www.futureleaders.com.au
DISCUSSION PAPER

Indigenous Children and Mental Health

Professor Margot Prior AO

Indigenous children in Australia experience high levels of vulnerability. They are over-represented in child protection, and juvenile justice systems, are at high risk of low participation in education and failing to complete their schooling; there are many without adequate levels of literacy and numeracy, so vital to equip them for employment opportunities.

Vulnerability begins early in life, with infant mortality more than twice that for non indigenous infants, a level of health risk three times the national average, and higher rates of out of home care, physical abuse, sexual abuse, neglect, and lack of access to health care. A substantial number do not have access to, or do not use playgroups, pre-schools, and early learning experiences which allow them to be better prepared for a more comfortable transition into school systems and ready for learning. Especially for those living in chronic poverty and disadvantage, a mix of sub standard housing, poor access to transport, poor nutrition, sub optimal language skills, and parent/family problems undermine early development across all domains. A significant proportion of young Indigenous children enter their first year of school without the level of language competencies, which are needed to underpin literacy development. It is not surprising then that they struggle to learn to read since they are without the necessary scaffolding for such learning and find themselves falling further behind in literacy with each year.

Indigenous families and their children are at elevated risk for mental health problems, which go hand in hand with social and educational disadvantage, stress, and social exclusion in any population.

While there are no comprehensive statistics on the mental health of young aboriginal Australians, a recently completed survey covering the aboriginal population of Western Australia "The Western Australian Aboriginal Child Health Survey" (WAACHS) (Zubrick et al 2004, 2005, 2006, 2007), (waachs@ichr.uwa.edu.au) provides reports on the social and emotional wellbeing of 3,993 aboriginal and Torres Strait Islander children and young people, aged 4 to 17 years. This survey is one aspect of the broad WAACHS assessment of health, educational experiences, and family and community health in the aboriginal child population of Western Australia. The study is notable in that it was planned and carried out in collaboration with indigenous people, many of who were trained to collect the data through interviews with the families across the state. To put this landmark survey and its population into an international geographical context:

"Western Australia comprises over one third of the continental landmass of Australia. Covering an area of 115 740 square kilometers it is larger than the USA and about the same size as Western Europe. The northwest and centre of the state includes large tracts of desert, which are some of the world's most remote and sparsely populated areas. The more populated southwest of the state includes extensive agricultural and forested areas with numerous small population centres. Over two thirds of the State's total population and one third of the Aboriginal and Torres Strait Islander pop ulation reside in the metropolitan area of Perth."(Zubrick et al 2004).

The data for the report on social and emotional wellbeing in WA Indigenous children and families come from responses to the 'Strengths and Difficulties Questionnaire' of Robert Goodman which comprises 25 questions covering emotional symptoms, conduct problems, hyperactivity, peer problems and prosocial behaviour. This rating scale is completed by primary carers of the children, and for the age band of 12 – 17 years, the young people also complete the questionnaire. Comparisons with non Indigenous children in WA were available for use as benchmark data to highlight the comparative state of Indigenous mental health. Relevant contextual points are that 34% of the indigenous children and young people were living in single parent households, and that more than 30% of families in the surveys had a history of forced removal of a family member.

This survey showed that 24%, i.e. a quarter of 4-17 year olds were at high risk of clinically significant emotional or behavioural difficulties. This compares with 15% of non-aboriginal children in Australia who have these problems.

For children aged 4-11 the prevalence of problems was 26% (compared with 17% non-aboriginal); for those 12 -17 years the percentage was 21% (compared with 13% of non aboriginal adolescents). Rates were twice as high in boys compared with girls. The survey took into account the living situation of the families involved, from most to least remote from the metropolitan area. Rates were highest in city and populous regional areas; they were lowest in areas of extreme isolation suggesting that isolation and adherence to traditional ways of life can be a protective factor against mental health problems.

A range of social and family factors, which might influence the development of behavioural and emotional difficulties, was assessed in the survey. The strongest risk factor for behavioural and emotional difficulties in the children and young people was the number of significant life stresses that families had experienced.

Forty two percent of children 4-11, and 34% of 12 – 17 year olds who had experienced 7 or more stresses had emotional and behavioural problems judged to be clinically significant on the rating scale. This compares with 15% and 12% in the clinical range respectively, in children experiencing 0 -2 stresses. One fifth of children in the sample had suffered 7 or more stress events in the last year making this group five and a half times more at risk of mental health problems.

The strongest risk factor for behavioural and emotional difficulties in the children and young people was the number of significant life stresses that families had experienced.

A further risk factor was quality of parenting, with a fourfold risk of various problems for children living in a situation of poor parenting. Living in a poorly functioning family doubled the risk for emotional and behaviour difficulties in children and young people. Other risk factors for mental health problems included having a sole parent, or a non-parent carer; or 5 or more changes of home since birth. As is commonly found, children with emotional and behavioural difficulties were more likely to have other health related problems such as speech impairments, runny ears (otitis media), vision problems, and/or to have carers who themselves had poor physical or mental health.

Adolescents were asked to provide information on themselves via the same Questionnaire completed by their parents. Additionally they completed a 'Youth Self Report', in which they reported their experiences with exercise, use of drugs and alcohol, smoking, and sexual activity.

Comparisons of carer report data of adolescents who did and did not complete the questionnaires indicated that those who did not complete were more likely to have mental health problems according to their parents reports, hence the figures based on self report data obtained are

highly likely to **underestimate** the youth behaviours sampled.

In summary, based on self-reports, 11% of adolescents showed clinically significant (serious) emotional or behavioural difficulties; more females showed emotional symptoms, while more males showed conduct problems (antisocial behaviour). Those being cared for by both original parents were at lower risk than those who were cared for by a sole parent, or had poor quality parenting.

In summary, based on self-reports, 11% of adolescents showed clinically significant (serious) emotional or behavioural difficulties; more females showed emotional symptoms, while more males showed conduct problems (antisocial behaviour). Those being cared for by both original parents were at lower risk than those who were cared for by a sole parent, or had poor quality parenting.

Smoking, not participating in sport, and being subject to racism also increased the risk of mental health problems significantly for young people. Sexual experience during adolescence began early and increased with age, with half of 17 year olds reporting that they had had sex before the age of 16. This was strongly associated with early school drop out, smoking, and alcohol and marijuana use. Alcohol and drug use were more common in males than females, and were less common in very remote areas.

Having carers who were part of "the stolen generation" was also a risk factor for mental health problems in young people. It is not hard to understand that those parents who had experienced disrupted and often traumatic separation from their own parents and who had diminished opportunities to learn adaptive parenting skills are likely to transmit these disadvantages through their parenting. When combined with alcohol and drug abuse, which is often associated with a history of troubled childhood, we have intergenerational risks for what an Indigenous colleague has called 'toxic parenting'. At least three generations of serious parenting deficiencies can be traced in the histories of many children currently presenting to clinics dealing with mental health problems.

Having carers who were part of "the stolen generation" was also a risk factor for mental health problems in young people. It is not hard to understand that those parents who had experienced disrupted and often traumatic separation from their own parents and who had diminished opportunities to learn adaptive parenting skills are likely to transmit these disadvantages through their parenting.

Hence the picture of mental health for Indigenous children and families is yet another disturbing indicator of the consequences of the suffering of generations of families. This has been chronicled so often it needs no repeating. But to see these high prevalence figures coming for a collaborative white/ Indigenous piece of substantial and high quality research highlights the need for an urgent focus on improving the psychosocial and educational prospects of Indigenous young people. This is a human rights issue for Australia.

Services for children and families with mental health concerns

Provision of care for mental health problems for indigenous families and their children is hard to find. In South Australia and the NT, intermittent visits to remote areas by visiting mental health teams is sometimes available but is less than satisfactory, since no long term psychological counseling and therapy can be provided in this way, and the very nature of mental health problems requires sustained support to achieve improvements. Access to GP advice can also be helpful,

but again is insufficient in terms of the expertise and sustained support which is needed to treat serious problems.

Only a tiny proportion of families and children who need mental health services actually attend any services.

Even in major cities, too few resources are available and even fewer which are culturally focused and sensitive to indigenous concerns. Standard Child and Adolescent Mental Health services may be in existence but are often not accessed, especially by troubled adolescents who are reluctant to talk to professionals about their difficulties. Some level of mental health expertise may be available in Aboriginal controlled Health Services although again resources are insufficient for the needs of children and families with significant mental health issues. Only a tiny proportion of families and children who need mental health services actually attend any services. This is the same for non Indigenous families (See M Sawyer et al "National Child Mental Health Report, 2000), but because of the higher prevalence of problems amongst indigenous children the relative shortfall is even worse.

There are scarcely any indigenous professionally trained psychologists, psychiatrists, psychiatric nurses, or paediatricians. In the case of psychology almost no indigenous students are coming to University to do Psychology courses, and to continue on to clinical training. Further back in this education and training pathway, too few indigenous young people are finishing school and going into any kind of tertiary training in social sciences, welfare studies, or mental health, which might bring an increase in the indigenous mental health work force. Currently there are about 25 indigenous psychologists in Australia although not all of these would be working in clinical settings.

In Victoria, a Certificate course is available for those indigenous people who are not formally trained but who are interested in working in child mental health settings. However, Indigenous students in this course, whose level of secondary or tertiary education may be low, often struggle with literacy problems, and with the complexities of assessment and diagnosis, which are formally taught via conventional psychiatric models. Non Indigenous personnel who often have minimal training but a special interest in, and sympathy with Indigenous issues deliver many available psychological services. Happily there are some Indigenous academics at some Australian universities who are developing courses designed to inform and sensitize psychology students to Indigenous issues, and in the longer term to produce professionals who can work effectively and in a culturally sensitive way with Indigenous peoples.

"...we have had the reviews, we know what needs doing, we can do it, why don't we implement recommendations coming from the reviews..."

Prevention

The value of early intervention/ prevention of mental health problems has reached the awareness of governments in recent years, and is on the agenda in mainstream health and education services. However, for Indigenous populations who are subject to much higher levels of family stress and developmental disadvantage there has been tragically little concerted action. Addressing the contributors to high risks in this arena, as has been done by the WAACHs research, brings up the same set of family and environmental problems, which apply to the whole range of vulnerabilities experienced by the Indigenous population. The basic needs for satisfactory housing, transport, health, nutrition, educational opportunity, employment, and cultural integrity are fundamental to mental health issues as they are to all other areas of life. As WA pediatrician, advocate and former Australian of the Year Fiona Stanley has emphasized,

we have had the reviews, we know what needs doing, we can do it, why don't we implement recommendations coming from the reviews including the most recent WAACH one.

Working in a Service for Indigenous Families

A steady stream of children and adolescents present for help with a wide range of problems including: anxiety and depression, acting out/antisocial behaviour; school difficulties including learning problems, poor language skills, poor school attendance, fighting, signs of neglect; smoking and alcohol problems; and antisocial behaviour such as delinquency/stealing/lying/vandalism/truancy/car stealing. This is frequently associated with conflict and coping difficulties in the families, and with poor parental monitoring of the child/adolescent (not knowing where the young person is, who he/she is with, when s/he is likely to come home etc.)

Children with 'attachment' problems (i.e. lack of opportunity to develop sustained, reliable, and trusted relationships with parent or other carer during childhood which are important underpinnings to psychosocial health throughout life) are often seen for mental health problems. Many of these young people are victims of family break up and abandonment, and are 'ín care'; they are especially at risk and often present serious and well entrenched management difficulties by the time they reach clinical services. Their difficulties lead to multiple changes of carers, which further compound the problems which have developed in the very vulnerable years of early childhood.

Agencies involved in child protection and management of alternative care are continually looking for 'therapy' which will overcome the severe damage which such children have suffered in their early lives. In too many cases this is a vain hope as the children's circumstances have been so harmful in the critical stages of early development that it is almost impossible to redeem them.

Some clinical case notes for illustration

Janis

Janis was referred from Child Protection services for "loss and grief issues; father deceased, mother in prison but has access visits, child had been out of parental care for a significant part of her life, multiple placements, emotional, physical, environmental neglect, attachment problems, exposed to domestic violence, showed developmental delay and learning difficulties. Behavioural concerns included: laughing excessively when stressed, immature, attention seeking, bed wetting, disruptive and disinhibited, social problems at school, displaying some sexualized behaviours. With good management, Janis's adjustment improved while she was placed with a stable carer and she was more settled. However follow up 4 years later showed that Janis was still struggling both academically and socially.

Brendan

Brendan was fostered by relatives all his life, both parents had persistent alcohol problems. Mother drank throughout pregnancy, child premature and low birth weight; Brendan had learning difficulties and behaviour problems at school, repeated a grade and showed severe receptive and expressive language delay and mild intellectual disabilities. His history, appearance and cognitive and language disabilities suggested that he might be a case of Fetal Alcohol Syndrome (FAS). (Children with FAS have brain damage sustained during the pregnancy, which can lead to learning disabilities, attention deficits and problems with social adjustment. Children/adults with FAS may also have certain organ deficiencies and limited physical growth).

This diagnosis had not been given and neither his foster family nor his school was aware of the extent of his difficulties. Arrangements were made to apply for special assistance at school to support Brendan in the classroom and to work on his language skills.

Jason

Jason, aged 10, brought to the clinic by his distressed and despairing parents who were very concerned about his aggression, swearing, and abusive behaviour at home. His parents detailed long stories about his bad and uncontrollable behaviour and wanted him 'fixed'. Jason was struggling at school and was many grades behind in literacy and numeracy.

He spent large periods of time not at home unsupervised, and his parents often had little idea where he was. Parents and child all expressed anger and animosity toward each other. There was a high level of conflict in the family with frequent violence between parents and towards Jason and his brothers. He habitually denied wrongdoing. Jason enjoyed sport and physical activities. The family housing situation was very unstable.

It was pointed out that it would be hard to just 'fix' Jason when there was so much violence throughout the home. Parents and child agreed to work together to reduce the level of aggression and abuse. The first thing they would tackle was swearing. This agreement worked for a short time with the family reporting a calmer and more positive atmosphere and less swearing and abusive language. However this contract was too hard to sustain as each blamed the other for starting fights and being abusive. The parents still wanted Jason to be 'fixed up'. After some time therapy broke down, as the level of conflict and aggression between the parents was so persistent and intractable that it was unrealistic to expect the boys to change their behaviour when the parents could not manage their own conflicts and aggression.

Ray

Ray, 12 year old boy of two urban indigenous parents, both of whom had experienced episodes of mental illness and problems with alcohol and drugs. His young brother had died suddenly of unexplained causes and this had traumatized the whole family. There was a history of intermittent fights between his parents and extended family members and neighbours. Ray was intellectually able and managing to keep up with the work at school, despite many changes of school and frequent absences when Ray's mother was hospitalised with alcohol problems and psychotic behaviour, and when he was living with his father who was often too depressed and disorganized to help Ray to get to school. Ray presented with high anxiety about the lack of security in his life at the time when he was just living with his father, and his mother's future was very uncertain. Ray maintained the hope that the family would be reunited one day, but visits with his mother only served to increase his distress as he realized just how ill she was. This often precipitated frightening dreams as well as problem behaviours, which his father could not manage.

Ray is an attractive child and talks easily with his many professional supports and relatives. His father was highly motivated to do the best he could for Ray but was sometimes not in control of his own mental state. Consistent support for Ray was difficult to provide as he was moved between houses and schools. The family complained that he was uncooperative and difficult to manage, and the psychologist found Ray to be anxious and depressed.

> His childhood experiences add up to a long history of hardships, insecurities, loss and grief, and shifting relationships. Ray loves his parents but they are struggling to care properly for him. His ever increasing anxiety is a threat to his longer term future. His positive personal attributes are very helpful but he will need a strong character to be able to complete his education, and to survive such a troubled history, as he moves into adolescence. Treatment of anxiety was provided but this cannot be really effective as long as Ray's living and parenting environment is insecure.

Three themes, as illustrated in these stories, are important in understanding Indigenous children's' mental health.

First, children usually present with a **package** of problems, rather than a specified psychological 'disorder'. They have diverse symptoms and problem behaviours, frequently with accompanying language and learning problems, and a background of adverse social and family histories. Part of this package (and this 'package' notion is not specific to Indigenous children) includes problems in self-management of behaviour and emotions, attention and concentration, distractibility and impulsivity; these are developmental challenges evident in the early years, which persist in troubled children and can have pervasive long-term negative consequences.

...the traditional western medicalisation of psychosocial problems is inappropriate for Indigenous child health where the picture is inevitably highly complex involving combinations of early biological risk factors, disruption to early social and emotional development, along with persistent social disadvantage.

Second, the traditional western medicalisation of psychosocial problems is inappropriate for Indigenous child health where the picture is inevitably highly complex involving combinations of early biological risk factors, disruption to early social and emotional development, along with persistent social disadvantage. A whole child, whole family, whole community approach, which is sustained over a long period, is needed to provide appropriate support. There are no quick fixes.

Third, parenting issues are commonly paramount in the clinical picture, with parents struggling to deal with their own mental health/alcohol/drug use/ relationship/generational/parenting difficulties. Hence while they love and value their children and are concerned for their welfare, their own needs hinder their capacities to be effective agents in helping their children. Supporting and educating the parents is commonly the most helpful thing health professionals can do for the better emotional health of the children.

Indigenous families often suffer from a double dose of problems: - those associated with social and economic disadvantage, unemployment, housing and transport difficulties, sub optimal health etc. i.e. the same problems faced by white families in disadvantaged circumstances; plus, those associated with Indigenous background including much higher risk of illness, and death of relatives and friends, and sometimes tribal conflict; low levels of education; and unresolved grief and anger over long standing injustice to indigenous people. These critically important social determinants of health are powerfully illustrated in work in communities of Indigenous families.

What will help?

Comments from Professor Ian Anderson formerly CEO of the Victorian Aboriginal Controlled Health Services, and now Professor of Indigenous Health at the University of Melbourne offer helpful pointers from an Indigenous professional with a long history in health practice and education.

...there are multiple determinants of poor health that intersect in all the identified problem areas. And we risk developing whole series of programs oriented to issues like family violence or sexual abuse, which never fundamentally deal with some of the common core determinants…

…an aboriginal health worker who knows the community, its cultural structures and dynamics and who is trained and able to recognize the symptoms of mental illness… access to fairly immediate clinical support, and to training and support which he or she can apply to the community members who ask for it, to assist them to deal with a relative who is ill... intervention which is community developed and community managed with a health worker acting as a conduit through which resources and bio medical expertise can be channeled when the community requests it, and alternatively, challenged when the community feels the need to do so.

In addition, better education of all helping professions to enhance their understanding and sensitivity about the nature and complexity of the problems families experience is needed to bring better-accepted services from the non Indigenous providers. This is becoming more available in larger cities but is still insufficient to underpin effective services. Increasing the numbers of aboriginal people who are interested in training for and working in health and welfare services is a sine qua non for more accessible service provision which Indigenous peoples will value and trust.

And of course better educational opportunities and achievement are fundamental to all aspects of these problems. Hence major improvements in the provision of education; wise and sustained support for families and children who struggle with the education systems; playgroup and pre-school experience incorporating language and pre-literacy skills made easy for **all** children and families; and raising the values, expectations and commitments of Indigenous communities to educating their children for a healthier and happier future are essential.

It is important to note that while the high rate of emotional, behavioural and learning difficulties is of grave concern, the other side of this story is that despite this wide range of disadvantaging circumstances, a substantial proportion of Indigenous young people do well. They complete school, go on to further education and training, find employment, and work hard to raise the next generation of children in the best circumstances they can achieve. The Indigenous population does have a gradually increasing rate of professionally qualified people, and many individuals with outstanding leadership skills, which they are applying to the health, education and well being of their people. The need for capacity building is also being emphasized. Awareness of, and attention to the importance of the early years for future life outcomes has grown in the last few years and it is critical that all children remain at the forefront of our concerns and that their rights and needs are given strong and effective action.

Professor Margot Prior AO

Margot Prior is Professor of Psychology at The University of Melbourne. She has been a lecturer, clinician and researcher in the field of family and child development. She was previously Director of Psychology and Founder of the Learning Difficulties Centre at the Royal Children's Hospital. Her books include *'Understanding Specific Learning Difficulties'* and *'Behaviour Problems in Asperger Syndrome'*, and *'No Time to Lose' (with Sue Richardson).*