. For instance in the short term Service Models which could be utilised immediately, include:

- Sessions at Aboriginal service or generic service locations.
- Joint assessments and support work with Aboriginal service employees or designated key community members.
- Membership of Aboriginal service client management groups or other committees which help specialised mental health and other services to work together to assist individual clients.
- Ensuring the developing Area extended hours services are accessible to Aboriginal people.
- Training for SAMHS staff, present staff of Aboriginal Services and Aboriginal health care students.
- Recruitment of Aboriginal staff.

In the longer term, new projects could be developed in partnership with Aboriginal Services. As an example one Aboriginal Service wishes to establish a hostel to assist people after discharge from the psychiatric system.

Report from the Director of Adolescent Psychiatry and A/Chief Social Worker, Forensic Psychiatry Unit/ Adolescent Outreach Service, Division of CAMHS, Women's and Children's Hospital, South Australia.

There is no single person responsible for child and adolescent Aboriginal mental health services in the state. Within the Division of Child and Adolescent Mental Health Services of the Women's and Children's Hospital (WCH, CAMHS) an interest group is convened that attempts to improve services provided by the current organisation, and to encourage the development of further services, especially Aboriginal controlled.

There is no organisational structure with respect to child and adolescent Aboriginal mental health services. These services are subsumed within WCH, CAMHS and Southern CAMHS which, between them, offer a statewide service.

At present no draft or actual policies for Aboriginal mental health in South Australia is known. There is however, what is believed to be an exciting plan that has been put up by the Aboriginal Health Service to the National Mental Health Strategy for an Aboriginal controlled Hostel to be developed in Adelaide. The Hostel would be directed towards Aboriginal patients newly discharged for psychiatric hospitals. Mr Lindsay Osborne, Clinical Director, Aboriginal Health Services, is the appropriate contact person.

There is no known person employed specifically in child and adolescent Aboriginal mental health services in the state. However, the Aboriginal Health Service employs two mental health workers (Rosie Howson and Trever Graham) who do some work with children and adolescents, sometimes in consultation with us.

Within CAMHS there have been several initiatives aimed at improving services to Aboriginal children including:

- (1) Access:
  - (a) providing priority access to Aboriginal referrals in an attempt to reduce the barriers to obtaining services.

(b)   providing clinical outreach services from locations that are familiar and comfortable to Aboriginal people (usually Aboriginal Organisations).

(2)   The undertaking of extensive liaison with Aboriginal health and welfare agencies in order to develop service strategies, strengthen networks etc. This has resulted in some joint projects.

(3)   The development of an Aboriginal Service Interest/Action group within CAMHS to:

(a)   develop strategies and approaches regarding servicing the Aboriginal community in respect to child and adolescent mental health needs.

(b)   develop specialist, culturally appropriate, clinical skills for members of the group through training and development, case discussion etc.

Utilisation data within Women's and Children's Hospital CAMHS concerning Aboriginality is currently not truly accurate.

Aboriginal medical/health services

Liaison with the Aboriginal Health Service provided information on a number of mental health initiatives. The involvement of Michael White (family therapist) has been beneficial. He became a consultant for the programme on a weekly basis and also ran a two year family therapy course. Sessional work once per week on a private practice basis was provided by Psychiatrist, Dr Paula Lagnado. Dr Jon Juredini a Psychiatrist involved with children and adolescents provided backup once a month. The team greatly appreciated the relationships they had with the counselling and psychiatric staff but said there was an increase in problems and there was a clear need for more staff.

Separations and utilisation

Unfortunately no summarised data on Mental Health services utilisation for Aboriginal people was provided or made available at closure date of consultancy.

Western Australia

Total indigenous population   47 300 (ABS, 1995)

Proportion of total state population 2.8%

State Mental Health Services

At time of the consultancy there were 4 programs directed specifically at Aboriginal Mental Health. Two Aboriginal specific services were:

•   Aboriginal Mental Health Unit
•   Kimberley Mental Health Project

and two educational programs:

•   Marr Mooditj Foundation Inc and
•   Curtin University Centre for Aboriginal Studies

Aboriginal Mental Health Unit: The Aboriginal Mental Health Unit function is to promote mental health and well-being of Aboriginal people in W.A. by: providing effective mental health services in the community for Aboriginal people with mental health problems; facilitating the development of a comprehensive and integrated system for Aboriginal people with mental health problems; and promoting mental health and mental health awareness within the Aboriginal community. The unit has a community development approach. There was reported to be a staff of three (Project Officer, Assistant Project Officer and Welfare Officer). The unit had seen a total of 44 clients from November 1993 to June 1994.

Aboriginal Medical Services provide counselling and responses to mental health needs, but not specialised mental health services.

State Mental Health

Community services provided for Aboriginal clients as appropriate, but no specific policies or programs were identified. Significant numbers of patients were identified in Graylands Hospital. Apparently there is an Aboriginal Liaison Officer to support such patients as needed. One Community Psychiatrist provides support to Aboriginal Mental Health needs.

Kimberley Mental Health Project: This is a combined project, a Kimberley-wide enterprise involving the Aboriginal Medical Services in the Kimberleys and the Northern Health Authority of the W.A. Department of Health.

Aims of the project include: offering training in mental health care practice for Aboriginal health workers and Aboriginal people working in related fields; resources and support for Aboriginal communities wishing to develop their own mental health care capacities; facilitation of closer working relationships with drug and alcohol treatment programs. The project will be focused on and lead by Aboriginal people.

Currently 4 non-Aboriginal registered mental health nurses have been employed and will liaise with and train Aboriginal Health Workers working with them. The introductory training program will be completed in June with 15 students but has not been accredited to date.

The Aboriginal Mental Health Team in this area reiterates that there is a lot of severe psychotic disturbance and suicide associated with Alcohol and Psychosis in their community.

Southern Region: State Mental Health Services and the community provide services which deal with Aboriginal people and have some Aboriginal health members which deal with Mental Health issues, but no specific Mental Health services

Kalgoorlie: Mental Health Worker positions are being developed.

Separations and utilisation

Data was not provided or made available by consultancy closing date.

Australian Capital Territory

Total indigenous population   1 775 (ABS,1995)

Proportion of total state population 0.6%

ACT Mental Health Services

Report from the Program Director, Community Mental Health.
- A mental health worker has been appointed to the Aboriginal Health Centre.
- Close links are being developed between staff in Community Mental Health Services and the mental health worker at the Aboriginal Health Centre through meetings on identifying needs and case discussions.
- The education officer appointed under the ACT Mental Health Strategic Plan is working with the Aboriginal Health Centre staff on identifying training needs, and development of programs to meet these needs.
- Links have been established between ACT Mental Health Services and the Queanbeyan Mental Health Worker training program.
- During 1995 a Project Officer is to be appointed for three months under the ACT Mental Health Strategic Plan, to prepare a report on the mental health needs of Aborigines and Torres Strait Islanders in the ACT.
- The current statistical data system for ACT Mental Health Services identifies Aboriginal people registered with the service and the number of occasions of services received.
- An Aboriginal Health Worker has been appointed to Woden Valley Hospital to assist Aborigines admitted to hospital and arrange discharge plans.
- ACT Department of Health EEO plan highlights and addresses incidents of discrimination as well as providing training to staff regarding the appreciation of cultural diversity. Plans are

being developed in training the staff selection panel in the application of EEO principles and practices.

Aboriginal Medical Services

Reports provided no evidence of Mental Health Services and extensive need.

Separations and utilisation

Data was not provided or made available by the consultancy closing date.

Queensland

Total indigenous population   79 800 (ABS, 1995)

Proportion of total state population 2.5%

State Mental Health Services

Inevitably State Mental Health Services provide services to Aboriginal and Torres Strait islander clients, particularly in regions with high indigenous populations (eg. Penninsula and Northern Regions). Specific policies for education of mainstream mental health professionals or Aboriginal cultural issues were not in place and the majority appeared not to have Aboriginal Liaison officers. A Project worker has been funded to develop a State Mental Health Policy.
Peninsula Region. Dr Ernest Hunter provides specialised psychiatric services to this region on a fulltime basis, serving Aboriginal and Torres Strait Islander patients in outreach to communities on the Peninsula. He has three Aboriginal Mental Health Workers working under him in training in an apprenticeship model, and also a child psychologist (non-Aboriginal). He works in outreach communities, and also Cairns.

Northern Region. A Queensland Health Department psychiatrist, Dr Michael Stone, is responsible for Aboriginal Mental health Services and is helped by a half-time registrar.

Queensland Aboriginal Health/Medical Services

The Aboriginal Medical Service (Townsville Aboriginal and Islander Health Services). This service runs a Social Health Unit which provides counselling and therapeutic services, and training workshops covering areas such as suicide intervention; grief management; domestic violence (perpetrators and victims); sexual abuse; anger management; anxiety; stress management; coping skills; parenting; mental illness. However, despite these initiatives, a crucial service to deal with these issues were seen as virtually non-existent, and existing mental health services as failing to be relevant to Aboriginal and Torres Strait Islander people.

The Townsville Mental Health Cooperative. (G. Smallwood) also provides counselling services for Aboriginal and Torres Strait Islander people on a range of issues relevant to mental health including women's issues, forensic issues, alcohol, violence, family problems. Both these units received funding from Queensland Health to develop a strategy for Aboriginal people with serious mental health problems in the Townsville area.

Brisbane. The Aboriginal and Torres Strait Islander Community Health Service in Brisbane was allocated $45,550 for salary and on costs for a Mental Health Worker 1994–95. This service has commenced on proposals included in the following areas:
- A supportive group program for Aboriginal and Torres Strait Islander patients with mental disorders at Wolston Park Psychiatric Hospital for patients from the secure wards.
- Workshops on issues relevant to Aboriginal Mental Health and Well-being particularly in relevance to culture, tradition and healing.
- Submission to NH&MRC for research and development of a proposal to determine beliefs and issues which are deemed necessary for providing a foundation of culturally appropriate mental health services.

Outreach is provided on links to this service from Princess Alexandra Hospital and Stones Corner

Community Mental Health Services.

Other regions

While all regions deal with significant numbers of Aboriginal and Torres Strait Islander clients, there appears to be little in the way of specific provision for them. No further data on workers and programmes was provided to this service.

Aboriginal Primary Health Care Project

This project is not a specific mental health project, but has the aim of providing a model of primary health courses including general practice which is appropriate to the needs of Aboriginal and Torres Strait Islander communities. This incorporates mental health aspects of primary care.

Indigenous Primary Health Care Course

The University of Queensland provides a major course for Indigenous Primary Health Care Workers and includes a significant mental health component.

Separations and utilisation

For data provided on Aboriginal separations or consultations it was noted that these were overrepresentative of Aboriginal and Torres Strait Islander people in the specialised forensic mental health services provided by the John Oxley Memorial Hospital, Wacol (14% of patients). Separations Psychiatric (Public Hospitals) 1992–93 are as indicated in the following tables.

Table 3:   Public hospital separations involving psychiatric disorders 1992/93

	Aboriginal or Torres Strait Islander Number of psychiatric separations	Aboriginal or Torres Strait Islander proportion of psychiatric separations	All Queensland Number psychiatric separations	All Queensland proportions of all psychiatric separations
Psychosis organic	192	16.3	1906	10.0
Psychoses other	244	19.0	6245	32.8
Neuroses	739	62.7	10806	56.7
Mental retardation	4	0.3	88	0.4
Total	1179	100	19045	100

Table 4: Public hospital separations involving external injuries 1992/93

	Aboriginal or Torres Strait Islander Number of separations due to external injuries	Aboriginal or Torres Strait Islander Number separations for external injuries proportion of population (rate/1000)	All Queensland Number separations due to external injuries	All Queensland separations due to external injuries as a proportion of the population (rate/1000)
Drug	180	2.57	3232	1.1
Accidental poisoning	25	0.36	327	0.1
Neglect	27	0.38	53	0.02

Self-inflicted	60	0.86	2149	0.7
International y inflicted	1191	17.0	4682	1.6
Total	1396	70.031	10.443	2,977,679

Aboriginal community controlled health services

This includes a summary of the findings on consultation with Aboriginal Community Controlled Health Services (both verbally and in writing) and with workers working in the field of Aboriginal health and mental health and summarised inclusion of other findings from those groups and individuals. A review from the National Aboriginal Health Strategy is included – see Appendix 1.

In addition there is a summary of recent findings on Aboriginal Community Controlled Health Services provided for the evaluation of the National Strategy and earlier references to Aboriginal Medical Services.

1.   Current mental health services provided and perceived adequacy

Services generally accessed regional mainstream mental health services. Apart from specific programs described below, these were usually on the basis of direct referral to these services, or with a psychiatrist or other mental health professional visiting to provide clinical services, perhaps fortnightly or monthly (e.g. Woolloongabba, Broome previously, Adelaide and other centres).

These services were most usually, however, provided in mainstream mental health service settings which were usually seen as inappropriate for Aboriginal people's needs, in that they were often threatening, based on white Anglo-Saxon models and biomedical models of mental health care. They frequently did not appear to understand Aboriginal people's culture and ways. It was perceived that they frequently misdiagnosed Aboriginal people's problems, particularly in terms of failing to understand spiritual components and traditional beliefs and culture and how these may influence behaviour.

Problems were most pronounced where inpatient admission was required. In rural areas this often involved evacuations under traumatic circumstances when the individual was acutely disturbed (e.g. under a net in a small plane, in the back of a police van; some disturbed Aboriginal people have been shot dead by police). While most of those involved were generally helpful it was considered a major negative aspect of mental health services and was also commented on in the Human Rights Enquiry (Burdekin, 1993).

Within inpatient services, particularly those in psychiatric hospitals, there were further difficulties with perceptions of incarceration, misdiagnosis, and separation from family or community who might be at a substantial distance away in a remote community (even 2,500km away was quoted in one instance). These matters were sometimes addressed by having Aboriginal staff, for instance an Aboriginal liaison officer, although these were sometimes not notified early in the person's admission so as to provide help.

Problems also arose with respect to Aboriginal people from remote communities, particularly those living more traditional lifestyles, because many did not have English as a first or even second language. Secondly concepts of mental health and mental illness were often alien and thus disorder not recognised or very late to present. In some instances disorder was attributed to sorcerers.

While these concerns still existed, it was only in very recent periods that problems were recognised as potentially being able to be treated effectively by mental health services.

There were also problems with lack of adequate community mental health services in some instances and a need for those as the primary focus of treatment was repeatedly emphasised. People sought services that could be provided in their own communities and by people who understood their culture and were appreciative of their social contexts and needs.

In some instances Aboriginal Health Services had carefully explored options seeking ways of relating to local Mental Health Services (mainstream) and being able to use them appropriately. This appeared to work well when there was a psychiatrist and other mental health professional who was perceived as understanding of and willing to learn more about Aboriginal people and their culture and their needs, and to be culturally informed and appropriate in working with local Aboriginal Health Services to provide care even if in mainstream settings. While this had come to fruition in a number of settings it required much further development. Particularly valuable models appeared to be the integrated approach proposed with Central Sydney Mental Health Service (see Initiatives), and a format evolved by South Australian Aboriginal Health Council with a local private practitioner, a child psychiatrist, and a family therapist. Key programs like the Victorian Aboriginal Mental Health Network were considered very positive outcomes in that they were under the auspices of the Aboriginal Health Service.

There was also an identified need for Aboriginal Consumer involvement. There was a feeling that Aboriginal consumers, while involved in mainstream Mental Health Advisory Groups, needed a separate group for Aboriginal issues to address these from a consumer point of view.

While many adaptations were made to get people into care, it was considered that there was often inadequate follow-up and there was a need for greater outreach for people in their communities. This applied too to the provision of psychotropic medication which was often seen and used negatively, both because of side effects and the willingness to take it, as well as lack of understanding. Furthermore there appeared to be few of the support programs for family, e.g. family psycho-education that may have helped family understanding and response, and little in the way of respite care.

The lack of accommodation for people whose illness had interfered with their relationship with families was also an identified problem, with a need for Aboriginal supported accommodation services, and respite care. These facilities were seen as being needed in forms and facilities acceptable to Aboriginal people, and to be provided for Aboriginal people.

While it was noted that some Aboriginal people would prefer to use mainstream Mental Health Services, it was also recognised that even so there was a need for these services generally to be aware of Aboriginal history and culture, the impact of colonisation and removal of children from families, the significance of land, the impact of racism and many other factors. The needs for education in this regard were repeatedly emphasised.

The need for Aboriginal Mental Health workers and Aboriginal Mental Health Professionals was also identified repeatedly as essential to understanding of mental health and to meeting needs, and as a potential way of bridging the gap that was frequently identified between state run Mental Health Services and Aboriginal Community Controlled Health Services.

The need for Aboriginal Community Mental Health Teams and the need for treatment facilities, Aboriginal wards and units in some places was also identified.

It was recognised however that secure wards or accommodation might need to be in mainstream mental health services, but these then needed to be educated so as to be appropriate in their response to Aboriginal people who required such care.

In addition it was emphasised that Mental Health services should recognise the potential role of Traditional healers and ensure that they could be involved in treatment as appropriate and their skills fully recognised and renumerated. There was also a need for Healing places in terms of the views of some Health Services.

A significant number of the respondents indicated the importance of linking drug and alcohol services with mental health services as these problems were frequently interrelated.

A need for special services in terms of Aboriginal people in forensic systems was also identified, both in terms of the findings of the Royal Commission into Aboriginal Deaths in Custody, and the high numbers

of Aboriginal people in custody and the problems they faced.

It was generally acknowledged that services needed to deal both with the problems impacting on mental health and well-being, for instance violence, trauma and grief, but also and specifically with mental illnesses, as they affected Aboriginal people.

2.   Main causes of mental health problems for Aboriginal people

Impact of history and the past and ongoing effects of colonisation were seen as primary causes of mental distress and contributing to mental ill health among Aboriginal peoples. These factors were identified by almost all respondents spontaneously and appeared repeatedly in presentations and discussions in a wide range of settings with both individuals, organisations and groups.

Associated with this were sociocultural dislocation, isolation, and related effects. These were contributed to by dislocation of people from lands and homelands, and from kinship networks and family. Institutionalisation was seen as contributing to this in that it separated people from their homelands, but also in its longer term effects through disruptions of relationships and relating capacities.

Grief, loss and trauma were seen as major contributing factors and were repeatedly reported by Aboriginal people, health services and organisations as a major factor. It was felt that special counselling services and programs were needed to deal with this ongoing effect. It was also suggested that people did not always recognise the effects of trauma on them and they might need education about this, as trauma was so prevalent, and they were a "traumatised people". Grief and loss related to the separations in past generations, and effects that were carried on to the next generation, plus the very high death rates in adult life. It was observed that during the consultancy that there were funerals and deaths of significant community members occurring repeatedly. The consultants attended 7 funerals during visits to Victoria, Northern Territory and New South Wales. Separation and loss also occurred in relation to institutionalisation, family kinship and relationship breakdown and so forth. Violence in family settings and in the community contributed to the experience of psychological trauma. There was also grief over loss of land, and loss of culture. Particular problems arose from suicide and deaths in custody and it was felt that the services that had been required were not available to help these families.

Poverty, unemployment, low socioeconomic status and poor living conditions contributed significantly to mental health problems according to many of those consulted. These had effects on health and well-being generally and were sources of chronic stress.

Identity, i.e. unresolved identify, an identity as an Aboriginal was seen as a source of stress when people had not dealt with this issue or felt that they had lost or were uncertain about their Aboriginal identity. Racism was also identified as a cause of problems and contributed to low self esteem.

Alcohol and substance abuse problems were seen as very significant problems by most of those consulted and were seen as causing problems or being linked with mental health problems, often inseparable. The consequences such as domestic violence were seen as significant problems in their own right, both as problems, and as a cause of further problems.

Hopelessness and low self esteem were also identified as problems by a large number of those consulted, and as contributing to mental health problems.

Violence was seen as a major cause of problems as well as an outcome. Domestic violence, violence between men, and men towards women, women towards men, as well as violence towards children. Repeated emphasis was placed on the high rates and severe effects of child abuse, sexual and physical.

Sexual assault was seen as a frequent and traumatic occurrence affecting men and women.

Other factors mentioned less frequently but still significant were: heat and weather experiences; traditional beliefs.

3. Main types of mental health problems

Those consulted identified both psychological distress and a range of disorders. The disorders described

are also those most frequently noted in the available inpatient data on Aboriginal people requiring inpatient psychiatric care (e.g. schizophrenia, depression, anxiety problems, bipolar disorder, alcohol related psychosis and organic states).

Distress, grief and despairing feelings were described as frequent problems. There was often a nihilistic approach to life and living. Behavioural problems were seen as common, affecting both young people and adults and across all age ranges. These problems were pervasive and were present in a great many patients presenting to health services and perceived as having mental health problems.

Domestic Violence was also identified as a mental health problem and a major problem for most communities. This problem was seen as associated with a number of other difficulties such as family breakdown, and alcohol problems, plus other elements of violence. The particularly negative outcomes for Aboriginal children for whom this was seen as a "norm" in many instances, were noted. These were identified as social health problems and at the core as problems of mental health and causing mental health problems, and needing to be dealt with by Aboriginal Health Services in this way, i.e. as mental health.

Child Abuse and Neglect and especially childhood sexual abuse were seen as major problems associated with mental health as well as social health and being a result of and causing major mental health problems. These problems were seen as having both immediate and long term effects.

Depression in its various forms was identified as a common and severe problem. This includes depression which was often unrecognised and not adequately diagnosed or treated. Depression that was a reaction to life circumstances was also identified as common particularly associated with nihilistic beliefs. Existential depression was also seen as a major problem.

Manic depression or bipolar disorder was noted as being among the more difficult problems having to be dealt with by communities. These problems often required Police involvement and families often felt helpless. There was inadequate follow-up or support for both patients and families. Furthermore there was often mis-diagnosis and very destructive impacts on children and other family members. During the period of disturbance people were often hesitant to call for help when the sick person was out of control for fear of the Police coming, going to jail, assault or suicide.

Post Natal depression was also seen as a significant problem, but often not recognisable, or able to be dealt with. It was often difficult to distinguish from the new mother's response to other adversity such as fear of alien birthing environment or separation from family in remote settings, or when hospitalised, or with a baby's death.

Schizophrenia was seen as a problem that had to be dealt with, in terms of patients being chronic and there being few supports or resources to care for them. The need for hospitalisation created particular difficulties, and patients could become alienated from families. Families also felt that the "bizarre behaviour" could be misdiagnosed. It was felt that spiritual things - such as talking to the spirits of those deceased were misinterpreted as delusional, while delusions might be misinterpreted as spiritual. One respondent described the problems of a number of family members with schizophrenia and the great difficulties that resulted. Hospitals also often failed to explain to families, or allow access and western explanation models did not often fit with cultural beliefs. Chronic forms of schizophrenia were particularly identified. These reports also fit with the admission data available covering Aboriginal people where residual and paranoid schizophrenia are frequent causes of admission.

Alcoholic hallucinations, Delirium tremens and other mental problems related to alcohol were also described as very common. These were identified separately from the social problems described above and relating to heavy drinking. These reports also fit with the admission pattern data available.

Anxiety states were also seen as relatively common patterns presenting to health services and identified as such by clinicians. This disorder was also identified in admissions data though less frequently.

Suicide and self harming behaviours were seen as very significant problems and linked to grief and trauma. People often felt helpless about this and that there was nothing that could be done. This was identified as a major need directly linked with services and also in terms of prevention, particularly with respect to Aboriginal people in Custody. As noted above, it was repeatedly affirmed that the

recommendations of the Royal Commission to prevent this had not been adequately put into effect, nor was it felt that there was adequate counselling for grieving families.

Borderline personality disorders were also specifically identified as a problem from some health centres although others did not use this label.

Violence was repeatedly mentioned as a social/mental health problem.

It must be emphasised also that while there appeared to be general agreement that mental illnesses were just as frequent among Aboriginal people it was frequently mentioned that they might not be recognised as such particularly in relation to traditional communities where there may be no clear concept of mental illness.

Those consulted frequently also emphasised the Aboriginal health and mental health concept as holistic involving social, emotional, psychological, cultural and physical well-being. Furthermore they emphasised the damaging effects of psychiatric labelling in western diagnostic systems in many instances, particularly when this did not seem to help to explain what was happening. Thus the recognition that such disorders occur and their diagnosis must be dealt with sensitivity to meaning and cultural issues.

Young people and children often presented with problems. Diagnosis was not clear but it was felt that many problems they had were the result of trauma and grief.

It was suggested also that many of the problems presenting may be complex forms of P.T.S.D. – Post Traumatic Stress Disorder in a variety of manifestations.

4.   Services that would be helpful to address these mental health needs

Adequate primary health care programs with understanding of and education for dealing with mental health problems were seen as being critical. These mental health primary health care provisions would be developed and controlled by local communities.

Broad based health promotion programs were also seen as important, not just those for mental health. This fits with the holistic approach to health and well-being identified above.

Community based mental health services were seen as being the most needed form of service to deal with mental health problems. These needed to respond to crisis and workers had to be educated to deal with this. In addition there was a need for outreach workers providing support to Aboriginal people in their communities by visiting them where they live. These needed to be "culturally and ethically appropriate". They needed to be staffed by fully trained mental health workers – preferably where possible Aboriginal people. There needed to be permanently based health workers educated as above, but also in the "medical model" of mental health services.

These programs needed Aboriginal Health Workers and other Aboriginal staff (professionals). These needed to be specifically educated in mental health. But Aboriginal Health Workers generally also needed a component of their program to be specific for mental health so that they could deal with mental health problems that were present with other problems, or could recognise or help or deal with them or refer them when needed. It was felt they would need basic skills for this matter, but also because at times they would be the only people available. It was repeatedly noted that there was a need for a male and female Aboriginal Mental Health worker in each community to deal with the private issues for men and women. In addition it was noted that Aboriginal Health Workers dealing with mental health and other issues suffered a high level of "burnout". This related to the strain of the enormous and frequent problems they were called upon to deal with many community members, and the fact that many problems infringed directly on their own lives. They might for instance, it was stated, have to deal with numerous problems with their own extended families before even arriving at work and have to attend many funerals etc. This specifically disrupted work patterns and meant that they often did not fit with western patterns of punctuality, regular hours. Another source of stress was the lack of "professionalisation" of Aboriginal roles in many areas of helping professions. By this, it is meant that people were expected to meet all communities needs at all hours of the day and night and to provide responses in terms of obligations to family and gave non-Government organisations expectations and requests. These might cut across the expectations of work.

Then there was often stress, even threat of payback. A number of instances were quoted of workers having to give up such roles and even leave after a short period because of the conflict, burden and uncertainty. These issues were identified very frequently by those consulted.

In addition there were problems with work patterns, career structure, need for educational programs, lack of relief systems and lack of a support structure, workers had at times to work very extensive hours with no time off and in some instances partners shared a job with little free time. Problems also arose if people came from different communities, as well as those problems that arose because people are intensely involved in their own communities. It was emphasised however that people needed to be from their own language group or related language to fill mental health roles as Aboriginal Health or Mental Health Workers. The matters of payment, education, adequate numbers of positions, recognition of previous learning and skills, a career path, would also need to be dealt with. Thus although most communities identified Aboriginal Mental Health Workers as essential to mental health service provision, it was explained that the above matters must also be fulfilled. Education programs for Aboriginal Health workers and Aboriginal mental health workers were repeatedly emphasised as essential. There needed to be an increased number of workers.

Accommodation was also a frequently identified need. However this need for supported accommodation for Aboriginal hostels etc. was separate from the need for places to care for Aboriginal people in their own communities wherever this was possible. It was suggested by a significant number of those consulted, particularly in terms of rural or remote areas that there was a need for a home or place in the community where those who were acutely disturbed could be cared for, by Aboriginal people, with other Aboriginal people, or perhaps with their families. However there was also a need for better access to secure wards where this was required and this was a significant problem for those in remote areas where no such service environment existed e.g. the Kimberly.

Healing places or Centres were also seen as needed, particularly places where traditional skills could be developed, or skills applied in a holistic way, e.g. narrative therapy and so forth. Healing places suggested ranged from those that might be used in the early stages to prevent or make someone better, to those that might be used to provide recovery after an illness episode. In addition "healing" for troubled youth in wilderness settings such as Mt Clump was seen as important. It was explained that traditional healers may have a place in such settings, as they may in formal health care settings.

The need for enhanced access to mainstream services was seen as important. This involved these services as being more culturally aware, and practicing in ways that would not be threatening or rejecting but would be acceptable. It was seen that such initiatives were urgently needed, particularly as it would take a period of time to build up the necessary staffing and services for Aboriginal people. It was also recognised that some Aboriginal people did use mainstream services. This sometimes related to concerns of confidentiality, but not always.

Counselling was repeatedly and frequently identified as an area of need that would be helpful. Special counselling services that were culturally appropriate were seen as urgently needed. Such counselling should be in forms that fitted with Aboriginal people's needs and culture. This was to help deal with trauma, loss, grief, stress, conflict and many other issues. Narrative therapy was seen as one potential mode of family therapy and therapy for the problems of children and young people was also seen as urgently needed, and was repeatedly indicated to be an important area of mental health service provision. It was felt that courses would need to be developed to deal with this.

5.   Helpful and unhelpful aspects of mainstream services

Most respondents identified few aspects of mainstream services that were perceived as helpful and listed details, problems and examples of difficulties.

However some issues were seen as helpful. The capacity to provide specialised and supervised care for those who were acutely or severely ill. Secure units when available fulfilled a valuable role.

It was also seen as positive that some mainstream mental health workers were increasingly recognising Aboriginal and Torres Strait Islander people as a special group needs group. There was increased

awareness of Aboriginal history and desire to learn culturally appropriate methods.

It must be emphasised however that these responses were reported by relatively few respondents.

Helpfulness was repeatedly emphasised as being generally more related to specific individuals than services per se in their orientation. Services which were willing to work with Aboriginal people and learn, and provide guidance and assistance as needed were seen as potentially becoming helpful. Where clinical services were provided in terms of need this was seen as helpful.

Nevertheless a number of services did indicate that they felt mainstream services were making a specific effort; and that they were moving towards more helpful relationships.

With respect to aspects of mainstream services that were perceived as unhelpful a wide range of problems were listed.

It was stated that services were spasmodic and even inaccessible, even when workers from health services made special contact they could not necessarily get disturbed clients seen urgently as needed. There were particular instances given of this with disturbed young people, for example even one perceived by the Aboriginal Health Services as possibly suicidal.

It was also felt that psychiatric labelling was used negatively by services. It was also used in a gatekeeping function to keep people out of services and this could prevent people from gaining access. It was suggested that clinicians were often too focussed on drug therapy rather than life circumstances and that this failed to take into account life circumstances which might be having a very negative effect on Aboriginal people. They experienced inflexibility, intolerance of those who did not "fit" into their systems, racism, prejudice and ignorance.

Services were often culturally inappropriate for Aboriginal people as these were based on white Anglo-Saxon middle-class values. They were often negative in their attitudes: patronising, neglectful and uncaring attitudes were described towards Aboriginal people from some medical professionals and their less qualified staff. Services were at times seen as neither culturally nor clinically suitable. They were often too bureaucratic.

Staff shortages in mainstream services or inadequate services created further difficulties – there were often long waiting lists. Often there were not enough qualified staff to cover large areas or in other instances there were not adequate specialised staff – for instance services for children, young people and families. Services were often too centralised. They also failed to provide support as need.

Services also needed to provide specific services for Aboriginal people – for instance secure beds, beds for agitated dementia sufferers.

There was also a need for mainstream services to recognise the importance of family and kinship.

Another point that was obvious on a number of occasions was the lack of a coherent collaborative framework for ongoing work between Aboriginal Health and Medical Services and State services providing mental health care and a failure of the latter to recognise and involve the former to a sufficient degree.

It was also felt that Aboriginal people did not necessarily get as thoroughly assessed as other clients, i.e. did not get the "works" and might be stereotyped e.g. as "personality disorders", so that nothing was done for them.

Payment and cost issues were also a problem, for instance potentially with new changes in some states with regard to payment for psychiatric drugs. As well, the call for efficiencies meant bed shortages and the special needs of Aboriginal people may not be met in these contexts. It was certainly a problem if people were expected to purchase medication they did not want to take. Funding needs for Aboriginal mental health were not met, inadequate or ignored.

Problems arose for people falling between mental health and alcohol and drug services, when they had problems with both e.g. a suicidal person with schizophrenia and polydrug use, whom no-one would treat.

6.   New initiatives or developments proposed

A number of developments were identified or proposed and seeking funding. These programs usually attempted to meet one of the needs described above, and often involved building on other initiatives funded from State or other sources. These professionals frequently sought, and were often successful in gaining funding from mental health Initiative money, or other sources, and a number are listed in this context, (see later section of report also).

Professionals and the employment of Aboriginal Mental Health workers or the education and employment of Aboriginal Mental Health Workers in new positions were seen as important. This initiative was being pursued in a number of states (e.g. Queensland, New South Wales rural, Northern Territory remote and rural Aboriginal Mental Health Worker training program proposals were also put forward through a number of initiatives (e.g. Batchelor College).

Establishment of Aboriginal Mental Health Networks or similar linking services was also proposed, either to extend the functions of current initiatives of its kind and to establish new mental health service frameworks.

Proposals for the establishment of a Community based mental health service integrated with inpatient components had commenced.

Initiatives for Forensic workers (in prison) were noted.

Accommodation and hostel proposals were also underway.

7. Healing programs that would be helpful

Respondents contributed a number of suggestions of areas of service provision that they believed would be helpful for people with mental health problems in their area.

Individual and family oriented therapeutic programs which are community based and linked to specialised and general services, were identified as very important in this regard. A number of respondents further expanded on the need for family therapy programs and programs for children and young people. Very few programs were currently available.

Self help and other programs to build self-esteem were repeatedly suggested. These were seen as possibly being in a variety of forms including education, groups, culture and self help programs, as well as programs for music, dance, arts, land, wilderness and so forth.

Educational programs were seen as needed to educate Aboriginal Health Workers in mental health and specific Aboriginal Mental Health workers. This issue was suggested in many different settings and as relevant both to teams and as part of educational programs in tertiary settings.

Cultural awareness programs were seen as necessary for non-Aboriginal mental health programs. These and other programs as identified previously were also needed to enhance access to mainstream services.

Services from allied health professionals were also seen as needed, for instance some outreach occupations therapy including counselling and organised social programs linking clients with friends, family and community.

Counselling programs were needed including narrative therapy, relationship counselling, stress management and relaxation therapy. Narrative therapy was seen to be particularly important as it reintroduced a story telling model which fitted well with Aboriginal culture. One example was given of successful therapy using narrative, dreams and paintings for a young girl with agoraphobia. Special counselling was needed for Women's issues and Men's issues and for sexual abuse both for adults and children.

8. Highest priority areas

The highest priorities were seen to be access to Aboriginal Community Controlled therapeutic services so that Aboriginal people could develop services appropriate to their needs.

This could then be followed by the development of health promotion programs.

Education was seen as critical in terms of the need to educate communities about mental health issues and help available, as well as cultural awareness education for non-Aboriginal Mental Health professionals. There needed to be highly qualified Aboriginal staff in Aboriginal Controlled Mental Health Services.

Accommodation needs were seen as important both for the care of people in the community that clients, relatives and families could be assisted, crisis accommodation (these were needed for acute care) and other

supportive accommodation including hostels for Aboriginal people. Places for crisis care and to heal were essential.

Outreach mental health workers and programs to support Aboriginal people were seen as urgently needed.

Aboriginal Mental Health Workers and positions, and educational programs for them were seen as an urgent priority.

Healing centres were also identified as a priority.

Assessment, management and treatment programs that were culturally appropriate were seen as critical and ideally Aboriginal people should be involved in providing these – for instance at least in assessment and ongoing care. All services needed to be culturally appropriate –Aboriginal workers learning with mainstream services and vice versa.

Counselling programs were a high priority for all those consulted.

Services for children and young people were repeatedly identified as a high priority.

Resources and funding were seen as critical and the most urgent priority by most respondents was that these resources needed to be provided in ways that allowed Aboriginal people to develop and provide their own services in their own ways. In addition it was essential that funding cycles be at least 3 years to allow positions to be put in place and develop. Resources needed to be for people, not infrastructure such as roads. There would need to be a real commitment with this. More funding, dollars on the ground and backing for staff positions in all regions were seen as central. There should be less red tape needed to get work funded.

Aboriginal medical services responses

Aboriginal Medical Services throughout Australia were contacted and a questionnaire distributed to elicit views and perceived needs on the current status of Mental Health of the Aboriginal and Torres Strait Islander Population. All (except 3) returned responses via mail, telephone or fax. Clear patterns emerged in relation to the central issues identified by the survey.

Four main causes were nominated as central to mental health problems for Aboriginal people. These were:
1. Alcohol and Drug Abuse
2. Abuse and Violence
3. Loss of Cultural and therefore Personal Identity
4. Organic causes

The main types of mental health problems experienced by Aboriginal people were Depression (e.g. manic depression, severe personal grief and post natal depression; Schizophrenia and Substance Abuse. Also neuroses, anxiety, psychoses and personality disorders were common.

Overall, the demand was for broad-based, accessible (i.e.. local), culturally appropriate mental health services. Specific services such as Education programs in mental health care and prevention were required. Additionally, counselling services were in short supply and desperately needed, as were healing centres for both patient and family members.

The AMS's were asked to detail any new proposals or developments in mental health for Aboriginal people in their areas. The overwhelming response was there were "none", and thus there were few if any new developments in the area.

Of the services that did list new proposals, the most common was Education and Employment programs for Aboriginal Mental Health Workers (AMHW's) and non-AMHW's. Secondly, new clinics and centres

were underway, and thirdly, a few AMS's were endeavouring to increase residential accommodation to provide more family support. Whilst these new proposals were in evidence, they were still the exception as funding was limited.

Examples of new proposals
- "funding from the Department of Health to commence an accredited certificate in mental health for Aboriginal people." (Batchelor College)
- "AMHW training; developing a community wide Mental Health program; developing groups with young men in relation to alcohol, anger, and violence." (Broome)

Two as yet are unsuccessful funding submissions. One to the Joint Health Planning Committee for a Family Support Unit and the second to the NT Government for a Psychologist and two Aboriginal Counsellors. (Danila Dilba, Darwin)

Aspects of mainstream mental health services that were helpful were "some specialised care in hospitals" and "an increasing awareness of Aboriginal needs".

In most cases particular people were nominated as being exceptional rather than the service itself. However, these were the exception, the majority of respondents saying "none" of these services were helpful.

The most unhelpful aspects were
- a) mainstream services were not culturally appropriate
    i.e. "they're based on a white (anglo-saxon), middle-class ethos".

b) severe availability problems

Centres were often too far away, causing extreme stress for the patient being removed from their community. Clinics that were accessible were under-resourced with few qualified mental health care professionals and few AMHW's.
- c) the care itself

Services commented that this was "drug focused", "inconsistent" and only "short-term with few longer term programs". The need for more liaison was highlighted as there is a present lack of communication and information sharing between sections of the health services.

There were a number of suggestions for the provision of more helpful services. All respondents wanted more local/community based and thus more accessible and culturally appropriate care. More training programs in cultural awareness and training programs for AMHW's is required. Counselling and support groups for individuals and families were required for issues like sexual abuse, violence, grief, and drug and alcohol dependence. Self-help programs for both men and women addressing low self-esteem and stress management were often nominated. Respondents identified that therapy programs should take a culturally focused form with narrative and massage therapy frequently listed.

Healing centres were overwhelmingly required in an effort to draw many aspects of mental health together and allow Aboriginal patients and their families to feel at ease in their environments.

The most critical priorities for all AMS's was increased resources (both financially and personnel) and liaison between allied health services. Secondly, supported accommodation that was appropriate for clients and families was frequently mentioned as were hostels for Aboriginal people. Thirdly, training and staffing centres were required. The need for more Aboriginal Mental Health Workers and the Education of non-Aboriginal Mental Health Workers in cultural issues was overwhelming. Employment training for Aboriginal job seekers was also needed. Community Education and programs in basic health care e.g.. diet, nutrition, hygiene, general mental health issues, preventative alcohol abuse programs, and womens health were frequently nominated. Increased funding for more Outreach workers and counsellors was mentioned particularly for young people and children.

The majority of services had no formal statistics. Of those who did it was primarily general data for the entire service and not specifically Aboriginal people. Of those who had data all were willing to provide it

for the project.

For services with no data, only 4 or 5 were unable to estimate figures.

The majority did not have specialist mental health staff working at the clinic permanently. A number commented that psychiatrists, psychologists and psychiatric nurses visited infrequently; "twice a month or less". None of these visiting staff were on call at any point. Approximately one-fifth of clinics did have specialist mental health staff. These ranged from psychiatrists and G.P.'s to mental health workers and part-time researchers.

Of all the responses only one clinic replied that the level of mental health staff was adequate. Most services required more staff at the most basic level of health care. The primary and generally listed requirements were for; more doctors, psychiatrists, psychologists, and nurses who were all needed on a daily basis rather than weekly or monthly visits. There was a comprehensive demand for Aboriginal and Torres Strait Islander Mental Health Workers. Often up to six per service were required. Counsellors in self-esteem and drug and alcohol dependence were also requested. All respondents added that an equal distribution of male and females were required to deal with differing issues. Youth workers, mental health co-ordinators, and traditional healers were also listed.

The majority of additional comments were concurrent in their concerns. The central themes were (as has been mentioned);

• 	the need for more liaison between Aboriginal Health Services and Mental Health Services

• 	the need for community education on Aboriginal mental health issues

• 	the need for training and increased awareness of drug and alcohol issues and suicide risk amongst young people.

Many respondents made the point that as a result of huge health problems, Aboriginal mental health is left on the "back burner" and only dealt with in a crisis. Many wanted this pattern changed from reactive to proactive. All reiterated that services were chronically understaffed and in need of fully trained, local specialists.

Education

Educational Programs in Aboriginal Mental Health were sought and Universities, TAFE Colleges and other educational institutions were contacted. The following report summarises the responses from institutions or groups and provides an overview of educational programs of relevance to Aboriginal Mental Health. While it is intended to be relatively comprehensive, it is recognised that some contributions may not have been included; the consultants did not have knowledge of them, particularly courses through Health services or other systems. It would be appropriate for those whose contributions do not appear in this report to notify the consultants with further details.

The relevant courses are reviewed by State and other matters noted generally. Professional education is noted at the end. The relevant groups contacted are listed at the end of this section.

New South Wales

New South Wales Board of Adult and Continuing Education

New South Wales Board of Adult and Continuing Education indicated that there was "little current involvement by Board–funded ACE Providers in any area of Aboriginal Health Education" (Thomas, p1). Some small projects involving community groups of Carers at Dubbo and far central and far west. The

Board indicated that it did, however, consider the area of Aboriginal and Torres Strait Islander Health as a priority area of special need and hoped to develop an Aboriginal Adult Education Strategic Plan for 1994/95. It saw partnership with Aboriginal Organisations as helpful to such program development.

New South Wales TAFE

Aboriginal Community Education, Health

This course is the first TAFE NSW certificate course developed for Aboriginal people. It teaches you how to communicate your needs in health institutions, deliver first aid, plan and prepare meals suited to your lifestyle, understand alcohol and other drug issues and develop preventative and educational health programs.

Aboriginal Vocational Preparation

This course is for people who have experienced barriers to education. It helps people to develop the skills and confidence they need to re-enter the workforce, training or further education. The course is negotiated with student groups in response to the needs of the local community.

Contact Person: Mr Peter Dwyer

Queanbeyan Hospital

Aboriginal Mental Health Worker Certificates were commenced in 1994. This course offers only 5 places. It aims to develop the necessary theoretical and practical skills to work as Mental Health Outreach Workers in Aboriginal and Torres Strait Islander Communities and involves a 22 months program module including Psychology, Sociology, Aboriginal studies, Communication, Psychiatry, Mental Health. This was developed through positions at Queanbeyan Hospital and RHSET program.

Diploma in **Aboriginal Mental Health** Faculty of Nursing, UTS, was developed in partnership with local Aboriginal Medical Services and the Department of Health.

This Diploma within the Faculty of Nursing will represent a significant contribution to the training of Aboriginal Mental Health Workers in New South Wales and nationally. The Diploma is 2 years full-time commencing in 1996. Support would be provided through Jumbunna with recruitment and supplementary course assistance where needed. The course will provide 440 hours theoretical class content and 280 hours community based self-directed work and 320 hours of supervised fieldwork. There will be core and elective components.

Selection It is envisaged this will provide 15–20 places in each year. The course is designed for Aboriginal people currently working in health and community service areas and will be oriented to the principles and processes of Primary Health Care.

Course aims to support students re developing
- Knowledge, skills and attitudes necessary to work as competent Mental Health Workers in Aboriginal communities.
- Competency in self-directed learning which will enable them to continue their professional development subsequent to completion of the course.
- Positive recognition of Aboriginal identity, culture and personal empowerment.
- Effective professional support networks.

Core subjects would be
Year 1:   Aboriginal Studies I and II, Mental Health and Distress I and II, Contexts of Mental Health Care I & II, Interpersonal Process in Aboriginal Health I and II, Mental Health Field Work I and II.
Year 2:   Health Care Strategies I and II; Mental Health Practice I and II, Community Development in Aboriginal Mental Health I and II, Mental Health Fieldwork III and IV.

Contact Person: Ms Robyn Shields

University of New South Wales

The University of New South Wales does not run any Courses and Programs covering Aboriginal Health issues. Dr Roberta Sykes, Deputy Director of the Aboriginal Research and Resource Centre is interested in the area and does give an overview of Aboriginal Health Problems in one of her Courses.

Charles Sturt University

Charles Sturt University, Bathurst has no specific courses in Aboriginal Health but does deal with Aboriginal Health in other courses, e.g. health sciences, nursing, health service management offered through Faculty of Health Sciences. Aboriginal Mental Health is dealt with in the postgraduate Masters of Health Sciences (Mental Health Nursing) course.

There are also proposed contributions through a distance education program on mental health for rural and remote community nurses. It is also proposed that a Master of Mental Health Course may be developed.

University of Newcastle

Offers a very significant contribution in terms of the provision of special programs in relation to Medical Education in the Faculty of Medicine and Health Sciences. These are Bachelor of Medicine: There has been a 10 year special initiative for Aboriginal people to graduate in Medicine.

Australia-wide there have been 12 Aboriginal graduates of Medicine with 4 of these from Newcastle.

At present there are 18 students enrolled at Newcastle in all 5 years of the course, compared to 16 enrolled in the 9 other Faculties around the country, mostly in junior years. There has been increasing success in retention of students, progression and graduation.

Selection Processes are consultative, and with broad eligibility, but specific application of selection criteria. Extensive administrative, financial, accommodation, personal and community support is offered.

Course content

Each year of the course involved significant input with respect to Aboriginal Health particularly in strands of Population medicine. There are currently plans for Cross Cultural Psychiatry as providing input in Aboriginal Mental Health. There are a broad range of possible electives in Aboriginal Health, for instance with Community Controlled Health Organisations.

Bachelor of Medical Science (Course Work)
Students successfully completing the Third Year of the Bachelor of Medicine Degree can enrol in a one year Bachelor of Medicine Science Degree in Aboriginal Health as one option. The course also has collaborative associations with health organisations and is involved in research development in Aboriginal Health.

Contact Person: Richard Gibson, Associate Lecturer

University of Sydney – Faculty of Medicine

There is some general teaching of Aboriginal Health in a number of Departments and plans to focus these areas and to have one direct, identified involvement. The Final year program has secondments to 3–6 weeks periods in rural practice and 60 students subsidised by the Faculty go to the Northern Territory, especially Darwin Hospital but also hospitals at Katherine and Gove, as well as to some New South Wales areas where there is specific contact with the problems of Aboriginal Health.

Aboriginal Mental Health has three teaching sessions during the Department of Psychiatry's scheduled teaching program – these are in seminar format and culturally and community oriented.

Broad issues to do with Aboriginal Health are discussed in courses Public Health, Law and Ethics.

Contact Person: Dr Cathy Owen

Central Sydney Area Health Service

Central Sydney Area Health Service, Rozelle NSW offers a two day course titled Grief and Loss Issues for Aboriginal Workers. This course looks at what happens when a whole culture experiences loss and the needs of persons suffering from grief and loss. It is only available once per year and has an entry requirement that one must work in the drug and alcohol field.

Contact Person: Chris Shanley

Western Australia

Curtin University

Within the general area of Health Services, the School of Nursing provides an Elective Unit, Mental Health III which does not specifically address mental disorders, however a number of relevant issues are covered, such as addiction.

The Centre for Aboriginal Studies provides a specific course within its Aboriginal Health Unit.

A Counselling and Training Development Course has commenced and provides a program which has "practical and experimental training formats" provided in culturally affirmative ways and aiming to address "counselling needs at community families and individuals levels" (Collard and Garvey, 1994).

Murdoch University

Murdoch University does not provide specific courses in Aboriginal Health or Mental Health but provides a number of subjects where some aspects are addressed: for instance the Sociology of Health and Medicine and Cross Cultural Psychology, and Culture in the Workplace. There is potential for other developments, with courses such as Introduction to Counselling.

However, there is a specific Aboriginal Health Worker Education Program run by the Institute of Environmental Science (this is under the auspices of the Remote Area Development Group). However this course is entirely oriented to physical environmental factors such as water, hygiene etc.

There is also an Aboriginal Health Worker College (Marr Mooditj Foundation Inc.) An Advanced Certificate in Aboriginal Health (one year part-time) is offered to Aboriginal people interested in working in the health field. This course has a holistic health approach. Students learn how to assess the health care needs of Aboriginal communities, families and individuals by using a problem solving approach. A Diploma in Aboriginal Health is also offered to Aboriginal people and aims to equip students with the knowledge and skills needed to be a Health Practitioner.

Contact Person: Elizabeth Gray

The University of Western Australia

The Faculty of Medicine and Dentistry reports no courses on Aboriginal Mental Health in the Department of Psychiatry. In the Department of Public Health there is one lecture in the Third Year on Aboriginal Health and Welfare, and some assignments and assessments. Within the Department of General Practice there is some contribution in undergraduate medicine education with electives, placement of students under a Doctor in the Perth AMS and some country placement with AMS's and in remote areas with high proportion of Aboriginal people. There are some mental health aspects covered in this but no specific training.

Northern Territory

Northern Territory University

The Northern Territory University offers a number of courses of relevance.

The School of Nursing conducts a broad-ranging unit on Mental Health within their undergraduate

program and this includes multicultural aspects, particularly those relevant to Aboriginal people. Family issues affecting Aboriginal Groups in urban, rural and remote areas are highlighted.

The School of Nursing will offer a Graduate Diploma in Mental Health in 1995 and this will cover health education in relation to Aboriginal Mental Health issues. Other relevant offerings include: health promotion and transcultural units which deal in part with Aboriginal Health. A Graduate Diploma in Primary Health is offered in 1995 and deals to some extent with Aboriginal Health issues. The Centre for Aboriginal and Islander Studies offers an Associate Diploma in Applied Science which includes cultural aspects of health and well-being.

Paraprofessional training also covers some matters relevant to mental health (e.g. Substance Abuse).

Batchelor College

Batchelor College is a multipurpose, semi-autonomous Institute of Aboriginal Territory Education specialising in the provision of accredited courses for Aboriginal peoples from remote and traditionally oriented communities in the Northern Territory and elsewhere. Batchelor is a township 100 kilometres south of Darwin. There is a second complex at Alice Springs, with annexes at Nhulunbuy, Katherine and Tennant Creek.

There is a School of Health Studies. Courses include:

Diploma of Health Science

The Diploma of Health Science is a one year course undertaken after the completion of the Associate Diploma of Health Science (Aboriginal Primary Health Care). The course is designed to equip students with more specialised skills in health service provision.

Associate Diploma of Health Science (Aboriginal Primary Health Care)

The Associate Diploma of Health Science (Aboriginal Primary Health Care) is a two year course undertaken after completion of the Certificate in Health Science (Aboriginal Community Health). The course aims to develop the health skills and knowledge necessary for employment in more senior health care positions.

Certificate in Health Science (Aboriginal Community Health)

The Certificate in Health Science (Aboriginal Community Health) is a one year course which aims to develop Aboriginal people's skills and knowledge for the planning and delivery of primary health care services. The course equips students to make culturally appropriate decisions about the development, practice and management of primary health care in Aboriginal communities. This course provides the minimum qualifications for employment as Aboriginal Health Worker.

Enabling Course in Health Science

The Enabling Course in Health Science is a 6 months full-time, or part-time equivalent, program designed to bridge the Basic Skills course, formerly offered by the NT Dept of Health and Community Services, and the Associate Diploma of Health Science (Aboriginal Primary Health Care). The program prepares students for entry to the Associate Diploma course. The course enables Aboriginal health workers to extend their health care knowledge and skills. This includes enhancing students ability to plan and deliver primary health care by making culturally appropriate and professional decisions about the development, practice and management of health care in Aboriginal communities.

While Mental Health is not specifically addressed it would be covered to some degree by holistic approaches and it would be possible through "intensives" or other course contributions.

Aboriginal Mental Health Training: Identifying the Need

A Draft Discussional Paper from the Northern Territory Department of Health and Community Services provides a valuable report following consultation and also a set of recommendations. These in essence recommend the support of Batchelor College and its subsidiaries as the legitimate Centre for Education for Aboriginal Health Workers. It further proposes that mental health modules are taught at all levels of

Aboriginal Health Worker Training (Certificate, Associate Diploma and Diploma) and are an integral part of these curricula. These mental health modules could also serve as update packages for currently employed workers. It goes on to recommend specific Aboriginal Mental Health worker education.

To train for this specific role it is suggested that all the modules from the other courses would form the basis, plus specific electives. This course is recommended as one that is community based and that successful completion should lead to registration as an Aboriginal Mental Health Worker. This course is urgently needed and it was recommended that it should start urgently at a Certificate level. These modules should also be made available to existing Aboriginal Mental Health Workers.

Selection Criteria were also seen as important and needed to encompass a number of principles including the following:

- The candidate must be able to clearly state and describe the group they would be able to serve as a mental health worker and the group's endorsement of their application.
- Candidates should be able to demonstrate both cultural sensitivity and competence and be able to act as a Cultural Consultant.
- They must be able to undertake training and have a commitment to achieving the required competence.

This report also provides a potential jobs description for Aboriginal Mental Health Workers, indicating the skills, knowledge and competence that should be achieved.

A Competencies Starter Pack covers some of the key areas for a curriculum (p28–45) and deals with:

- Prerequisite training
- Mental health
- Health Promotion
- Legal Aspects
- Assessment
- Depression

- **Intentional Self Injuries**

  - Mental Disorders
  - Domestic violence
  - Counselling
  - Childhood Disorders

This valuable review also includes a bibliography and overview paper on early intervention.

Contact Person: Ms Alison Worrell

Nungalinya College

Nungalinya College Darwin offers courses on Aboriginal Physical and Mental Health including Substance Abuse Awareness Counsellor, Pastoral Care in Crisis, Family Violence, Substance Abuse, Bereavement, Suicide, Youth. There is a strong Theological basis to this program, involving a number of religious leaders of different denominations.

Menzies School of Health Research, Darwin

The Menzies School of Health Research (in conjunction with University of Sydney) offers a Diploma in Public Health and a Master of Public Health and both courses include an elective subject on Aboriginal Health.

Queensland

Queensland TAFE

Queensland TAFE indicated a number of initiatives which encompassed areas dealing with Aboriginal Health and/or Mental Health. These courses are run through the Cairns College of TAFE and are as follows:

Certificate of Aboriginal and Torres Strait Island Primary Health Care (Cairns, Hervey Bay, Rockhampton)

This encompasses only one module "Mind" (PHC III) which has outcomes related to counselling, mental well-being, spiritual disharmony, stress and developmental strategies to reduce disharmony. Some 90 Health Workers have studied at certificate level and 30 are completing Associate Diplomas.

Associate Diploma of Health Science (Aboriginal and Torres Strait Islander Primary Health Care) (Cairns)

This encompasses the full curriculum of the Certificate plus electives and modules allowing speculation in the field chosen. The basic curriculum option includes Mental Health (PHC042), but it is noted that this could be further developed to a Mental Health Worker Course.

Diploma in Health Science (Aboriginal and Torres Strait Islander Primary Health Care)

It is proposed that this will be offered for the first time in 1995. Two Curriculum Development Advisory Committees operate for Aboriginal and Torres Strait Island Nutrition and Environmental Health Worker Courses.

South Bank Institute of TAFE

This group does not offer any full course or program on Aboriginal Health or Mental Health. They offer an Associate Diploma of Applied Science (A&TSI Welfare) which has 2 subjects of some relevance to mental health, namely "identity" and "interpersonal skills" (for counselling).

University of Queensland offers a course through the Tropical Health Program.

Bachelor of Applied Science (Indigenous Primary Health Care)

Subjects relevant to Mental Health include

IH203/213   Communication, Counselling and Mental Health

IH211 Understanding Human Sexuality

IH214 Alcohol and Substance Abuse

These subjects will be offered for the first time in 1995. There is further development planned with the Department of Psychiatry, and an interdisciplinary subject on Aboriginal Health as part of an Anthropology major in Aboriginal Studies. Some relevant material is also presented in Social Work.

Contact Person: Cindy Shannon

This Course liaises with TAFE courses on Aboriginal Health and there may be opportunities for progression from the TAFE to the Bachelor course.

The University of Queensland Tropical Health Program also conducts an Introductory Course in Bachelor of Applied Health Science where priority is given to Aboriginal and Torres Strait Islander Health Workers to prepare them in skills, knowledge and attitudes needed in approaching tertiary education. This short course runs over two x ten day workshops.

Contact Person: Cindy Shannon

James Cook University (Townsville, North Queensland)

Public Health and Tropical Medicine Programs are offered through the Anton Breinl Centre and there is a Special Advisory Committee on Indigenous Health. The Centre thus links with Broome (Western

Australia) and Nhulunbuy (Northern Territory) to support distance programs. There are Masters, Diplomas and Post Graduate Diplomas awarded.

The Centre has nine Doctoral students, 2 of whom are Aboriginal. The Centre is part of a consortium to develop an International Centre for Tropical Medicine. The majority of students enter the Public Health Stream. The Centre provides special entry levels for Aboriginal Health Workers and Nurses. Twenty one percent of Diploma students (June 1994) were Aboriginal Health Workers. It also runs special courses (e.g. in Obstetrics for Indigenous Primary Health Care Workers).

However neither in the Anton Breinl Centre nor at the James Cook University are there specific Courses in Aboriginal Mental Health. There is discussion about a possible curriculum for a Bachelor of Indigenous Mental Health being developed by the Centre for Aboriginal and Islander Participation Research and Development Program of James Cook University. There are courses in Psychology also of relevance, for instance Cross Cultural Psychology (PY3007)(Aboriginal Health and Mental Health are included) and a new course in the Master of Clinical and Health Psychology – namely Cross Cultural Health and Mental Health to commence in 1996.

Griffith University

Offers no specific courses in Aboriginal Health or Mental Health but considers that a number of its courses have subjects which consider Aboriginal Health

Master of Mental Health to be offered 1995 by Faculty of Health and Behavioural Science at Nathan campus.

Bachelor of Health Science on the Gold Coast campus in 1996 will offer a course on Health of Indigenous Australians.

Race and racism are dealt with in Nursing and Mental Health Nursing Curricula.

Bond University

Bond University does not at present have any courses specifically addressing Aboriginal Health but plans to offer courses in Counselling, Health and Community Psychology which may be relevant.

Australian Catholic University, Queensland campus

Australian Catholic University, Queensland campus. Currently has no courses addressing Aboriginal Health or Mental Health, but a unit in Aboriginal Health in the Bachelor of Nursing Course and a course in Community Health for Aboriginal People.

Victoria

Melbourne University

Melbourne University, Faculty of Medicine, Dentistry and Health Sciences. There are no specific courses for Aboriginal Health or Mental Health. However there is some coverage of Aboriginal Health in the Public Health and Community Medicine Strand in Years 1, 3 and 5. Some coverage is also provided in the Pharmacology and Physiotherapy courses. The Department of Psychiatry does provide some course content and experience in this area.

Monash University

Faculty of Medicine and the subfaculty of Nursing have some teaching in Aboriginal Health and Mental Health. It is covered in the final year of the medical course in Community Medicine.
The Bachelor of Nursing covers some aspects such as placements with respect to Aboriginal Health.

The Graduate Diploma (Community Nursing) specifically addresses Aboriginal Health in a number of strands and it is suggested that Aboriginal Mental Health is integrated into this.

The Master of Health Sciences (Nursing) covers Aboriginal Health integrated into core subjects.

The Centre for Rural Health: Graduate Diploma and Master degrees include electives in Aboriginal Health and also in Mental Health.

Monash also has a special support program for Aboriginal students (MOSA, Monash Orientation Scheme for Aborigines).

La Trobe University

La Trobe University has no courses in Aboriginal Health or Aboriginal Mental Health. However it has a number of courses that should be relevant to Aboriginal Mental Health, such as the Graduate Diploma of Health Science (Mental Health Studies) and possibly other courses in Health Sciences, Nursing, Health Promotions, Community Health and Rehabilitation Studies.

Deakin University

There are no courses or units related solely to Aboriginal Health although it is a component of units in some nursing courses such as Nursing people with Mental Disorders.

Australian Catholic University, Melbourne Campus

Australian Catholic University, Melbourne Campus offers no courses in Aboriginal Health or Mental Health.

Australian Capital Territory

University of Canberra

Faculty of Applied Science. There are no programs on Aboriginal Health or Mental Health.

Australian National University

No courses are reported.

Australian Catholic University, Canberra Division

No courses reported.

Canberra Institute of Technology

This Institute does not offer any specific courses in Aboriginal Health or Mental Health. In their Associate Diploma of Social Science in Welfare, Aboriginal Health and Mental Health are discussed only briefly through a series of workshops relating to Aboriginal issues.

Mental health is very rarely addressed. The Yurauna Centre offered a one off course for Certificate in Welfare Studies for Aboriginal and Torres Strait Islander people, but there was no mental health component.

Tasmania

Institute of Adult Education

The Institute of Adult Education in Tasmania offers a range of programs seen as helpful to families and the community. It employs three regional Aboriginal Adult Education Officers who liaise with Aboriginal communities across the State to develop and deliver programs appropriate to identified needs.

Aboriginal Health Care Course 9–470 supposed to be offered through Hobart, Launceston and North West Regional College. This course is based on the Queensland TAFE Aboriginal and Torres Strait Islander Primary Health Care Certificate Course. It deals with Mental Health (14 hours).

South Australia

Flinders University

Flinders University does not offer any specific courses or programs in Aboriginal Health or Mental Health. It offers a Master of Primary Health Care and a Master of Science (Primary Health Care). Both of these have options of a Major in Community Mental Health. There are Prevention, Family, Child and Community Mental Health as components of this Major and there is also a Major in addiction studies.

However, no specific reference is made to Aboriginal Health or Mental Health.

University of South Australia

No courses identified.

University of Adelaide

No specific courses are offered in Aboriginal Health or Mental Health, although some education programs have been offered and a component is proposed in the Sixth Year of the Medicine Course.

Adelaide Institute of Vocational Education

Adelaide Institute of Vocational Education, Adelaide offers a six month Certificate in Community Services (Introductory) to Aboriginal students and workers. An Aboriginal Primary Health Care Certificate is also offered through distance education (one year full-time, two years part-time) and aims to provide Aboriginal students and health workers with particular expertise in one of the following fields: Primary Health Care; Hospital Liaison; or Drugs and Substance Abuse.

Professional education in Aboriginal mental health

Nursing Education is covered in the above sections, but the recent nursing review has made specific recommendations with respect to Aboriginal and Torres Strait Islander people and Nursing. These are attached. However they do not cover Mental Health for Aboriginal and Torres Strait Islander people.

Psychology. Some special initiatives exist, for instance at James Cook University as reviewed above. The Australian Psychological Society is currently addressing this issue.

Medicine. There is some limited coverage in this area in undergraduate medical education as indicated above and proposals such as the Aboriginal Primary Health Care Project in General Practice.
Psychiatry. Educational programs vary by State and while qualification requires coverage of broad cross cultural mental health areas, there was no specific curriculum. New initiatives are addressing Aboriginal Mental Health.

Some current initiatives in Aboriginal mental health

Aboriginal primary health care project

This is a National initiative funded under the Division and Projects Program (Commonwealth Government initiative in general practice). The aims of this type of initiative are to
   • ensure effective integration of general practice with other elements of the health care system
   • provide better access to available and appropriate services
   • enhance efficiency of health system and quality of services provided.

The Aboriginal Primary Health Care Project is based in Cairns and supported through the North Queensland Clinical School of the Faculty of Medicine, University of Queensland.

The project seeks to establish a model of primary health care, including general practice service provision, which is appropriate to the needs of Aboriginal and Torres Strait Islander communities and was developed in recognition of the gross inequalities in the health outcomes of these people and local, regional and national recognition of severe inadequacies in health service provision including access to general practitioner services. The related need for the establishment of a supportive network and infrastructure for providers as well as consumers in these communities is also identified as a major impediment to the improvement of Aboriginal and Torres Strait Islander health outcomes.

The project consists of three main areas of activity:
- developing a project management approach and consultation framework which allows maximum flexibility in assessing the needs of Aboriginal and Torres Strait Islander communities;
- designing a model of health service provision which includes general practice services that are culturally appropriate to the varying needs of these communities and developing a support network for further development of the model through the consultation process; and
- defining a role for the provision of general practice services in Aboriginal and Torres Strait Islander communities.

Conceptual framework for the project

Principles

The project has been guided by the following general principles in the formulation of strategies:
- it is underpinned by the National Aboriginal Community Controlled Health Organisation definition of health;
- it recognises the right of Aborigines and Torres Strait Islanders to be self-determining in health;
- it meets the principles of primary health care as outlined in the Alma Ata 1978; and
- is integrated with all sectors which impact on the health of Aborigines and Torres Strait Islanders.

Process for developing the primary health care model and support mechanism

The process to date has sought to develop a consultation framework for assessing the service requirements of Aboriginal and Torres Strait Islander communities through the development of a series of discussion papers, and conducting meetings and focus groups with all key stakeholders. The process for the development of the Project can be described as follows:
1. **Steering Committee**
   i. Aboriginal communities and organisations
   ii. Stakeholders
   iii. Other "interested" parties
   A series of Discussion Papers are being developed in consultation with the Steering Committee and cover the following topics:
   - Protocols for Consultation with Aboriginal and Torres Strait Islander Communities
   - What is Health?
   - Primary Health Care
   - Effective General Practice in Aboriginal and Torres Strait Islander Primary Health Care
2. **Aboriginal Communities and Organisations**
   Consultation with Aboriginal communities is undoubtedly the most important process in the project and the most complex given the diversity of groups the project is involved with. The

process followed for consultation has fallen into two stages. It is anticipated that the papers entitled What is Health? and An Ideal Primary Health Care Service will be developed further as a result of the consultation process.

3.   Service Providers
4.   Other Stakeholders

The Kimberley Mental Health Project

Until now, little attention has been given to understanding mental health problems experienced by Aboriginal people nor to developing mental health care services that incorporate and respect Aboriginal culture and tradition.

The response is the formation of the Kimberley Mental Health Project, a Kimberly-wide enterprise which combines the resources of the Aboriginal Medical Services in the Kimberley and those of the Northern Health Authority of the WA Department of Health. The aim is to enable Aboriginal people which draw on traditional and contemporary health care practices.

The Project will:
- offer training in mental health care practice for Aboriginal health workers and other Aboriginal people working in related fields.
- assist with resources and support those Aboriginal communities who wish to further develop their own mental health care capacities.
- facilitate closer working relationships with existing drug and alcohol treatment programs.

An Aboriginal Focus is central to this project. There is major Aboriginal participation in each aspect of the Project. The Project Director will be an Aboriginal person. The training program is being developed by mental health practitioners and Aboriginal Health Workers. The Project Management committee will have predominant Aboriginal representation and the Kimberley Aboriginal Medical Service Council will provide financial administrative services.

Training in mental health care will begin with five-month introductory courses in Broome and in Kununurra, early in 1995 and will consist of study blocks, tutorials and supervised clinical work. A formal one year training course in Aboriginal mental health will start in July/August 1995.

Who is eligible for this training? Training is available to Aboriginal Health Workers, trained or in training and to other Aboriginal people working in related areas, e.g. in drug and alcohol programs.

Aboriginal and Islander Community Health Service, Brisbane (AICHS)

This service and the workers involved have developed a number of initiatives, while at the same time identifying many needs in terms of patients with mental health problems and mental disorders. These include
- A supportive group program for Aboriginal and Torres Strait Islander patients with mental disorders at Wolston Park Psychiatric Hospital for patients from the secure wards.
- Workshops on issues relevant to Aboriginal Mental Health and well-being, particularly in relation to culture, tradition and healing.

- **Lobbying and comments on Mental Health Policy Initiatives.**
  - Submissions to NH&MRC "to investigate and consult with Aboriginal and Torres Strait Islander communities with a view to defining and validating those beliefs and values which are deemed necessary for providing the foundation for culturally appropriate mental health services."

A number of issues identified as important for the National Aboriginal Mental Health Policy included
- Services for counselling to deal with grief and loss including proper counselling services for families surviving deaths in custody.
- Need for services for mentally ill, including homeless mentally ill.
- Need for more Aboriginal and Torres Strait Islander Health and Mental Health Workers including male and female workers.
- Need for Traditional Healers and Healing systems.
- Need for attention to specific mental illness and how these are manifested among Aboriginal people.

- • Need for an Aboriginal and Torres Strait Islander Consumer Advisory Group.
- • Need for culturally appropriate assessment in management services.

Townsville Aboriginal and Island Health Services Ltd

This Aboriginal Community Controlled Health Service runs a Social Health Unit which provides
- • Counselling and Therapeutic Services
- • Training Workshops

Areas covered include: Suicide Intervention; Grief Management; Domestic Violence (Perpetrators and Victims); Sexual Abuse; Anger Management; Anxiety; Stress Management; Coping Skills; Parenting; Mental Illness.

All these Counselling/Therapy and Training Workshops are achieved in "Culturally Appropriate" ways.

Problems seen as important and presenting to the service include Psychoses – Schizophrenia; Neurosis; Delirium; Dementia; Alcohol Abuse; Personality Disorder; Aggressive states; Psychosomatic Disorders; Mental subnormality; Cultural exclusion.

It was considered that appropriate services for Aboriginal and Torres Strait Islander people in the mental health area were virtually non-existent. Furthermore because existing services were not adapted to be relevant to Aboriginal and Torres Strait Islander people, and thus it was believed much mental distress goes unnoticed, undiagnosed, and untreated. There is a need for mental health professionals to be culturally appropriate and a need for Aboriginal and Torres Strait Islander people as mental health workers and professionals in teams.

Mental health status of Victorian Aboriginal communities

A study reported by McKendrick (1990) and McKendrick et al (1992) showed that two thirds of patients attending the Victorian Aboriginal Health Service general practice, when systematically assessed over a three year period for psychological distress to the level of that usually seen in psychiatric outpatients, were significantly distressed for most of the study period. Eight-two percent of diagnoses were of Depression. Those at risk of disorder, were more likely to have had a main caregiver in childhood who was not Aboriginal, to be not in paid employment, and those who had a forensic history were more often clinically depressed. On the other hand those who had grown up with their Aboriginal families and had a strong sense of their Aboriginal identity and culture, appeared to be less likely to show chronic psychological distress. Aboriginal people clearly were likely to experience high levels of distress but were often reluctant to use mainstream mental health services, with which they did not feel comfortable. However eighty-eight percent of the respondents in the study quoted had sought help for mental health problems through the Victorian Aboriginal Mental Health Network.

Victorian Aboriginal mental health network

(J. McKendrick and M. Thorpe)

This is a unique program addressing the mental health of Aboriginal people. It is a valuable model in that it stands alone in terms of its base being in the Aboriginal community working through the Victorian Aboriginal Health Service and using resources from St Vincents Public Hospital Academic Department of Psychiatry, and a psychiatric hospital (North Eastern Metropolitan Psychiatric Services). It also services the State of Victoria through the supra-regional network of community based Aboriginal Medical Services. Component programs that have evolved since its inception in 1987 includes: a community consultation unit; inpatient services; educational seminars in Aboriginal culture and health and general mental issues; and ongoing community evaluation and research.

This unit has achieved national and international recognition and overwhelming support from Aboriginal people. Funding appears to have been limited and at times uncertain, despite the expanding roles of this Unit, its potential as an educational focus. There is a wish to expand support programs to include transitional housing for community treatment, Aboriginal community based rehabilitation programs, plus

expansion of existing programs for the elderly, children and adolescents, people with dual disorders and forensic patients.

Victorian Aboriginal health service, housing and support project

What is the Housing and Support Program?

This program is a joint initiative by the Office of Housing and Health and Community Services. This program supplies stable housing and accommodation support for people with different types of disabilities, including psychiatric disabilities. If a project is approved, the Office of Housing buys housing stock and the relevant Health and Community Service program area funds a disability housing support worker.

The type of projects funded so far for people with psychiatric disabilities have involved the Office of Housing buying one or two bedroom flats and Psychiatric Services funding a non-government organisation to employ one disability support worker for 10 people with serious mental illness.

Project plan

The aim of this project is to provide stable housing in the community for 8–10 Aboriginal people with serious mental illness, in a communal setting. Residents will still have privacy because they will have their own bed-sitting room with en-suite facilities. Residents will receive support aimed at enhancing independence. It is proposed that a resident house-keeper would assist in the development of a community atmosphere, assist with the preparation of meals and be available for on call emergencies.

Criteria to become a resident:
- Identify themself as Aboriginal.
- Have a history of psychiatric disability with admissions to a psychiatric hospital.
- Are homeless and/or are unable to live more independently.
- Not require 24 hour care.
- Able to care for themself with some supports.
- Is able to live with others in a communal setting.

Supports available

There is a disability worker supporting the residents during the day. This worker would assist people to be linked into social activities and treatment services plus assist individuals with daily living activities. The worker's key roles are to support the residents, maintain residents independence and ensure they are linked into needed resources. Funding has been made available for this position to VAHS from the Psychiatric Services non-government budget (CSDA funds).

There will be a resident house-keeper. This person would be in charge of the day to day running of the house, buying in food, maintaining the communal areas, preparation of midday and evening meals and being on call for emergencies. VAHS has been seeking funding for this position from ATSIC.

Responsibilities

VAHS will manage this project. The house will be run under similar guidelines to those of the rooming house program. VAHS will select the tenants. Housing management will be kept separate from Disability Support by having the rent collected by the administrative section of VAHS.

Aboriginal mental health initiatives

A number of initiatives have developed or are in process or proposed.

Central Sydney Mental Health Service
Koori Mental Health Residential Facility

(Jan Yow Yeh, AMS Redfern and Christopher Dunn, Adult Mental Health Team, Redfern Community Health Centre)

The establishment of long term residential facility aims to provide for homeless Aboriginal people with Mental Disorders.

> *"The orientation of the residential program is teaching with reinforcement of necessary self-care and community skills so that residents are able to achieve their optimal level of functioning in the community."*

> The aims are specifically (p2)
> "i)   to establish a culturally appropriate and sensitive, long term accommodation, for Aboriginal people who live in the Sydney metropolitan area and are restricted due to a mental disorder"
> "ii)   to provide accommodation for homeless Aboriginal people who are restricted by mental disorder, or become isolated from their families due to illness"
> "iii) to provide short to medium respite care for Aboriginal people affected by mental disorder and who live in the Sydney metropolitan area with their family".

Development of a model for integrated mental health service for Aboriginal people: A Partnership Approach between local Aboriginal Medical Services and the Department of Health

(Professor M. Bashir)

This proposal provides for a special service to address Aboriginal client needs linking together the following components:
a)   acute care either inpatient or 24 hour crisis care in the community with support of an Aboriginal Liaison Officer (A.L.O.) who would have substantial involvement in discharge planning.
b)   Post acute care and rehabilitation including needs assessment, provided from cottage-ward accommodation staffed jointly by Aboriginal and non-Aboriginal staff with input and support from the A.L.O.
c)   Post discharge supported accommodation in a community based dwelling administered by an Aboriginal Community Controlled NGO to support continuing rehabilitation.
d)   Community reintegration support via contact with family and significant others, with Aboriginal organisations addressing grief, loss and trauma issues (link-up, Correction Services, Juvenile Justice and/or training/paid work opportunities).
       (C.D.E.P., DEET, TAFE and Land Councils)
e)   Consultation/Liaison to community clinics by the designated A.L.O.

It was encouraged that this would support a substantial minor city Aboriginal population (n=2000 approximate). This project is funded and currently in process of development and implementation.

Proposal to establish Aboriginal mental health services for Central West, Evans and Lachlan Districts of New South Wales

In 1992, in response to recognised need a policy and plan was drawn up for Central Western Region for an "Aboriginal Mental Health Services Policy". This proposal was not followed through, but recent initiatives indicate there will be some significant developments in this country region, with the renewal of this policy proposal. This report suggested a number of facets:

Primary Prevention: emphasising the building of self-esteem among Aboriginal people; the promotion of Australian Aboriginal culture and heritage to all Australians; the promotion of "mainstream" mental health services in Aboriginal communities; education of non-Aboriginal care-givers to an understanding of Aboriginal culture and the specific needs of Aboriginal people.

Provision of Aboriginal Mental Health services: with the development of a Network of Aboriginal Mental Health Workers (positions for these)

Improving access to Services through treatment, other access, regular contact and extending community mental health services.

Drug and Alcohol issues. It was emphasised that drug and alcohol programs would specifically be addressed through mental health services.

Education of mental health staff to Aboriginal culture and mental health issues, and Aboriginal communities about mental health, plus the education of Aboriginal mental health workers.

Consultation with Aboriginal Communities to achieve such aims.

The current status of funding for the six Aboriginal Mental Health Workers Positions sought to cover this Region is unknown.

Northern Territory five year development plan

This plan provides an overview of Mental Health Services in the Northern Territory. This is constituted by a network of services organised into seven districts. Districts are responsible for identifying and meeting service needs and supervising staff. While the Centre Program Directorate is responsible for formulating goals and objectives, developing policies and procedures and monitoring goal achievements.

Community based services are provided in all districts and encompass assessment, treatment and continuing care. Services include consultation, liaison, community outreach, and accommodation services. In smaller Districts (Darwin Rural, Alice Springs Rural, Katherine, East Arnhem and Barkly) services are provided by Community Psychiatric Nurses, and in some Districts, Aboriginal Health Workers. The community staff provide visiting services to remote communities in their Districts. Districts are visited on a regular (4–6 weekly) basis by a Psychiatrist from either Darwin or Alice Springs. Darwin and Alice Springs have full Community based multidisciplinary teams for assessment, treatment and ongoing management of people with mental health problems and mental disorders. Living skills, social skills training and other day rehabilitation programs are provided. In Darwin there is also a specialist Child, Adolescent and Family Therapy Team. This provides both direct service and consultation and Liaison to hospitals and other agencies. There is also a Forensic Team in Darwin, and limited Child and Forensic services are provided by the community team in Alice Springs. There is no psychiatric hospital but there are 12 acute, 10 rehabilitation and 10 secure beds in Darwin, and 7 acute, 5 rehabilitation, and 0 secure beds in Alice Springs. There are also 8 transitional beds in Darwin. There is no stand alone psychiatric hospital in the Territory. Current Services vary substantially across districts and are both mainstreamed and integrated.

Services are distributed as far as possible to the population areas delineated below.

Table 5:   Estimated prevalence of mental disorder in the NT

ABS Aboriginal Statistical Subdivision	Total Aboriginal and Torres Strait Islander population	Number of people population Northern Territory	people with a mental disorder
Darwin City	4977	70071	2102
Palmerston	1202	8330	250
Darwin Rural	1137	11596	348
Bathurst	1630	1820	55
Alligator	3720	7021	210
Daly	2202	3655	110
East Arnhem	5936	11531	346
Barkly	2732	6746	202
Lower Top End NT	5910	17083	512
Central NT	10455	36617	1099
Off Shore	9	1421	43
TOTAL	39910	175891	5277

NT Mental Health Services Five Year Plan: 1994–1999

It is estimated, in general, that this service treats about one percent of the population (see 1992–93 Mental Health Act report) and using Andrews' conservative estimate of the treated prevalence rate of 3% this suggests that only one of the population who would be receiving treatment is so doing.

With respect to the Aboriginal people 68.9% reside in rural areas. The 1992–93 report indicates that a total of 172 Aboriginal people were admitted to hospital with 91 into Royal Darwin and 80 into Alice Springs. This was one third of the total numbers in Alice Springs and 16% of those in Darwin. There appears to be no other data available on other utilisations.

It is intended that the plan will continue to fulfil the 1992 National Mental Health Policy principles that notes several issues relevant to Aboriginal Mental Health. The need to address cross cultural issues is emphasised, both for Aboriginal people and the significant numbers of people from ethnic backgrounds.

A key Territory objective is to increase the participation of Aboriginal people in the delivery of Mental Health Services. The draft discussion paper on "Aboriginal Mental Health Training: Identifying the Need" proposes that a mental health curriculum should be developed in conjunction with educational institutions. Pilot training programs in Aboriginal Mental Health, and Aboriginal Mental Health Worker positions will be further developed. As well cultural training for Department staff will be actively developed. In terms of workforce development Aboriginal Mental Health workers will be identified as a new category of Clinical Staff.

Research developments in terms of Aboriginal Mental Health Research are also seen as a priority with the Northern Territory being ideally placed to research this field. There is currently underway a project to develop a measure to assess depression in Aboriginal people (Dr Kyaw, Rural Psychiatrist).

Future direction

It is proposed that the service will continue to provide "a comprehensive, accessible Mental Health Service that encapsulates the concepts of primary, secondary and tertiary prevention, and which is provided in the least restrictive way" (p25).

The relatively recent establishment of this service means that the emphasis is on development rather than reform.

It is proposed that a resource allocation model will be developed to ensure the equitable distribution of mental health resources across the Territory. It is believed that the establishment of Aboriginal Mental Health Workers positions will enhance access. Community services will be enhanced through formalising case management and supplying additional staff, particularly to refine outreach and accommodation services. Community education will also be enhanced.

A specific Objective and Strategy was proposed by the Northern Territory Report with respect to Aboriginal Mental Health as well as other strategies which will be relevant.

Objective 14:   Increase participation of Aboriginal people in service delivery

Strategy: To negotiate for Aboriginal Health Workers and Aboriginal Mental Health Workers and to develop and implement pilot training programs and packages and to establish positions by the end of 1995.

Indicators would be the number of positions.

Aboriginal health workers and health information in rural Northern Territory

A study was carried out with Aboriginal Health Workers in Rural Northern Territory. There were individual interviews (a total of 81 Aboriginal Health Workers), group discussions with Aboriginal Health Workers usually from the same health Centres and unstructured telephone interviews.

This study and report are important in that they deal with the need for health information systems.

It highlighted the urgent need to develop health information systems in health centres and made the following recommendations:

1. Employees, in consultation with AHW's, should develop clear guidelines on all areas of health information systems and in their health centres.
2. A working group, which includes a large number of AHW's, should develop a health information system that deals with ways of feeding back health information to their communities.
3. Training at Batchelor College on all areas of health information and statistics in the Certificate and Associate Diploma courses should be reviewed.
4. Training at Batchelor College on all areas of numeracy and literacy for the Certificate course should be reviewed.
5. An in-service training and support for working AHW's on health information and statistics must be developed as soon as possible and should be implemented by the AHW Trainers with support from others in that area.
6. A lot of training is needed for the AHW Trainers if they are to properly support AHW's in the area of health information and statistics." (Djoymi et al, 1993)

Clearly these issues are also of central relevance for mental health. The more so with the lack of any significant utilisation data.

Aboriginal mental health workers in Darwin rural district: proposal for the employment of Aboriginal mental health workers in Darwin rural district

This proposal is already in part established and built upon an initiative funded originally from the Royal Commission into Aboriginal Deaths in Custody. Following discussions with Aboriginal communities and following key objectives of the Commission and the National Aboriginal Health Strategy.

Three community-based Aboriginal Mental Health Workers were employed in Darwin Rural District. Henry Moreen by Belyuen Community Council, full time; and Pius Tipungwuti and Mathew Wonaemirri

in a shared full time position with Milikapiti Community Council.

The major role fulfilled by these workers may be termed "Cultural Counselling" as they work within the existing family and community networks, making use of Law and traditional knowledge. They use these frameworks for diagnosis and intervention. Among the major areas of involvement is dealing with family and interpersonal conflict, and the alcohol problems and violence that may be associated. The work is carried out through cultural systems and they may be called upon to deal with community issues identified by community leaders – for instance changes to alcohol distribution, sale patterns, or responding to an increase within a community of suicide attempts. They may also need to approach Elders to seek their advice and intervention. They also develop relationships with Mental Health Service providers so that a process of referral is established which respects cultural practices, and allows the community some control over the service, leading to much more effective work with these services.

The persons selected as Mental Health Workers are senior people in their own community. Further positions to a total of 6 was sought, plus a Clinical Nurse Consultant and Aboriginal Mental Health worker in Darwin to provide liaison, support and funding for the full network.

This is an Aboriginal Community base initiative, funded through the State and Federal Mental Health funding basis, but working autonomously in a way that is in function community controlled.

An Evaluation of this Proposal is also proposed and should commence in 1995:

Anticipated Outcomes: (Norris, 1994)
- Culturally appropriate Mental Health Services available to residents of remote Aboriginal Communities in Darwin Rural District
- A model of Community Controlled Mental Health Services delivery to residents of remote Aboriginal communities.
- A model of how to integrate mainstream Mental Health Service with Community Controlled Aboriginal Mental Health Services
- Culturally appropriate education for Aboriginal Mental Health Workers
- Cross-Cultural education for mainstream Mental Health Service Providers.

Current needs in mental health, Torres sector:
proposal for the provision of mental health educators, indigenous mental health resource persons and mobile remote area mental health nurses

The following submission (February, 1995) has been prepared by Dr E Hunter, Regional Psychiatrist, Aboriginal and Torres Strait Islander Health and is fully endorsed by Dr Holt, Medical Superintendent and G. Jackson, AEO, Torres Sector.

Over the last two years a mental health service to service the remote communities of Cape York has gradually been evolving. It has grown from a centrally based, evacuation service with no follow-up or monitoring, to become community based and mobile. At present this service remains limited to one psychiatrist visiting each community and remaining there for several days approximately every three months (this does not include all the Islands in the Torres Sector which are visited considerably less frequently and serviced largely through Thursday Island.) This has recently been supplemented by the arrival of a child psychologist, working in a similar fashion. From the beginning of next year the service will be expanded as three Aboriginal and Torres Strait Islander Mental Health Educators move out to the communities after having finished their first year of training in Cairns. Their roles will focus on the education of Aboriginal and Torres Strait Islander Health Workers in remote communities to increase their basic mental health competencies. Perhaps the most urgent priority in terms of funding at the moment is to ensure continuing funding for the two of these three positions that are currently being grant-funded, that lapsing at the end of 1995.

The only other mental health resources in this vast area are visiting Social Work services to Weipa,

counselling provided through the Family Resource Centre in Cooktown and a part-time Social Worker on Thursday Island. While valuable, the turnover of staff in these positions and their urban base has limited their ability to respond to the needs of the more remote settings.

There thus remain several notable areas of deficiency. The first of these is the monitoring and follow-up of individuals with chronic mental illness. At present, I am seeing nearly 400 patients in the communities north of Cairns (excluding the Tablelands sector), most of whom have been referred for serious problems and many of whom are maintained on psychotropic medications. At present there is no mechanism for ensuring follow-up, both in terms of monitoring those individuals who are on medications and administering depot preparations, and continuing the treatment plans for others. Given understaffing and the extraordinary demands of remote communities, to expect that these activities will be carried out by the regular medical staff in those settings is unreasonable. This could be addressed by the appointment of Mobile Remote Mental Health Nurses, at least in the town settings close to Aboriginal and Islander populations (Cooktown, Thursday Island and Weipa). The populations potentially served from these centres are:

Cooktown

Cooktown	1500
Hopevale	1100
Wujal Wujal	500
Laura	350
Lakeland	300
Ayton/Rossville	150
TOTAL	3900

Thursday Island

Torres Strait	8000
NPA	2200
TOTAL	10,200

Weipa

Weipa	2000
Napranum	900
Lockhart River	600
Aurukyn	1200
Pormpuraaw	750
Kowanyama	1100
Elsewhere	1050
TOTAL	8600

Not only are these substantial populations in their own right, but have large indigenous populations, the Torres Sector being estimated in the 1991 Census to be 77% Aboriginal or Islander, and the Cape Sector 52% (it is almost certain that these proportions are low, the census consistently underestimating Aboriginal and Islander populations). They are thus populations with great need, being indigenous, remote, socioeconomically underprivileged, and in communities with widespread problems on a social level such as inadequate housing, unemployment, widespread substance use and its psychosocial consequences. These problems are further compounded by an almost total absence of services (such for the intellectually disabled and children at risk) available to urban dwellers. Recognising this, these very populations have been prioritised in the National Mental Health Policy and as a result of the Burdekin report.

The provision of a Mobile Remote Mental Health Nurse in each urban setting would provide for a variety

of roles, including:

- coordinated discharge plans for patients leaving Cairns Base Hospital;
- supervision of those patients remaining under the Mental Health Act;
- monitoring of chronic patients and administration of medications;
- support for nursing and health worker staff on remote communities with provision of supervision and education;
- coordination with the Regional Psychiatrist in the assessment of emergent problems and the initiation of treatment;
- management of certain crisis situations in a local hospital setting in consultation with specialists in Cairns.

I have provided some preliminary costings for these positions. Clearly such remote locations will present some difficulties, particularly in terms of permanent accommodation. However, it may be possible to recruit suitable mental health nurses who are already resident in these centres. There are at present at least three interested parties, one in Weipa, one at Lockhart River and the other on Thursday Island.

One of the areas of savings that could arise from these positions is in the local handling of psychiatric cases that would otherwise be evacuated to Cairns Base Hospital. That has substantial direct financial costs in terms of RFDS flights (@ $900 per flying hour, being 3 hours return to Weipa and 4 hours to TI), return airfares, hospital and other accommodation costs, not to mention the disruption to the lives of those patients and their families by their removal from their community.

Experience from Broken Hill has demonstrated that such evacuations can be substantially reduced by providing an intensive care suite in or close to the local hospital in which certain patients can be admitted with their families under the supervision of a mental health professional supported by hospital staff, maintaining close liaison by phone with an urban based psychiatrist. Given the current or imminent construction of hospital facilities it is possible that space could be assigned that would meet this need, space which could also be used for other non-mental health purposes. In addition to selected psychiatric emergencies, other mental health uses could include occasional respite (for instance patients with dementia) to support ongoing home care and an area for counselling bereaved relatives. Having a locally based mental health nurse would be the critical factor in providing such a service.

The second major area that needs to be addressed is to ensure that each of the remote communities have an indigenous mental health professional presence. The need for this person to be Aboriginal or Islander reflects not only the obvious cultural demands but also the realities of rapid turnover among nursing staff in these communities. At present the major initiative in this direction is the provision of Education and supervision to Health Workers on those communities, an initiative that will be expanded next year. However this clearly is insufficient and it is unlikely that a specific mental health specialisation role for remote area health workers would suffice. In part this reflects the workload of these Health Workers who, if requested to take on a specific mental health role in addition to others, would probably end up compromising mental health in the face of more immediately pressing needs. In addition it also reflects the clinic based nature of Health Worker practice which would necessarily restrict the range of functions of such a professional.

Over the last four months I have spoken directly with the Council or council representatives of Pormpuraaw, Kowanyama, Aurukun, Coen, Lockhart, Napranum, Bamaga, Injinoo, Wujal Wujal, Hopevale, Cooktown, Laura, Saibai, Dauan, Yorke, St Pauls, Yam and Boigu, as well as the Mayor of TI, Mr Pedro Stephens, the chairperson of the Torres Strait and NPA Health Council, Ms Grace Fischer, and to a meeting of the newly formed Cape York Health Council (Apunipima). In the course of the first discussion a suggestion was made which I later relayed in each of the other settings. That was regarding the possibility of developing a Mental Health Coordinator position in the community which would be a person selected by and responsible to the Community Council. That position could be widely defined, addressing mental health per se as well as working in allied social areas such as youth and recreation and aged care, as well as coordinating submissions for funding for specific projects.

The selection of an appropriate candidate would clearly have to reflect local issues and could be an

individual with traditional healing status or pastorall skills, or someone elsewhere held in esteem by the community. The suggestion in Pormpuraaw was that such a position could be funded by CDEP with the balance to a professional wage made up from other sources. It would better be considered "shared responsibility" both because of the implications of CDEP and the reality that certain settings, such as TI, do not have CDEP.

Obviously not all communities are large enough to warrant such a position, but most are. So far the verbal responses offered by each community have been positive and I have left documentation to be considered in their respective council meetings. Written feedback to date has supported the initial impressions. Should such a position be feasible it would provide a local informed mental health presence which we would support by part funding as well as the provision of supervision and support (by the local health staff, the Regional Psychiatrist and Child Psychologist, the Aboriginal and Torres Strait Islander Mental Health Educator and, if possible, the Mobile Remote Mental Health Nurse). From strictly a size and location perspective, the communities that would appear appropriate for such a position are Wujal Wujal, Hopevale, Pormpuraaw, Kowanyama, Lockhart River, Aurukun, Napranum, Bamaga (covering the 5 communities) and Thursday Island. However, as a trial it would be prudent to begin with Mental Health Coordinator positions for each nursing position would be appropriate, to be expanded as experience and resources dictate. The most obvious communities would be Wujal Wujal and Hopevale (Cooktown), Napranum and Aurukun (Weipa), and, Thursday Island and Bamaga (Thursday Island).

Costings for these positions are somewhat more difficult. A guide may be suggested by the experience at Laura where the Health Department provides $30,000 towards two health workers each, with the remainder of the salaries being provided by the community. Thus some two thirds of these worker's salaries are covered by the Health Department. Considering that these positions would have to attract individuals of high standing, and while there may be on costs (such as transport to Cairns for in-service) it is probable that on this sort of arrangement the cost to the Department would be reasonable. Considering that there are six communities identified at this stage the cost of the program would ultimately be considered reasonable.

It is my opinion that by ensuring the continuation of funding for the positions of the Mental Health Educators, providing for sector based Mobile Remote Mental Health Nursing positions in Cooktown, Weipa and Thursday Island, supporting Mental Health Resource Persons (based in local communities, responsible to the Community Council and working closely with and supported by Health Department Staff) Cape York would have the most comprehensive mental health service for remote indigenous populations in the country. By providing multi-purpose facilities in each of those urban centres capable of managing selected psychiatric cases that would otherwise be evacuated, part of those costs would be offset.

Funding is sought for:
- 3 Mental Health Educators
- 6 Indigenous Mental Health Resource Persons
- 3 Mobile Remote Area Mental Health Nurses

Evaluation of Aboriginal mental health services for children

(A. Mihulka and Dr. M. Ortiz, 1994)

This project proposed a literature review, an examination of the cultural sensitivity of mainstream services, and to liaise with relevant bodies to determine available, current and needed mental health services for Aboriginal Children and Young People.

The basic philosophy of the project is to test the hypothesis that mainstream mental health services are not sufficiently aware of cultural sensitivities which may hinder or prevent the effective delivery of services to NSW Aboriginal youth.

Proposal for national mental health project funding Brewarrina/ Bourke/ Walgett regional pilot program: alternative approach to Aboriginal

mental health

(Patricia Rosenberg)

This project aims to provide a culturally alternative approach to addressing the mental health problems of the Aboriginal communities of Brewarrina, Bourke, and Walget and Environs, that will encourage the target group, historically reticent to use mainstream service, to avail themselves of this service. The project also aims to provide a training program for Aboriginal Health Workers that will empower them, and the target group, to address the multiple mental health disorders in these remote and isolated communities in a manner that will develop confidence and self esteem in the worker and the clients and to provide a therapy system for addressing Aboriginal Mental Health disorders in a manner that explores traditional and cultural mores i.e. through story telling, touch, comforting and nurturing, with regard for spiritualism that may have significance on a broader application nationally.

Rural health support, education and training (RHSET) program grants

Grant no 5. (A/Prof. A. Eckermann)

The Department of Aboriginal and Multicultural Studies, University of New England, Armidale have developed a Training Package to introduce non-Aboriginal Health Workers to the needs of Aboriginal Australians. The aim of this cross-cultural orientation program is to familiarise non-Aboriginal Health Workers with relevant aspects of Aboriginal society and culture.

Grant no 14. (Ms. M. Harris)

The University of Wollongong, Faculty of Health and Behavioural Science have produced a report on the Evaluation of the Provision of Specialist Medical Services to Remote and Isolated Patient Groups. This report evaluated different methods of providing specialist medical services to remote areas, in particular the Patient Transit Service and the Aero-Medical Service in Queensland.

Grant no 15. (Ms. S. Ross)

The Menzies School of Health Research, Casuarina, NT, have formulated a Short Course in Health for Aboriginal Leaders. This aim of this project was to develop and evaluate modular courses to enable Aboriginal community elders and leaders in remote communities to become familiar with the broad range of information and issues concerning Aboriginal health.

Grant no 16. (Dr. T. Nienhuys)

The Menzies School of Health Research, Casuarina, NT, have formulated a project entitled -Introduction to Aboriginal Culture and Health in Remote Communities. The aim of this project is to familiarise non-Aboriginal health professionals with appropriate and existing health services for Aboriginal people to provide health professionals with understanding, skills and knowledge of the health needs of Aboriginal people.

Grant no 23. – (Dr. C. Geefhuysen)

The University of Queensland, Tropical Health Program, has developed a Pilot Training Program - Use of Local Health Data to Monitor the Health Status of the Community. The project evaluated the effects of training in health surveillance on the effectiveness of health services provided by a small remote hospital in an Aboriginal community.

Grant no 31. (Ms. R. Ellis)

The Eastern Sydney Area Health Service, La Perouse, NSW, received assistance for fund production and national distribution for the Aboriginal and Islander Health Worker Journal for six months.

Grant no 50. (Ms. C. Franks)

The Northern Territory Department of Health, Casuarina have a two year grant to apply the Healthy Aboriginal Life Team (Halt) principles to health promotion and to develop, produce and distribute a manual based on the HALT principles to health professional working in Aboriginal Health. This project is

entitled 'Ngapartji-Njapartji Working in Partnership Development of a Manual for Workers in Rural and Remote Aboriginal Communities.

Grant no 51. (Mr. J. Daby)

A Research Team from the Northern Territory Department of Health and Community Services, Casuarina have investigated Aboriginal Health Workers (AIHW's) Retention and support. This team performed structured and semi-structured interviews with both employed and prematurely retired Aboriginal health workers.

Grant no 58. (Ms. J. Krakouer)

The Southern Aboriginal Corporation Inc. Albany, WA, developed a pilot scheme to address the mental health needs of the Nyoongar people of the South West Region of Western Australia. Information was drawn from a study tour to research community models of services addressing the psychological, social, physical and spiritual needs of indigenous communities in North America and Canada.

Grant no 64. (Ms. M. Gaffney)

A project from Karrayili Adult Education Centre, Fitzroy Crossing, WA entitled 'Three projects Aboriginal Culture; Nursing training and Kriol language aids -Fitzroy Valley Area WA.' has enabled an Aboriginal resource person to produce information (including a video for hospital staff) about local Aboriginal culture language for orientation of new Community Health Workers.

Grant no 71. (Ms. T. Tse)

The Curtin University of Technology, Perth, WA project Mental Health Assessment and Intervention: A Self Directed Learning Program for Rural Nurses: involves 2 P/T salaries and clerical support to develop and pilot with 50 nurses, a distance learning educational program in mental health for rural and allied health professionals. This will include videos, audiotapes and teleconference.

Grant no 74. (Ms. C. Rae)

The Northern Territory Department of Health and Community Services, Casuarina project – Strong Women, Strong Babies, Strong Culture: describes the development of a be-cultural storyline and supporting graphics to inform Aboriginal women in Northern Australia about the impact of their nutrition on the birth weight and subsequent growth of their babies.

Grant no 75. - (Ms. R. Barker)

A project from the Northern Territory Department of Health and Community Services entitled 'Resource Procedures Package – Aged/Disabled people in Remote Aboriginal Communities (NT)' involves a physiotherapist and occupational therapist working in consultation with other remote health professionals and Aboriginal community members developing an orientation and resource package for allied health professionals.

Grant no 76. – (Ms. R. McDonald)

The Disabled Persons Bureau, Alice Springs, NT. (Northern Territory Department of Health and Community Services) are working on a project – Allied Health Resource Library for Rural and Remote Service Providers – NT. The aim is to establish a resource library for Allied Health and Aboriginal Health Workers, for support, education and development of rural and remote staff.

Grant no 97. – (Ms. J. Wotherspoon)
Batchelor College held a 3 day workshop involving representatives of Batchelor College, NT ATSIC Health council and four interstate representatives of Health Worker Education Programs to review the existing "Handbook for Aboriginal Health Workers". This project is entitled -Handbook for Aboriginal Health Workers – Seeding grant for further development of proposal.

Grant no 106. – (Mr. C. Penter)

The Family Planning Association of WA are investigating a project – Sexuality Education and Training Program for Aboriginal Youth in Rural Areas. The aim is to develop curricula for culturally appropriate

sexuality education and training program for use by Aboriginal Health Workers with Rural Youth.

Grant no 109. – (Dr. R. Brandon)

The Peninsula and Torres Strait Is. Health Authority, Cairns QLD. have developed a 'Manual for Remote Primary Clinical Care' including standard treatment protocols for use by remote area registered nurses and Aboriginal and Torres Strait Islander Health Workers.

Grant no. 116. – (Prof. A. Eckermann)

Binan Goonj – (They hear but they don't listen – Bridging cultures in Aboriginal Health): This project at the University of New England, Armidale, NSW is adapting the existing cross-cultural package Binan Goonj to be relevant to remote areas and is applying principles of computer assisted learning to cross-cultural training and has a train-the-trainer in-service component for Aboriginal organisations.

Grant no. 119. – (Envoy A. Staines)

The National Youth Foundation, Haymarket NSW has outlined a project entitled – 'Intervention and prevention of youth suicide'. This project aims to provide educational resources, co-ordinate and sponsor workshops, gather data, statistics and offer professional support to rural health and community service workers and educationists for the intervention and prevention of youth suicide.

Grant no. 120. – (Ms. C. Bradford)

Youth Development Network Inc., Kyneton, VIC. received funds to employ two part-time youth workers to work with youth in developing individual and community options and responses that may prevent youth suicide.

Grant no. 132 – (Dr. K. McNab)

Central Australian Aboriginal Congress, Alice Springs, NT. project – Central Australian Rural Practitioners Orientation Package. Development of a standard orientation package to familiarise new health professionals with aspects pertinent to working in predominantly Aboriginal health care in rural and remote communities in Central Australia.

Grant no. 134 – (Dr. G. Byrne)

The Alzheimer's Association of Qld's current project – Qld Rural Dementia Training Project aims to develop and implement a comprehensive dementia-specific education and training package for rural Queensland Health Workers.

Grant no. 144 – (Mr. M. Reid)

Reid Harris and Associates, Glebe, NSW are involved in a project entitled 'Australian Health Ministers' Advisory Council (AHMAC) working party on the health services workforce in rural and remote areas. This aim of this project is to assist in the development of a framework for the roles and inter-relationships of Aboriginal health workers, nurses and doctors in remote areas.

Grant no. 146 – (Ms. M. Randall)

Bendigo and Regional Psychiatric Service, Eaglehawk, VIC have received funding to employ a rural mental health educator to resource existing isolated health and welfare workers.

Grant no. 152 – (Mr. G. Lennox)

Tasmanian Department of Health, Moonah, TAS has a current project – 'Mental health rural outreach program' in which specialist mental health workers will provide training for rural health workers in order to continue treatment of mental illness, provide early intervention, and increase the perception of support.

Grant no. 157 – (Ms. J. Parham)

The NSW Institute of Psychiatry, Rozelle, NSW is currently assessing Education and training needs of mental health professionals. This project aims to identify the additional education and training needs of mental health professionals working in rural and remote NSW and develop a training strategy to meet those needs.

Grant no. 170 – (Dr. C. Jeffries)

The WA Research Institute for Child Health, Subiaco, WA is involved in the project – 'The Mooditj Mums – Enhanced antenatal and Postnatal Care for Aboriginal Women. The project involves the selection and training of Aboriginal Health Workers, chosen from the target community, to provide antenatal and postnatal care, including ultrasound, and infant follow-up, plus the evaluation of this method of health care.

Grant no. 172 – (Ms. S. Bryce)

The Nganampa Health Council, Alice Springs, NT are conducting a Cross-cultural action research project in women's health on the Anangu Pitjantjara lands in SA supporting local Aboriginal women's initiatives, traditional midwives and healers as educators, and developing a data base.

Grant no. 174 – (Mr. D. Edwards)

Yalata Maralinga Health Service, Ceduna, SA received project funding for a Community health development officer at Yalata Aboriginal Community to co-ordinate the delivery of primary health care services at Yalata. This includes the facilitation of the Aboriginal health worker training program and coordination of the delivery of a counselling service.

Grant no. 176 – (Mrs C. O'Farrell)

The WA Health Kimberley Region, Derby WA are working on a project to clarify the roles and professional inter-relationships between Aboriginal health workers, remote area nurses and medical officers in remote Kimberley Aboriginal Communities.

Grant no. 181 – (Ms. R. Ellis)

The Eastern Sydney Area Health Service, Aboriginal and Islander Health Workers's Journal, NSW are developing a national register of all Torres Strait Islander and Aboriginal Health Promotion Education material which would allow Aboriginal and Torres Strait Islander Health Workers access and adaption for local usage particularly in rural and remote areas.

Grant no. 185 – (L. Chandler)

The Northern Regional Health Authority, Townsville, QLD are working on a project to identify the incidence of dementia within the Aboriginal and Torres Strait Islander community and to develop appropriate assessment and management strategies.

Grant no. 190 – (Dr. E. Hunter)

The Peninsula and Torres Strait Regional Health Authority, Cairns, QLD's project – 'Mental Health Skills Development for Remote Area Aboriginal and Torres Strait Islander Health Workers' aims to provide funds to train experienced Aboriginal and Torres Strait Islander health workers as mental health trainers. These trainers will undertake worksite-based training in mental health care and then work with remote health workers.

Grant no. 193 – (Ms. J. Barton)

The NSW Health Orana Region, Dubbo project aims to establish an Aboriginal Mental Health Worker Training position to increase access and standard of mental health care for Aboriginal people in the Orana region of NSW.

Grant no. 195 – (Dr. J. Davies)

Mental Health Services, SE Region, NSW Health project 'Koori mental health liaison/outreach worker training programme' aims to make mental health care services more accessible to Aboriginal and Torres Strait Islander people in the south-east region of NSW.

Grant no. 196 – (Dr. B. Bartlett)

Central Australian Aboriginal Congress, Alice Springs, NT project 'Central Australian Aboriginal Health Workers: perceived roles, support and training needs' will involve consultation with Aboriginal communities, Aboriginal health workers and non-Aboriginal health professionals. These will be conducted to clarify the role of AHWs, attitudes of their communities, and of other health professionals to develop support education.

Grant no. 197 – (Prof P. Brooks)

The University NSW Faculty of Medicine project 'Development of Undergraduate and Graduate Education for Alice Springs area' aims to develop an integrated programme to expose medical undergraduates to the problems of Aboriginal health and provide a postgraduate educational activity to both the hospital and the local health community in Alice Springs.

Grant no. 199 – (Dr. C. Geefhuysen)

The University of QLD, Tropical Health program project 'Health Information and Surveillance Systems for Local Community Use' focuses on training in health information and surveillance to people in rural communities and assistance to local personnel to develop appropriate record systems.

Grant no. 202 – (Ms. H. Everist)

The Rumbalara Mental Health Project involves training of Aboriginal Health Workers in early identification of mental health problems and improving access of the target community to mainstream mental health services.

Grant no. 211 – (P. Poelina)

The Council of Remote Area Nurses project funding application for CRANA Conference 1993 aimed to provide a valuable forum for remote area nurses and Aboriginal health workers to discuss issues and innovations that directly relate to their practice at local, state and national levels.

Grant no. 218 – (Ms. B. Scott)

Hedland College, WA project 'Bachelor of Science (Nursing) Bridging Course of 6 months duration is primarily designed for students including Aboriginal students who do not meet the entrance criteria to Curtin University.

Grant no. 224 – (Mr T. Agius)

The Aboriginal Health Council of SA project 'SA Aboriginal Mental Health Program (SAAMHP)' will be an integral initiative in developing a culturally appropriate training and education program with support for Aboriginal mental health workers throughout the State.

Grant no. 249 – (Dr. C. Owen)

The University of Sydney project 'Mental Health Skills Development Programme for Rural Health Services' aims to establish a team approach to rural mental health care and to maximise multi-skilling and continuity of care, in a primary health care setting. This project will use a combination of co-joint and small group learning techniques.

Grant no. 255 – (Dr. V. Gidley)

The Cairns Rural Health Training Unit, Peninsula and Torres Strait Regional Health Authority, QLD project 'Accelerated development of health worker in-service training' aims to provide a full program of in-service training courses for Aboriginal and Torres Strait Islander health workers in the Peninsula and Torres Strait region. This project will involve curriculum development and adaption, piloting and evaluation.

Current data collection on Aboriginal admissions from 1/3/91 to 30/11/94 Bloomfield Hospital

(Mr Bert Prusiak, Clinical Nurse Specialist)

This is an important initiative outlining utilisation data and classification status of mental illness of Aboriginal people being admitted to Bloomfield Hospital. The Consultancy Report has recommended that Data and Information Systems be a key Policy Initiative (Policy Section 16) as Baseline Data on Aboriginal Health generally and in particular the Mental Health of Aboriginal people is sadly lacking.

Therefore the following summary distils important data and information that reflects the mental health needs and problems of Aboriginal people in the Bloomfield district.

There were a total of 171 Aboriginal admissions to Bloomfield Hospital between March 1991 and November 1994. The average age of all admissions was 31 years. The average Length Of Stay (LOS) for all patients was 39 days. The breakdown of the Aboriginal admissions by Classification Status shows there were 49 admissions as a Voluntary Patient. However there were also 40 admissions on an Inebriate Order by a Magistrate; 38 admissions on a Schedule as Mentally Disordered; and 33 admissions on a Schedule as Mentally Ill. The data also shows various dual diagnosis categories mainly comprising drug and alcohol problems and mental health problems. This data substantiates other reports, reviews and research highlighting specific mental health problems and provides an example of data collection that should be linked into a National Data Base in Aboriginal Mental Health.

• **all of the above information was provided to the consultants**

List of all individuals, communities and organisations consulted/contacted

Aboriginal Medical Services
Aboriginal Community Recreation and Health Services Centre of S.A.
Aboriginal and Islander Community Health Service, Brisbane
Aboriginal Medical Service Co-op LTD Redfern
Anyinginyi AMS
Armidale and District Services Incorporated
Awabakal AMS

Biripi AMS
Bourke AMS
Brewarrina AMS
Broome AMS
Bulgarr Ngaru AMS
Boree Aboriginal Corporation

Caroona AMS
Carnarvon AMS
Central Gippsland Aboriginal Health and Housing Co-op
Central Queensland AMS
Central West Dental Health Aboriginal Corporation
        Coomealla Health Aboriginal Corporation
Cummeragunja Housing and Development Aboriginal Corporation (Health Service)
Danila Dilba Medical Service

Daruk Aboriginal Community Controlled Medical Service Co-op
Dubbo Central and Western Aboriginal Health Education and Promotion Centre
Durri Aboriginal Corporation Medical Service
Doonooch Self Healing Aboriginal Corporation

East Kimberley AMS
Erambie AMS, West Cowra

Geraldton Regional AMS
Gomilaroi Health Committee
Griffith Aboriginal Corporation for Drug and Alcohol Rehabilitation
Griffith Health Committee
Gumbangerri New England Aboriginal Elders Tribal Regional Council
Gomilaroi Aboriginal Corporation Medical Centre

Illawarra AMS Aboriginal Corporation

Kalano AMS
Kalgoorlie AMS
Karmilaroi AMS, Gunnedah
Katungal Aboriginal Corporation Community and Medical Service

Leeton and District Aboriginal Corporation

Mackay AMS
Maitland Aboriginal Community Health Committee
Mookai Rosie Be Bayan AMS
Mutitjula Community Health Service

Narrandera Family Support Group for Alcohol and Drug Dependants Abor. Corp.
Ngalkanbuy, Echo Island, NT
Nganampa Health Service
Nowra AMS

Perth AMS
Pika Wiya Health Services, S.A.
Pintubi Homelands Health Service
Puis X Aboriginal Corporation

Riverina Medical and Dental Aboriginal Corporation
Rumbalara Aboriginal Co-op and Medical Clinic

South Coast Medical Service Aboriginal Corporation
Stradbroke Island Aboriginal Community Health

Tasmania AMS, Hobart and Launceston
Tharawal Aboriginal Corporation
Townsville Aboriginal and Islander Health Service
Tweed Heads Health Committee

Walgett AMS Co-operative LTD.
Walhollow Aboriginal Corporation
Wanarunah Land Council
Wellington Aboriginal Corporation
Weigelli Centre Aboriginal Corporation
Wu Chopperen Medical Service

Yalata/Maralinga Health Service, Ceduna
Yawarra AMS

Aboriginal Summit attendees

Mrs Angie Akee	Qld Trachoma and Eye Health Programme
DrIan Anderson	Victorian Aboriginal Health Service
DrPeter Arnold	AMA Executive Councillor
Mr Bernie Ayers	Diabetes Australia
Mr Mark Baker	The Age
Dr Muriel Baker	Australian Red Cross
Ms Jeannette Baldwin	Australian Diabetes Society
Ms Majorie Baldwin	NACCHO Executive
Mrs Maureen Barnett	Medical Observer
Dr Ben Bartlett	Central Austalia Aboriginal Congress
Prof Marie Bashir	Central Sydney Area Health Services
Dr Victor Bear	Australian Society for Otolaryngology
Dr Shrina Begg	Darwin Hospital
Ms Stephanie Bell	Central Australia Aboriginal Congress
Mr Sol Bellear	Aboriginal Health Research Council
Dr Kuldeep Bhatia	Australian Institute of Health and Welfare
Mr Steve Blunden	Durri AMS
Dr John Boully	Medical Practitioner
Ms Maggie Brady	Aust Institute Aboriginal and Torres Strait Islander Studies
Dr Frank Brennan	Redfern
Dr Gary Brian	Hollows Foundation
Mr Paul Briggs	Rumblora AMS
Mr Gordon Briscoe	Fred Hollows Foundation
Mrs Mary Buckskin	Woden Valley Hospital
Ms Donnaleen Campbell	Aboriginal and Island Health Workers Journal
Mr Gordon Carey	Australian National Audit Office
Mr Jim Carlton	Red Cross
Ms Betty Carter	Congress NACCHO
Ms Cheryl Cole	Central Australia Aboriginal Congress
Mr Les Collins	Aboriginal Health Design
Ms Rose Collis	NACCHO Executive WuChopperen
Dr Bill Coote	Australian Medical Association
Dr Robert Cooter	
Mr Vince Copley	Fred Hollows Foundation
Mr Kevin Cox	AMS – Broome
Mr Paddy Dalton	Moorewell
Miss Gemma Dashwood	Student
Dr Diane Davis	Northern Territory Department of Health
Mr Michael Dodson	ATSI
Prof Robert Douglas	NCEPH
Dr David Dunn	Begagambirringu Health Service

Dr Sandra Eades	Aboriginal Medical Service, Perth
Mr Alan Eldridge	NSW Health Department
Ms Rose Ellis	Aboriginal and Island Health Worker Journal
Dr Patricia Fagan	Queensland Department of Health
Ms Barbara Flick	Aboriginal Medical Services Darwin
Dr Tom Gavranic	Medical Practitioner
Prof Alan German	Perth –Dean of Medicine
Comm Steve Gordon	ATSIC
Dr Steven Guthridge	Darwin Rural District Medical Office
Prof John Hamilton	University of Newcastle
Mrs Maisie Harkin	Begagambirringu Health
Dr William Hart	Australian Faculty of Public Health –Vic
Prof Peter Herdson	College of Pathologists of Australia
Mr Arnold Hunter	NACCHO Executive
Dr Ernest Hunter	Queensland Department of Health
Dr Gerry Jacobson	Australian Geological Survey Organisation
Mr Norman Jensen	DEET
Mr Bary Johnson	Qld Trachoma and Eye Health Programme
Prof Ross Kalucy	Flinders University of SA
Mr Ray Kent	Assistant General Manager (Health), ATSIC
Dr John Kibukamusoke	Renal Specialist
Mr John King	Wilcania
Dr Lee Lenton	Royal Australian College of Opthalmologists
Dr Neville Leslie	Rumbalara AMS
Dr P Lickliss	Tuggeranong Square Medical Centre
Ms Nancy Long	NACCHO Executive
Ms Tammie Lovett	Rumbalara AMS
Dr Peter Macneil	Royal Australian College of Surgeons
Ms Mary Martin	Aboriginal Medical Service
Dr Colin Mathers	Australian Institute of Health and Welfare
Ms Naomi Mayers	Australian Medical Service
Ms Fiona Mcleod	Royal Australian College O&G
Mr George Menham	General Manager (Health), ATSIC
DrAndrew Miller	Australian College of Dermatologists
Dr Lindsay Mollison	Alice Springs Hospital
Mr Timothy Moore	Council for Aboriginal Reconciliation
Dr Pat Mowbray	Community Health Services
Ms Kaye Mundine	Aboriginal Health Clinic and Health Services
Dr Richard Murray	Kimberley Aboriginal Medical Service
Prof John Murtagh	Monash University
Dr Brendan	Nelson President, AMA
Mr Peter Nugent	Shadow Minister for Aboriginal Affairs
Miss Lois O'Donoghue	ATSIC
Mr Shane O'Keefe	WA Department of Health
Dr Colin Owen	RACGP
Dr Louis Peachey	Aboriginal Health Design
"Pip"	Congress Alukura
Ms Val Power	South Australia
Ms Colleen Pridgaux	Australian Medical Service
Dr Ian Pryor	Tuggeranong Square Medical Centre
Prof Beverley	Raphael University of Queensland
Dr Ranjit Ratnaike	University of Adelaide
Dr Ian Rechtman	Aust and NZ College of Anaethetists
Dr Andrew Refshauge	Deputy Opposition Leader, NSW

Sr Martina Rice	NATSCC
Dr Beryl Rich	Medical Pratitioner, Queanbeyan
Dr Bill Roberts	Victorian Aboriginal Health
Mr Philip Ruddock	Shadow Minister for Social Security
Dr Peter Sharp	Aboriginal Health Clinic and Hth Services
Mrs Jan Sheales	Australian and NZ College of Anaesthetists
Dr John Stewart	Associate Dean University of Sydney
Miss Sally Stokes	Student
Dr Victor Storm	Royal Aust and NZ College of Psychiatrists
Dr John Stuart	Newcastle
Ms Pat Swan	AMS Redfern
Prof Colin Tatz	Professor of Political Science, Macquarie University
Ms Irene Taylor	Uniting Church in Australia
Ms Alma Thorpe	Melbourne VAHS
Ms Lois Tickner	
Mr Robert Tickner	Federal Minister for Aboriginal and Torres St Island Affairs
Prof David Tiller	Royal Australian College of Physicians
Dr Paul Torzillo	Royal Australian College of Physicians
Dr Toni Upton	Kirwan TSV Hospital for Women – Townsville
Dr Alan Walker	Royal Australian College of Physicians
Mr Douglas Walker	Central Australia Aboriginal Alcohol Program
Mr Storry Walton	Royal Flying Doctor Service
Ms Denise Watego	Stradbroke Island Medical Services
Mr Jack Waterford	The Canberra Times
Dr David Weedon	Australian Medical Association
Mr Ted Wilkes	Australian Medical Service Perth
Dr Peter Wilkins	Australian Medical Association
Dr Mick Williams	Northem Territory Department of Health
Nr Owen Woolley	Flinders Island Tasmania
Prof Ian Wronski	Head of Dept. of Public Health and Tropical Medicine, James Cook University

Individuals/organisations consulted/contacted

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Mr Doug Abbott	Alice Springs
Ms Maureen Abbott	Alice Springs
Aboriginal Children's Service	Redfern
Aboriginal Consumer Forum	Mt Druitt, NSW
Aboriginal Consumer Group	Western Sydney
Aboriginal Legal Service	Redfern
Ms Fay Acklin	University of Sydney
Mr Steve Adams	Principal, Hopevale School
Mr Henry Alberts	Framlingham, Vic
Mrs Barbara Amitage	Consumer Advisory Group
Dr Ian Anderson	Victorian Aboriginal Health Services
Ms Margaret Anderson	Campbelltown and District Aboriginal Co-op
Mrs Patricia Anderson	Darwin Danilla Dilba
Ms Barbara Amitoge	Lismore
Mr Gerard Appo	Clump Mountain
Ron Archer	ACC
Mr Bruce Armstrong	

Ms Tina Atkinson	Yarrabah Council, Qld
Annie Bailey	Menzies School Research, N.T.
Ms Sandra Bailey	NSW Aboriginal Health Resource Co-op
Kimberley Baird	Kunnanurra, WA
Marjorie Baldwin	Wu Chopperen
Dr David Bathgate	Derby, WA
Belyuen Community	
Mrs Sandra Biles	
Manu Bola	Wu Chopperen
Ms Daphnie Bounghi	Yarraba Council, Qld
Mr Stan Bowden	Linkup
Allen Boywoys	Wu Chopperen
Ms Maggie Brady	Canberra
Dr Simon Bridge	Wu Chopperen
Ms Beverley	Briggs Redfern
Mr	Paul Briggs Rumbalara AMS
Mr Rod Briggs	Rumbalara AMS
Ms Narelle Brooks	Townsville
Dr Kate Burgess	AMS Redfern
Ms Colleen Burns	Karu Child Care, Casuarina, NT
Mr Brian Butler	Aboriginal Community Rec and Health Services, Adelaide
Ms Sandra Ceissman	Redfern
Ms Sharon Charles	Rumbalara
Mr Geoff Clark	National Federation for Land Councils
Dr Charlie Cohen	Alice Springs
Ms Margaret	Colbung Geraldton
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Clair Crombie Brown	Dept of Health, NSW
Paddy Dalton	VAHS
Dr John Danials	Redfern
Ms Carmen Darling	Family Youth and Children's Services, NT
Mr Brian Davis	Framlingham
Ms Mazie Davis	Framlingham
Mr Sandy Davis	Geraldton
Ms Jacky Delaney	Mt Druitt
Ms Joanne Delaney	Daruk AMS
Mr John Delaney	Chairperson Sydney ATSIC Regional Council
Mr Nigel De Sousa	SNAICC
Mr Brian Dixon	S.A. Dept of Health
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Mr Tim Edwards Clump	Mt Wilderness Camp
Sr Sophie Erzay	Tumut, NSW
Dr Trish Fagan	Cairns
Ms Sharon Firebrace	Rumbalara AMS
Ms Barbara Flick	Danila Dilba, Darwin
Sr Dulcie Flower	AMS Redfern
Ms Christine Franks	Alice Springs
Ms Cheryl Fulton	Tasmania AMS
Dr Stewart Garrow	Broome, WA
Mr Darren Garvey	Perth, WA

Ms Millie Gordon	Hopevale, Qld
Willie Gordon	Hopevale, Qld
Ms Barbara Grant	Rural Services, Darwin, NT
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Rita Gutchen Kuranda	
Rebecca Harkin	Kalgoorlie Bega Gamberringa
Mr Lional Harradine	Framlingham
Ms Elizabeth Hayden	South Australia
Ms Paula Herbert	Human Services, NT
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Mr Shane Houston	Dept of Health, WA
Mrs Marline Howard	Moree, NSW
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Mr Gordon Jacko	Hopevale Council
Mr Lance James	VAHS
Mr Ron James	Victoria State Health
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Mrs Stella Johnson	Qld Health
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Mr Bruce Lynch	
Mackay AICHS	Qld
Patsy Madeenan	Mareeba
Ms Wendy Maloney	Mooka Rosi Be Bayan
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Mr Neil McCloud	
Ms Tania McInnes	Human Services, NT
Dr Jane McKendrick	VAHS
Dr Bruce McLaren	Elco Island, NT
Mr Neil McLeod	Gove Hospital, NT
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Ms Wendy Molony	Rumbalara
Mr Henry Moreen	Belyuen Community, NT
Dr Craig Morris	Cooktown, Qld
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Mr Lindsay Osborn	South Australia
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Ms Fiona Patterson	Yarraba Council, Qld
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Mr George Rose	Walgett
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Mr Garry Scapin	Darwin Rural Services, NT
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Mr Bob Smith	Newcastle
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SNAICC	
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Ms Kathy Stapley	Cooktown, Qld
Ms Cathy Stephens	Cooktown, Qld
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Mr Gary Stoper	
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Ms Dot Taylor	Rumbalara
Ms Dea Theile	Mt Druitt
Mrs Alma Thorpe	VAHS
Mr Bootsie Thorpe	VAHS
Ms Liza Thorpe	VAHS
Ms Marjorie Thorpe	VAHS

Ms Jenny Timor	Qld
Mr John Tragenza	Tennant Creek, NT
Mr Frank Vincent	Daruk Land Council
Mr Denis Walker	Stradbroke Island
Mr Bob Wallis	Aust Bureau of Statistics
Eslyn Wargert	Wu Chopperen
Ms Anne Weldon	Redfern
Dr Harvey Whiteford	Brisbane
Mr Richard Wilkes	Leederville, WA
Ms Joyce Williams	Wellington
Mr Gordon Willie	Hopevale, Qld
Marilyn Wilson	James Fletcher Hospital
Mr Steve Woods	Grafton, NSW
Miss Alison Worrell	Batchelor College, NT
Board of Directors and Staff	Wu Chopperen AMS
Mr Ken Wyatt	Perth
Staff Yarrabah Hospital	Yarrabah, Qld
Yarrabah Council	Yarrabah, Qld
Yulu Burri Ba	ACFCH
Mr Kevin Cox	

TAFE Colleges

Ms Pamela Thornton,	NAISDA, Glebe NSW
Ms Sam Thomas,	NSW Board of Adult and Community Education, Darlinghurst NSW
Ms Pam Gill,	TAFECOM, Sydney Institute of Technology, Ultimo NSW
Mr Kevin Cook,	Tranby College, Glebe NSW
Mr Larry Steel,	TAFE, Melbourne VIC
Mr Roger Thomas,	Dept of Employment and TAFE, Adelaide SA
Mr Clem Love,	Aboriginal Community College, Port Adelaide SA
D. Egan, DEVETUR,	Brisbane Qld
Ms Wendy Ludwig,	TAFE, Cairns Qld
Mr Graham Hooper,	TAFE, Cairns Qld
Ms Lyn Macbeth,	Aboriginal Services Bureau, Mt Lawley WA
Prof Ron McKay,	Northern Territory Uni, NT
Ms Martha Swart,	Nungalinya College, NT
Mr Keith Stacey,	DIRVET, Hobart, Tasmania
Ms Denise Grant,	Institute for Aboriginal Development, NT
Ms Julie Scott,	Canberra Institute of Technology, Canberra ACT
Mr Keiran Walsh,	TAFE, Kangaroo Pt Qld

Universities

Prof Gavin Brown,	University of Adelaide, SA
Dr R. Storrier,	Aust Catholic University, Dickson, ACT
Prof M. Dynan,	Aust Catholic University, Strathfield, NSW
Prof B. Daffey,	Aust Catholic University, East Melbourne, Vic
Ms Margaret Browne,	Aust Catholic University, Everton Park, Qld
Prof Dean Terrell,	Aust Catholic University, Canberra ACT
Prof Harry Messel,	Bond University, Qld
Ms Anne McMahon,	University of Canberra, ACT
Prof C.D. Blake,	Charles Sturt Uni, Bathurst, NSW
Prof John Maloney,	Curtin Uni of Technology, Perth, WA
Ms Pat Dudgeon,	Curtin Uni of Technology, Perth, WA
Prof John Hay,	Deakin University, Geelong, Vic
Prof Roy Lourens,	Edith Cowan University, Geelong, Vic
Mr Stephen Jones,	Flinders University of SA, Adelaide, SA
Prof L.R. Webb,	Griffith University, Qld
Prof Ray Golding,	James Cook University, Qld
Prof W.G. Carson,	La Trobe University, Vic
Prof Di Yerbury,	Macquarie University, NSW
Prof Boris Schedvin,	University of Melbourne, Vic
H. Curzon-Siggers,	Monash University, Vic
A/Prof Laurence Hartley,	Murdoch University, WA
Prof Raoul Mortley,	University of New England, NSW
Gem Cheong,	University of Newcastle, NSW
Prof Tony Wicken,	University of NSW
Dr Roberta Sykes,	University of NSW
Prof M.E. Nairn,	Northern Territory University
Prof Brian Wilson,	University of Queensland
Prof Dennis Gibson,	QUT Gardens Pt Campus, Qld
Prof David Robinson,	University of SA
Ms Helen Bradley,	University of SA
Prof Don McNicol,	University of Sydney
Prof Alan Gilbert,	University of Tasmania
Prof B.C. Low,	University of Technology, Sydney
Mr Neil Frazer,	University of Technology, NSW
Mr Bob Morgan,	University of Technology, NSW
Prof Jarlath Ronayne,	Victoria University of Technology
Ms Susan Pike,	University of WA
Prof Brian Smith,	University of Western Sydney, NSW
Prof Ken McKinnon,	University of Wollongong, NSW

Mental health services

Ms Jennifer Williams,	Victoria
Dr Jennifer Bowers,	South Australia
Dr Stephen Rosenman,	Canberra, ACT
Mrs Mary Blackwood,	Tasmania
Dr Noel Wilton,	New South Wales
Dr Geoff Smith,	Western Australia
Mr Jim Torkington,	Darwin, NT
Dr Harvey Whiteford,	Brisbane, Qld

Appendix 1

Community controlled Aboriginal health services

(Prof Ian Wronski et al., Dec, 1994 – Evaluation Report commissioned by ATSIC for the National Aboriginal Health Strategy)

A recent review of Community Controlled Aboriginal Health Services for the National Aboriginal Health Strategy Evaluation contacted a total of 88 services. It noted that the actual number of currently funded AMS's was closer to 49. It reported that a useful categorisation of AMS's was as follows (p3)

Category 1

These are Aboriginal Medical Services which have a medical service within their own organisation with a medical officer under the control of the service. There are 3 subcategories

- 1(a) The regional Aboriginal Medical Services
- 1(b) The large AMS's operating in communities with very large Aboriginal Populations – often but not always major urban centres. Comprehensive service provision includes primary medical care, health promotion, prevention, education and counselling services. The report states that they provide mental health services. These matters will be discussed below.
- 1(c) A group of AMS's whose services range in comprehensiveness from expanded GP to a range of complexity (Budgets under $400,000 to $1,000,000 annually)

Category 2

Community Controlled Aboriginal Health Services which provide clinical services but do not have a medical service within their own organisation.

Category 3

Covers health services which provide services such as counselling or perhaps screening services, but do not play an active clinical illness role.

The review involved a survey of these organisations, of which there were 49 Category 1, 22 Category 2, 17 Category 3. There was a 51% response rate for Category 1, but much lower rates for the other two, with overall rate of 38%.

Sociocultural problems or problems related to mental health rated high amongst the major problems of the communities serviced by these agencies. Urban health services identified Alcohol, diabetes, and mental health as their greatest problem areas (in that order) followed by STD's, Child abuse, sexual abuse and neglect, then heart disease and hypertension, followed by domestic violence. In rural and remote communities, education ranked highest, but there was also a relatively high ranking of social and behavioural problems. Alcohol, Child abuse/sexual abuse and neglect and mental health all ranked in the first 10 in rural areas, but were not so identified in the remote areas that responded, perhaps because of the overwhelming physical health problems and lack of awareness and conceptualisation of mental health issues.

Mental health services were seen as a significant area of work. Particularly in urban and rural areas, mental health and domestic violence were areas staff felt ill equipped to handle. Psychiatry and mental health referrals ranked highly in this regard. Remote services seemed to have little capacity to run mental health programs. Mental health ranked high in both Category one and Category two services in terms of programs provided.

However these findings must also be considered in terms of the identified need for services where overall mental health rated highly, but 3rd in rural areas, where also grief and loss counselling were an identified need.

When examining issues that services did not feel fully equipped to manage mental health ranked highest in all areas and overall, with domestic violence/ sexual assault also ranking high (2) and substance abuse (3). These social health problems link closely to mental health, This high priority of mental health indicates the need for education and personnel to provide more appropriate response.

The use of mainstream services was primarily determined by the AMS location and availability of other services in the area. Referral to psychiatry and mental health services occurred on weekly to monthly bases probably because of feelings of inadequacy and lack of resources in dealing with this area. Services which assisted Aboriginal people to use mainstream services included support and advocacy, hospital liaison, and the use of Aboriginal health workers in the service are seen as being helpful. Inappropriateness was seen as a major problem with mainstream services and reluctance was added to by being culturally inappropriate. Services were often not available and the absence of mental health referral services was the main concern of rural AMS's. The majority of AMS's felt that mainstream services did little to support Aboriginal people to help their people use their services. Some grants for new initiatives in mental health had been provided in a small proportion of instances but it appears unlikely that these were anywhere near meeting needs, although helpful. (These were not NAHS Grants.) In some States communities were concerned that Aboriginal Mental Health Workers were being employed in mainstream services with no consultation with Aboriginal communities.

Appendix 2

Recommendations of the National Aboriginal Mental Health Conference

Funding

Staffing levels

That there be funded positions within organisations for family support workers and that these positions be designated.

That part time Aboriginal Mental Health workers be increased to full-time Mental Health workers due to the identified poor mental health of Aboriginal people. as presented at this conference.

That more Aboriginal Mental Health workers be employed by the State Governments as well as Aboriginal Health Services.

Specific program funding

That all State and Territory Governments provide funds for supported accommodation for Aboriginal people suffering from a mental health problem in order to allow the early release of Aboriginal people from psychiatric institutions. And that these supported accommodations services be initiated. staffed and controlled by Aboriginal people.

That the money promised by the Commonwealth Government and ATSIC to the families of Aboriginal people who have died in custody for grief counselling be released immediately.

That Aboriginal Children's Services be resourced to provide culturally appropriate mental health and counselling services to their client group.

Due to the major role that Aboriginal and Torres Strait Islander women play in the survival of our people and due to the small amount of funding available during the International Year of the Worlds Indigenous people, we call on the Federal Government to provide adequate funding in 1994 the International Year of the Family to enable Aboriginal and Torres Strait Islander organisations to fund community members to attend meetings and conferences both nationally and internationally.

That a working party be established to fight for the release of funds from HACC and other departments to employ counsellors at non-government agencies to support the parents of disabled kids who otherwise fall through the net.

That a free medication scheme for the Northern Territory be introduced eg antibiotics etc as required.

That there should be an extension of funding and support of programs such as LINKUP and ANOPS which examine and "treat" the effects of separation from families (ie community driven support services)

Funding priorities

That Federal and State Governments provide appropriate resources at a high level for prevention programs for mental health to be developed by and for Aboriginal people within the next two years with continued funding to follow.

That mental health services should be provided as a normal component of Aboriginal community controlled (primary) health services and mechanisms be established to enable the just and equitable flow of dollars to Aboriginal communities so that we may effectively take care of health business.

That the Federal Government immediately dispense $100 million for the implementation of comprehensive counselling services to be set up in all Aboriginal and Torres Strait Islander community based organisations throughout Australia. to mobilise human resources from the Aboriginal and Torres Strait Islander communities to tackle the immediate issues confronting grass root community needs in the area of Mental Health.

That the State and Federal Governments immediately fund the established community controlled Aboriginal and Torres Strait Islander mental health services, example Townsville.

That funding be on a dollar for dollar basis, from the state and federal governments in accordance with their strategic plan National Aboriginal Health Strategy (NAHS) recommendation and the appropriate Deaths in Custody (DIC) recommendations.

That State and Federal Governments immediately increase the number of mental health agencies.

That alternative funding mechanisms for Aboriginal traditional healing and alternative western medicine which is embraced by Aborigines be examined.

That the State and Federal Governments provide a high level of resources for mental health services for Aboriginal people to be developed by, run by and for Aboriginal people in ways that they see appropriate to their people.

Self-determination/colonisation

That this conference views the participation by Aborigines in (colonial) government processes which are governed by rules derived from colonial notions of democracy as a strategy to complete the oppression of Aborigines and as tantamount to ceding our Aboriginal right to self-determination and crucially as a fundamental cause to Aboriginal mental ill-health. This Conference recognises that the majority of Aborigines are largely uninformed in this area and therefore unwittingly participate in the hope that they can address the needs of their communities. However, this conference aims to inform Aborigines of the possible implications of participation in such processes and in the interim calls for a moratorium in processes which fall within this framework.

Mental Health Conference

Thai recommendations from this Aboriginal Mental Health Conference be referred to the National Aboriginal Community Controlled Health Organisation (NACCHO) for endorsement, consideration and action.

That the second National Aboriginal Menial Health Conference be held in Geraldton W A in 1995.

That NACCHO provide backup support of the National Aboriginal Mental Health Conference 1995.

That a working party be elected to negotiate with relevant governments to ensure carriage of resolutions to the stage of implementation and that this working party be resourced fully to carry out their task.

That all papers of future conference either be screened or authors issued with guidelines to avoid issues that should not be discussed in the larger forum with women and men present being discussed.

Aboriginal Mental Health Organisation/Administration

That NACCHO be recognised as the peak representative body on Aboriginal health and well-being as a response to the situation where non-Aborigines define Aboriginal mental ill-health.
That Aboriginal mental health rights and needs be provided for by the NACCHO in the context of the Aboriginal definition of health.

That the Federal Government contract Aboriginal controlled health organisations to deliver comprehensive health services to Aboriginal communities.

That the Federal and State departments of health and ATSlC transfer responsibility for Aboriginal mental health to Aboriginal community controlled services and adequately resource and appropriately staff them.

That the Australian Medical Association recognise that NACCHO as the peak representative body of Aboriginal health and seek a partnership which reflects this recognition.

That responsibility for Aboriginal health policy and programs be transferred from ATSIC to HHLGCS in Commonwealth Government with an appropriate and effective structure is established under the guidance of the NACCHO and under the control of the NACCHO.

That an equal and effective partnership is established at a peak level with the NACCHO, the State and Federal Governments and appropriate peak bodies concerned with the conduct and training of health professionals including the Australian College of Psychiatrists and General Practitioners to raise the level of understanding of Aboriginal health and wellbeing.

That each State should establish Aboriginal Mental Health Reference teams in order to assist, support and help direct the establishment of mental health services.

That a network of support services providing psychological, welfare services similar to that of community health services which are largely inaccessible to blacks, be established.

Self determination colonisation

Self determination is when Aboriginal people decide policies, where funds go and what style of training Aboriginal people need to be effective within their community.

Native title – Mabo legislation

That while not necessarily supporting amendments to the Native Title Bill put forward by the "Green" senators, this meeting does endorse the proposal to refer the bill to a Senate Committee so that the Aboriginal and Torres Strait Islander Community as a whole can consider the Bill and its implications and negotiate further changes and improvements.

In the High Court's ruling that Terra NuIlius was both fictional and racialist. this conference rejects the notion of Native Title as illegal and call on non-Aboriginal Australia to enter an arrangement with Aboriginal people which formerly recognises their unceded ownership of and control over their domain, which includes their right to their own social, economical, cultural and political institutions.

Child care and protection

That funds become available for existing Early Child Care Centres for:
  - educating staff,
  - research into children's needs,
  - counsellors for child/parent and staff needs,
  - relief staff funding,
  - parents training in behavioural management.

That there be increase attention paid to mental health issues for young people in correction services eg community based.

That closer attention be paid to the process of young people through the mental health system, especially indigenous people.

Legislation

That the Federal Government immediately introduce national legislation for the protection of Aboriginal and Torres Strait Islander children that outlaws any form of removal from their indigenous family and community.

Child abuse is a complex and difficult area. Mandatory reporting of such problems must be done within a framework that deals with family and cultural differences.

That State legislation be redrafted to take cultural factors into account when dealing with Aboriginal

children and young people.

Land rights/health

That the broader and perhaps underlying political issues such as dispossession of land should be addressed in a separate forum.

We condemn participation in neo-colonial mechanisms as a process aimed at completing the oppression of Aboriginal peoples and as tantamount to ceding our Aboriginal rights. This process as with all other colonisation processes is directly responsible for the existing state of ill health (including mental ill health)in Aboriginal peoples.

That one of the most important ways of addressing the mental health needs of Aboriginal and Torres Strait Islander people is the establishment of places of healing on the land such as the Clump Mountain Youth Wilderness Project. Further that all Governments, State, Federal and ATSIC should support and facilitate adequate access and management of those healing places within National Parks, State Forests and other appropriate lands as determined and negotiated by the respective Aboriginal people.

That the Federal and State Governments and all other relevant organisations recognise the severe and adverse effects of the dislocation of Aboriginal people from their lands and disruption of their families and take all possible measures to prevent further dislocation and disruption because of the very adverse effects on mental health and physical health and wellbeing.

We must remove ourselves from this position of abject dependency and the welfare/poverty cycle in order to minimise the incidence of Aboriginal ill health. As such political change will require a sustained and unified struggle on our part, the "way forward" is without doubt a renewed commitment to our culture and the land.

Aboriginal families

That family links be encouraged especially with the extended family by:
- art and drawing classes for kids
- breaking the cycles of kids being placed in care from mothers who were in homes.
- taking out and resolving family problems after separation
- Aboriginal people sticking together
- art as therapy for hurting and encourage expression of feelings, using whatever medium the person is good at.
- therapy may not work especially with non-Aboriginals.
- more cross cultural workshops

That files or records relating to removed/separated people be available for access to LINKUP staff.

That safe places (refuges) for families be established for members of the family where one member has a mental health problem.

That putting people back in touch with their families is a priority in achieving Aboriginal wellbeing and mental health.

That the importance of grieving the loss of family caused by forced removal of children be acknowledged.

Aboriginal cultural practices and death

That the use of ceremonies for dealing with death be promoted by:
- healing through Aboriginal ceremonies and burials.
- being assertive with funeral directors to get what you want and be in control.
- need to ask for what you want eg getting a tombstone, putting dirt on Aboriginal people reclaiming their practices as therapeutic.
- need to look not only at individual grief but also family and community grief.
- workplaces to recognise need for Aborigines to attend funerals and to leave work swiftly.

- need to educate Aboriginal workers to do grief and loss work.
- use non-Aboriginal professionals as resource people.
- need to educate doctors especially when delivering babies to be culturally sensitive especially if baby dies.
- Aboriginal cultural awareness needed in all hospitals.
- stop sterilisation of Aboriginal women, take control.
- non-Aboriginal people to learn about Aboriginal culture.

Models of service delivery

That it is vital that there are services for people with mental illness which meets the needs of Aboriginal people and their families and that these services are developed and controlled by Aboriginal people.

That there be a national body/group set up consisting of care givers and individuals with mental health diagnosis' and issues.

That Aboriginal Health Services develop mental health programs to address:
- Family Violence
- Substance Abuse
- Sexual Assault
- Grief and Loss
- Aboriginal Men's Issues
- Aboriginal Women's Issues
- Aboriginal Children's Issues
- Aboriginal Youth Issues

That Aboriginal Health Services develop mental health services to care for:
- People with psychiatric disorder
- Carers of people with psychiatric disorders
- Primary preventative programs
- Psychiatric follow up and support services.
- Mental Health Crisis Intervention Programs.

That culturally appropriate Aboriginal family therapy programs be developed by Aboriginal Legal, Medical and Children's Services.

That Aboriginal Children's Services be funded to provide primary preventative mental health programs.

That Link Up be resourced to provide treatment and healing to their client groups.

That Aboriginal prenatal and postnatal classes be enriched through cultural components by Aboriginal elders.

That young women be given support through programs run by Aboriginal women that promote self awareness, self esteem and life realities.

That substance abuse be recognised as only one symptom of other mental health problems and treated holistically.

That Aboriginal communities develop their own models of mental health and not adopt medical models or systems.

That mental health services for Aboriginal people should aim to maintain Aboriginal people in their communities not put them in mental institutions.

That Aboriginal mental health worker be placed in remote areas eg Pilbara, in community controlled

services.

That specialist health services be made available to remote communities on a regular basis.

That psychiatrists work more in line with community based organisations.

Staffing

That States need to identify, acknowledge and expand the use of Aboriginal counsellors within Aboriginal Communities.

That Aboriginal workers come from that community and that the community have the right to say who they want as the Aboriginal workers.

That Aboriginal health workers provide the basis of health care services to Aboriginal people.

That Health Housing Community Services and Local Government continue to employ Aboriginal Rehabilitation officers on a national scale and provide training necessary for them to be able to provide that service for Aboriginal people and that all of those positions be identified positions and not under the current Administrative Services category.

That there should be more Aboriginal Mental Health Workers.

Definitions of mental health

The majority of mental health disorders and mental health problems in Aborigines and Torres Strait Islanders do not require dual intervention for specialised secondary services. It is therefore illogical to separate emotional well being issues and therefore mental health services from primary health care (as defined by the NACCHO). A holistic, integrated team approach to well being is required through community controlled health services (as recommended by National Aboriginal Health Strategy and RCADIC) resourced effectively by professionals and through financial resourcing.

That mental health be seen in the holistic definition of Aboriginal health of total wellbeing of the whole community. This cannot be fully achieved without the recognition of Aboriginal sovereignty in this country as the horrific problems we experience today are symptoms of ongoing dispossession of land and cultural devastation.

That mental health should be seen as part of primary health care services and not as separate from them.

That the importance of spiritual life and traditional ways in Aboriginal well being be acknowledged.

Discharge planning

That there be implemented an effective and co-ordinated discharge plan for Aboriginal patients from psychiatric hospitals in order to decrease the prevalence of the re-entry to hospital due to mental breakdown in the community.

Ways of healing

That Aboriginal ways of counselling, Aboriginal ways of healing be identified.

That an advisory/support group be established to support those with mental illness, their family, community and carers.

Aboriginal mental health workers be employed by the State Health Departments within the psychiatric clinics to decrease structural disadvantages which disallow Aboriginal accessing of these services.

That mental health assessments of Aboriginal people need to be culturally based - must involve a trained Aboriginal worker as well as a white professional.

That the Federal and State Governments acknowledge the trauma and grief that has been caused to Aboriginal people and provide resources to Aboriginal people to develop healing and counselling for the trauma and grief policies to prevent further trauma and grief.

Planning issues

That Aboriginal mental health inter-agencies be set up in each health area whereby all the workers (Aboriginal and Non-Aboriginal) dealing with a particular population (eg kids in Redfern) meet informally to share skills and knowledge. The aim initially is for the white psychology experts to gain knowledge of Koori issues.

Education/training

Education for Aboriginal workers

That more Aboriginal people receive the education to be employed in mental health services.

That Aboriginal child care workers have study leave provisions to enable skills development and training in order to be able to better deal with children who have experienced/witnessed violence and family disruption.

That workers need education in protective behaviours that recognise that abusers will be from the family and community.

That scholarships be made available for Aborigines to study Psychology therapy.

That Aboriginal mental health workers be educated to work with children and adults alongside existing services eg Aboriginal School Counsellors.

That Aboriginal people working in the Aboriginal community and doing counselling as part of their duties (specified or unspecified) be entitled to attend counselling skills courses and receive any ongoing training they feel they need to perform their job adequately. LINK UP (NSW) be involved in educating Aboriginal and non-Aboriginal mental health workers (on effects of removal).

Significantly more (2:100 population) Aboriginal people should be educated in health issues in all areas of health, in all disciplines and employed at all levels of the health system immediately.

Education/training

That there be an injection of funds into all levels of training/education in Aboriginal mental health, ie, lay counsellors and Aboriginal health visitors, undergraduate health disciplines and graduate/post-graduate specialty education in Aboriginal mental health.

That relevant State and Commonwealth funding authorities be informed about the urgent need to fund courses that enable Aboriginal people to gain qualifications in psychology that are approved by relevant State Registration Boards and the APS.

Education/training for non Aboriginal workers

That the education of the psychiatric profession on the historical factors that lead to mental health problems of Aboriginal people, be a key elementary component of any training of these professionals.

That psychiatrists be educated in Aboriginal culture.

That the Australian Psychologist Association (APS) and the Australian College of Psychiatrists ensure/set a requirement that students in psychology and psychiatry programs have Aboriginal Studies/Issues as a core part of the curriculum(s).

That mainstream/white organisations which employ Aboriginal workers recognise their different style of working and have policies which validate and acknowledge these. This may include leave provisions to cover after hours' work and family commitments/ pressure – Stress Leave?

That all mental health workers learn cultural awareness and Aboriginal notions of health and wellbeing in their curriculum.

That the larger issue be looked at in regards to books in the area of sociology, anthropology discussing specifics of men and women's law be banned.

That non-Aboriginal people must learn to listen to Aboriginal people.

That all teachers learn something about Aboriginal history, culture, and issues in their training courses.

All health professionals in this country should effectively learn the political and interracial realities and cultural imperatives in their training curricula along with an understanding of the Aboriginal and Torres Strait Islander philosophy of health care as defined by the NACCHO definition of health. This should be undertaken immediately.

Administration of training

That the Government of Australia and non-Aboriginal Health Professionals include representatives of the NACCHO at all levels in deliberations concerning education standards and resource allocation for Aboriginal health in equal participation.

Recognition of prior learning and experience

That Aboriginal health workers skills and knowledge be recognised by the health care system and that systems of support and adequate resources be provided.

Curriculum and accreditation

That there be the creation of undergraduates and post graduate courses designed to train Aboriginal persons to become psychologists to the standard required by the relevant State Psychological Registration Board and the Australian Psychological Society. That this conference advises the APS about the recommendations and asks them to disseminate information about the development of Psychology courses for Aboriginal persons as a matter of urgency.

That this conference raise the issue of accreditation for Aboriginal workers with the universities.

An Aboriginal Reference Group be set up to write the curriculum for Aboriginal mental health education and that it be accredited and supported and owned by Aboriginal people.

Worker support

Cultural strategies and techniques be developed and implemented to ensure the well being of the worker in mental health related areas.

That Aboriginal community controlled services ensure that all workers are supported and that steps are taken to prevent burnout.

That all Aboriginal mental health workers should be adequately resourced and supported in their work to reduce burnout.

The importance of mental health workers wellbeing must be recognised regardless of employment setting ie community, hospital or elsewhere and should not be assumed to be entirely self regulating.

Resources should be provided (determined by the number of workers and setting) that are available solely for health worker mental health issues, These are in addition to traditional means of mental health self-management. Resources might include:
- opportunity for supervision
- opportunity for peer support
- education
- skills development opportunities eg stress management
- plus other projects or tangible resources that might assist workers to maintain and foster their own mental health
- such resources and processes must be formally recognised and stated as policy
- workers should be made aware of such resources and be involved in their modification and development for future mental health workers. Such resources and processes must be formally

recognised and stated as policy. Such provisions are made in consideration of the Aboriginal or Torres Strait Islander setting.

Research

The Conference demanded that research into all aspects of Aboriginal And Torres Strait Islander communities, be undertaken only within Aboriginal and Torres Strait Islander community designed guidelines, including community participation and only with full consent of the particular community, with whom research is to be undertaken.

National Aboriginal Mental Health Needs Survey

Women

This National Mental health Conference recommends that there 'be a National Aboriginal Women's Conference and convenor be the National Aboriginal Community Controlled Organisation.

Due to the major role that Aboriginal and Torres Strait Islander women play in the survival of our people and due to the small amount of funding available during the International Year of the World's Indigenous People/We call on the federal government to provide adequate funding in 1994, the International Year of the Family to enable Aboriginal and Torres Strait Islander organisations to fund community members to attend meetings and conferences both nationally and internationally. The attendance of these events is very important and necessary as the knowledge and skills gained can be utilised in the communities to provide better understanding and services to our people.

That safe places are established for women and children with mental health problems.

That Aboriginal women's refuges be resourced to provide culturally appropriate counselling and mental health problems to their client group.

Aboriginal Deaths in Custody

When the death of a loved one is used for a political purpose, in a conference like this, the pain which is like a cancer becomes re-activated. We don't intend to come to such conferences to re-address and hear about the deaths in custody, we come to hear front each other on other issues. I believe the time has come that we stop using these deaths and let 'us get on with supporting each other to make better conditions for future generations so that they do not suffer as we have. Let us be united in making these decisions.

The indigenous children of men who have died in custody need to have their future secured financially, emotionally and culturally. The Aboriginal family needs to have a say about the welfare of their grandchildren.

The deaths of Aboriginal people in custody are experienced as personal grief by the family members involved. The deaths have created a multitude of problems including difficulties in health, mental and spiritual wellbeing and financial difficulties. In many cases a consequence has been complete family breakdown and destruction.

We need the support of Aboriginal organisations who are providing services to families to plan preventative programs to strengthen Aboriginal family life. In this way the people who have died in custody will not have given their lives in vain. That the pain and suffering that the families have endured will be able to begin a healing process.

The families request that services be made available immediately to help address the suffering and grief and provide opportunities for healing. The services need to be planned by the families to meet their individual needs.

Other issues

That this conference insists that the Federal Government implement the recommendations of the Human Rights and Mental Illness Report as outlined in Volume 1 and Volume 2 of the Report.

That this workshop support the Burdekin Report in. relation to its recommendations as far as Aboriginal mental health services.

That this conference call on the Federal Government to intervene in WA to override that State's juvenile justices legislation which threatens to incarcerate first time offenders many of whom will be Aboriginal.

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Attachment A

"Our Way": National Aboriginal Mental Health Conference

The National Aboriginal Mental Health Conference was held in November 1993 (25th–27th). This conference brought together more than 900 Aboriginal people from around Australia, the majority coming together for the first time to discuss mental health issues. A detailed report is available (Swan and Raphael, 1994). Summarised recommendations are found in Appendix 1. Details are also incorporated as relevant throughout the report. Further detailed information is available.

Four videos have been produced and launched on the highlights and main themes of this conference. These cover the following areas and are available from Aboriginal Medical Services, Redfern.

1. Grief and Loss
2. Aboriginal mental health
3. Mental ill health
4. Drug and Alcohol issues

A full transcript of presentations has also been made. It is noted that this will eventually be available as a book of proceedings but resources are not yet available to produce this.

Attachment B

Consultancy report: Naccho Meetings

Two National meetings of National Aboriginal Community Controlled Health Organisations were held in September 1993 (Cairns) and a meeting in Darwin (March 1994) and the consultants attended these.

The Draft Report of the National Aboriginal and Torres Strait Islander Mental Health Policy was presented to NACCHO Executive Meeting, February 1995.

Cairns, September 1993 This was an extensive meeting well represented from Aboriginal Medical Services and Community Controlled Health Organisations nationally. A wide range of health issues were discussed as well as funding and resource implications, service needs and so forth. A special session was devoted to Mental Health and debate held over the problems of the use of the word "mental". Ms P. Swan presented reasons for more open recognition of the reality of psychiatric disorders and their need for treatment. These matters were discussed in depth in the general meeting with acknowledgement of the frequency of these problems and need associated with them. There was also specific small group discussion with final agreement on a motion on social mental health – which should be reviewed in an holistic framework, and the principles associated with this. The Consultancy was fully endorsed by NACCHO at this meeting.

Darwin, March 1994 This meeting was held to examine key issues following the growing recognition of Aboriginal Health problems from a number of sources. In particular there were presentations by Professor B. Armstrong, Director of the Australian Institute of Health and Welfare, with acknowledgement of the very limited data available and the very adverse outcomes indicated by that data that was systematically assessed e.g. mortality rates with high rates of diabetes, cardiovascular disease, kidney disease, eye disease etc.

This meeting was also attended by representatives of the Department of Human Services and Health who put forward the Commonwealth's views and needs for data. Data and information possibilities were seen as important. However NACCHO representatives identified the great difficulties in providing systematic data firstly because information systems were lacking; secondly because staff were so busy providing direct clinical services that there was not time to gather it; thirdly, infrastructure such as computer systems were often lacking and staff may not be trained for this type of computer work (i.e. client infrastructure data); concerns about confidentiality; concern about purposes to which data would be put. The community numbers indicated their cynicism over the numerous reports that had been produced, the data that had been gathered, and the failure of this to come back to Aboriginal people, with there being no demonstrable benefits to health resulting from this activity to date.

It was acknowledged that some centres did have data, for instance on utilisation, but that additional resources would be necessary to examine this and gather it into any form of report. Much had yet to be collected systematically. Mental health data was also lacking and special initiatives would be needed to gather this.

This meeting subsequently undertook a discussion of the nature of health and its conceptualisation and how mental health fitted into this picture. Problems that had occurred leading to stigmatisation of mental problems both because of the bizarre behaviour and the institutional forms of care were noted.

Nevertheless it was agreed that there were high levels of need in this area and an urgent need for a National Aboriginal Mental Health Strategy to complement this National Aboriginal Health Strategy.

The holistic nature of health was further discussed with a model incorporating recognition of spiritual, physical, emotional, mental, land culture and ethnic factors that come together for health and well-being. This model was accepted. Further discussions of mental health need took place generally and are incorporated into this report. It was emphasised however that mental health must be reviewed in the context of this holistic concept, and that the social aspects must be taken into account.

This organisation produced a draft manifesto of Aboriginal Well Being (September 1993) which includes a position paper on Aboriginal Mental Health and this is included. Also attached are other aspects of this

manifesto in which Aboriginal Mental Health is set, in the holistic concept of Aboriginal health.

Attachment C

Copy of ATSICletter of response

Attachment D

Data and information systems

There is an acknowledged shortage of data and information on Aboriginal Mental Health. This shortage of data arises from the following causes:

1. There are no unified mental health data systems Nationally. This matter is currently being addressed by a group of the National Mental Health Working party of AHMAC to develop a National Minimum Mental Health Data Set and Data Dictionary. Efforts have been made previously to define a unified National approach to mental health, but have been unsuccessful, principally because of different State collection systems, data etc.

2. Health data does not always provide adequate identifications of Aboriginality, or people are not asked, or are hesitant to use these because of fears they will be adversely affected if they do so. Nevertheless some State data is available and has been provided in the relevant sections. Further data from these services should continue to be available and should be improved.

3. Aboriginal Health Services almost invariably indicated that they did not have adequate resources to fully identify the mental health problems of clients. Services were often without guidelines to develop these systems. Some records were kept and these were client files. Nevertheless systematic data collection had yet to be developed in these community based organisations. It must be noted that many health systems and community mental health systems do not as yet have adequate data and information systems and a number of different approaches are currently being trialed.

4. Infrastructure was also absent in terms of the data gathering mechanisms, comprising resources and expertise and so forth. (The need for further computing skills was also noted by staff in the report to the NAHS Evaluation.) Resources to gather data were also seen as vital, including personnel time.

5. Concerns exist for Aboriginal people as to the nature of data gathered, the outcomes for which it will be used. There is ongoing anxiety about it being used to further negatively stereotype Aboriginal people. The need for Aboriginal people themselves to determine the nature, utilisation and access to data systems and their potential benefits was seen as critical. issues of privacy and access was seen as very important.

6. The value of information in terms of lobbying for resources, and its politic uses in a positive sense have been acknowledged but it is seen that Aboriginal people need more support and expertise to be able to achieve such ends.

7. Ethics of health data information systems for Aboriginal people, particularly with relevance to the nature and utilisation and Aboriginal people's cultural needs and understanding in this sphere.

8. A valuable summary of some of the key issues about health information is provided in the summary below of a paper prepared for the Aboriginal Health Worker Journal by Dr Tarun Weeramanthri (Weeramanthri, 1992).

Health information is seen as powerful information both politically and in the community; making a difference at a local level in guiding community action. Weeramanthri contests the current National Aboriginal Health Strategy (NAHS) saying it is too "disease – specific" thereby encouraging a "something in it for everyone" approach where any disease – specific program for each disease category would be justified.

Current health information reflects morbidity and mortality rates for all groups of disease are much higher in Aboriginal people than non-Aboriginal people. He therefore argues that an "underlying factors" approach presents a more "sustained attack on the basic problems".

Bartlett and Scrimgeour (1989) classified three groups of causes. The first is the physical environment which encompasses; shelter, water, sewerage and pollution problems which link to diarrhoeal and respiratory diseases, infections and rheumatic fever. The second is the social/mental environment that links stress, economic disadvantage, and loss of land to problems with alcohol, petrol sniffing, STD, trauma

and mental illness. The third group; nutrition/exercise links the changes in diet and exercise to the "lifestyle diseases" of heart disease, obesity, diabetes etc.

A change in how information is used needs to occur. Most importantly, information must get back to the people it is supposed to help and the people who provided it. The delays in previous data's outcomes and even the lack of its use means that present providers are sceptical about its provision and value.

Deciding upon a limited number of goals relating to an "underlying cause" and linking this to community health indicators need to be collected and returned regularly thereby addressing these goals and encouraging more community response and avoiding delays. Broader information requirements would not be requested until this initial limited goal-related information was seen to be disseminating usefully.

This community level information level information flow is especially important in the Northern Territory. As one part of strategic planning and as a requirement for funding, there is a move towards both process and outcome indicators. These indicators need to be defined by Aboriginal people and should be achievable by and acceptable to them.

As a result of all the factors involved in outcomes (in education, employment) and because initiatives take time to work, health information should be initially geared towards process indicators. This is a direction similar to the Community Health Accreditation and Standards Project in the Northern Territory.

The Council of Aboriginal Health in their recent paper on Health Goals and Targets is more aware of the limitations of the disease – specific thinking of the NAHS. This presents an ideal opportunity for Aboriginal people to provide their comments. Also, current planning of a NT Aboriginal Health Strategy by the Tripartite Forum in the NT is an opportunity to link health systems delivery, hardware, information and health promotion to the same set of priorities. This will entail; widespread community input, describe types of useful information, state who collects and analyses information, and define a structure for local feedback.

The role of Aboriginal Health Workers (AHW) is a key resource in both collection and distribution phases. The importance of this process means that more education and support of AHW in handling information is needed.

In an effort to learn from and prevent individual events such as sudden and unexpected deaths, Aboriginal people also need to become involved in the morbidity and mortality review processes. These death and illness reviews need wider community involvement encouraging a greater community focus and the inclusion of a whole range of non-medical factors to be considered.

Finally, the collection of health information is seen as health intervention and should therefore be subject to the ethical guidelines of current Aboriginal health research. This means that Aboriginal people should be defining the problem, and have control over conduct of collection, and the right to receive results.

This will ensure the primary purpose of all health information gathered, in that it is relevant, sustained, and will lead to effective community action.