



Guest Editorial

Commonality, difference and confusion: Changing constructions of Indigenous mental health

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Over the last three decades the arena of Indigenous affairs in Australia has been transformed and re-transformed. Most recently the reorganisation and subsequent demise of the Aboriginal and Torres Strait Islander Commission (ATSIC) has shifted key Commonwealth responsibilities back to mainstream departments (health shifted from ATSIC to the Commonwealth Department of Health some eight years ago - see http://www.oipc.gov.au/About_OIPC/downloads.asp for a summary of post-ATSIC arrangements). With each transition the chrysalis portends something marvellous – real outcomes – but delivers, instead, much the same old caterpillar. However, the future, we are assured, is brighter and will be underpinned by whole-of-government strategies oversights at the highest levels. This is both reassuring and dismaying; reassuring that there is recognition that effectively addressing any of the key problems confronting Indigenous Australians cannot be undertaken in isolation; dismaying in that the principle argument informing these changes is hard to challenge. That is, that despite good will, ideas, energy and resources – little seems to have changed.

In fact, much has changed, perhaps more obviously for those who experienced the coalface of Indigenous health three decades ago and appreciate the awful state of services and infrastructure, and the absence of Indigenous presence in the health workforce at that time (Hunter, 2003). This is an enormously complex area, the more so given competing political and other agendas that resulted in constructions of Indigenous ‘health’ which were presented as incompatible with health and healthcare as understood (and practiced) by non-Indigenous Australians. Probably the best summary of this period that I have come across is in a recent book by Maggie Brady (Brady, 2004). Because understanding this trajectory is critical and as Brady has summarised these matters succinctly, I will quote her.

Building on foundations in the Indigenous rights movements of the 1970s, Indigenous activists mobilised the notion of cultural difference and claimed a unique identity – both of which had far-reaching effects on the ways in which governments and bureaucracies have dealt with Indigenous people. Harnessing these concepts was necessary in order for Aboriginal and Torres Strait Islander people to claim their rightful share of national resources and to

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redirect these resources to services which stood the best chance of providing sympathetic and amenable health care to people who were otherwise grossly disadvantaged.

This health activism built up a discourse informed by the intellectual and internationalist traditions of the United Nations and WHO [World Health Organization], traditions that provided some of the groundwork for the distinctiveness and maintenance of Indigenous cultural forms. When an Aboriginal definition of health was assembled, this had considerable political utility, both for government ... and for the community controlled health movement.

Part of this process involved aligning an alternative Aboriginal view of health with that of WHO, as this was accepted by health activists as being in keeping with holistic Indigenous definitions. In order for this to make sense, two issues were downplayed – that the WHO definition was itself formulated largely by Europeans (many of whom were medical practitioners), and that WHO's philosophy of achieving complete health and well-being for all was based on a thoroughly Western belief in progress. The stress on fundamental differences meant that 'Western' and 'Indigenous' approaches to health were often depicted as polarised, separate domains. In order to support these differentiated identities it was necessary to by-pass the heterogeneous histories in the West of alternative traditions in which nature, the spirit, and the balance of psyche and body are all a part of health and healing Instead, Western traditions of health were often presented as being solely reductionistic, scientific and biomedical, and therefore posed in opposition to the holism of Indigenous traditions. (Brady, 2004:125).

Brady (2004:91) also points out that: 'Many official representations of what are said to be Aboriginal understandings and definitions of health emphasise cultural differences and our attention is often directed to their exotic and supernatural features rather than their natural and prosaic ones'. In so doing the wealth of 'natural and prosaic' practices supporting Aboriginal and Torres Strait Islander health and wellbeing, probably many of which are shared across cultures, is de-emphasised.

These issues are particularly pertinent to mental health which, even by the standards of Indigenous health, is a tensely contested arena. Indigenous mental health began to be talked

about and acted on systematically in the 1980s at the very time that Indigenous health was defining itself in opposition to the understandings and approaches of the majority society (Hunter, 1997). The situation was compounded in the aftermath of the Royal Commission into Aboriginal Deaths in Custody (1991) and the Stolen Generations inquiry (Human Rights and Equal Opportunity Commission: HREOC, 1997). The former demonstrated clearly, as had the Report of the National Inquiry into the Human Rights of People with Mental Illness (HREOC, 1993), that mainstream services had failed in their responsibilities to Indigenous mental health patients. As the Royal Commission proceeded the National Aboriginal Health Strategy was released (National Aboriginal Health Strategy Working Party, 1989), the combined effect being to emphasise separateness from the mainstream in Indigenous approaches to mental health. This was embraced within the community-controlled sector and supported by the Commonwealth with the emergence of social and emotional wellbeing as an alternative, holistic, 'Indigenous' construction. The resulting tensions were most marked between commonwealth-funded, local community-controlled organisations, and state-based mental health services which adhered to conventional understandings and were, generally, defensively dismissive.

This situation was compounded after the release of the HREOC (1997) report into the removal of Aboriginal and Torres Strait Islander children from their families. It is my opinion that political expediency encouraged the 'medicalisation'¹ of a critical social justice issue which, by focusing on consequential mental health harm (at the level of individuals proven to have been affected), avoided the implications of responding directly to the social injustice itself, that is, compensation (as called for by the Commission and which could, of course, be to the collective). That grief

¹ Medicalisation has been defined by Parker (2004) as 'the annexation to medical dominion of areas of life previously categorized differently, through the exercise of institutionalised medical power.' Medicalisation as discussed in this editorial, I contend, has resulted primarily from politically motivated attribution rather than medical annexation per se. For a wider discussion of medicalisation see the *British Medical Journal* (2002), 324(7342).

and loss is felt by those affected is undeniable and should necessarily be attended to (as also called for by the Commission). However, grief and loss now both attest to injustice done and is representative of injury experienced. As I have pointed out elsewhere, ‘the Commonwealth is thus in the odd situation of funding grief and loss counsellors to address the acknowledged mental health consequences of past policy while vigorously resisting personal or group claims on the basis of such harm or its cause’ (Hunter, 2002).

What does this mean for health practitioners? A significant result is continuing lack of clarity at the level of policy and in service planning, and uncertainty at the clinical coalface. This is not just a matter of semantics; it has significant consequences in terms of treatment planning and workforce development – particularly for the Indigenous workforce. Ironically, the ambiguities are compounded by the broadened horizons of mental health practice that has followed the foregrounding of mental health promotion and prevention within the Second National Mental Health Plan (Australian Health Ministers, 1998), and the increasing recognition of the critical importance of the social determinants of health. Given the burden of social adversity impacting Indigenous communities and the purported opportunities for prevention it is not surprising that there are loud demands that resources be spent to address causal social problems rather than their downstream effects.

To return to where this commentary started – this is about broad social change and really does require whole-of-government commitment. Bringing about such changes is certainly not within the capacity or resources of the mental health sector alone and if it results in a reduction of scarce resources for children and adults with manifest problems it is arguably unethical. This is not to suggest that practitioners in these fields do not have roles more broadly than clinical care, but rather to emphasise that it is important to understand that significant changes will come about through activity at many levels and they should reflect on where they fit, broadly, into the scheme of things. That may demand challenging ambiguities and, sometimes, political correctness.

Table 1. Examples of coordinated activity at four levels

Level	Activities
Society	Social justice, reconciliation
Community	Community development/empowerment
Family/clan	Family wellbeing & parenting programs
Individual	Indigenous therapies Adapted/appropriated therapies (e.g. narrative therapy) Culturally appropriate conventional therapies

My view is that major change will come about through coordinated activity at four levels – society, community, family/clan, and the individual. In Table 1 examples of the particular activities at those levels are identified. Where is the legitimate domain of mental health? – How long is a piece of string? While it may not be confined to the ‘individual’ domain, it must, of necessity, include it. It demands thinking about cultural factors but not being blinded by them. It should require consideration of difference but awareness of commonality. It may mean being aware of particular cultural practice, but it may also mean respecting what is ‘natural and prosaic’ in that particular setting. It is all about awareness, balance, and doing what one can do well, as Leonard Syme (1997) suggested:

Insisting only on fundamental and revolutionary social change is dooming us to programs that will take years and generations to take effect. Since it is difficult to implement such major social change, it is easy to ignore inequalities because, they say, nothing can realistically be done about them. Moral outrage about inequalities is appropriate but may be self-indulgent. If we really want to change the world we may have to begin in more modest but practical ways. (Syme, 1997:9)

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