

# Psychosocial health issues among young Aborigines

**THE PREVIOUS CHAPTER** has examined social aspects of some of the major diseases and infections experienced by young people, but there are also pressing psychological, social and emotional issues which bear upon this age group and have an impact on their health. Researchers elsewhere have highlighted the fact that adolescents and young adults request help with school problems, drugs, sex, getting along with family, depression and sadness, fatigue, nervousness – in short, a host of social and emotional issues – rather than conventional illnesses. It is unlikely that Aboriginal young people are any different in terms of the issues that concern and worry them.

## Prevalence of drug and alcohol use

The use of alcohol and other drugs by Aboriginal people is just one facet of the overall use of these substances by all Australians. Alcohol use in particular is accepted, condoned and encouraged as part of being Australian. My own work in a country town showed that alcohol was used and misused by both whites and Aborigines in the town, and that to be a white non-drinker was considered quite atypical (Brady 1988).

Like other young Australians, some young Aboriginal people use a variety of drugs in order to change their mood. Their choice of substance depends very much on availability, peer group preference and social circumstances. For example, an Aboriginal youth living in Sydney or Melbourne is more likely to experiment with illegal drugs such as cannabis or heroin than his counterpart growing up in Maningrida or Yuendumu in the Northern Territory, who will try sniffing petrol. Alcohol is undoubtedly easier to obtain in towns and cities, as many Aboriginal settlements have either been declared dry under various state or territory legislations, or have sporadic alcohol supplies. Communities with on-site licences (in Queensland and the Northern Territory, for example) can attempt to control the amounts of alcohol consumed through various procedures, such as selling opened cans or through a rationing system. Kava (a

soporific beverage imported from the Pacific) is available primarily in northern coastal communities of the Northern Territory and is not used elsewhere. Cannabis is available in urban areas and rural towns and in some remote regions such as Broome, but rarely finds its way into isolated communities. Analgesics are easily available (through chemists in urban areas and local clinics in remote communities), and the various volatile solvents (petrol, glue, cleaning fluids) are not difficult to buy or steal.

Estimating the prevalence of the use of various alcohol and drug substances is not at all easy, and very few surveys of Aboriginal alcohol use have been undertaken. Such data as is available is state- or territory-specific.

There was a survey of drug use undertaken across a variety of Aboriginal populations in the Northern Territory in 1986 and 1987. This examined 10% of the population in a sample of major Aboriginal communities, town camps in larger urban centres, cattle stations, and outstations. This survey found that 36.6% of young Aborigines aged 15 to 20 consumed alcohol, and 48% of the 21 to 30 age group. Males predominated in both groups. In the 15 to 20 age group, 57% of young men and 12% of young women drank alcohol. Women reported that they began to use alcohol between the ages of 16 and 20 but few younger than this. Men reported that they began to use alcohol before the age of 15, or between 16 and 20 (Watson et al. 1988). Those interviewed said that they started drinking with friends, without parental approval, and when they visited towns. In the Kimberley region of Western Australia, researchers found much higher usage: 86% of males and 60% of females aged 16 to 20 years consumed alcohol (Hunter et al. 1991).

The only survey to focus specifically on young people in urban and rural New South Wales questioned Aboriginal schoolchildren in five different regions. Of those questioned, 56% knew of “large numbers” (i.e. 20 or more) of their peers who drank alcohol, while only 13% replied that they did not know any young Aboriginal people who drank (Williams 1986). But the results of this study are difficult to assess, as the survey was not aimed at the respondent directly, but asked: “Do you know of any young Aboriginal people from your town or suburb who drink alcohol?” Sixty-three per cent knew someone

drinking alcohol between the ages of 15 and 18, but 12% thought that older than 18 was the usual age for drinking. The schoolchildren were also asked why they thought young people might drink, and the most common answers were: because it is part of life for them; to socialise; to ease pressures; and nothing or no one else to turn to. A majority said that it was easy to obtain alcohol.

The only other data on urban drinking among young Aborigines is impressionistic. The Youth Support Scheme in Adelaide, which operates as a crisis intervention service for street kids, is primarily Aboriginal-oriented. A spokesperson reported that “virtually all” their young clients used alcohol. Similarly, staff at the Aboriginal Medical Service’s Aboriginal Neighbourhood House in Elizabeth (Adelaide northern suburbs) observed that young Aborigines there started drinking at 10 or 11 years of age. In Port Augusta (rural, SA) Pika Wiya, the Aboriginal community health service, reported that some Aboriginal children aged 10 years or so were using alcohol.

While the illnesses associated with chronic abuse of alcohol do not show up among people under the age of 25, young drinkers experience trauma associated with alcohol use: injuries associated with accidents and violence, motor vehicle accidents, suicide attempts, and self-mutilation. It hardly needs reiterating here, in view of the work of the Royal Commission into Aboriginal Deaths in Custody (Commonwealth of Australia 1991), but a significant number of deaths investigated by the Commission involved Aborigines who were intoxicated at the time of their arrest, or their detention. Sixty-seven per cent of the deaths in custody between 1980 and 1988 were of Aborigines detained for offences or circumstances related to alcohol (Muirhead 1988, p.25). Muirhead states:

*The vulnerability of an intoxicated person at the time of arrest and detention cannot be over-emphasised. There is much medical evidence and material which shows that a person who is intoxicated or suffering from withdrawal may be under a great deal of stress, both physiological and psychological, and thereby at risk if unsupervised (ibid., p.26).*

Deaths in custody are skewed towards the younger age groups for both Aboriginal and non-Aboriginal detainees, except for the 16-19 age group, which comprises 11% of Aboriginal deaths and 7% of non-Aboriginal deaths. In the National Report there is a breakdown of the age, sex and employment status of Aborigines who died in custody as well as those imprisoned (Commonwealth of Australia, 1991 Volume One, Chapters 2 and 6). The prison population itself shows that in the age groups 16 to 19 years and 20 to 24 years there are proportionately more Aboriginal than non-Aboriginal prisoners (ibid., p.99). If we assume that alcohol plays a role in a significant proportion of detentions, then alcohol use among 16 to 24-year-old Aborigines carries with it a high risk of arrest, police custody, imprisonment, and the unknown consequences of the last two forms of detention.

Tobacco use – of cigarettes and chewing tobacco – is common among young Aborigines. The Northern Territory survey found that smoking was usually well established by the age of 20; 54% of Aborigines between the ages of 15 and 20 smoked tobacco. In the New South Wales survey, the question on smoking was asked directly; 70% of the schoolchildren said they did not smoke, but 90% of those who knew others who smoked said that they began before the age of 12. Many of the personal stories told by teenagers living in rural New South Wales and published in *Growing Up Walgett* (Zagar 1990), refer to smoking tobacco, marijuana and drinking alcohol. The use of chewing tobacco is regionally specific, with more desert dwellers than other groups chewing. It is more prevalent among older age groups, and among women, but nevertheless girls learn to chew in their teens. I have seen young girls of seven years of age (in Western Desert communities) chewing tobacco. With respiratory diseases being ranked the second most common cause of death for Aboriginal women, and the third for Aboriginal men, smoking among youth is of great concern.

The prevalence of injection drug use among urban Aborigines is unknown, but the existence of preventive posters (aimed at AIDS prevention) featuring Aborigines and syringes is indicative of the presence of this method of drug taking. The New South Wales survey indicated also that children knew of other young Aborigines using cocaine or heroin, as well as tranquillisers and speed. It was thought to be “reasonably” or “very” easy to obtain these substances (Williams 1986).

Volatile solvent use was investigated by a Senate Select Committee in 1985, it noted the use of a variety of solvents among young Aborigines in urban areas, and petrol inhalation among certain groups in remote areas (Commonwealth of Australia 1985). Such socially-oriented research as exists emphasises the social nature of sniffing for young people. In a study of homeless youth in Newcastle, New South Wales, Mills observed that sniffing was not a solitary pursuit:

*It was essentially a social activity bound up with a peer group. It involved a career from innocent novice outsider towards a fully fledged group participant status (Mills 1986, p.12).*

The language and style, the training of novices and shared experiences of the high, were all part of the shared lifestyle of these urban sniffers, contributed to by their poverty. “We can’t afford grog or dope...it’s our scene man, just us Spunks together – and we can afford it” (ibid.). Aboriginal youths were part of this group as well.

The importance of the peer group and the shared rituals of sniffing petrol among remote Aboriginal youth are described by Brady (in press). Not all remote communities have young people who sniff petrol; the practice is particularly marked in Arnhem Land, southern Central Australia and the Central Reserves region of Western Australia – in general, populations living on ex-

mission or welfare settlements. The practice is rare among Aboriginal groups who were associated with the pastoral industry (Brady, in press). In remote communities, petrol sniffing is practiced mostly by boys, although girls also participate, and the age of users ranges from 10 (or younger on occasions) to the late twenties. However, the mean age of sniffers in a sample of communities studied by Brady, was 19 years. It is comparatively rare for sniffers to be older than 25.

The use of petrol as an inhalant has a number of serious physical and social consequences. While the reported Aboriginal deaths associated with the practice number a minimum of 35 from 1981 to 1988, the extent of permanent neurological impairment as a result of the toxic components of petrol (not just tetraethyl lead, but a cocktail of toxic hydrocarbons) is unknown. Researchers have noted that chronic sniffers appear intellectually dull, but in Australia there has been no clinical research into the extent of intellectual impairment among Aboriginal sniffers despite the fact that such impairment is undoubtedly widespread in regions where sniffing is endemic. The physical effects of sniffing leaded petrol have been documented both in Australia and in North America (see Brady 1990; Morice et al. 1981). Apart from the persistence of hallucinations and of bizarre behaviour, seizures and writhing movements – which can continue for some weeks after a chronic sniffer ceases inhaling – sniffers suffer anorexia (loss of appetite and thus loss of body weight), tremor, ataxia and toxic encephalopathy. They occasionally die suddenly after sniffing and engaging in vigorous exercise, as a result of hydrocarbon induced cardiac arrhythmia. Of the 35 documented deaths among Aboriginal sniffers, the majority (20) occurred in 12 to 19-year-olds; the mean age being 19 years (Brady, in press). All except one were male.

## Social factors associated with drug use

Faced with the over-use, misuse or dysfunctional use of drug substances (including alcohol) we all seek to understand why it is that individuals, particularly young people, behave in ways that are often patently self-defeating or destructive. There are many theories of drug use, both sociological and psychological, but when the users of substances are Aboriginal people a range of other social, historical and cultural influences are perceived to be involved. The social oppression of Aboriginal people is viewed by many to be an overall explanation for the over-use of alcohol and drugs. This view is epitomised by evidence presented to the Senate Select Committee which inquired into volatile substance abuse:

*Communities have identified a number of causes of petrol sniffing and substance abuse and these include the destruction of Aboriginal culture; the denial of Aboriginal*

*rights; enforced isolation; inadequate housing, community facilities and appropriate educational opportunities; the destruction of the traditional economy; the enforcement of inappropriate laws, values and social systems...It follows in our minds that the unacceptable practice of petrol sniffing and substance abuse is a symptom of that environment and thereby directly attributable to the planned destruction of our society (Senate Select Committee into Volatile Substance Abuse; Hansard 18/3/85, pp.807-8).*

In a description of the pressures felt by urbanised Victorian Aborigines, an unnamed Koorie wrote:

*All of these problems and many more can make life for a Koorie, at times, unfair...To relieve the anxiety and tension, we sometimes start to depend on such things as smoking, drinking (to drown our sorrows) or drugs (help numb the brain and make it easier to forget unwanted pressures)...All of these pressures and worries we encounter that always seem to keep us on the go, cause stress (quoted in Anderson 1988, p.58).*

While at one level factors such as these underlie the lives of all Aboriginal people, we must look deeper into the social complexities in order to understand how it is that drug and alcohol use and misuse affect different individuals and different populations. It is also important to note that the use of alcohol and drugs is not evenly distributed among Aboriginal people, as some of the surveys undertaken have shown. There are many Aboriginal people who are abstinent, others who drink "socially", but among those who do drink, most drink "dangerously" according to Watson and her colleagues (Watson et al. 1988). This high intake often occurs in public and is highly visible, thus reinforcing racist stereotyping, particularly in small country towns.

The changes of mood associated with different substances differ markedly from each other, and people select substances to achieve different aims. Similarly, the impacts of past colonisation and present discrimination make themselves felt to different degrees. Aboriginal people in Arnhem Land, Northern Territory, for example, have never been forcibly removed from their land, now own it outright under the NT Land Rights Act, actively pursue their ceremonial and traditional economic activities, and have the option of establishing family-based camps (outstations) on their own tracts of country. Nevertheless, people in this region use (and at times abuse) alcohol, kava, cigarettes and petrol. Their lives are in stark contrast to those of southern Aborigines living on the fringes of country towns, or in urban areas, who (if of mixed descent) may have been forcibly removed from their families at an early age and institutionalised in homes, have experienced low-paid work as domestics or labourers, and are now, still, frequently assailed by experiences of racism. Of the 99 deaths in custody investigated by the Royal Commission, 43 individuals had experienced childhood separation from their natural

families through intervention by the state, mission organisations or other institutions (Commonwealth of Australia 1991, I, pp.44). This will be discussed more fully in relation to stress, below.

For young Aborigines, the most compelling social factor in their drug and alcohol use is probably the desire to be part of the peer group – in this respect they are no different from any other young people. Another factor (again not specific to Aboriginal youth) is simply that the experience is pleasurable. As a 17-year-old girl from Walgett explained,

*I know a lot of people that take drugs or smoke it. They say you feel a lot better and happier. I didn't try it but I think the people I know use enough for them and me. If there would be no smokes, alcohol or drugs in the world I would think that there would be no more fun, excitement because without them people wouldn't be as happy as they would be (Zagar 1990, p.18).*

Aboriginal people stress that the young imitate their elders: “the kids follow their parents and relations, they watch what we do, they follow you, copy you” (Central Australia Aboriginal Alcohol Conference 1990, p.3). If, as it seems, most Aborigines who drink do so to dangerous levels, then we can assume that young Aborigines are also learning to drink in this way: the models of moderate intake are few. We know from anthropological studies of Aboriginal drinking that the pressure of the group is immensely strong among adults, that drunkenness is a valued state among drinkers, and that drinking is a way of life and has a style of its own (Bain 1974; Sansom 1980). O'Connor, writing of Alice Springs town campers, explains:

*To belong to the group and to live in the fringe camp is to drink with the group. If one does not drink with the group one may have a physical presence there, but one does not belong. The choice is simple: drink and belong, or abstain and remain outside (O'Connor 1984, p.181).*

Young men become part of such drinking groups naturally; they “learn” to drink from older men: their brothers, uncles, fathers. Drinking makes possible the deeds and words not accomplished when sober: sexual liaisons, speaking out, demonstrations of affection or anger. These things are appealing to the young. Among petrol sniffers, the peer group is also crucial. As with drinking, sniffing is a social activity, rarely engaged in in private. And, again as with drinking, sniffers must learn the rituals of the practice and are inducted into these by experienced users. My fieldwork has shown that, particularly in the Northern Territory, young Aborigines in remote communities have a rich subcultural life which includes styles of clothing, music and activities; in some regions young men, particularly, organise themselves into named gangs (the Warriors, the Mad Dogs, the Wongs). Some gangs are inspired by videos and are

obsessed with the crazes of the moment (kick-boxing, for example, or rap dancing); some are associated with petrol sniffing. The practice of petrol sniffing fluctuates widely and while these fluctuations are influenced by a number of factors (seasons, availability, local popularity), the reactivation of interest in sniffing usually occurs in association with a critical number of users resuming the practice. People describe this as “learning again” or “starting them up” and the process is intimately related to interaction with peers and sometimes with visiting youths or relatives from elsewhere. At major inter-community events (such as sports carnivals, or even Christian meetings) where large numbers of people from a region congregate, sniffing is likely to be practised as a critical mass of sometime users find themselves together, and while older people are preoccupied with other matters.

A major social ramification of sniffing has been that the behaviour of these young people has caused a crisis of faith among Aboriginal people in their society's ability to deal with problems. Young people who sniff exert considerable power over others, both because they are in an altered state which is bewildering and frightening to the uninitiated, and because in this altered state they often run wild, breaking windows, causing affray and screaming out. People in different regions have observed to me that “the sniffers are on top”, or that they are “boss over mother and father” – expressions that betray the disquiet they feel about this reversal of the old patterns. A term used by older people to describe sniffers in Ngaanyatjarra (a Western Desert language) is *tunguntungunpa*, which can be translated as disobedient, stubborn, unyielding, resistant, insolent or contrary. These translations give some idea of the perceptions that mature Aborigines have of their youth who are indulging in this activity. The old healing methods do not work for either petrol sniffers or drinkers, and the powers of traditional healers are thought to be insufficient (Dunlop 1988):

*The Aboriginal people to whom Dunlop spoke were concerned at the limitations of their old methods of therapy and social control. Aborigines' sense that their culture is at a turning point, unable by itself to deal with all disturbed behaviour, was found...to be widespread (Menziess School of Health Research 1991, p.29).*

While many outsiders romanticise the “caring and sharing” of the extended Aboriginal family, and the strengths of Aboriginal “communities”, the reality in many regions is that these groups have been powerless to deal with sniffing. The powers of community councils, traditional healers and even parents themselves are in doubt (ibid.). At a loss to deal with the unwillingness of young sniffers to listen to their parents, many adults leave their children to their own devices and hope that outside help and programs, or even institutionalisation, will solve the problem. The complexities of these attitudes and the difficulties of intervention are explored by Brady (in press) and in the Menziess School's evaluation of a

Central Australian intervention program, the Healthy Aboriginal Life Team (ibid.).

## Stress and mental health

It is not easy to define “stress” precisely, and it is even more difficult to make generalisations about its precursors, intensity and prevalence. It has been termed an “overworked and ill-defined concept” (Sibthorpe 1988, p.317). Even so, there is a growing body of research which supports the notion that sociocultural stressors can lower bodily resistance to disease, and that negative life situations (both acute and chronic) are associated with an increased incidence of mental and physical disorders (ibid., p.322).

Urban and remote Aboriginal people experience different levels of stress, from divergent causes, and with variable degrees of intensity. For example, Aborigines living in outstations or settlements in Arnhem Land, their own land, deal for the most part with non-Aboriginal staff who choose to work there, and who are generally sympathetic to Aboriginal aspirations and culture. Their resources and at least some of their services are delivered through Aboriginal organisations and personnel; their housing, electricity, education, medical and water supplies are provided free of charge. They probably have a local Aboriginal police aide who acts as an intermediary between any offender and the police. They may be able to supplement their purchased foods with hunted, fished, or gathered items. They may experience direct instances of racism or discrimination on the occasions when they travel to larger urban centres, but this would not form a major portion of daily experience for them. In contrast, Aboriginal people living on the fringes of larger towns or in urban areas are more likely to have been separated from their parents and placed in institutions as children. They must confront regular expressions of racial intolerance (from shopkeepers, police, public) and may have to deal with impersonal non-Aboriginal bureaucracies, including when seeking medical treatment. In addition, housing is likely to be ramshackle (if in a fringe camp), with poor services and facilities, or (if in Housing Commission accommodation) there will be struggles to pay rent or mortgage on limited funds. Unemployment is likely in both situations. As an urban Victorian Aborigine explained,

*Over the past few generations Koories have moved to the cities. In a city existence we face changes that put us under pressure...most modern stresses faced by Koorie can last for a long time. Our days are so often crowded with worries - money, competition, dispossession of our land. We struggle for privacy and solitude, worry about education and housing, and the hassles with the European political situation such as Land Rights, welfare etc. (quoted in Anderson 1988, p.58).*

Bereavement is a major “life event” in any society, and the high premature death rate among Aborigines means that large numbers of individuals are frequently grieving for and burying their relatives. Alan Gray addressed some of the social consequences of mortality and identified parental loss as a major feature of the social disadvantage of children. In his survey he found that the percentage of young Aboriginal people with both parents living decreased from 89% of 11 to 13-year-olds to only 60% of 15 to 19-year-olds (Gray 1987, p.16; Sibthorpe 1988).

Until the Royal Commission into Aboriginal Deaths in Custody established several research units to examine the “underlying issues” surrounding deaths in prisons and police lock-ups, very little broad-based research had been undertaken on the high levels of stress that are now manifesting themselves through suicide, self-mutilation and self-destructive levels of alcohol use and petrol sniffing. Much of the earlier work on the psychological stress and mental health of Aborigines was marred by excessively brief surveys, a reliance on third parties for information, and by patently ethnocentric diagnoses and orientation. Three recent studies stand out as providing a more measured appraisal of the issues. The first of these, by Radford and colleagues (1988/9), examined stress and destructive behaviours among urban Aborigines in Adelaide; the second, by Hunter (1990), analysed suicide, attempted suicide and self-harming behaviours in the Kimberley. The third, a study based at the Central Australian Aboriginal Congress in Alice Springs, documented the extent of disturbed behaviour in the region and Aboriginal perceptions of it (Dunlop 1988).

Radford and colleagues review recent data and alert the reader to what amounts to a crisis situation in which, despite the myriad advances that have taken place over the past 20 or 30 years in Aboriginal affairs, the destructive behaviours are now prevalent at such a level that they signify a deep level of disturbance – “something connected to the loss of hope for practical day-to-day living”:

*Perhaps then it is not surprising that data is emerging to lend credence to the likelihood that increasing suicide amongst Aborigines is symptomatic of a general increase not just in self-destructive behaviours but in all forms of destructive, violent behaviours, substance abuses and unnatural deaths – at least amongst a significant minority of Aboriginal people confined neither to rural nor to urban Australian locations (Radford et al. 1989, p.28).*

At the crisis intervention Youth Support Scheme in Hindley Street, Adelaide, Rosie Moyle, the Aboriginal coordinator of the scheme, identified “threatened or attempted suicide” as the chief presenting problem her workers encounter. She described the Aboriginal kids she sees as being old in their minds although their bodies are young – kids who “grow up too quickly”.

Working in the Kimberley region of Western Australia, Hunter (in a number of published papers) has undertaken some of the most detailed and sensitive cross-cultural

psychiatry to date in Australia. He highlights particularly the psychological vulnerability to suicide and heavy alcohol use of young Aboriginal males, and the distress which both precedes and follows from heavy alcohol use. He suggests that the anxiety and depression felt by these young men is particularly acute because they have borne the brunt of the impact of rapid social changes (Hunter 1988a;1988b).

Apart from these deeper issues, which have wrought profound psychosocial stress in some Aboriginal populations, young Aborigines – particularly those living in urban areas – experience very negative confrontations with the police. This was highlighted in Radford’s study, which documented interactions with police ranging from physical abuse to “unreasonable attention” (i.e. harassment). One-quarter of the urban Aboriginal households in the study reported the frequency of contact with the police as the most stressful matter in their lives (Radford et al. 1989, p.62). Incidents included the following, which relate particularly to young Aborigines:

*My son was riding a new bike; police stopped him in the street to ask him if it was stolen.*

*My kids were accused of stealing their bikes, police came in and searched house...“for guns” they said.*

*Trying to pin things on us that had nothing to do with us...following us continually;*

*Was with a white girl but they only questioned us (Aboriginal boys) while just walking home from town.*

*They were questioning my eldest daughter in Darlington Station (in lock up) they hit and kicked her...She was picked up on warrant for a fine, later realised she was under 18...no further action (Radford et al. 1989 pp.63-4).*

This level of harassment is also documented by Little and Trezise who note that young Aboriginal people predominate in the Children’s Court list in Port Augusta (rural South Australia) out of all proportion to their percentage in the community. One young man charged with several offences was then charged, twice, with failing to walk across a road with due care (Little & Trezise 1991, p.19). Another piece of research documented that 88% of Aboriginal juveniles interviewed reported being hit, punched, kicked or slapped by police, and that Western Australia showed the highest percentage of these incidents (Cuneen 1991). These incidents are far less likely to occur in remote settlements, where there are no police stationed or where, if there are police (as in many Northern Territory communities), community members have more opportunity to monitor the behaviour of police.

In a move away from traditional psychiatry, which has failed to place the subject in an historical as well as a social context, Hunter (1990) examined suicide and self-destructive behaviour within this framework in the Kimberley. He found that deaths from external causes (accidents, poisonings and violence) have risen

dramatically since the early 1970s to a peak between 1982 and 1986, when 22.6% of male deaths were attributable to external causes (ibid., p.193). Self-mutilatory behaviours have also arisen only in recent years, with all those individuals having histories of self-mutilatory behaviour being under 50 years of age, and most are under 35. Hunter shows how this younger age group is composed of the children of people who were young adults in the mid-1960s to 1970s – a period of tumultuous change and destabilisation in the lives of Kimberley people:

*Dislocated and disoriented, such Aborigines had been catapulted without any consideration or preparation from the highly paternalistic structures of station environments into a cash economy...The mid-1960s through the 1970s thus represented a period of dramatic transformations in terms of location, resources, relationships and structure (ibid., p.194).*

Hunter’s work has served to reinforce a growing concern over the responses of young adult Aboriginal men to the social, political and inter-personal stressors in their lives. A recent anthropological study of young Tiwi men (Bathurst or Melville Island, Northern Territory) referred to the changes in Tiwi life which have contributed to

*the precariousness of integration of young men, and to the emergence of the historically new pathological forms implied by the contemporary rise in the number of instances of suicide (Robinson 1990, p.161).*

While Robinson stresses that his work is not to be taken as a contribution to the debate on recent concerns over suicide, it nevertheless provides a precise description of a limited number of cases. He argues that the abandonment of the subsistence economy and the drastic attenuation of adolescent rites of passage into adult status have left young people, particularly young men, in a “cycle of conflict, guilt and hopelessness”. They are trapped in ambivalent, conflict-ridden relationships with their parents, to which the adults respond with defensive withdrawal and sometimes outright rejection and indifference (ibid., p.175). In short, he adds, “young Tiwi men have difficulty dying as children and seeing themselves born again as adults” (ibid., p.176).

Looking specifically at “mental health”, Dunlop’s study (in conjunction with the Congress, Aboriginal health service in Alice Springs), both enumerated and categorised behaviour disorders, and documented the type of servicing and assistance Aborigines said they needed to cope with certain individuals. Dunlop’s study was heavily influenced by Aboriginal perceptions of disordered behaviour (rather than by outside diagnostic categories), and as such provides rare and valuable insights. The most severe problems (of all types) were found in the age range 16 to 45, with generally disruptive behaviour being most common in those under 16. Those who were said to “hear voices” or “move around restlessly” were primarily older people (45 to 65). Petrol sniffers were

included in the study and this practice, together with the disturbed behaviours associated with it, provoked negative reactions from others. Dunlop notes that many families had given up trying to control their sniffing children, and two-fifths of the age group were treated with “indifference” by others. “A community’s tolerance is most likely to be strained by the under 25-year-olds”, she adds (Dunlop 1988 A. p.10, pp.383).

An earlier study had compiled a register of child mental health cases from the northern portion of the Northern Territory. This showed a preponderance of young males, with the greatest number of cases showing up in the age ranges five to nine and 10 to 14. The diagnoses ranged from mental retardation and behaviour problems to brain syndrome (including cerebral palsy and epilepsy) and personality disorder (Webber 1980). “A proportion” of the retarded individuals had suffered serious deprivation and malnutrition. In a broad-ranging study of the Aboriginal population of a town in rural New South Wales, Kamien (1978) documented psychiatric and behaviour disorder, finding that the most common problem among children was bed-wetting – regarded as a symptom of anxiety. Although he found no petrol or glue sniffing, drug taking or regular drinking in young people under 15, he found that

*few of these Aboriginal children possessed the building blocks commonly regarded as desirable for the development of good mental health. They came from families in which quarrelling, alcoholism and physical violence were common, and in which the moods and actions of their parents, especially their fathers, were unpredictable and often inconsistent...Poverty was chronic and often deprived them of the bare necessities of life. Separation from the parents was common owing to the repeated hospitalisation of chronically ill children...(Kamien 1978, p.135).*

More recently, psychiatric problems among young urban Aborigines in Adelaide have led to calls for a special Aboriginal psychiatric unit at the Adelaide Children’s Hospital (Dr J. Jureidini). The Aboriginal Medical Service in Adelaide has no funding to employ a counsellor: their doctors have to act as counsellors as well.

## Interpersonal violence, accidents and poisonings

In view of the publication of the National Report of the Royal Commission into Aboriginal Deaths in Custody (1991), and the preparation of numerous submissions on the “underlying issues” which have influenced the detention and fate of Aboriginal people in police or prison custody, I do not intend to analyse in detail the issue of violent deaths. Several major commissioned papers, including those by Mary Edmunds, Marcia Langton, David Martin and Jo Reser, prepared specifically for the

Royal Commission address these issues in detail.

Accidents, violence and poisonings (“external causes”) are among the leading causes of death for young male Aborigines – but young people in majority populations are also engaging in similar risk-taking behaviour that can have fatal consequences. A National Adolescent Student Health Survey in the US, for example, found that 49% of the boys had been in at least one physical fight in the last year; 23% said that they had carried a knife, and 3% had carried a handgun to school at least once during the past year. In addition, 56% of adolescent students reported that they had not worn a seatbelt the last time they rode in a vehicle (MMWR 1989). When some Aboriginal youths are reported to be drinking and driving, drinking and fighting, chronically using petrol as an inhalant, and dying in high-speed car chases in urban areas, they are engaging in the sort of risk-taking that teenagers and young adults act out in many parts of the world. Graffiti-spraying teenagers in London lean out of train windows to paint and occasionally are killed in the process; “train surfers” in Rio de Janeiro illegally ride the roofs of electric trains, an activity that kills around 150 youngsters a year (*The Age*, 30/4/88). Violent criminal gangs of young “rascals” and “warriors” roam urban streets in Papua New Guinea and the Caribbean, respectively. In a study of drinking in Micronesia, Marshall (1979) explains how contemporary flamboyant drunkenness among young men is a transformation of earlier “warrior” displays:

*Public drunkenness is not a major new problem afflicting youth in Truk, rather it is merely the present-day mode of doing what young men have always done as they progress along the path to full-fledged manhood (Marshall 1979, p.125).*

There have been a few analyses of the place of violence within an Aboriginal cultural context. For example, McKnight (1986) has studied a traditionally-oriented remote community (Mornington Island); Sansom (1980) documents drinking and disputation among Darwin fringe-dwellers; and Langton (1988) has focused on swearing and fighting among contemporary rural NSW Aborigines. These authors stress that such events are “dispute processing and social ordering devices” (Langton 1988, p.202). Langton shows how ritualised swearing and fighting, involving specific codes of action are accepted practice among the Aboriginal community; but they are interpreted differently by the police, who intervene in “an indigenous social process aimed at conflict resolution” (ibid., p.219). Alcohol use, of course, is usually responsible for the transformation of “controlled” or ritualised physical aggression into unsanctioned violence; blows which were aimed at one part of the body fall carelessly on more vulnerable parts, and with more strength than was intended. In this way, an act deemed to be a rightful or justifiable punishment or response becomes a grievous assault.

## Domestic violence and child abuse

The issues of domestic violence, sexual assault and child abuse are now being openly discussed among Aboriginal people throughout the country. It has taken some time for people to bring these issues into the public arena, for previously they were considered too difficult and sensitive, and some Aboriginal women took the view that these matters were not the business of the wider community. Many “outsiders” (researchers, health professionals, legal aid lawyers) observed incidents with growing alarm but usually felt powerless to intervene. Recently the silence of “outsiders” has been broken in Australia (Daylight & Johnstone 1986; Bell 1989; Brady 1990b), as it has elsewhere. Graburn (1987) wrote a courageous article about severe child abuse among Inuit in Canada, saying that he did not want to write the paper, and had in fact “sat on” the information for 15 years. Aboriginal people too are now changing from their earlier reticence, and women particularly are speaking out and initiating a variety of interventions – organising workshops, establishing refuges, arranging counselling and negotiating with police.

This is not the occasion to enter into a debate about the origins and causes of violence and abuse between and among Aboriginal people – the history of their treatment at the hands of the colonisers is well-known. The positive aspects of the contemporary situation are that previously suppressed issues are being aired and that individuals and communities alike are taking action. Perhaps the key Aboriginal individual pursuing these matters is Judy Atkinson, a woman from Queensland who has worked energetically by producing published documents, speaking at conferences, developing resources such as videos, and conducting skills-based workshops (see her publication *Beyond Violence* 1990). Some of the comments from Aboriginal people throughout the country in Atkinson’s booklet highlight the significance of violence and abuse for young Aborigines:

*“Women come into the refuge here with their kids and you can see the next generation. The kids have already been socialised. Putting your fist up, picking up a stick, solves problems.”*

*“A lot of young fellows don’t understand their traditional customs and abuse them – Aboriginal women are being bashed and not enough is being done about it.”*

*“Men make excuses – it’s the old way. But that’s not true. It wasn’t like this in the old times.”*

*“Now young girl get touched by anyone, they broke all her body. If that girl likes that man, all right, but he can’t force it, can’t push himself. She be scared, she has to have feeling. No-one can take your body – that’s her own thing” (quoted in Atkinson 1990, pp.6-7,14).*

Several local workers I met stressed the need for professional help to be made available to families, particularly in the areas of family support and of viable alternatives to violence as a solution to crises. Atkinson quotes an Islander woman:

*Families need help. Who teaches you how to be a parent. Who teaches human relations so you know how to work through the stress of marriage partnerships? And our families! They are the products of 200 years of massacres, removals, dormitories, dispossession. Before they even begin, the burden they carry is pretty heavy (ibid., p.20).*

In Broome a worker involved with Katherine House, a family support unit, drew my attention to the absence of parental models for Aboriginal people who were institutionalised in mission dormitory systems, segregated from their parents, and subjected to a mishmash of authority figures (Wendy Albert, pers. comm.). Whatever beneficial outcomes there may have been from the missionisation of Aboriginal people, missionaries were not experienced in parenting, in relationships between spouses, in providing realistic role models for those in their care. Modelling is crucially important as a learning tool for both urban and remote people. I have already discussed the role of imitation in socialisation with reference to Harris’s work among Arnhem Land people. In addition, an anthropologist from Darwin has compared the different socialisation practices of Aboriginal and non-Aboriginal families in Adelaide, finding that the Aboriginal families taught nurturing and proper behaviour by modelling, while the urban white Australian families relied heavily on verbal controls and instructions (Maylin 1990).

It is important to remember that in many regions the institutionalisation of Aboriginal people meant that adults did not even prepare their own meals – they were served in settlement dining-rooms. This communal feeding was aimed at providing “hygienically prepared and served” food (Middleton & Francis 1976, p.86) and at making sure sufficient food was equally distributed to all. This institutionalised feeding did not only take place in the girls and boys homes of the “settled” south-eastern part of Australia (such as Cootamundra Home) but in bush communities too, such as Yuendumu, NT, (welfare settlement) and Warburton, WA, (United Aborigines Mission). At Warburton the provision of meals and clothing for Aborigines did not cease until the extraordinarily recent date of 1978. Through a complex process in which Aboriginal people in remote regions willingly and unwillingly participated in a progressive dependency upon white administration, many came to believe that whites were there to “help” and to solve a variety of personal, interpersonal and community problems (this is documented particularly well by Myers 1986). In this process, local solutions to a variety of problems were downgraded and lost. The idea, then, that Aboriginal people require additional resources now in

order to recontact and recreate skills in solving interpersonal difficulties, in parenting, in alternatives to violence, is not so fanciful.

The resources available to families, and particularly to women experiencing violence, are differentially distributed in urban and rural Australia. Until very recently there were very few, if any, Aboriginal women's refuges in rural towns or remote communities, compared with metropolitan areas. Daylight and Johnstone, after their consultations with Aboriginal women in 1986, concluded that the use of "mixed" refuges by Aboriginal women depended on the approach of the women who ran them. However, most Aboriginal women said that they would prefer to attend refuges run by Aboriginal people, or at least those employing Aboriginal people on their staff. In Adelaide, for example, an Aboriginal counsellor is employed at the Rape Crisis Centre, and the refuge has Aboriginal staff, which helps to mitigate this alienation.

The disparity between urban and rural resources is beginning to decline. There are refuges in such towns as Port Augusta, Tennant Creek, and Broome, and women in Aboriginal settlements are establishing safe houses, or women's centres that can also function as refuges when necessary. Informal support networks may be stronger in remote communities, but countering this is the fact that

the ethic of non-interference in "private" dispute and violence is probably stronger in these communities. In urban locations, there is a greater range of institutionalised support systems, but it is likely that Aboriginal women feel alienated from these (Daylight & Johnstone 1986). Aboriginal women in cities were reported to be frightened of going to the police for fear of being assaulted by them (*ibid.*, p.66).

It is clear that more resources are going to be required, both for the protection of women and children, and for the rehabilitation and counselling of their assailants. This is undoubtedly needed most acutely in remote areas, where women are highly vulnerable to sexual and physical violence, and where they have been, to some extent, conditioned to accept such actions. The role of what is often termed "customary law" is a confounding factor in these areas, where men (usually spouses) assert that they are allowed by Aboriginal "tradition" to discipline and punish their wives. Customary law submissions have been used in cases of manslaughter as well. Cases in which these arguments are used to mitigate sentencing of male assailants are seen frequently before courts in rural towns. Brady (1990b) has discussed several, and raises some questions about the validity of using these customary arguments to defend violence against women.