Review Article

Disadvantage and discontent: A review of issues relevant to the mental health of rural and remote Indigenous Australians

Ernest Hunter

The Centre for Rural and Remote Mental Health, Cairns, Queensland, Australia

Abstract

Objective: To provide an overview of the mental health of Aboriginal and Torres Strait Islander residents of rural and remote Australia and to identify associated factors.

Findings: Indigenous Australians have higher rates of serious mental disorders and of mental health problems associated with social disadvantage. This disadvantage is greater for Indigenous Australians living outside metropolitan centres. Contrary to romanticised constructions of remote Aboriginal Australia, those living in such settings are not immune to such hardship – which is often unrelenting. The psychological and behavioural problems that emerge as a result are compounded by narrowly focused and inadequate mental health services, with children being particularly vulnerable.

Conclusion: Indigenous residents of rural and remote Australia experience high levels of mental disorder. Although addressing the predisposing social disadvantage will demand significant whole-of-government investment, ensuring equitable access to effective mental health services is an immediate priority.

KEY WORDS: mental health, Indigenous, disadvantage, remote.

Introduction

‘While there are several things that COULD provide better for the needs of this man, I cannot in good faith make such recommendations when it is clear that the resources to sustain them are not present.’ With this statement of bland fact, I concluded a forensic report on a patient with a serious psychotic disorder who had been charged with assault after spitting at a policeman. Were this young Aboriginal man in a city or town I would have doubts about ensuring functional access to the range of services he needed. However, he had been raised and lives in a remote community typical of what Peggy Brock termed ‘outback ghettos’. The course of his mental disorder and the likelihood of influencing it (beyond using the provisions of the Mental Health Act to ensure he received medications) were and are determined by that context and the historical, political and social factors that inform it.

His community is typical of many in Queensland, which has a particularly odious history of concentration and control. However, it is NOT typical of the rest of rural and remote Indigenous Australia, which is conspicuously more diverse than non-Indigenous rural and remote Australia. Differences by ethnic group (only the most obvious of which is Aboriginal versus Torres Strait Islander), language, custom, postcolonial history and involvement with the mainstream economy are substantial. Summarising mental health status, then, is fraught with the twin dangers of generalisation and decontextualisation – context is critical.

History

While human presence on the continent of Australia spans at least 60 000 years, European settlement dates from only 1788 with Indigenous experiences of first contact in remote Australia extending until the 1970s. Despite significant variability a number of phases can be identified in terms of European occupation. Although ‘exploration’ was not necessarily violent, the appropriation of land and resources was, with ‘pacification’ lasting through the 19th century and accompanied by massive Indigenous depopulation, largely from disease (particularly smallpox). A protracted period of total institutional control followed with Indigenous Australians concentrated in government, pastoral and mission settlements, disappearing from the gaze and awareness of mainstream Australia – a ‘great Australian silence’ lasting until the...
1960s, this being Stanner’s term for the ‘cult of disremembering’ regarding Aboriginal Australians in the wider Australian consciousness.3

This began to change only in the 1960s at which time assimilation was national policy and Aboriginal affairs almost exclusively the preserve of states. In 1967 a Commonwealth Referendum, supported by 90% of the national electorate, included Indigenous Australians in the national census and provided for the Commonwealth to legislate in Indigenous affairs. Social transformation accelerated and in the following decade funding and services were increased, and access facilitated to the social security system as missions and government settlements were transformed into ‘communities’ with variable (but illusory) degrees of self-management. While there was little preparation or planning in this process of ‘deregulation’, through the 1970s a paradigm shift occurred from a colonial mindset in which Indigenous people were the objects of regulation, to Indigenous leadership through the 1980s.4 Two decades later much remains to be done and there is increasing awareness that even with the ‘best of intentions’ social policy has often further disadvantaged the original peoples of this land.5,6

Demography

According to Australian Bureau of Statistics data the Aboriginal and Torres Strait Islander population was estimated in 2001 to be nearly 460 000 or 2.4% of the Australian population; 90% identified as of Aboriginal origin, 6% Torres Strait Islander origin and 4% both. The population is also highly dispersed, about one-third living in cities, just over 40% in regional centres and one quarter in remote or very remote areas.7 However, the proportion of the population of Indigenous descent increases with distance from metropolitan centres – from 1% in major cities, to 2.1% in inner regional centres, 4.7% in outer regional, 10.2% remote and 35.2% in very remote areas. By comparison with the rural and remote non-Indigenous population, the Indigenous population is growing fast and is less likely to lose young adults to internal migration than the wider rural population.8

Health context

The excess burden of mortality among Indigenous Australians is now well known, as it is that it is significantly worse than that of Indigenous peoples in other ‘Anglo-settler societies’ – New Zealand, Canada and the USA – and by contrast, not improving.9,10 Not surprisingly, the broader impact of ill health is profound, with data from the Northern Territory indicating that the Indigenous burden of disease is some 2.5 times that of non-Indigenous Territorians, in the 35–54 years age group being 4.1 times higher,11 with 37% of Indigenous Australians over 15 years of age having a disability or chronic health problem.12

Mental health

In terms of mental health there is a paucity of reliable information. However, Australian Institute of Health and Welfare data for 1998–1999 reveals that Indigenous men and women are hospitalised for ‘mental and behavioural disorders’ at 2.0 and 1.5 times the rate, respectively, of their non-Indigenous peers, with the Indigenous : non-Indigenous rate ratios for men and women for mental disorders due to psychoactive substances being 4.1 and 3.5, and for psychotic disorders 1.8 and 2.0. For 2002–2003 to 2003–2004 not only were admissions for mental disorders twice as high as for the non-Indigenous population, so too were admissions for accidents and injuries with young adult women being particularly vulnerable.12

One area in which data are more reliable is suicide, which increased dramatically over the last three decades from levels that were previously much lower than the wider Australian population. In Queensland the Indigenous suicide rate for 1999–2001 was 56% higher than for the state as a whole, with the rate for young men aged 15–24 years 3.5 times higher. Some 83% of Indigenous suicides were less than 35 years of age (42% for the state) with 90% of these deaths by hanging.13
However, suicide is unevenly distributed. The total number of Indigenous suicides increased nearly fourfold in the period 1992–1996 (accounted for by an increase in young male hanging deaths), a disproportionate number occurring in the north of the state where three remote communities contributed to this excess at different times, overlapping ‘waves’ of suicides suggesting a condition of community risk varying by location and time.14 The pattern of suicide has continued to change with the emergence of child suicides. For the period July 2004–June 2006 the six Aboriginal child suicides represented 20% of all such deaths in Queensland while making up only 6.3% of the youth population.15 Material from the north of that state has raised concerns about exposure to self-harming behaviour as a risk factor.16,17 Unfortunately, reliable data for non-fatal self-harm are not available. Because of issues relating to identification of race and cause of death, it is likely that the available data on completed suicide are an underestimate. Neither these nor the other available mental health data accurately convey the burden of mental and behavioural disorders experienced by Indigenous Australians. This is particularly so for rural and remote settings where service access is limited and underlying social determinants particularly pressing.

Social context

In terms of social determinants, the Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma, identifies a range of factors impacting on health that vary by location.18 This includes income levels that fall from 70% of non-Indigenous levels in major cities to 40% in very remote areas (where costs of living are correspondingly higher), and levels of employment that fall from 57% in cities to 46% in very remote areas – which will almost certainly fall further as the Community Development and Employment Program is dismantled. Indeed, it has been suggested that current government policy incorporates ‘categories of competence’ with particular salience to rural and remote Indigenous residents, Arabena suggesting three levels: (i) competent Indigenous people who reside in urban areas and who have no access to Indigenous-specific funding; (ii) those who live in remote areas and lack competence because of disadvantage-related circumstances and should be helped; (iii) those who continue to choose to live in disadvantaged communities and who choose to lack competence, that is, those who cannot be helped at all.19

This presumption of ‘choice’ flies in the face of the lived reality of most remote Indigenous Australians.17 The reality is that it is highly unlikely that reliance on government transfers in such settings will be substantially reduced in the foreseeable future. Indeed, the level playing field of a globalised economy will present more challenges than opportunities, particularly with educational retention20 and performance21 significantly worse in remote areas. This obviously has implications for ‘fair equality of opportunity’ and, consequently, for the health and wellbeing of individuals and communities.22 Other relevant factors known to be worse in remote Indigenous settings include the education level of primary carers, family financial strain and household crowding.23 It should thus be no surprise that the foundations of mental health and emotional wellbeing – the growth and health of children – is poorer in remote than in urban Indigenous populations.24

In such settings psychosocial development is further challenged by rapid changes in family structure and function that have occurred over the last four decades and which have had particular salience for paternal roles.24 Across Australia, young Aboriginal men – fathers and role models – have staggering rates of arrest and incarceration26 that, at least in non-metropolitan settings, are clearly associated with alcohol abuse.27 Indeed, in some remote Queensland communities arrest has become a normative experience for young men,28 most commonly as a result of alcohol-related family violence, those most vulnerable being young women (mothers) and children, among whom there are also dramatically elevated rates of sexually transmitted infections.29 With data from Western Australia showing rates of HIV infection increasing significantly in the Aboriginal population, and parallels drawn to the patterns of transmission in sub-Saharan Africa,30 the threat for rural and remote communities is grave (particularly given the conjunction of sexually transmitted infection endemicity, high rates of incarceration, alcohol-related behavioural disinhibition, lack of investment in effective preventive programs, and wariness of health services).

By their effects on family life and the psychosocial developmental tasks of childhood these manifestations of disadvantage support the transmission of vulnerability across generations. Furthermore, the vulnerability of Indigenous children is increased not only as a result of exposure to a larger number and more intense levels of risks, but also to compromise of those family, social and service factors that would otherwise support resilience, the complex interactions of which across child development11 can result in what has been termed ‘risk amplification’.17 Arguably, this is more so where health, social and other services mandated to address the needs of the disadvantaged are also lacking – as is the case across most, if not all, of remote Indigenous Australia.

Services

The realities of remote area Aboriginal health have been summarised by medical observers as ‘hardship, suffer-
Mental Health Framework, which identifies five key domains of wellbeing – authenticity, the last referring both to high levels of unrecognised and untreated illness, and to the lack of understanding of the difficulties Indigenous people experience in accessing help. That is, where there are services – according to the 1999 Community Housing and Infrastructure Needs Survey, 30–50% of residents of discrete Indigenous communities have no access to allied health or mental health care workers.

Access to Indigenous health professionals is even more restricted and particularly so at higher professional levels – a ‘pear shaped’ distribution weighted towards service roles with least training and responsibility. Although there is increasing attention to developing the Indigenous health workforce, because of basic educational disadvantage this has not, as yet, resulted in significant gains, with students from remote areas faring worst.

Developing the mental health workforce is complicated by ambiguities and tensions historically associated with two quite different approaches. On the one hand are ‘treatment’-orientated services that operate, largely, through State Health Departments. On the other are social and emotional wellbeing models that are funded through the Commonwealth. The tensions have been reduced, somewhat, through the Social and Emotional Well Being Framework, which identifies five key domains of wellbeing: (i) focus on children, young people, families and communities; (ii) strengthening community-controlled services; (iii) improving access and responsiveness of mental health care; (iv) coordination of resources and planning; and (v) improving quality, data and research. Hopefully, significant Council of Australian Governments funding increases will flow to rural and remote, and to Indigenous Australians in 2007.

Unmet need

Regardless of how this complex area is defined, the needs of rural and remote Indigenous communities, as is the case for all Australians living in these areas, are enormous and unmet. Even in terms of mainstream treatment approaches, issues such as transport, medication literacy and compliance, and needs-based resource allocation are critical and need to be considered differently in this population. Ensuring adequate care for people suffering serious mental disorders will demand innovation and flexibility. Particularly in remote settings this should involve the inclusion of traditional practitioners in an holistic approach to health, and the development of Indigenous mental health workers. However, with Indigenous health workers as yet unregistered (save for in the Northern Territory) standardisation of training, definition of roles and accreditation are yet to be resolved. Mainstream mental health practitioners will remain essential and different approaches – from outreach specialist services to use of telemedicine approaches – that need to be considered. Regardless, the gold standard should be that Indigenous mental health consumers, regardless of location, should have access to mental health services of the same quality, predictability, sustainability and practitioner continuity as is available in metropolitan Australia. This should include substantially improved community-based mental health services with particular attention to addressing non-clinical needs. Although those working in these roles might or might not be Indigenous, a corollary gold standard should be that Australian mental health consumers should expect equitable distribution of Indigenous practitioners at ALL professional levels.

Conclusion

Indigenous Australians are disadvantaged by comparison with the mainstream population of this privileged country and this is compounded for those living in rural and remote settings. In contrast to romanticised constructions that conflate remoteness, ‘traditionality’ and ‘authenticity’, the lives of most Aboriginal people living in remote communities and on the fringes of rural towns are not romantic – they are hard. As a consequence, disorders of mental health and of social and emotional wellbeing are common but often unrecognised and frequently not addressed through the health care system. That the strength and integrity of Indigenous people rises above that uncompromising social landscape is despite rather than because of what, historically, has been ‘done’ in their ‘best interest’. Indeed, we should be mindful of the persistence of racism across urban and rural Australia, and in the health care system itself.

Developing effective services, then, will demand more than ensuring that Indigenous people have equitable access across the full spectrum of interventions from mental health promotion to providing for long-term care, or that those living in rural and remote settings are not disadvantaged, or that such services are attuned to local circumstance and custom, or that the Indigenous workforce is appropriately expanded. It will demand all and more – that is a matter of equity and social justice. However, improved services, alone, will not eliminate the excess burden of mental disorder and emotional distress experienced by remote Indigenous Australians. In these settings it will also require broad, transdisciplinary, health-affirming approaches that are attuned to the circumstances and priorities of remote communities, and initiatives that support empowerment at individual, family and community levels. In particular, real change will demand that these approaches are responsive to the needs of remote children. There are existing examples of each (see citations). Ultimately it will also
demand much broader social change, such as suggested by Noel Pearson. That, however, is a long-term political agenda. Meantime, although health practitioners and those committed to the mental health needs of Indigenous residents of rural and remote Australia should be cognizant of, and willing to challenge underlying social disadvantage and injustice, it is important to avoid being immobilised by the task of social change. As Leonard Syme aptly points out: ‘If we really want to change the world we may have to begin in more modest but practical ways.’ Although getting reliable and accessible services in place will not be sufficient, it would be a good start.

References


Trott P. The Queensland Northern Regional Health Authority telemental health project. *Journal of Telemedicine and Telecare* 1996; 2 (Suppl. 1): 98–104.


