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Mental Illness in Aboriginal and Torres Strait Islander Peoples

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OVERVIEW

This chapter specifically deals with mental illness, a concept associated with a 'clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and is associated with significant distress and disability'.[1(pxxi)] The common types of mental disorders that affect people are anxiety disorders, mood disorders, psychosis and personality disorders and these are discussed in this chapter in terms of what Aboriginal and Torres Strait Islander peoples may have experienced in both traditional and current contexts.

It is important to view the information in this chapter in the context of other material in this book, particularly the chapters on psychology, social determinants, and harmful substance use (see Chapter 3, Dudgeon and colleagues; Chapter 6, Zubrick and colleagues; and Chapter 8, Wilkes and colleagues). We also caution that any diagnosis of mental illness affecting an Aboriginal and Torres Strait Islander person should be conducted by expert clinicians, such as psychiatrists and psychologists within a culturally safe context, wherever possible. This allows for a more accurate assessment of the person being reviewed, with recognition of culturally relevant issues, in addition to the recognised availability of adjunctive therapeutic supports, such as social and emotional wellbeing counsellors, to assist the person, if appropriate. The chapter does not recommend any specific treatments for the conditions discussed per se, but mentions a number of standard resources that may be used by the Aboriginal and Torres Strait Islander person suffering from mental illness and their family membersto discuss available treatments with their clinician.

WHAT IS MENTAL ILLNESS?

An appropriate introduction to this chapter should focus on the question of 'What is mental illness?' in respect of Aboriginal and Torres Strait Islander peoples in Australia. Since it was first published in the early fifties the DSM has been recognised as a key diagnostic manual. It has been updated on a regular basis to reflect new understandings about mental illness. The newly released DSM-5 (replacing the DSM-IV) is the standard text for classification of psychiatric disorders and mental illness in a Western cultural context. It emphasises the need for explicit definitions as a way of promoting reliable clinical diagnoses.[1(pxxii)] However, there has been an increasing recognition of other factors that may affect the validity of such diagnoses in cultural groups, such as the Aboriginal and Torres Strait Islander population. These include, the standards of what constitutes scientific evidence, the meaning and uses of ethnic and racial categories, interpretations of differences of prevalence for mental disorders, and the tension between universal and group-specific approaches to mental health research and policy.[2]

An inherent concept in the reliability of the definition of such data is an atmosphere of, and commitment to, cultural safety as an essential component of any mental health intervention with Aboriginal and Torres Strait Islander peoples. See Chapter 12 (Walker and colleagues) for a detailed discussion of cultural safety.

Unsafe cultural practice is defined as:

> *any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual, whereas culturally safe practice is simply defined as 'effective clinical practice for a person from another culture'.*[3(p2)]

The emphasis on culturally safe practice with Aboriginal and Torres Strait Islander peoples is particularly important in the context of perceived deficiencies in medical practice in Aboriginal communities in remote Australia, where 'serious and unrecognised miscommunication is pervasive in non-Aboriginal doctor/Aboriginal patient interactions'.[4(p203)] This can also be true in the cities, as miscommunication can occur on a variety of levels and there can also be significant misinterpretation of symptoms and behaviour within the mental health context.[5] Chapter 15 (Dudgeon and Ugle) further explores the issues and strategies for communicating and engaging effectively with Aboriginal and Torres Strait Islander peoples in diverse contexts.

English may not be the first language of remote community-based Aboriginal people and might be the fifth or sixth language. Other compounding influences in the remote setting include differing belief systems regarding illness, a potential perceived inefficiency of health systems and the disempowerment of Aboriginal patients, compliance issues and an overwhelming high burden of disease.[4(p204)] In addition, mental illness issues are often compounded by issues of stigma where the term:

> *mentally ill … causes a variety of reactions when used with Aboriginal people, depending on their level of education, knowledge and the way that they use language … [P]eople gave warnings about how the term could be reinterpreted in ways that would reflect other meanings than [w]hat was intended. These meanings cluster around both what people have heard about their relatives' experiences with mental health services and what they would have heard or seen of peoples' behaviour when experiencing a mental illness.*[6(p95)]

Hunter also comments on the increasing complexity of defining mental illness in Aboriginal and Torres Strait Islander peoples.[7] He notes an increasing coincidence of mental disorders associated with harmful substance use and the problem that this leads to in diagnostic systems where the two entities are often separate. In addition, Hunter notes that:

> *Indigenous societies have undergone rapid social change and it should be no surprise that there have been changing patterns of mental health problems including mental health disorders.*[7(p129)]

He adds that:

> *a constant across most of the above considerations … is a change, both in the patterns of disorders for social and emotional wellbeing and in the social context in which these disorders arise.*[7(p130)]

A number of factors therefore contribute to the accuracy of diagnosis or definition of any mental illness in Aboriginal and Torres Strait Islander peoples. Sheldon notes the particular importance of an appropriate review of contextual data and the familiarity of an interview setting in engaging Aboriginal and Torres Strait Islander peoples in any therapeutic process for mental health issues.[8] The involvement of family, along with Aboriginal and Torres Strait Islander Mental Health Workers (AMHWs) in assessments of Aboriginal and Torres Strait Islander clients, is also an important component of culturally safe practice and the reliability

of information thus obtained.[9] Additional factors involve the use of translation services where appropriate, along with Social and Emotional Wellbeing (SEWB) workers, where the affected person may have specific needs in respect of grief or loss and the Stolen Generations. See Chapter 17 (Atkinson and colleagues) for further discussion of these factors.

Given the above cautionary factors, the remainder of this chapter attempts to review the past and current burden of mental illness as it affects the Aboriginal and Torres Strait Islander population.

Depression

Mood disorders are currently defined by the ICD-10 classification system with a graded transition from mild mood disturbance (commonly described as adjustment disorders) to the more severe types of depression such as major depression with melancholia, and major depression with psychosis. The category also covers bipolar disorder (previously known as manic depression). The new DSM-5 has removed the 'mood disorder' category and made changes to the major depression (also known as clinical depression) and depressive disorders area. There is a new condition known as 'persistent depressive disorder' which includes both chronic major depressive disorder (MDD) and the previous dysthymic disorder.

Major depression, as defined by DSM-5,[1] usually involves the affected person developing a low mood along with feelings of worthlessness and loss of interest in normal activities, which is out of character with their normal persona. The person may experience suicidal ideation. They often have altered vegetative features such as poor sleep, reduced appetite with weight loss and impaired concentration. The person may also have developed emotional restriction and anxiety in the context of the mood disturbance. The DSM-5 made no changes to any of the core criteria symptoms of major depression.

There is also a new condition introduced in the DSM-5 called 'Distruptive Mood Dysregulation' disorder. This new disorder can be diagnosed in children up to age 18 years who exhibit persistent irritability and frequent episodes of extreme, out of control behaviour.

Pink and Allbon, using the ICD-10 criteria, note that the admission to hospital of Aboriginal and Torres Strait Islander men with severe mood and neurotic disorders is 1.2 times the rate of the non-Aboriginal population, with the rate for Aboriginal and Torres Strait Islander women being the same as the non-Aboriginal population.[11] However, individual Aboriginal community surveys have found differing rates of mood disorder, with these being variously reported at 2.5 per cent for Mornington Island, 6 per cent at Bourke, but 1 per cent for a community in the Kimberley.[7] McKendrick conducted a survey of Aboriginal people attending a community-controlled health service in Victoria, reporting that 54 per cent of the people tested with standard psychiatric rating scales were suffering from psychiatric illness and that depression was the most common among this group.[12] Jorm reports that recent community surveys have shown similar high levels of psychological distress (anxiety and depression) amongst Aboriginal and Torres Strait Islander peoples, with a rate of 50 per cent of respondents to the survey being three times higher (overall rates 20.2%–26.6%) compared with other Australians.[13]

In terms of atypical features of mood disturbance that may be present in the Aboriginal and Torres Strait Islander population, Jones and de la Horne, in a survey of a Central Australian Aboriginal group, noted that people affected by mood disturbance in the group suffered vegetative disturbance and restriction of emotional response.[14] They also noted that the affected population often projected feelings of unworthiness and guilt onto others, were more aggressive and had more physical or somatic symptoms. Cawte also describes a number of features of atypical depression experienced by Aboriginal people.[15] He notes a 'suicide fit' in the context of alcohol withdrawal, where a person develops a significant degree of anxiety following an intense encounter with a relative. The affected person will often run away to seek a private

place and may then attempt to harm themselves. Cawte describes depression precipitated by a person being shamed or being fearful that they were subject to sorcery or payback.[15] Morice has reported that the Pintubi have a range of words to express a range of feelings of sadness and depression from mild to severe.[16] Brown, in a survey of Aboriginal men from Central Australia, found that symptom profiles for depression were comparable to other Australians.[17] However, what the Aboriginal men understood and related to depression was as a weakness or injury of the spirit. In addition, the Aboriginal participants felt that depression related to a loss of connection to social and cultural features of Aboriginal life, cumulative stress and marginalisation.[16] The participants identified a reluctance to talk about their emotional issues and described anger and impulsivity as prominent features of depression, particularly in the context of trying to suppress the anger they felt in respect to what had occurred in their lives.[16] The importance of strong spirit and strong mind is explored in Chapter 26 (Casey).

Ketchell, following a description of normal funeral rituals required by members of the Torres Strait Islander population, notes that people may become emotionally distressed if they are unable to fulfil these duties for some reason related to their present circumstances.[18]

Given the high rates of social disadvantage affecting Aboriginal and Torres Strait Islander mothers, along with additional factors such as being a member of the Stolen Generation and having much higher numbers of children in out-of-home care,[19] it would be considered that the potential for postpartum depression in Aboriginal and Torres Strait Islander women would be greater. A recent survey of 25,455 women in South Western Sydney did not reveal a greater prevalence of postpartum depression in the very small component number (481) of Aboriginal and Torres Strait Islander women sampled.[20] However, the survey did point to some significant health and social issues leading to an increased prevalence of postnatal depression (PND) that also commonly affect Aboriginal and Torres Strait Islander peoples. These included placement in public housing, difficult financial situation, single status, poor rating of own health and poor rating of their child's health.[20] A study of 210 Aboriginal and Torres Strait Islander mothers in Queensland using an adapted, more culturally appropriate form of the Edinburgh Postnatal Depression Rating Scale (EPDS) found higher rates of participants with 'at risk' issues (27.7 per cent) on the culturally adapted scale compared with 16.7 per cent identified with the normal scale. This disparity suggests that miscommunication and cultural safety issues may be leading to a poor recognition of postpartum depression within the Aboriginal and Torres Strait Islander population.[21] The issues and strategies around perinatal maternal and infant mental health are discussed in detail in Chapter 19 (Marriott and Ferguson-Hill).

Anxiety

Anxiety disorders encompass a range of mental illness conditions, where there is elevated psychological arousal accompanied by physical sensations of fear.[1] The psychological and physical features, along with avoidance behaviour to reduce these issues, are core features of anxiety disorders. There are seven categories of disorders listed in the 'anxiety disorder' section of the new DSM-5 criteria. Some of these disorders may be a fear of a particular object or situation (phobia); fear in response to certain social or performance situations (social anxiety disorder); chronic persistent fear with physical overactivity (generalised anxiety disorder); sudden unexpected episodes of fear (panic attack) and the fear of experiencing anxiety or having a panic attack (agoraphobia). The symptoms of anxiety disorders may sometimes be the consequence of medical conditions such as thyroid disease, and are frequently associated with substance misuse, both intoxication and withdrawal. It is therefore important to have these matters examined before a diagnosis of anxiety disorder can be definitively made.

Listed under a new heading in the DSM-5 called 'obsessive-compulsive and related disorders', is the intrusive thoughts and associated ritualistic avoidant behaviour known as obsessive compulsive disorder. Acute Stress Disorder (ASD) which is emotional numbing and recurrent

traumatic memories and dreams following exposure to a severe traumatic incident and post traumatic stress disorder (PTSD) are now listed under the new DSM-5 heading known as 'trauma and stressor-related disorders'.

Anxiety conditions rarely reach the severity required for admission to hospital. However, community surveys of mental illness point to varying prevalence rates of anxiety, from 1.5 per cent of community members in Mornington Island and 1.4 per cent of community members in the Kimberley, to 5 per cent of community members in Bourke.[7] More focused surveys, such as the Western Australian Aboriginal Child Health Survey, showed that up to one-quarter of surveyed children aged 4–17 years may have been at risk of developing emotional and behavioural disorders that may be associated with anxiety conditions.[22] This finding is not surprising against a background where Aboriginal and Torres Strait Islander peoples are exposed to high levels of multiple life stressors. Forty-four per cent of Aboriginal and Torres Strait Islander respondents surveyed by the Australian Bureau of Statistics reported at least three life stressors in the previous 12 months, and 12 per cent of respondents reported experiencing at least seven life stressors that included the death of a family member or close friend, serious illness or disability, inability to get work, overcrowding at home, and alcohol and drug-related problems. Multiple stresses were more prevalent for Aboriginal and Torres Strait Islander peoples living in remote and rural locations.[23] Walker and colleagues discuss the issues associated with anxiety, depression and behavioural issues for young Aboriginal and Torres Strait people in Chapter 22.

The high level of exposure to stress can be contrasted with Aboriginal and Torres Strait Islander cultural factors that appeared to reduce stress and anxiety in traditional cultures. Hunter and Eastwell have commented on the ability of Aboriginal and Torres Strait Islander peoples to express strong feelings within a defined cultural context such as a funeral.[24,25] Eastwell also comments that the Yolgnu tribe of Eastern Arnhem Land relieved stress by ascribing significant adverse personal events, such as the unexpected death of an individual, to sorcery, which was satisfying to individuals and the community and carried great local conviction.[25] However, there are also occasional reports of significant anxiety disorder in the traditional Aboriginal and Torres Strait Islander context. During his time with the Walpiri in the 1960s, Meggitt described what is most likely a case of dissociative fugue, secondary to intense anxiety resulting from a woman accidentally viewing sacred items.[26] Morice reports that Pintubi language describes extreme fear, in addition to other grades of anxiety, that could also account for such a phenomenon.[16]

Psychosis

Psychotic disorder usually refers to a complex of symptoms of mental illness. These include hallucinations (abnormal sensory perceptions), delusions (false beliefs), disorganised speech and behaviour, and cognitive issues such as emotional blunting, limited intellectual function and ability to motivate oneself.[1] The experience of psychosis is often very frightening for the individual concerned and is related to a range of conditions, such as schizophrenia (a long-term condition where the affected person has disability related to persistent psychosis), mania (elevated mood related to bipolar disorder or manic depression), severe depression and substance misuse. Occasionally, psychosis may be precipitated by a severe emotional stress.

The experience of psychosis in traditional Aboriginal and Torres Strait Islander culture was likely to have been rare. As an example, Kidson and Jones estimated that the rate of schizophrenia among tribal Aboriginal people in Central Australia was about 0.46 per cent.[27] This estimate stands in significant contrast to the high rate of psychosis currently affecting the Aboriginal and Torres Strait Islander population. Pink and Allbon report that Aboriginal and Torres Strait Islander men were admitted to hospital with mental disorders due to psychoactive substance misuse, at 4.5 times the expected rate for their proportion of the Australian population, and the same population had hospital admission for schizophrenia and related

disorders at 2.7 times the expected rate. Aboriginal and Torres Strait Islander women have 3.3 times the expected rate of mental disorders due to psychoactive substance misuse and 2.5 times the expected rate of hospital admission for schizophrenia and related disorders.[11]

It appears, therefore, that the experience of psychosis, particularly in the context of substance misuse, is a significant issue for the Aboriginal and Torres Strait Islander population at present. A recent study by McKetin and a review by Paparelli point to the contribution of substances such as cannabis and amphetamines in the current epidemic of psychosis, and how it is often difficult to differentiate psychosis related to substance misuse from psychosis associated with a more pervasive cause such as schizophrenia.[28,29]

The recognition of cultural factors and use of AMHWs is an important component of care and diagnosis for any Aboriginal and Torres Strait Islander person presenting with psychosis. As an example, it is common for Aboriginal people to experience the voices of their relatives, and this may be misinterpreted as a hallucination by clinicians who do not have an appropriate understanding of relevant cultural issues.[30]Notwithstanding the above cultural factors, psychotic disorders have been reported in a number of cases of the traditional Aboriginal and Torres Strait Islander context. Aboriginal people apparently suffering from positive symptoms (hallucinations) and negative symptoms (emotional and cognitive blunting) of schizophrenia were observed by Jones and de la Horne in Central Australia in the 1970s.[14,31] Morice notes that the Pintubi words to describe someone suffering from schizophrenia are having closed ears or living in a world of their own.[16] Meggitt described the case of a woman suffering from psychosis, most likely related to emotional stress, as well as a person suffering from mania in the Walpiri.[26] Eastwell commented on transient delusional states in certain Yolgnu family groups in East Arnhem Land.[32,33] Ketchell also reports on delusions that affect Torres Strait Islanders where they become abnormally jealous of their partner, incorrectly believing that they are having an affair, or believe that sorcery is being performed against them.[18]

Personality Disorder

Personality disorders are a class of social disorders characterised by enduring maladaptive patterns of behaviour, cognition and inner experience, exhibited across many contexts and deviating markedly from those accepted by the individual's culture. The DSM-5[1] now lists personality disorder in exactly the same way as other mental disorders, rather than on a separate 'axis' as previously. Personality, defined psychologically, is the set of enduring behavioural and mental traits that distinguish human traits. Hence, personality disorders are defined by experiences and behaviours that differ from societal norms and expectations.

Pink and Allbon note that Aboriginal and Torres Strait Islander men have a rate of admission to hospital for personality issues that is 1.8 times the rate expected for their proportion of the population.[11] The rate of admissions for Aboriginal and Torres Strait Islander women with similar issues is 0.8 times the rate. Community prevalence surveys have reported rates of personality disorder of 4 per cent in Mornington Island, 16 per cent in Bourke and 8.2 per cent in a Kimberley community.[7] However, one has to be careful diagnosing personality disorder in situations where an atmosphere of cultural security was not maintained or supported during the assessment, as outlined at the beginning of the chapter. Morice notes a number of qualifying issues in the diagnosis of personality disorder when the assessor is from a different culture to the person being assessed. He cautions that:

> *there are many people who exhibit atypical (for themselves) behavioural responses to certain environmental stimuli. These behavioural reactions occur in direct response to the stimuli and usually disappear when the stimuli are removed … A diagnostic dilemma occurs when adverse environmental stimuli are prolonged and behavioural responses may appear to be relatively fixed.*[34(p296)]

Given this caution, there is still a range of information about the vulnerability of Aboriginal and Torres Strait Islander peoples to personality issues. A number of authors[35-37] have commented on tribal sanctions that were applied to continually disruptive individuals (usually young men) that may be indicative of antisocial personality, as currently defined by DSM-5.[1] The significant amount of stressors affecting young Aboriginal and Torres Strait Islander peoples currently, seen against the historical background of the negative impacts on their health, culture and society generally, may be considered vulnerability factors for further continuing personality dysfunction.[23] This may be an issue in the case of members of the Stolen Generations in Western Australia, where surveys have shown that people are more likely to live in households where there is problematic gambling and drinking, more likely to have been in contact with mental health services, and almost twice as likely to have been charged by police.[22] The findings may also indicate that, although personality disorders are problematic categories of illness due to historical, cultural and political factors, they cannot be ignored due to the cumulative impact of trauma, grief and loss on a person's development and hence require strategies for management.

ISSUES FOR FAMILIES

The 2008 submission of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to the Australian Government House of Representatives Standing Committee on Family, Community, Housing and Youth Inquiry into Better Support for Carers, outlines a number of issues which affect the carers of people suffering from mental illness that are also quite applicable in the Aboriginal and Torres Strait Islander context. The College submission points out that those general attitudes to mental illness add to the existing social exclusion and pressures faced by carers. In addition, most people are largely uneducated in the effects of mental illness on the individual, let alone carers. The College submission adds:

> *The reality is that mental illness is difficult to understand and often generates fear and considerable stigmatisation for the consumer and their family. It is often seen as being in the 'too hard basket' by many in the service system and the greater community. Consequently, social support structures such as housing, rehabilitation, justice systems, income support arrangements, employment assistance etc., all face particular difficulties and are often less effective in providing well tailored services and outcomes to people with mental illness. For carers, these difficulties and complexities are at least as great, but the pressures they face in trying to deal with all of the issues and interactions can be extreme and unrelenting. As a result, carers' own health needs can suffer adversely and/or be overlooked .*[38(p3)]

These issues are further complicated for the families of Aboriginal and Torres Strait Islander peoples with mental illness in remote Australia. According to Dillon and Westbury, there may be a performance gap in terms of the provision of services, a legitimacy gap in that standards of governance are deficient, and a security gap in that levels of violence are high.[39] A similar situation may also face families of Aboriginal and Torres Strait Islander peoples with mental illness who reside in cities where they tend to be poorer and more marginalised than their non-Aboriginal counterparts, thus reducing their access to quality support services.[39]

Thus, an appropriate clinical response to the large majority of Aboriginal and Torres Strait Islander peoples suffering from mental illness would involve a comprehensive appreciation of the community that they live in.[8,40] Further, the essential interaction between the family of individuals suffering from mental illness and AMHWs within a primary health setting is considered an important component of the management of that individual.[41] The authors go on to suggest a range of ways that mental health clinicians, including AMHWs, can work with families. These include clarifying mutual goals; not forcing families to fit specific models

to encompass the diversity of Aboriginal and Torres Strait Islander culture and social issues; acknowledging your own limitations as a therapist when working with Aboriginal and Torres Strait Islander families; working with the families as a team; pointing out family strengths; learning to respond to the family's intense feelings; encouraging family enrichment to fulfil their own needs in the context of care for the affected individual; providing information about the illness and therapies (including medications) required; providing practical advice (including information on community resources); encouraging family involvement in support and advocacy groups; acknowledging a diversity of beliefs; and making a personal commitment to the issues at hand.[41]

Forensic Issues

Aboriginal and Torres Strait Islander peoples continue to make up a disproportionate amount of prison populations in Australia. In 2004, they were 11 times more likely to be imprisoned than non-Aboriginal Australians.[42] It is estimated that approximately 19 per cent of men and 30 per cent of women in full-time custody in Australia are Aboriginal and Torres Strait Islander. Butler[42] suggests that the high rates of mental illness recorded for Aboriginal and Torres Strait Islander women indicate that they are one of the most psychologically vulnerable groups in the community.[42] Forensic mental health issues are particularly pertinent for Aboriginal and Torres Strait adolescents. Over one-third of young people under juvenile justice supervision during 2005–06 were identified as being Aboriginal and Torres Strait Islander[43] (44.9 per 1,000 population compared with 2.9 per 1,000 population for non-Aboriginal young people Australia-wide).[42]

Another review notes that prison data give a more severe picture of mental illness and impairment for Aboriginal and Torres Strait Islander prisoners than general population data.[44] A local prisoner health study found that one-in-seven Aboriginal and Torres Strait Islander men and one-in-five Aboriginal and Torres Strait Islander women prisoners reported having been hospitalised at least once in the past for psychiatric reasons. Particularly high rates of substance misuse, post-traumatic stress disorder, acquired brain injury and comorbidity were evident or inferred for Aboriginal and Torres Strait Islander prisoners. A strong link between substance misuse and offending was evident, especially crimes involving assault. Contradictory findings for depression, upon closer analysis, revealed a pattern of under-diagnosis, wherein the symptoms needed to be more extreme before services were accessed or made available to Aboriginal and Torres Strait Islander prisoners. It was also considered likely that Aboriginal and Torres Strait Islander prisoners experienced higher rates of subjective distress, not adequately picked up by current systems of assessment and diagnosis, relating to loss of identity, acculturation stress and/or 'spiritual sickness'.[44]

Overall, the findings in the report by Jones and Day pointed to the need for more culturally attuned mental health assessments and responses for Aboriginal and Torres Strait Islander peoples involved in the criminal justice system, and a much higher standard of culturally appropriate data collection in the mental health field[44] (refer to Chapter 10, Heffernan and colleagues; and Chapter 30, Hovane and colleagues).

There has been a range of innovative programs devised for Aboriginal and Torres Strait Islander adolescents within the juvenile justice system that, may provide models generally for the improved care of Aboriginal and Torres Strait Islander peoples within prisons, who may be vulnerable to mental illness. Stathis and colleagues describe a program conducted in a prison for Aboriginal and Torres Strait Islander adolescents that was coordinated across a number of departments.[45] Education Queensland provided substance use information to all adolescents attending the prison school. The Queensland Department of Communities offered psycho-educational programs as part of regular life skills programs, and clinical treatment was offered to young people identified as suffering from significant substance misuse disorders. The recruitment of an AMHW to the team was a further incentive for Aboriginal and Torres Strait

Islander adolescents to engage in the program.[45, 46] In addition, the AMHW was able to assist the other clinicians with the definition of cultural issues affecting the adolescents, allowing them more accurately to define issues of mental illness and personality dysfunction. The AMHW also engaged the adolescents in concepts of emotional and spiritual wellbeing. Other strategies such as the use of a 'buddy system' have also been suggested to assist adolescents adjust to custody.[47]

Treatment

It is not within the scope of this chapter to critically review therapies currently available for the treatment of mental illness. Australian practice guidelines developed by the RANZCP are a good initial reference point for this issue, and clinicians should be able to discuss their proposed treatment with affected individuals and their families in the context of these guidelines.[48] People affected by severe mental illness such as psychosis, severe depression and mania, may be at risk of death or serious injury to themselves by accidents or suicide. They may also be a danger to others, through fear or aggression. Urgent medical attention should generally be sought to help the person affected by these disorders. It is not inevitable that the person who is affected by mental illness will be admitted to hospital—they may be able to be treated in their community with the help of family, AMHWs and Mental Health Services. People affected by mental illness and their families may be aware of National Standards in Mental Health, which emphasise treatment in the least restrictive environment for people affected by mental illness.[49] Other publications such as the CARPA manual also have protocols for treating Aboriginal people with mental illness in their community.[50] However, if the mental illness is severe and the person suffering from it may be a danger to themselves or others as a result of their illness, the person may need to be treated involuntarily under the *Mental Health Act 1996* for a period before returning to their community and family.

There have also been a number of innovative strategies to improve the outcome for people affected by mental illness. The Northern Territory AIMhi project has developed a *Story Telling Project* to improve compliance and reduce recurrence of mental illness for people living in remote communities, as well as attempting to reduce the stigma in the community for people affected by mental illness.[51] The developed stories are produced in collaboration with a range of clinicians, service providers and the communities concerned. These programs work on a concept of improving mental health through strength in spiritual, physical, family, work, social, mental and emotional components of the life of the person affected. The stories emphasise the importance of culture and of the Aboriginal and non-Aboriginal way of working together to improve the outcome for the person. The stories developed were then used to preface a further intervention strategy of motivational interviewing, problem-solving therapy and chronic disease self-management, to improve outcomes for a group of people suffering from severe mental illness.[52] Other resources include the DVD collection of personal stories of Aboriginal and Torres Strait Islander peoples, in addition to a guide for the care of Aboriginal and Torres Strait Islander peoples experiencing severe mental illness produced by ORYGEN.[53, 54] The use of these resources to inspire and educate Aboriginal and Torres Strait Islander peoples, their families and service providers is a welcome trend.

CONCLUSION

This chapter demonstrates that mental illness was present in Aboriginal and Torres Strait Islander culture prior to European colonisation of Australia but was, most likely, a fairly rare occurrence. The much greater prevalence of mental illness in the Aboriginal and Torres Strait Islander population currently is a reflection of the significant disruption to Aboriginal and Torres Strait Islander society and has a strong context of social and emotional deprivation. Management of the issues of mental illness requires a strong emphasis on cultural safety, along with the recognition of family, culture and community in any healing process.

REFLECTIVE EXERCISES

1. Discuss how the significant changes to Aboriginal and Torres Strait Islander culture and society since European colonisation have led to changes in patterns of mental illness.
2. Discuss how you may go about the assessment of an Aboriginal and Torres Strait Islander person who is referred to you by another clinician for assessment of 'depression'.
3. Discuss how the experience of an Aboriginal and Torres Strait Islander person suffering from mental illness may affect that person's family, and ways that you as a clinician may assist the family.

REFERENCES

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). 2013.
2. Chang D. An introduction to the politics of science: culture, race, ethnicity, and the supplement to the Surgeon General's report on mental health. Culture Medicine and Psychiatry. 2003; 27:373-83.
3. Clear G. A re-examination of cultural safety: a national imperative. Nurs. Prax. N. Z. 2008; 24(2):2-4.
4. Morgan S. Orientation for general practice in remote Aboriginal communities: a program for registrars in the Northern Territory. The Australian Journal of Rural Health. 2006; 14(5):202-8.
5. Helen Milroy. In: Personal communication. 2012
6. Lette H, Wright M, Collard S. Aboriginal youth: Mental health. In Dudgeon P, Garvey D, Pickett H, editors. Working with Indigenous Australians: A handbook for psychologists. Perth: Gunada Press; 2000.
7. Hunter E. Mental health. In: Thomson N, editor. The Health of Indigenous Australians Melbourne: Oxford University Press; 2003.
8. Sheldon M. Psychiatric Assessment in remote Aboriginal communities of Central Australia. CAMHSNET Nexus; 2005.
9. Parker R. The Royal Australian and New Zealand College of Psychiatrists Statement on Indigenous Mental Health Workers. Aboriginal and Islander Health Worker Journal. 2003; 27(1):3-6.
10. World Health OrganiZation. In: The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines. 1992. Geneva.
11. Pink B, Allbon P. In: The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples. 2008. Canberra: Australian Bureau of Statistics.
12. McKendrick J, Cutter T, Mackenzie A, Chiu E. The pattern of psychiatric morbidity in a Victorian urban Aboriginal general practice population. The Australian and New Zealand Journal of Psychiatry. 1992; 26:40-7.
13. Jorm A, Bourchier SJ, Cvetkovski S, Stewart G. Mental health of Indigenous Australians: a review of findings from community surveys. Medical Journal of Australia. 2012; 196:118-121.
14. Jones I, de la Horne D. Diagnosis of psychiatric illness among tribal Aborigines. Medical Journal of Australia. 1972; 1:345-49.
15. Cawte J. The devil's dozen: Thirteen Aboriginal depressions. The Aboriginal Health Worker. 1987; 12:19-28.

16. Morice R. Know your speech community. Aboriginal Health Worker. 1986; 10:12-32.

17. Brown A, Scales U, Beever W, Rickards B, Rowley K, O'Dea K. Exploring the expression of depression and distress in Aboriginal men in central Australia: a qualitative study. BMC Psychiatry. 2012; 12 (97).

18. Ketchell M. In: Grief, loss and the healing, a brief awareness: 'Mifla Way-Ilan Pasin or Our Way-Island Protocol.' 2004 Unpublished.

19. Australian Institute of Health and Welfare. In: The health and welfare of Australia's Aboriginal and Torres Strait Islander people an overview 2011. Canberra: AIHW.

20. Eastwood JG, Phung H, Barnett B. Postnatal depression and socio-demographic risk: factors associated with Edinburgh Depression Scale scores in a metropolitan area of New South Wales, Australia. The Australian and New Zealand Journal of Psychiatry. 2011; 45(12):1040-6.

21. Campbell A, Hayes B, Buckby B. Aboriginal and Torres Strait Islanders women's experience when interacting with the Edinburgh Postnatal Depression Scale: A brief note. Australian Journal of Rural Health. 2008; 16:124-131.

22. Zubrick SR, Silburn SR, Lawrence DM, Mitrou FG, Dalby RB, Blair EM et al. The West Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People. Perth: Curtin University of Technology and the Telethon Institute for Child Health Research, 2005.

23. Trewin D, Madden R. In: The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples. 2005. Canberra: Australian Bureau of Statistics.

24. Hunter E, Reser J, Baird M, Reser P. An analysis of suicide in Indigenous communities of North Queensland: The historical, cultural and symbolic landscape. Canberra: Mental Health/Health Services Development Branch, Commonwealth Department of Health and Aged Care; 1999.

25. Eastwell H. The low risk of suicide among the Yolngu of the Northern Territory: the traditional Aboriginal pattern. The Medical Journal of Australia. 1988; 148:338-40.

26. Meggitt MJ. The desert people. Sydney: Angus Robertson; 1962.

27. Kidson M, Jones I. Psychiatric disorders among Aborigines of the Australian Western Desert. Archives of General Psychiatry. 1968; 19:413-17.

28. McKetin R, Lubman DI, Baker AL, Dawe S, Ali RL. Dose-related psychotic symptoms in chronic methamphetamine users: evidence from a prospective longitudinal study. JAMA psychiatry (Chicago, Ill.). 2013; 70(3):319-24.

29. Paparelli A, Di Forti M, Morrison PD, Murray RM. Drug-induced psychosis: how to avoid star gazing in schizophrenia research by looking at more obvious sources of light. Front. Behavioural Neuroscience. 2011; 5(1):1-9.

30. Parker R, Milroy H. Schizophrenia and related psychoses in the Aboriginal population of Australia. The Aboriginal and Islander Health Worker Journal. 2003; 27(5):17-19.

31. Jones I, de la Horne D. Psychiatric disorders among Aborigines of the Australian Western Desert. Further data and discussion. Soc. Sci. Med. 1973; 7:219-28.

32. Eastwell HD. Associative illness among Aboriginals. The Australian and New Zealand Journal of Psychiatry. 1976; 10:89-94.

33. Eastwell HD. Projective and identificatory illnesses among ex-hunter-gatherers: a seven-year survey of a remote Australian Aboriginal community. Psychiatry. 1977; 40:331-43.

34. Morice R. Personality disorder in transcultural perspective. The Australian and New Zealand Journal of Psychiatry. 1979; 13:293-300.
35. Hart C, Pilling A, Goodale J. The Tiwi of North Australia (3rd Ed). New York: Holt, Rinehart & Winston; 1988.
36. Hiatt L. Kinship and conflict: A study of an Aboriginal community in Northern Arnhemland. Canberra: ANU Press; 1965.
37. Strehlow T. Geography and the totemic landscape in Central Australia: A functional study. In: Berndt RE, editor. Australian Aboriginal Anthropology. Canberra: Australian Institute of Aboriginal Studies; 1970.
38. Royal Australian and New Zealand College of Psychiatrists. Carers. [Internet]. 2008 Available from: http://www.aph.gov. au/House/committee/fchy/carers/subs/sub672.pdf.
39. Dillon MC, Westbury ND. Beyond humbug: Transforming government engagement with Indigenous Australians. West Lakes, SA: Seaview Press; 2007.
40. Crawford F, Dudgeon P, Garvey D, Pickett H, editors. Interacting with Aboriginal communities. Perth: Gunada Press; 2000.
41. McKelvie G, Mallard J, editors. Working therapeutically with Aboriginal families. Perth: Gunada Press; 2000.
42. Butler T, Allnutt S, Kariminia A, Cain D. Mental health status of Aboriginal and non-Aboriginal Australian prisoners. The Australian and New Zealand Journal of Psychiatry. 2007; 41(5):429-35.
43. Australian Institute of Health and Welfare. In: Juvenile Justice in Australia 2005–06. Canberra; 2007.
44. Jones R, Day A, Justice S. In: Indigenous mental health in the criminal justice system: A review for the Justice Mental Health Strategy, Justice Health and Indigenous Issues Unit. 2008. Melbourne: Victorian Department of Justice.
45. Stathis SL, Letters P, Doolan I, Whittingham D. Developing an integrated substance use and mental health service in the specialised setting of a youth detention centre. Drug Alcohol Rev. 2006; 25(2):149-55.
46. Stathis S, Letters P, Dacre E, Doolan I, Heath K, Litchfield B. The role of an Indigenous Health Worker in contributing to equity of access to a mental health and substance abuse service for Indigenous young people in a youth detention centre. Australian eJournal for Advancement of Mental Health. 2007; 6:1-10.
47. Troth G, Grainger J. The psychological impact of custody on the Aboriginal adolescent. Psychiatry Psychology and Law. 2000; 7(1):89-96.
48. Royal Australian and New Zealand College of Psychiatrists. Guides for the Public. [Internet]. 2008 [cited November]. Available from: http://www.ranzcp.org/resources/clinical-practice-guidelines.html
49. National Standards for Mental Health Services. 1996. Canberra: AGPS.
50. CARPA. Standard Treatment Manual (3rd Ed.). 1997.
51. Nagel T, Thompson C. AIMHI 'Mental Health Story Teller Mob': Developing stories in mental health. Australian eJournal for the Advancement of Mental Health. 2007; 6:1-6.
52. Nagel T, Robinson G, Trauer T, Condon J. An approach to treating depressive and psychotic illness in Indigenous communities. Australian Journal of Primary Health. 2008; 14:17-24.
53. ORYGEN. Discussing suicide: Brian's story. 2008.
54. ORYGEN. (Centre). Mental health first aid for psychosis in Aboriginal and Torres Strait Islander communities. 2008.